WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #1

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SECRETARY OF STATE

NOTICE OF PUBLIC HEARING ON A PROPOSED RULE

AGENCY: Health Care Cost Review Authority TITLE NUMBER: § 16-2D

RULE TYPE: Procedural ; CITE AUTHORITY W. Va. Code, § 16-2D-8

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Not applicable

TITLE OF RULE BEING PROPOSED: Certificate of Need Application Forms

DATE OF PUBLIC HEARING: Thursday, September 1, 1988 TIME: 2:00 p.m.

LOCATION OF PUBLIC HEARING: Large Conference Room
West Virginia Health Care Cost Review Authority
Suite 201, 100 Dee Drive
Charleston, West Virginia 25311

COMMENTS LIMITED TO: ORAL___, WRITTEN___, BOTH X

COMMENTS MAY ALSO BE MAILED TO THE FOLLOWING ADDRESS:
West Virginia Health Care Cost Review Authority
Attn: John H. Kozak
Suite 201, 100 Dee Drive
Charleston, WV 25311

The Department requests that persons wishing to make comments at the hearing make an effort to submit written comments in order to facilitate the review of these comments.

The issues to be heard shall be limited to the proposed rule.

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

Walter J. Bale
WALTER J. BALE
Chairman

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Certificate of Need Application Forms

Type of Rule: _____ Legislative _____ Interpretive __X__ Procedural

Agency Health Care Cost Review Authority

Address Suite 201, 100 Dee Drive
Charleston, WV 25311

1. Effect of Proposed Rule	ANNUAL Increase	ANNUAL Decrease	FISCAL YEAR Current	FISCAL YEAR Next	FISCAL YEAR Thereafter
Estimated Total Cost	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Other					

2. Explanation of above estimates.

The certificate of need division is an ongoing agency. The present forms replace other forms heretofore in general use. Hence, there should not be any impact upon the division's budget.

3. Objectives of these rules:

To simplify, clarify, and tailor the certificate of need application forms to fit the specific type of reviews now permitted by the Act and the implementing legislative rules.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None; except when a state government agency is an applicant. In that case see 4 B. below.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of citizens.

The agency estimates that it costs from $3,000 to $10,000 to complete a certificate of need application form at the present time. It is the intention of the agency to present several forms with each being more closely tailored to the type of review at issue. This should reduce the cost to the applicant.

C. Economic Impact on Citizens/Public at Large.

None.

Date June 28, 1988

Signature of Agency Head or Authorized Representative

Walter J. Dale

WALTER J. DALE
Chairman

Summary

This procedural rule consists of a series of application forms for use by the certificate of need division. Applicants must complete a form in order to initiate a review under the provisions of West Virginia Code, § 16-2D-1 et seq., and the legislative rules pertinent thereto.

STATE OF WEST VIRGINIA

HEALTH CARE COST REVIEW AUTHORITY

CERTIFICATE OF NEED PROGRAM

APPLICATION FOR CERTIFICATE OF NEED REVIEW

CASE FILE NUMBER: _____

(Assigned upon receipt of letter of intent)

GENERAL INFORMATION

1. This application is a general purpose form. Not all items relate to a specific project. If you have any questions about the Certificate of Need process or the applicability of any item to your project, feel free to contact the Certificate of Need Program staff.

2. A letter of intent must be submitted at least fifteen (15) days prior to the application. The letter of intent must include enough information to indicate the name of the project, its approximate location, nature, scope, cost and the time frame for the development of the service.

3. The Certificate of Need staff will review the application for completeness upon its receipt. Within fifteen (15) days, the application will either be declared complete or a request for additional information will be issued.

4. Any amendment to the application must be made in writing. If an amendment is deemed to be substantial by the Certificate of Need Program, the review of the application may be extended or the application may be withdrawn and made subject to a new review cycle.

5. An applicant may withdraw its application at any time without prejudice. Applicants must notify the Certificate of Need Program in writing of such action.

6. Assemble the application in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the page number. In the upper left hand corner of each page, repeat the facility name and case file number. Responses to items on the colored pages should be provided on white paper, repeating each question before providing your response. Those parts of the application printed on white paper should be completed and inserted following the item to which it is referenced.

7. Applicants must provide a signed original as well as four (4) copies of the entire application to:

   Director, Certificate of Need Program
   West Virginia Health Care Cost Review Authority
   100 Dee Drive, Suite 201
   Charleston, West Virginia 25311

   These copies should be submitted in the following manner:

   a. The original and three (3) copies of the application must be in three-ring, hard-back notebooks with alphabetized section dividers.

b. One (1) copy is to be submitted unbound and unstapled, in order that we may use it as a "copy master".

In addition, one (1) copy of the entire application is to be submitted to:

West Virginia Department of Health
Division of Planning
1800 Washington Street, East
Charleston, West Virginia 25305

8. The application and any other material in the case file become public documents and are available for inspection and copying upon request.

9. Data, State Health Plan Standards, and approved need methodologies will be provided by the HCCRA upon request only.

10. Certificate of Need law and regulations may be obtained by contacting:

Administrative Law Division
Secretary of State's Office
Building 1, Suite 157-K
Charleston, West Virginia 25305
(304) 345-4000

SECTION A: IDENTIFICATION OF THE APPLICANT

Note: The applicant is the governing body or person proposing a new institutional health service and who is, or will be, the licensee of the health care facility in which the service will be located. In those cases not involving a licensed health care facility, the governing body or person proposing to provide the service is the applicant. Incorporators or promoters who will not constitute the governing body or person responsible for the new service may not be the applicant.

1. _____
Name of Facility at Which Project Will Be Developed

_____
Project Name

_____
Address

_____
City County State Zip Code

Medicare Provider Number: _____

Medicaid Provider Number: _____

Type of License (attach copy): _____

2. _____
Name of Applicant

_____
Address of Applicant

_____
City County State Zip Code

_____
Name and Title of Chief Executive Officer Telephone

3. Person to contact regarding this application

_____
Name and Title

_____
Organization

_____
Street

_____
City State Zip Code

_____
Telephone

4. Type of Project _____

5. Check the appropriate category which describes the applicant:

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
____Individual	____Corporation	____State
____Partnership	____Church	____County
____General	____Other(Specify)	____Other(Specify)
____Limited	_____	_____
____Corporation		
____Other(Specify)		
_____		

6. Attach certificate of incorporation and filed articles of incorporation or certificate of limited partnership. If out of state corporation, attach a copy of the West Virginia Certificate of Authority. If already submitted with another application, cite name and case file number of project.

7. List the current membership of the Board of Directors and principal officers of the corporation. If partnership, provide the names of all general partners.

8. If an existing facility, list the owner(s) of record if other than the applicant.

SECTION B: AUTHORIZATION TO PURSUE PROJECT

1. Attach a copy of the resolution or minutes of the governing body meeting(s) or certified abstracts wherein this project and any related capital expenditures were approved.

2. Attach written authorization of the governing body empowering the signer of the application, the contact person(s) listed in Section A and any other individuals to act on behalf of the applicant during the course of this review.

SECTION C: DESCRIPTION OF PROJECT

1. Generally describe the project. The description should include:

   --objectives of the project
   --components of the project
   --capital expenditures associated with the project

2. If the facility or service is/will be managed or operated by someone other than the owner, specify and explain the relationship. Attach a copy of the contract or proposed contract under which the facility or service will be managed or operated.

3. Complete this table regardless of the effect the project has on the facility's bed capacity.

BED CLASSIFICATION	LICENSED BEDS	CON APPROVED	TOTAL CURRENT	PROPOSED PROJECT CHANGES		TOTAL PROPOSED BEDS
				INCREASE	DECREASE	
Gen. med/surg (adult)						
Gen. med/surg (pediatric)						
Psychiatric						
Obstetrics						
Orthopedic						
Chemical Detox						
Other acute (specify)						
Swing beds						
Medical/surgical intensive care						
Cardiac intensive care						
Pediatric intensive care						
Neonatal intensive care						
Burn care						
Psychiatric intensive care						
Other special care						
Other intensive are (specify)						
Total acute care						

BED CLASSIFICATION	LICENSED BEDS	CON APPROVED	TOTAL CURRENT	PROPOSED PROJECT CHANGES		TOTAL PROPOSED BEDS
				INCREASE	DECREASE	
Skilled nursing long-term care						
Intermediate long-term care						
Psychiatric long-term care						
Mental retardation						
Personal care						
Respite						
Rehabilitation						
Chronic disease						
Chemical dependency						
Other (specify)						
Total non-acute						
TOTAL FACILITY						

4. Complete the following table for each ancillary service affected by the project. Complete for most recently completed fiscal and first full year of operation after completion of the project. Use separate lines for inpatient and outpatient components of the same service. Define service units used and state all assumptions used on a separate sheet of paper and attach.

SERVICE	CURRENT YEAR ENDING _____		PROJECTED YEAR ENDING _____	
	CAPACITY	UTILIZATION	CAPACITY	UTILIZATION

5. Movable Equipment Cost

Provide a listing of movable equipment associated with project. Major items of equipment valued under $100,000 may be grouped by department or service. In the case of rooms, units, etc., list what common items each will contain. For donated equipment, list appraised value.

a. Equipment To Be Acquired by Purchase or Donation:

EQUIPMENT DESCRIPTION	COST	INSTALLATION RENOVATION	FAIR MARKET VALUE	TOTAL COST
TOTAL				

b. Equipment To Be Acquired by Lease:

EQUIPMENT DESCRIPTION	COST	INSTALLATION RENOVATION	LEASE COST	TOTAL COST
TOTAL				

*Specify terms of maintenance agreement if included in lease payment.

**Complete if the only capital expenditure associated with proosal is for the acquisition of equipment.

6. For construction projects, complete or provide the following for each site under construction:

   a. Description.

   b. Location described in writing and shown on a map.

   c. Acreage.

   d. Purchase cost or documented appraised value. Attach a copy of appraisal report.

   e. Estimated site development cost.

   f. Documentation of availability.

   g. Health Facilities Licensure and Certification Section survey form, if proposed facility is subject to licensure.

7. Provide one full-size set of schematic (single-line) drawings, to scale, of the project which show the relationships of the various departments or services to each other and the room arrangement in each department. Note the name of each room. Include reduced, but readable, copies in your application.

8. Provide a tabulation of square footage for each affected department of the facility and any proposed changes using the following format:

SERVICE/ DEPT.	EXISTING	PROPOSED PROJECT			TOTAL DEPT/ SERVICE WITH PROJECT	COST
		NEW	RENOVATED	DELETED		
TOTAL FACILITY						

9. Capital Cost of Project

Complete if any of the capital expenditure associated with the project is for land or buildings as well as equipment.

Note: Complete only those subitems which apply to your project.

Costs should be based on timetable provided in Section D of this application. Review of cost increases, if necessary, will be based on delays in that timetable or rates of inflation that exceed the assumptions used to calculate costs.

			Subtotal
a.	Site Acquisition Costs:		
	1. Purchase Price	_____	
	2. Closing Costs	_____	
	3. Other (specify)	_____	
	Subtotal (a)		_____
b.	Site Preparation Costs:		
	1. Demolition	_____	
	2. Earthwork	_____	
	3. Site Utilities	_____	
	4. Roads, Parking and Walks	_____	
	5. Other (specify)	_____	
	a.		
	b.		
	c.		
	Subtotal (b)		_____

c. Architectural and Engineering: Subtotal

1. Architectural Fees _____

2. Engineering Fees _____

Subtotal (c) _____

d. Other Consultant Fees:
(List each separately)

1. CON Preparation and Review Fees _____

2. Legal Fees* _____

3. _____ _____

Subtotal (d) _____

* If no specific amount agreed to, state the rate per hour and estimated number of hours.

e. Direct Construction Costs:

1. Cost of Materials _____

2. Cost of Labor _____

3. Fixed Equipment Included in Construction Contract _____

4. Contingency (___%) _____

Subtotal (e) _____

f. Movable Equipment Costs:

(From Question 5 of Section E, page 7) _____

Subtotal (f) _____

g. For all types of financing, complete the applicable items:

		Subtotal
1.	Legal Fees:	
	a. Bond Counsel*	_____
	b. Underwriter's Counsel*	_____
	c. Applicant's Counsel*	_____
	d. Other*	_____

* If no specific amount agreed to, state percentage or rate per hour and estimated number of hours.

2.	Capitalized Interest (Interest earned less interest paid during construction.)	_____
3.	Feasibility Study	_____
4.	Other (Specify):	
	a. _____	_____
	b. _____	_____
	Subtotal (g)	_____

TOTAL PROJECT COST _____

Anticipated construction start and end dates on which cost estimates are based:

_____ and _____

Estimated annual inflation rate used to project costs:

_____

SECTION D: PROJECT TIMETABLE

Provide a timetable for incurring the obligation for any capital expenditure associated with the project and for implementation of the project.

SIGNIFICANT PHASES OF PROJECT	ESTIMATED MONTHS SUBSEQUENT TO CON APPROVAL
a. Land (site) acquired	
b. Final plans and specifications submitted to the HFED	
c. Financing arrangements completed	
d. Initial capital expenditure obligated	
e. Construction contract secured and signed	
f. Construction started	
g. Remaining capital expenditure obligated	
h. Equipment orders submitted	
i. Construction completed	
j. Request for substantial compliance review submitted to CON Program	
k. Project completed and in operation	

SECTION E: THE NEED AND ACCESSIBILITY OF THE POPULATION TO BE SERVED

1. Identify the study area or service area for the proposed project as defined in the State Health Plan. If the identified service area is not defined in the State Health Plan, provide rationale for the area proposed.

2. In all cases, provide an analysis of the need for the project which, at a minimum, should address:

   a. Estimated population of the service area (current year and future five years). (Data provided by the HCCRA shall be used; in addition, the applicant may propose to use other data - in which event, the source of the data must be stated as well as the rationale for using it.)

   b. Calculation of need utilizing the metholology contained in the State Health Plan (data provided by the HCCRA must be used; in addition, a need calculation may be stated based on the data used in response to question 2.a. of this Section E.)

   c. Other need methodologies may be used in the absence of a State Health Plan methodology or to supplement item b. (above).

   d. A map of the service area.

   e. A list of all of the existing providers of similar services and utilization rates for each of them.

3. What are the proposed hours and days of operation for the facility or health services?

4. What arrangements will be made for individuals requiring access to services during those hours that it is not operating?

SECTION F: POLICIES FOR PATIENT ADMISSION AND PROVISION OF UNCOMPENSATED CARE

1. Describe the facility's policies for patient admission as listed; include copies of policies or of proposed policies if available.

a. Medical criteria.

b. Financial criteria.
c. Other criteria related to non-discriminatory access to services and placement.

2. Specifically describe policies for provision of uncompensated care as listed.

a. Note the projected value of 1) uncompensated care and 2) charity care, consistent with financial projections in Section O.

b. Describe admissions screening procedure for medically indigent patients.

c. If applicable, describe the facility's progress in meeting its Hill-Burton obligation or other charity care policies or requirements.

SECTION G: ANALYSIS OF ALTERNATIVES

1. Describe how this proposal is the most desirable alternative as compared to maintaining the status quo and providing the service in a less restrictive setting in terms of:

a. Financial feasibility.

b. Extent of construction, renovation, and related capital costs.

c. Capacity and utilization of existing providers of similar services in proposed service area (refer to Section E, item 2(e).

d. Cost containment.

e. Consumer input and participation.

f. Special considerations (if applicable):

1. Energy efficiency.

2. Improved access for medical and health professional training.

3. Enhancement of biomedical and behavioral research designed to meet a national need.

SECTION H: RELATIONSHIP TO EXISTING HEALTH CARE SYSTEM

1. Describe the project's relationship to the existing health care system in the service area with regard to accessibility and continuity of services.

2. List and describe the nature of all working relationships--formal arrangements that have been made to assure shared and support services. Attach copies of all agreements or proposed agreements.

Service/Facility	Nature of Agreement	Attached/ Will Be Developed

SECTION I: RELATIONSHIP TO THE APPLICANT'S LONG RANGE PLAN

1. Provide a copy of the facility's long range plan if not on file with the HCCRA.

2. Explain the relationship of this proposal to the facility's long-range plan.

SECTION J: RELATIONSHIP TO THE STATE HEALTH PLAN

1. Provide a documented analysis of the project's relationship to the State Health Plan. List each applicable objective in the State Health Plan chapter directly pertaining to the proposal and demonstrate the extent to which the project will meet each of those objectives, and the recommended actions.

SECTION K: ANALYSIS OF COMPETITIVE FACTORS

1. For each service being proposed or affected by this project, respond to the following:

   a. Describe the impact the proposal may have upon the utilization of similar services offered by existing providers in the service area.

   b. Describe the potential impact the proposal will have upon the cost of available services to consumers in the area; provide a comparison of charges for similar services in the proposed service area.

c. Describe the impact the proposal will have upon the quality of such health service(s) in the area.

SECTION L: RELATIONSHIP TO LICENSURE, CERTIFICATION, ACCREDITATION AND SAFETY STANDARDS

1. Describe the extent to which the proposal will be developed and implemented in accordance with state licensure, Medicare/Medicaid certification, accreditation, and fire and life safety code standards.

2. If the proposal serves to correct cited deficiencies in any of the aforementioned standards, explain. Attach copies of prior citations and/or statement of deficiencies and plan of correction.

SECTION M: AVAILABILITY OF NEEDED RESOURCES

1. PROPOSED PLAN FOR FINANCING

Complete applicable items and describe source, type, amount, rate, etc. Attach documentation, letters of commitment, additional information as pertinent.

Type of Financing		Total Amount
____ **Lease** (Check appropriate blanks)		_____
Land ____ Building ____ Equipment ____		
Fair Market Value	$_____	
____ **Cash**		_____
Source: _____		
_____		
____ **Conventional**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
____ **Bonds**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
Debt Service Reserve	$_____	
____ **Gifts**		_____
____ **Grants**		_____

Type of Financing		Total Amount
_____ Land Equity		$_____
_____ Other Owner Equity		$_____
Notes	$_____	
Stock	$_____	
Other	$_____	
TOTAL FINANCING		$_____

2. Complete this schedule of staff required for the services affected by this project.

JOB CLASSIFICATIONS	CURRENT FTEs	PROPOSED FTEs

3. Present evidence of the availability of staff, including the medical staff, for the proposed project. Commitments or tentative commitments from prospective employees should be attached, if available.

4. If any facility-based personnel are to be provided through contractual arrangements, give the name of the secured or potential source(s) and the services to be provided. Attach a copy of a contract, draft contract, or letter of commitment from each source, if available.

SECTION N: POLICIES REGARDING STAFF EMPLOYMENT AND MEDICAL STAFF MEMBERSHIP

1. Provide copies of existing or proposed policies for training and employment of facility staff.

2. Describe the facility's policies and procedures for medical staff membership, including the policy concerning granting staff privileges to allopathic and osteopathic physicians.

3. Describe existing or proposed in-service training programs for the types of employees who are associated with the proposal.

SECTION O: PRELIMINARY FINANCIAL FEASIBILITY

1. Provide historical and projected utilizations for the facility using the following tables. Unless directed otherwise, provide data for the two past fiscal years, current and future fiscal years prior to the project's implementation, and the first two years after completion of the project.

   If this is a start-up project, provide data for the first four years of operations. On a separate sheet, set forth all the assumptions upon which the projections are based.

   INPATIENT DATA
   Provide the month and day for fiscal year ending _____

a. UTILIZATION STATISTICS	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
Inpatient days:				
FY-1 19_____				
FY-2 _____				
FY-3 _____				
FY-4 _____				
FY-5 _____				
FY-6 _____				
Inpatient discharges:				
FY-1 _____				
FY-2 _____				
FY-3 _____				
FY-4 _____				
FY-5 _____				
FY-6 _____				

b. AVERAGE LENGTH OF STAY	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
Inpatient days:				
FY-1 19____				
FY-2 _____				
FY-3 _____				
FY-4 _____				
FY-5 _____				
FY-6 _____				

c. BEDS AND OCCUPANCY	LICENSED BEDS	PERCENTAGE OCCUPANCY LICENSED	BEDS SET UP STAFFED	PERCENTAGE OCCUPANCY SET UP
Inpatient days:				
FY-1 19____				
FY-2 _____				
FY-3 _____				
FY-4 _____				
FY-5 _____				
FY-6 _____				

Service	d. UTILIZATION STATISTICS				
	Value for Standard Units of Measure	FY	FY	FY	FY
1. Operating Room (General)	•Surgery Minutes				
	•Patients				
2. Operating Room (Ambulatory)	•Surgery Minutes				
	•Patients				
3. Operating Room (Open Heart)	•Surgery Minutes				
	•Patients				
4. Delivery and Labor Room	•Births				
5. Outpatient a. Clinic	•Patient Visits				
b. Emergency Room	•Patient Visits				
c. Other_____	•Patients				
d. Psychiatric	•Patient Visits				
6. Cardiac Catheterization	•Procedures				
7. Radiological	•Procedures				
8. CT Scan	•Procedures				
9. MRI Scan	•Procedures				
10. Kidney Transplant	•Procedures				
11. Lithotripsy	•Procedures				

Service	d. UTILIZATION STATISTICS				
	Value for Standard Units of Measure	FY	FY	FY	FY
12. Radiation Therapy	•Procedures				
	•Patients				
13. Home Health	•Visits				
	•Patients				

2. CURRENT AND PROJECTED RATES

Please complete the following table as applicable to any changes or additions of service and/or beds.

	Actual for Current FY	As set by Prior Order	PROJECTED WITH PROPOSAL		
			1st Year	2nd Year	3rd Year
All beds Per diem rate					
Private	_____		_____	_____	_____
Semi Private	_____		_____	_____	_____
Hospitals Average charge per discharge	_____	_____	_____	_____	_____
Average charge per day	_____	_____	_____	_____	_____
All Charge for each proposed new service or for each service affected by the proposal.	_____		_____	_____	_____
	_____		_____	_____	_____
	_____		_____	_____	_____

NOTE: If the applicant is a hospital or if the proposal affects a hospital, as part of the CON order HCCRA will set the rates for the proposal and will adjust previously set revenue limits pursuant to W. Va. Code, §16-2D-1 et seq., if the proposal is approved.

3. Submit statements of 1) revenues and expenses, 2) balance sheets, 3) statements of changes in fund balances, and 4) statements of cash flow for each of last two fiscal years. If audited financial statements have been prepared, submit them. If 10-K Reports are required to be submitted to the Securities Exchange Commission by either the applicant or a related entity, submit them for the preceding three (3) years.

4. Provide a preliminary financial feasibility study including, at a minimum, pro forma financial statements for the current fiscal year and future fiscal years prior to the project's implementation, and the first three years after the project's implementation. State all assumptions used including projected payor mix, charges and/or revenues for each category of payor.

   APPLICANTS SHOULD CONSULT WITH THE CERTIFICATE OF NEED PROGRAM TO DETERMINE THE SCOPE OF THE PRO FORMAS TO BE SUBMITTED.

SECTION P: SPECIAL NEEDS AND CIRCUMSTANCES OF FACILITIES PROVIDING A SUBSTANTIAL PORTION OF SERVICES TO OUT-OF-STATE POPULATIONS

1. If the proposed service will provide a substantial portion of its services or resources to individuals not residing in the project's service area or in West Virginia, document that fact with pertinent information and data.

SECTION Q: COMMUNITY SUPPORT

1. If you wish, you may attach letters of support and endorsement from:

   - the service population at large
   - members of the medical community and provider organizations/institutions/services
   - consumer/civic organizations
   - community service providers

The following affidavit must be completed by the chief executive officer identified in response to question 2 of Section A on page 1.

COUNTY OF _____

STATE OF _____, to wit:

Upon first being duly sworn, I hereby state that, to the best of my information, knowledge, and belief, the information provided in this application is true and correct.

_____
(Signature)

_____
(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____, 19___.

_____
Notary Public

STATE OF WEST VIRGINIA

HEALTH CARE COST REVIEW AUTHORITY

CERTIFICATE OF NEED PROGRAM

AMBULATORY SURGICAL CENTER APPLICATION

Expedited Application for CON Review

CASE FILE NUMBER: _____

(Assigned upon receipt of letter of intent)

GENERAL INFORMATION

1. This application is an expedited Certificate of Need application for the development of ambulatory surgical centers. **ALL QUESTIONS** in this application must be addressed.

2. A letter of intent must be submitted at least fifteen (15) days prior to the application. The letter of intent must include enough information to provide the name of the project, its approximate location, nature, scope, cost and the time frame for the development of the service.

3. The Certificate of Need staff will review the application for completeness upon its receipt. Within fifteen (15) days, the application will be declared complete or a request for additional information issued. Any amendments to the application must be made in writing.

4. It shall be the policy of the HCCRA that a final order should be issued thirty-one (31) days after the date the application was deemed complete, and in no case shall a decision be issued later than (60) days after completeness. If it is determined that the project described in this form is not eligible for expedited review, then a decision will be issued to that effect within seven (7) days, and the applicant will be directed to file a standard application form.

5. Applications may be withdrawn at anytime without prejudice. Applicants must notify the Certificate of Need Program in writing of such action.

6. Assemble the application in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the page number. In the upper left hand corner of each page, repeat the facility name and case file number. Responses to items on the colored pages should be provided on white paper, repeating each question before providing your response. Those parts of the application printed on white paper should be completed and inserted following the item to which it is referenced.

7. Applicants must provide a signed original as well as four (4) copies of the <u>entire</u> application to:

   Director, Certificate of Need Program
   West Virginia Health Care Cost Review Authority
   100 Dee Drive, Suite 201
   Charleston, West Virginia 25311

   and, one (1) copy of the entire application to:

West Virginia Department of Health
Division of Planning
1800 Washington Street, East
Charleston, West Virginia 25305

8. The application and any other material in the case file become public documents and are available for inspection and copying upon request.

WV HCCRA Expedited Application

1. IDENTIFICATION OF THE APPLICANT

A. _____
Name of Facility at Which Project Will Be Developed

_____
Address of Facility

_____
Project Name

B. _____
Name of Applicant

_____
Address of Applicant

_____
Name and Title of Chief Executive Officer Telephone

C. _____
Contact Person

_____
Address Telephone

D. Type of Organization

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
____Individual	____Corporation	____State
____Partnership	____Church	____County
____Corporation	____Other(Specify)	____Other(Specify)
____Other(Specify)		

E. _____
Medicare/Medicaid Provider Numbers

2. AUTHORIZATION

A. Attach articles of Certificate of Incorporation or filed articles of general or limited partnership.

B. List members of board of directors of the corporation, or general partners if a general or limited partnership.

C. Attach a copy of the resolution or minutes of the governing body meeting(s) wherein this project was approved. Also include authorization designating the signer of the application and contact person in question #1 to act on behalf of the applicant.

3. PROJECT DESCRIPTION

Generally describe the project. Include (a) specific services to be provided, (b) proposed service area and population to be served, (c) capacity of the proposed services(s), (d) capital expenditure, (e) projected annual operating expense for the first five (5) years of operation, and (f) general organization and management structure.

4. PROJECT COST

A. Provide detailed information regarding the capital expenditure associated with this project in Table 4.A.

B. Include schematic drawings, site plan, options, lease agreements, and consturction contracts, as applicable.

C. Provide a breakdown of equipment acquisition costs as indicated in Table 4.A, item f.

5. FINANCING

A. Describe the proposed method of financing the project in Table 5.

B. Does the project require any refinancing? If so, explain financing details.

C. Indicate the project's requirement for new working capital, including requirement due to start-up expenses. Indicate source of funds. If working capital is to be borrowed, indicate principal, interest rate and term. Also indicate the total working capital to be financed.

6. TIMETABLE

Provide a timetable for implementation of this project in Table 6.

7. NEED ANALYSIS

Provide an analysis of the need for the proposed service based upon five year population projections for the service area and consistent with the State Health Plan objectives.

8. CONSISTENCY WITH THE STATE HEALTH PLAN

Provide an analysis of the project's consistency with the State Health Plan. List each applicable objective and standard in the Day Surgery Standards of the State Health Plan and demonstrate the extent to which the project meets each of these objectives.

9. FINANCIAL FEASIBILITY

For each of the most recently completed fiscal year, the current and next future fiscal years prior to the project's full completion, and for the first three years of operation after completion, submit the following information as applicable:

A. Financial statements:

9.A.1 Statements of Revenues and Expenses

9.A.2 Balance Sheets

9.A.3 Statements of Changes in Fund Balances or Financial Position

B. Provide a listing of assumptions utilized in the preparation of the financial statements including staffing and salaries, expenses, utilization data, fee schedule or charges, and projected revenues based on payor mix in Table 9.B.

10. AVALIABILITY OF HEALTH SERVICES

A. Describe the relationship of this project to the existing health care system in the service area.

B. How will this proposal enhance the availability of day surgical services to the population?

C. How will the proposed service affect the utilization and operation of existing health care facilities in the service area?

11. COST CONTAINMENT

A. Describe how this proposal will result in the efficient and effective delivery of day surgical services.

B. Discuss the availability of needed resources.

C. What alternatives to the development of this proposal were considered?

12. FACILITY POLICIES

A. How will the proposal fulfill the needs of medically indigent persons?

B. Describe the facility's policies for admission of patients.

13. LETTERS OF SUPPORT

Attach letters of support and endorsements, if any.

14. SIGNATURE

COUNTY OF _____

STATE OF _____, to wit:

Upon first being duly sworn, I hereby state that, to the best of my knowledge and belief, the information provided in this application is true and correct.

_____
(Signature)

_____
(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____, 19___.

_____
Notary Public

(SEAL)

TABLE 4.A

CAPITAL COST OF PROJECT

Complete if any of the capital expenditure associated with the project is for land or buildings as well as equipment.

Anticipated construction start date on which cost estimates are based:

_____.

Estimated annual inflation rate used to project costs:

_____.

Note: Complete only those subitems which apply to your project.

Costs should be based on timetable provided in Question 6 of this application. Review of cost increases, if necessary, will be based on delays in that timetable or rates of inflation that exceed the assumptions used to calculate costs.

			Subtotal
a.	Site Acquisition Costs:		
	1. Purchase Price	_____	
	2. Closing Costs	_____	
	3. Other (specify)	_____	
	Subtotal (a)		_____
b.	Site Preparation Costs:		
	1. Demolition	_____	
	2. Earthwork	_____	
	3. Site Utilities	_____	
	4. Roads, Parking and Walks	_____	
	5. Other (specify)	_____	
	a.		
	b.		
	c.		
	Subtotal (b)		_____

TABLE 4.A (cont'd)

c. Architectural and Engineering: Subtotal

1. Architectural Fees _____

2. Engineering Fees _____

Subtotal (c) _____

d. Other Consultant Fees:
(List each separately)

1. _____

2. _____

3. _____

Subtotal (d) _____

e. Direct Construction Costs:

1. Cost of materials _____

2. Cost of Labor _____

3. Fixed Equipment Included in Construction Contract _____

4. Contingency (____%) _____

Subtotal (e) _____

f. Equipment Costs:

[From Question 4 (c)] _____

Subtotal (f) _____

TABLE 4.A (cont'd)

g. For all types of financing, complete the applicable items:

		Subtotal
1. Legal Fee:		
a. Bond Counsel	_____	
b. Underwriter's Counsel	_____	
c. Applicant's Counsel	_____	
d. Other	_____	
2. Capitalized Interest (Interest earned less interest paid during construction.)	_____	
3. Feasibility Study	_____	
4. Other (Specify):		
a.	_____	
b.	_____	
c.	_____	
Subtotal (g)		_____
TOTAL PROJECT COST		_____

TABLE 5.A

PROPOSED PLAN FOR FINANCING

Complete applicable items and describe source, type, amount, rate, etc. Attach documentation, letters of commitment, additional information as pertinent.

Type of Financing		Total Amount
____ **Lease** (Check appropriate blanks)		_____
Land ____ Building ____ Equipment ____		
Fair Market Value	$_____	
____ **Cash**		_____
Source: _____		
_____		
____ **Conventional**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
____ **Bonds**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
Debt Service Reserve	$_____	
____ **Gifts**		_____
____ **Grants**		_____

TABLE 5.A (cont'd)

____ Land Equity		_____
____ Other Owner Equity		_____
Notes	$_____	
Stock	$_____	
Other	$_____	
TOTAL FINANCING		_____

TABLE 6

PROJECT TIMETABLE

Provide a timetable for incurring the obligation for any capital expenditure associated with the project and for implementation of the project.

		Estimated Months Subsequest To CON Approval
a.	Land (site) acquired:	
b.	Final plans and specifications submitted to the HFLC&S:	
c.	Financing arrangements completed:	
d.	Initial capital expenditure obligated:	
e.	Construction contract secured and signed:	
f.	Construction started:	
g.	Remaining capital expenditure obligated:	
h.	Equipment orders submitted:	
i.	Construction completed:	
j.	Request for substantial compliance review submitted to CON Program:	
k.	Project completed and in operation:	

TABLE 9.B

Provide the following information for the most recently completed fiscal year, current and future fiscal years prior to the project's completion and for the first year of operation after completion of the project. State all assumptions upon which the projections are based.

Year Ending _____

	Gross Revenue	Allowance	Net Revenue
Medicare			
Medicaid			
Blue Cross/ Blue Shield			
Commercial Insurance			
Self Pay			
Other			
Total*			

* Total should correspond to operating revenue shown on pro-forma revenue and expense statements submitted for first year of operation.

STATE OF WEST VIRGINIA

HEALTH CARE COST REVIEW AUTHORITY

CERTIFICATE OF NEED PROGRAM

AMBULATORY HEALTH CARE FACILITY APPLICATION

Expedited Application for CON and 1122 Reviews

CASE FILE NUMBER: _____
(Assigned upon receipt of letter of intent)

GENERAL INFORMATION

1. This application is an expedited Certificate of Need application for the development of ambulatory care centers (including primary care centers or community health centers, satellite clinics, urgent care centers, etc.). **ALL QUESTIONS** in this application must be addressed.

2. A letter of intent must be submitted at least fifteen (15) days prior to the application. The letter of intent must include enough information to provide the name of the project, its approximate location, nature, scope, cost and the time frame for the development of the service.

3. The Certificate of Need staff will review the application for completeness upon its receipt. Within fifteen (15) days, the application will be declared complete or a request for additional information issued. Any amendments to the application must be made in writing.

4. It shall be the policy of the HCCRA that a final order should be issued thirty-one (31) days after the date the application was deemed complete, and in no case shall a decision be issued later than (60) days after completeness. If it is determined that the project described in this form is not eligible for expedited review, then a decision will be issued to that effect within seven (7) days, and the applicant will be directed to file a standard application form.

5. Applications may be withdrawn at anytime without prejudice. Applicants must notify the Certificate of Need Program in writing of such action.

6. Assemble the application in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the page number. In the upper left hand corner of each page, repeat the facility name and case file number. Responses to items on the colored pages should be provided on white paper, repeating each question before providing your response. Those parts of the application printed on white paper should be completed and inserted following the item to which it is referenced.

7. Applicants must provide a signed original as well as four (4) copies of the entire application to:

   Director, Certificate of Need Program
   West Virginia Health Care Cost Review Authority
   100 Dee Drive, Suite 201
   Charleston, West Virginia 25311

   and, one (1) copy of the entire application to:

West Virginia Department of Health
Division of Planning
1800 Washington Street, East
Charleston, West Virginia 25305

8. The application and any other material in the case file become public documents and are available for inspection and copying upon request.

WV HCCRA Expedited Application

1. IDENTIFICATION OF THE APPLICANT

A. _____
Name of Facility at Which Project Will Be Developed

_____
Address of Facility

_____
Project Name

B. _____
Name of Applicant

_____
Address of Applicant

_____
Name and Title of Chief Executive Officer Telephone

C. _____
Contact Person

_____
Address Telephone

D. Type of Organization

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
____Individual	____Corporation	____State
____Partnership	____Church	____County
____Corporation	____Other(Specify)	____Other(Specify)
____Other(Specify)		

E. _____
Medicare/Medicaid Provider Numbers

2. AUTHORIZATION

A. Attach articles of Certificate of Incorporation or filed articles of general or limited partnership.

B. List members of board of directors of the corporation, or general partners if a general or limited partnership.

C. Attach a copy of the resolution or minutes of the governing body meeting(s) wherein this project was approved. Also include authorization designating the signer of the application and contact person in question #1 to act on behalf of the applicant.

3. PROJECT DESCRIPTION

Generally describe the project. Include (a) specific services to be provided, (b) proposed service area and population to be served, (c) capacity of the proposed services(s), (d) capital expenditure, (e) projected annual operating expense for the first five (5) years of operation, and (f) general organization and management structure.

4. PROJECT COST

A. Provide detailed information regarding the capital expenditure associated with this project in Table 4.A.

B. Include schematic drawings, site plan, options, lease agreements, and consturction contracts, as applicable.

C. Provide a breakdown of equipment acquisition costs as indicated in Table 4.A, item f.

5. FINANCING

A. Describe the proposed method of financing the project in Table 5.

B. Does the project require any refinancing? If so, explain financing details.

C. Indicate the project's requirement for new working capital, including requirement due to start-up expenses. Indicate source of funds. If working capital is to be borrowed, indicate principal, interest rate and term. Also indicate the total working capital to be financed.

6. TIMETABLE

Provide a timetable for implementation of this project in Table 6.

7. NEED ANALYSIS

Provide an analysis of the need for the proposed service based upon five year population projections for the service area and consistent with the State Health Plan objectives.

8. CONSISTENCY WITH THE STATE HEALTH PLAN

Provide an analysis of the project's consistency with the State Health Plan. List each applicable objective and standard in the Primary Care Chapter of the State Health Plan and demonstrate the extent to which the project meets each of these objectives.

9. FINANCIAL FEASIBILITY

For each of the most recently completed fiscal year, the current and next future fiscal years prior to the project's full completion, and for the first three years of operation after completion, submit the following information as applicable:

A. Financial statements:

9.A.1 Statements of Revenues and Expenses

9.A.2 Balance Sheets

9.A.3 Statements of Changes in Fund Balances or Financial Position

B. Provide a listing of assumptions utilized in the preparation of the financial statements including staffing and salaries, expenses, utilization data, fee schedule or charges, and projected revenues based on payor mix in Table 9.B.

10. AVALIABILITY OF HEALTH SERVICES

A. Describe the relationship of this project to the existing health care system in the service area.

B. How will this proposal enhance the availability of primary care services to the population?

C. How will the proposed service affect the utilization and operation of existing health care facilities in the service area?

11. COST CONTAINMENT

A. Describe how this proposal will result in the efficient and effective delivery of primary care services.

B. Discuss the availability of needed resources.

C. What alternatives to the development of this proposal were considered?

12. FACILITY POLICIES

A. How will the proposal fulfill the needs of medically indigent persons?

B. Describe the facility's policies for admission of patients.

13. LETTERS OF SUPPORT

Attach letters of support and endorsements, if any.

14. SIGNATURE

COUNTY OF _____

STATE OF _____, to wit:

Upon first being duly sworn, I hereby state that, to the best of my knowledge and belief, the information provided in this application is true and correct.

_____
(Signature)

_____
(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____, 19___.

_____
Notary Public

(SEAL)

TABLE 4.A

CAPITAL COST OF PROJECT

Complete if any of the capital expenditure associated with the project is for land or buildings as well as equipment.

Anticipated construction start date on which cost estimates are based:

_____.

Estimated annual inflation rate used to project costs:

_____.

Note: Complete only those subitems which apply to your project.

Costs should be based on timetable provided in Question 6 of this application. Review of cost increases, if necessary, will be based on delays in that timetable or rates of inflation that exceed the assumptions used to calculate costs.

		Subtotal
a.	Site Acquisition Costs:	
	1. Purchase Price _____	
	2. Closing Costs _____	
	3. Other (specify) _____	
	Subtotal (a)	_____
b.	Site Preparation Costs:	
	1. Demolition _____	
	2. Earthwork _____	
	3. Site Utilities _____	
	4. Roads, Parking and Walks _____	
	5. Other (specify) _____	
	a.	
	b.	
	c.	
	Subtotal (b)	_____

TABLE 4.A (cont'd)

c.	Architectural and Engineering:		Subtotal
	1. Architectural Fees	_____	
	2. Engineering Fees	_____	
	Subtotal (c)		_____
d.	Other Consultant Fees: (List each separately)		
	1.	_____	
	2.	_____	
	3.	_____	
	Subtotal (d)		_____
e.	Direct Construction Costs:		
	1. Cost of materials	_____	
	2. Cost of Labor	_____	
	3. Fixed Equipment Included in Construction Contract	_____	
	4. Contingency (___%)	_____	
	Subtotal (e)		_____
f.	Equipment Costs:		
	[From Question 4 (c)]	_____	
	Subtotal (f)		_____

TABLE 4.A (cont'd)

g. For all types of financing, complete the applicable items:

		Subtotal
1.	Legal Fee:	
	a. Bond Counsel	
	b. Underwriter's Counsel	
	c. Applicant's Counsel	
	d. Other	
2.	Capitalized Interest (Interest earned less interest paid during construction.)	
3.	Feasibility Study	
4.	Other (Specify):	
	a.	
	b.	
	c.	
	Subtotal (g)	

TOTAL PROJECT COST

TABLE 5.A

PROPOSED PLAN FOR FINANCING

Complete applicable items and describe source, type, amount, rate, etc. Attach documentation, letters of commitment, additional information as pertinent.

Type of Financing		Total Amount
____ **Lease** (Check appropriate blanks)		_____
Land ____ Building ____ Equipment ____		
Fair Market Value	$_____	
____ **Cash**		_____
Source: _____		
_____		
____ **Conventional**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
____ **Bonds**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
Debt Service Reserve	$_____	
____ **Gifts**		_____
____ **Grants**		_____

TABLE 5.A (cont'd)

____ Land Equity		_____
____ Other Owner Equity		_____
Notes	$_____	
Stock	$_____	
Other	$_____	
TOTAL FINANCING		_____

TABLE 6

PROJECT TIMETABLE

Provide a timetable for incurring the obligation for any capital expenditure associated with the project and for implementation of the project.

		Estimated Months Subsequest To CON Approval
a.	Land (site) acquired:	
b.	Final plans and specifications submitted to the HFLC&S:	
c.	Financing arrangements completed:	
d.	Initial capital expenditure obligated:	
e.	Construction contract secured and signed:	
f.	Construction started:	
g.	Remaining capital expenditure obligated:	
h.	Equipment orders submitted:	
i.	Construction completed:	
j.	Request for substantial compliance review submitted to CON Program:	
k.	Project completed and in operation:	

TABLE 9.B

Provide the following information for the most recently completed fiscal year, current and future fiscal years prior to the project's completion and for the first year of operation after completion of the project. State all assumptions upon which the projections are based.

Year Ending _____

	Gross Revenue	Allowance	Net Revenue
Medicare			
Medicaid			
Blue Cross/ Blue Shield			
Commercial Insurance			
Self Pay			
Other			
Total*			

* Total should correspond to operating revenue shown on pro-forma revenue and expense statements submitted for first year of operation.

STATE OF WEST VIRGINIA

HEALTH CARE COST REVIEW AUTHORITY

CERTIFICATE OF NEED PROGRAM

APPLICATION FOR THE PROVISION OF HOME HEALTH CARE SERVICES

Expedited Application for CON and 1122 Reviews

CASE FILE NUMBER: _____

(Assigned upon receipt of letter of intent)

GENERAL INFORMATION

1. This application is an expedited Certificate of Need application for the development of home health services. **ALL QUESTIONS** in this application must be addressed.

2. A letter of intent must be submitted at least fifteen (15) days prior to the application. The letter of intent must include enough information to provide the name of the project, its approximate location, nature, scope, cost and the time frame for the development of the service.

3. The Certificate of Need staff will review the application for completeness upon its receipt. Within fifteen (15) days, the application will be declared complete or a request for additional information issued. Any amendments to the application must be made in writing.

4. It shall be the policy of the HCCRA that a final order should be issued thirty-one (31) days after the date the application was deemed complete, and in no case shall a decision be issued later than (60) days after completeness. If it is determined that the project described in this form is not eligible for expedited review, then a decision will be issued to that effect within seven (7) days, and the applicant will be directed to file a standard application form.

5. Applications may be withdrawn at anytime without prejudice. Applicants must notify the Certificate of Need Program in writing of such action.

6. Assemble the application in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the page number. In the upper left hand corner of each page, repeat the facility name and case file number. Responses to items on the colored pages should be provided on white paper, repeating each question before providing your response. Those parts of the application printed on white paper should be completed and inserted following the item to which it is referenced.

7. Applicants must provide a signed original as well as four (4) copies of the entire application to:

   Director, Certificate of Need Program
   West Virginia Health Care Cost Review Authority
   100 Dee Drive, Suite 201
   Charleston, West Virginia 25311

   and, one (1) copy of the entire application to:

West Virginia Department of Health
Division of Planning
1800 Washington Street, East
Charleston, West Virginia 25305

8. The application and any other material in the case file become public documents and are available for inspection and copying upon request.

WV HCCRA Expedited Application

1. IDENTIFICATION OF THE APPLICANT

A. _____
Name of Facility at Which Project Will Be Developed

_____
Address of Facility

_____
Project Name

B. _____
Name of Applicant

_____
Address of Applicant

_____
Name and Title of Chief Executive Officer Telephone

C. _____
Contact Person

_____
Address Telephone

D. Type of Organization

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
____Individual	____Corporation	____State
____Partnership	____Church	____County
____Corporation	____Other(Specify)	____Other(Specify)
____Other(Specify)		

E. _____
Medicare/Medicaid Provider Numbers

2. AUTHORIZATION

A. Attach articles of Certificate of Incorporation or filed articles of general or limited partnership.

B. List members of board of directors of the corporation, or general partners if a general or limited partnership.

C. Attach a copy of the resolution or minutes of the governing body meeting(s) wherein this project was approved. Also include authorization designating the signer of the application and contact person in question #1 to act on behalf of the applicant.

3. PROJECT DESCRIPTION

Generally describe the project. Include (a) specific services to be provided, (b) proposed service area and population to be served, (c) capacity of the proposed services(s), (d) capital expenditure, (e) projected annual operating expense for the first five (5) years of operation, and (f) general organization and management structure.

4. PROJECT COST

A. Provide information regarding any capital expenditure associated with this project including a listing of equipment.

B. Provide information regarding office space including a copy of lease or rent agreement.

5. FINANCING

A. If there is a capital expenditure associated with the proposal, complete Table 5.

B. Indicate the project's requirement for new working capital, including requirement due to start-up expenses. Indicate source of funds. If working capital is to be borrowed, indicate principal, interest rate and term. Also indicate the total working capital to be financed.

6. TIMETABLE

Provide a timetable for implementation of this project in Table 6.

7. NEED ANALYSIS

Provide an analysis of the need for the proposed service by county using the methodology contained in the State Health Plan.

8. CONSISTENCY WITH THE STATE HEALTH PLAN

Provide an analysis of the project's consistency with the State Health Plan. List each applicable objective and standard in the Long-Term Care Chapter of the State Health Plan and demonstrate the extent to which the project meets each of these objectives.

9. FINANCIAL FEASIBILITY

For each of the most recently completed fiscal year, the current and next future fiscal years prior to the project's full completion, and for the first three years of operation after completion, submit the following information as applicable:

A. Financial statements:

9.A.1 Statements of Revenues and Expenses

9.A.2 Balance Sheets

9.A.3 Statements of Changes in Fund Balances or Financial Position

B. Provide a listing of assumptions utilized in the preparation of the financial statements including staffing and salaries, expenses, utilization data, fee schedule or charges, and projected revenues based on payor mix in Table 9.B.

10. AVALIABILITY OF HEALTH SERVICES

A. Describe the relationship of this project to the existing health care system in the service area.

B. How will this proposal enhance the availability of home health care to medically underserved areas.

C. How will the proposed service affect the utilization and operation of existing health services in the service area?

11. COST CONTAINMENT

A. Describe how this proposal will result in the efficient and effective delivery of home health care services.

B. Discuss the availability of needed resources.

C. What alternatives to the development of this proposal were considered?

12. FACILITY POLICIES

A. How will the proposal fulfill the needs of medically indigent persons?

B. What is your policy for acceptance of patients?

13. LETTERS OF SUPPORT

Attach letters of support and endorsements, if any.

14. SIGNATURE

COUNTY OF _____

STATE OF _____, to wit:

Upon first being duly sworn, I hereby state that, to the best of my knowledge and belief, the information provided in this application is true and correct.

_____
(Signature)

_____
(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____, 19____.

_____
Notary Public

(SEAL)

TABLE 5.A

PROPOSED PLAN FOR FINANCING

Complete applicable items and describe source, type, amount, rate, etc. Attach documentation, letters of commitment, additional information as pertinent.

Type of Financing		Total Amount
____ **Lease** (Check appropriate blanks)		_____
Land ____ Building ____ Equipment ____		
Fair Market Value	$_____	
____ **Cash**		_____
Source: _____		
_____		
____ **Conventional**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
____ **Bonds**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
Debt Service Reserve	$_____	
____ **Gifts**		_____
____ **Grants**		_____

TABLE 5.A (cont'd)

____ Land Equity		_____
____ Other Owner Equity		_____
Notes	$_____	
Stock	$_____	
Other	$_____	
TOTAL FINANCING		_____

TABLE 6

PROJECT TIMETABLE

Provide a timetable for incurring the obligation for any capital expenditure associated with the project and for implementation of the project.

		Estimated Months Subsequest To CON Approval
a.	Land (site) acquired:	_____
b.	Final plans and specifications submitted to the HFLC&S:	_____
c.	Financing arrangements completed:	_____
d.	Initial capital expenditure obligated:	_____
e.	Construction contract secured and signed:	_____
f.	Construction started:	_____
g.	Remaining capital expenditure obligated:	_____
h.	Equipment orders submitted:	_____
i.	Construction completed:	_____
j.	Request for substantial compliance review submitted to CON Program:	_____
k.	Project completed and in operation:	_____

TABLE 9.B

Provide the following information for the most recently completed fiscal year, current and future fiscal years prior to the project's completion and for the first year of operation after completion of the project. State all assumptions upon which the projections are based.

Year Ending _____

	Gross Revenue	Allowance	Net Revenue
Medicare			
Medicaid			
Blue Cross/ Blue Shield			
Commercial Insurance			
Self Pay			
Other			
Total*			

* Total should correspond to operating revenue shown on pro-forma revenue and expense statements submitted for first year of operation.

STATE OF WEST VIRGINIA

HEALTH CARE COST REVIEW AUTHORITY

CERTIFICATE OF NEED PROGRAM

BEHAVIORAL HEALTH GROUP HOME APPLICATION

Expedited Application for CON and 1122 Reviews

CASE FILE NUMBER: _____

(Assigned upon receipt of letter of intent)

GENERAL INFORMATION

1. This application is an expedited Certificate of Need application for the development of behavioral health group homes. **ALL QUESTIONS** in this application must be addressed.

2. A letter of intent must be submitted at least fifteen (15) days prior to the application. The letter of intent must include enough information to provide the name of the project, its approximate location, nature, scope, cost and the time frame for the development of the service.

3. The Certificate of Need staff will review the application for completeness upon its receipt. Within fifteen (15) days, the application will be declared complete or a request for additional information issued. Any amendments to the application must be made in writing.

4. It shall be the policy of the HCCRA that a final order should be issued thirty-one (31) days after the date the application was deemed complete, and in no case shall a decision be issued later than (60) days after completeness. If it is determined that the project described in this form is not eligible for expedited review, then a decision will be issued to that effect within seven (7) days, and the applicant will be directed to file a standard application form.

5. Applications may be withdrawn at anytime without prejudice. Applicants must notify the Certificate of Need Program in writing of such action.

6. Assemble the application in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the page number. In the upper left hand corner of each page, repeat the facility name and case file number. Responses to items on the colored pages should be provided on white paper, repeating each question before providing your response. Those parts of the application printed on white paper should be completed and inserted following the item to which it is referenced.

7. Applicants must provide a signed original as well as four (4) copies of the entire application to:

   Director, Certificate of Need Program
   West Virginia Health Care Cost Review Authority
   100 Dee Drive, Suite 201
   Charleston, West Virginia 25311

   and, one (1) copy of the entire application to:

West Virginia Department of Health
Division of Planning
1800 Washington Street, East
Charleston, West Virginia 25305

8. The application and any other material in the case file become public documents and are available for inspection and copying upon request.

WV HCCRA Expedited Application

1. IDENTIFICATION OF THE APPLICANT

A. _____
Name of Facility at Which Project Will Be Developed

_____
Address of Facility

_____
Project Name

B. _____
Name of Applicant

_____
Address of Applicant

_____
Name and Title of Chief Executive Officer Telephone

C. _____
Contact Person

_____
Address Telephone

D. Type of Organization

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
____Individual	____Corporation	____State
____Partnership	____Church	____County
____Corporation	____Other(Specify)	____Other(Specify)
____Other(Specify)		

E. _____
Medicare/Medicaid Provider Numbers

2. AUTHORIZATION

A. Attach articles of Certificate of Incorporation or filed articles of general or limited partnership.

B. List members of board of directors of the corporation, or general partners if a general or limited partnership.

C. Attach a copy of the resolution or minutes of the governing body meeting(s) wherein this project was approved. Also include authorization designating the signer of the application and contact person in question #1 to act on behalf of the applicant.

3. PROJECT DESCRIPTION

Generally describe the project. Include (a) specific services to be provided, (b) proposed service area and population to be served, (c) capacity of the proposed services(s), (d) capital expenditure, (e) number and type of beds or proposed certification, (5) years of operation, and (f) general organization and management structure.

4. PROJECT COST

A. Provide detailed information regarding the capital expenditure associated with this project in Table 4.A.

B. Include schematic drawings, site plan, options, lease agreements, and consturction contracts, as applicable.

C. Provide a breakdown of equipment acquisition costs as indicated in Table 4.A, item f.

5. FINANCING

A. Describe the proposed method of financing the project in Table 5.

B. Does the project require any refinancing? If so, explain financing details.

C. Indicate the project's requirement for new working capital, including requirement due to start-up expenses. Indicate source of funds. If working capital is to be borrowed, indicate principal, interest rate and term. Also indicate the total working capital to be financed.

6. TIMETABLE

Provide a timetable for implementation of this project in Table 6.

7. NEED ANALYSIS

Provide an analysis of the need for the proposed service based upon five year population projections for the service area and consistent with the State Health Plan objectives.

8. CONSISTENCY WITH THE STATE HEALTH PLAN

Provide an analysis of the project's consistency with the State Health Plan. List each applicable objective and standard in the Behavioral Health Chapter of the State Health Plan and demonstrate the extent to which the project meets each of these objectives.

9. FINANCIAL FEASIBILITY

For the current and next future fiscal years prior to the project's full completion, and for the first three years of operation after completion, submit the following information as applicable:

A. Financial statements:

9.A.1 Statements of Revenues and Expenses

9.A.2 Balance Sheets

9.A.3 Statements of Changes in Fund Balances or Financial Position

B. Provide a listing of assumptions utilized in the preparation of the financial statements including staffing and salaries, expenses, utilization data, fee schedule or charges, and projected revenues based on payor mix in Table 9.B.

10. AVALIABILITY OF HEALTH SERVICES

A. Describe the relationship of this project to the existing health care system in the service area.

B. How will this proposal enhance the availability of primary care services to the population?

C. How will the proposed service affect the utilization and operation of existing health care facilities in the service area?

11. COST CONTAINMENT

A. Describe how this proposal will result in the efficient and effective delivery of primary care services.

B. Discuss the availability of needed resources.

C. What alternatives to the development of this proposal were considered?

12. FACILITY POLICIES

A. How will the proposal fulfill the needs of medically indigent persons?

B. Describe the facility's policies for admission of patients.

13. LETTERS OF SUPPORT

Attach letters of support and endorsements, if any.

14. SIGNATURE

COUNTY OF _____

STATE OF _____, to wit:

Upon first being duly sworn, I hereby state that, to the best of my knowledge and belief, the information provided in this application is true and correct.

_____
(Signature)

_____
(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____, 19___.

_____
Notary Public

(SEAL)

TABLE 4.A

CAPITAL COST OF PROJECT

Complete if any of the capital expenditure associated with the project is for land or buildings as well as equipment.

Anticipated construction start date on which cost estimates are based:

_____.

Estimated annual inflation rate used to project costs:

_____.

Note: Complete only those subitems which apply to your project.

Costs should be based on timetable provided in Question 6 of this application. Review of cost increases, if necessary, will be based on delays in that timetable or rates of inflation that exceed the assumptions used to calculate costs.

			Subtotal
a.	Site Acquisition Costs:		
	1. Purchase Price	_____	
	2. Closing Costs	_____	
	3. Other (specify)	_____	
	Subtotal (a)		_____
b.	Site Preparation Costs:		
	1. Demolition	_____	
	2. Earthwork	_____	
	3. Site Utilities	_____	
	4. Roads, Parking and Walks	_____	
	5. Other (specify)	_____	
	a.		
	b.		
	c.		
	Subtotal (b)		_____

TABLE 4.A (cont'd)

c. Architectural and Engineering: Subtotal

1. Architectural Fees _____

2. Engineering Fees _____

Subtotal (c) _____

d. Other Consultant Fees:
(List each separately)

1. _____

2. _____

3. _____

Subtotal (d) _____

e. Direct Construction Costs:

1. Cost of materials _____

2. Cost of Labor _____

3. Fixed Equipment Included in Construction Contract _____

4. Contingency (___%) _____

Subtotal (e) _____

f. Equipment Costs:

[From Question 4 (c)] _____

Subtotal (f) _____

TABLE 4.A (cont'd)

g. For all types of financing, complete the applicable items:

		Subtotal
1.	Legal Fee:	
	a. Bond Counsel	
	b. Underwriter's Counsel	
	c. Applicant's Counsel	
	d. Other	
2.	Capitalized Interest (Interest earned less interest paid during construction.)	
3.	Feasibility Study	
4.	Other (Specify):	
	a.	
	b.	
	c.	
	Subtotal (g)	

TOTAL PROJECT COST

TABLE 5.A

PROPOSED PLAN FOR FINANCING

Complete applicable items and describe source, type, amount, rate, etc. Attach documentation, letters of commitment, additional information as pertinent.

Type of Financing		Total Amount
____ **Lease** (Check appropriate blanks)		_____
Land ____ Building ____ Equipment ____		
Fair Market Value	$_____	
____ **Cash**		_____
Source: _____		
_____		
____ **Conventional**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
____ **Bonds**		_____
Principal	$_____	
Interest	$_____	
Term	$_____	
Debt Service Reserve	$_____	
____ **Gifts**		_____
____ **Grants**		_____

TABLE 5.A (cont'd)

____ Land Equity		_____
____ Other Owner Equity		_____
Notes	$_____	
Stock	$_____	
Other	$_____	
TOTAL FINANCING		_____

TABLE 6

PROJECT TIMETABLE

Provide a timetable for incurring the obligation for any capital expenditure associated with the project and for implementation of the project.

		Estimated Months Subsequest To CON Approval
a.	Land (site) acquired:	_____
b.	Final plans and specifications submitted to the HFLC&S:	_____
c.	Financing arrangements completed:	_____
d.	Initial capital expenditure obligated:	_____
e.	Construction contract secured and signed:	_____
f.	Construction started:	_____
g.	Remaining capital expenditure obligated:	_____
h.	Equipment orders submitted:	_____
i.	Construction completed:	_____
j.	Request for substantial compliance review submitted to CON Program:	_____
k.	Project completed and in operation:	_____

TABLE 9.B

Provide the following information for the most recently completed fiscal year, current and future fiscal years prior to the project's completion and for the first year of operation after completion of the project. State all assumptions upon which the projections are based.

Year Ending _____

	Gross Revenue	Allowance	Net Revenue
Medicare			
Medicaid			
Blue Cross/ Blue Shield			
Commercial Insurance			
Self Pay			
Other			
Total*			

* Total should correspond to operating revenue shown on pro-forma revenue and expense statements submitted for first year of operation.

STATE OF WEST VIRGINIA

HEALTH CARE COST REVIEW AUTHORITY

CERTIFICATE OF NEED PROGRAM

CERTIFICATE OF NEED EXEMPTION APPLICATION FORM

(Applicable to West Virginia Legislative Rules
Chapter 16, Article 2D, Section 4)

CASE FILE NUMBER: _____
(Assigned upon receipt of letter of intent)

GENERAL INFORMATION

1. This is a Certificate of Need exemption application form. ALL **QUESTIONS** in this application must be addressed.

2. A letter of intent must be submitted at least fifteen (15) days prior to the application. The letter of intent must include enough information to provide the name of the project, its approximate location, nature, scope, cost and the time frame for the development of the service.

3. The Certificate of Need staff will review the application for completeness upon its receipt. Within fifteen (15) days, the application will be declared complete or a request for additional information issued. Any amendments to the application must be made in writing.

4. It shall be the policy of the HCCRA that a final order regarding an exemption should be issued ten (10) days after the date the application was deemed complete. If it is determined that the project described in this form is not eligible for an exemption, then a decision will be issued to that effect and the applicant will be directed to file either a standard or expedited application form.

5. Applications may be withdrawn at anytime without prejudice. Applicants must notify the Certificate of Need Program in writing of such action.

6. Assemble the application in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the page number. In the upper left hand corner of each page, repeat the facility name and case file number. Repeat each question before providing the response.

7. Applicants must provide a signed original as well as four (4) copies of the entire application to:

   Director, Certificate of Need Program
   West Virginia Health Care Cost Review Authority
   100 Dee Drive, Suite 201
   Charleston, West Virginia 25311

   and, one (1) copy of the entire application to:

   West Virginia Department of Health
   Division of Planning
   1800 Washington Street, East
   Charleston, West Virginia 25305

8. The application and any other material in the case file become public documents and are available for inspection and copying upon request.

WV HCCRA Exemption Application Form

1. IDENTIFICATION OF THE APPLICANT

A. _____
Name of Facility at Which Project Will Be Developed

_____
Address of Facility

_____
Project Name

B. _____
Name of Applicant

_____
Address of Applicant

_____
Name and Title of Chief Executive Officer Telephone

C. _____
Contact Person

_____
Address Telephone

D. Type of Organization

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
____Individual	____Corporation	____State
____Partnership	____Church	____County
____Corporation	____Other(Specify)	____Other(Specify)
____Other(Specify)		

E. _____
Medicare/Medicaid Provider Numbers

2. A. Attach articles of Certificate of Incorporation or filed articles of general or limited partnership (you may reference another case file).

   B. List members of board of directors of the corporation or general partners if a general or limited partnership.

   C. Attach a copy of the resolution or minutes of the governing body meeting(s) wherein this project was approved. Also include authorization designating the signer of the application and contact person in question #1 to act on behalf of the applicant.

3. Generally describe the project. Include (a) specific services to be provided, (b) proposed service area and population to be served, (c) general organizational and management structure, and (d) schematic drawings (if applicable).

4. Provide detailed information regarding the capital expenditure, if any, associated with this project.

5. Provide a timetable for implementation of this project or for incurring the obligation for any capital expenditures associated with this project.

6. Provide an analysis of the project's relationship to the State Health Plan. List each applicable objective in the relevant chapter of the State Health Plan and demonstrate the extent to which the project meets each of these objectives.

7. Provide revenue and expense projections for the proposed service for three full years of operation along with a listing of all assumptions used in the preparation of the projections. The listing of assumptions should include but is not limited to the following: proposed charges for the service, contractual allowances, charity care, payor mix, anticipated utilization, proposed staffing and other operating expenses, such as supplies, etc.

COUNTY OF _____

STATE OF _____, to wit:

Upon first being duly sworn, I hereby state that, to the best of my knowledge and belief, the information provided in this application is true and correct.

_____
(Signature)

_____
(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____, 19___.

_____
Notary Public

(SEAL)