STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

CERTIFICATE OF NEED APPLICATION PACKET

Adopted December 9, 2005

Sarah Palin
Governor

Karleen K. Jackson, PhD
Commissioner

This Certificate of Need Application Packet has been adopted by reference in regulations of the Alaska Department of Health and Social Services. Only the version that has been adopted by reference will be accepted by the department for review. To ensure that you have the correct packet, please check the current version of 7 AAC 07.040 or contact the Certificate of Need Coordinator. Any questions may also be directed to the Coordinator:

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The Office of the Commissioner
Office of Rate Review
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Additional information is available at the department's Internet web site:
http://dhss.alaska.gov/dhcs/Pages/CertificateOfNeed/default.aspx .

Table of Contents

General Instructions

This document contains the information, instructions, and forms necessary to prepare a certificate of need application.

The department may schedule, or you may request, a pre-application conference before submission of the application [see 7 AAC 07.035].

Please read all the materials in this packet and closely follow these instructions in preparing an application for a certificate of need:

- Complete the application in the same order that is presented in this packet, retaining the section numbering. The department has prepared an electronic submission version of this packet (downloadable from the department's website) for each type of service for which review standards have been developed. The text of each requirement should be in a bold font, but please do not use a bold font for each response.

EXAMPLE

Section II. Summary Project Description

(1) A brief description of each proposed service, including whether equipment will be purchased or replaced and a list of that equipment.

Place response here

(2) The number of square feet of construction/renovation.

Place response here

(3) The number and type of beds/surgery suites/specialty rooms.

Place response here

etc.

- Number each page in the application.

- Answer all of the questions that apply to the proposed project. If an item of requested information does not apply, enter "Not Applicable". Well-written, complete answers will expedite review of the application.

- Attach and identify any documents necessary to complete sections or forms included in this packet.

- Describe (in Section VI of the application) how the proposed project meets each of the general review standards that are applicable to all activities, and how it meets each of the service-specific review standards applicable to each activity proposed. These standards are set out in the department's publication *Alaska Certificate of Need Review Standards and Methodologies*, adopted by reference in 7 AAC 07.025. For an application expected to be reviewed concurrently with another competing application, address how the project meets the review standards that are specific to concurrent reviews for activities of the type proposed. Retain the same order and numbering for each standard that is used in that publication. Complete this section of the application as shown in the above example. (Standards for each type of activity have been included in Section VI of the applicable electronic submission version of this packet that is downloadable from the department's website.)

- Provide references for each source (articles, statistics, quotations, strategic plans, etc.) of any factual data or information included in the application (for example, population projections). If a source is not readily available to the public, provide a copy of the source document in an appendix. The department may request copies of any source material not included with the application.

- All construction cost estimates must be "certified estimates" as that term is defined in 7 AAC 07.900.

- Carefully check all information, numbers, calculations, and other data presented in the application to ensure accuracy. If information is presented more than once, ensure that it is consistent throughout.

- Submit three (3) paper copies and one electronic copy of the application to the Certificate of Need Coordinator (see the inside cover of this packet for contact information). <u>One copy must have an original signature of a certifying officer of the organization.</u> Submit an additional copy in an electronic version, using the e-mail address set out on the inside cover of this packet.

- Retain at least two copies of the application: one that you make available at your place of business, and the other that you place at the public library in your community, for public review and comment after the application is declared complete. After determining that the application is complete, the department will place a copy on the department's website.

- If the application is for modification of an existing certificate of need, submit the request form provided in this packet.

- Submit the application fee required under 7 AAC 07.079, with a signed copy of the form used to determine the amount of the fee (see page 32 of this packet).

Applicable Statutes and Regulations

Applications for certificates of need are subject to the applicable provisions of Alaska statutes (AS 18.07.021 – 18.07.111), and Alaska regulations (7 AAC 07).

Other applicable regulations include but are not limited to: **(1)** 7 AAC 12 (Facilities and Local Units); **(2)** 7 AAC 43.686 (Allowable Reasonable Operating Costs (Medicaid Audits)); and **(3)** other applicable provisions in 7 AAC 43 relevant to the type of activity. The provisions of these regulations could affect the ability to be licensed or to receive Medicaid payments if a certificate of need was required, but was not obtained.

Section I. General Applicant Information

On the following page is a form that must be completed and signed for each application.

CERTIFICATE OF NEED APPLICATION

APPLICANT IDENTIFICATION AND CERTIFICATION OF ACCURACY

1. Applicant Identification

Facility Name	**Medicaid Provider Number**
Facility Address (*Street/City/State/Zip Code*)	**Medicare Provider Number**
Name and mailing address of organization that operates the facility (if different from above)	
Facility Administrator (*Name, title, mailing address, including City/State/Zip Code*)	**Telephone** **Facsimile** **E-mail**
Applicant (*Name, title, mailing address, including City/State/Zip Code*)	**Telephone** **Facsimile** **E-mail**
Principal Contact Person (*Name, title, physical address, mailing address, including City/State/Zip Code*)	**Telephone** **Mobile Phone** **Facsimile** **E-mail**

2. Ownership Information

A. Type of Ownership (*check applicable category*)

☐ For profit: individual
☐ For profit: partnership
☐ For profit: corporation
☐ Not for profit: government
☐ Not for profit: corporation
☐ Other (specify): _____

B. List of all Owners *(Page 2 of application*)

C. Accreditation Information *(Page 2 of application*)

3. Agreement to participate in the Uniform Statewide Reporting System

I hereby agree to participate in the uniform statewide reporting system required under AS 18.07.101 when requested to do so under 7 AAC 07.105(c).

4. Certification of Accuracy by Certifying Officer of the Organization

I hereby certify that the information contained in this application, including all documents that form any part of it, is true, to the best of my knowledge and belief. I agree to provide, within 60 days from receipt of a request from the department under 7 AAC 07.050(b), any additional information needed by the department to make a decision.

Name	**Title**
Signature	**Date**

For Part 2.B. of the application form, provide the following ownership information under each requirement, using as much space as necessary to provide complete information:

(1) For individual owners and partnerships, list the names, titles, organizational name, mailing and street addresses, and telephone and facsimile numbers of the owner or partners.

(2) For corporations, list the names, titles, and addresses of the corporate officers and Board of Directors. If the facility is a subsidiary of another company or has multiple owners, provide the names and addresses of the all of companies that have ownership in the facility.

(3) For governmental or other nonprofit owners, list the names and addresses of hospital board members.

For Part 2.C. of the application form, provide the following information:

Is this facility accredited or certified by a recognized national organization? ☐ **Yes** ☐ **No**

If yes, identify the organization, the date of accreditation or certification, and attach as an appendix to this application a copy of the most current accreditation or certification.

Section II. Summary Project Description

Provide a one-page summary of the proposed project including:

(1) A brief description of each proposed service, including whether equipment will be purchased or replaced and a list of that equipment.

(2) The number of square feet of construction/renovation.

(3) The number and type of beds/surgery suites/specialty rooms.

(4) Services to be expanded, added, replaced, or reduced.

(5) The total cost of the project.

(6) How the project will be financed.

(7) Estimated completion date.

Section III. Description of Facilities and Capacity Indicators

A. Proposed changes in service capacity. Provide either the number of beds, surgery suites, rooms, pieces of equipment, or other service.

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	TOTAL PROPOSED CAPACITY
IN-PATIENT ACUTE CARE HOSPITALS			
Med/Surg Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
ICU Beds			
Obstetrics Beds			
Pediatric Beds			
Acute Rehab Beds			
Obstetrics Beds			
Pediatric Beds			
Ancillary Services (list)			
BEHAVIORAL HEALTH CARE			
In-patient Acute Psychiatric Beds			
RPTC Beds			
In-patient Substance Abuse Beds			
LONG-TERM CARE			
Acute Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
Nursing Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
DIAGNOSTIC AND DIAGNOSTIC IMAGING SERVICES			
CT Scanner			
MRI			
PET or PET/CT			
Cardiac Catherization			
Emerging Med. Tech. (list)			

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	TOTAL PROPOSED CAPACITY
SURGICAL CARE			
Ambulatory Surgery or Dedicated OP Suites			
Suites for IP & OP			
Endoscopy Suites			
Open-Heart Surgery			
Organ Transplantation			
Other Services (list)			
THERAPEUTIC CARE			
Radiation Therapy			
Lithotrypsy			
Renal Dialysis			
Other (List)			
Total Capacity			

B. Provide a detailed narrative description of each service identified in "A" above, including the type of change (addition, expansion, conversion, reduction, replacement, elimination). Include, as appropriate, detailed information relative to the scope and level of service.

C. Provide in the following table information regarding equipment to be purchased.

Equipment to be Purchased			
Equipment Description	**Make**	**Model**	**Cost**

D. Provide in the following table information regarding equipment to be replaced or retired.

Equipment to be Replaced or Retired				
Equipment Description	**Make**	**Model**	**Date Placed Into Service**	**Reason for Replacement or Retirement**

E. Describe replacement or upgrading of utilities including the electrical, heating, ventilation, and air conditioning systems.

F. Describe the structural framing, floor system, and number of floors (including the basement).

G. Total square footage in current facility/project.

H. Total square footage of proposed facility/project.

I. Area per bed, service unit, or surgery suite (if applicable).

J. Percentage of total floor area used for direct service (non-bed activity).

K. Additional volume of service (non-bed activity) expected.

L. Provide a brief history of expansion and construction for the past five years, including new equipment purchases, additional beds, and new services. Describe how this project fits into the facility's long-range plans, including potential projects planned for development within the next five years.

Section IV. Narrative Review Questions

A. RELATIONSHIP TO APPLICABLE PLANS AND NATIONAL TRENDS

Indicate how the application relates to any relevant plans, including the applicant's long-range plans, appropriate local, regional, or state government plans, the current *Alaska Certificate of Need Review Standards and Methodologies,* adopted by reference in 7 AAC 07.025, and current planning guidelines of recognized national medical and health care groups. If the proposal is at variance with any of these documents, explain why. (See the department's website for state planning processes and materials and links to federal websites.)

B. DEMONSTRATION OF NEED

1. Identify the problems being addressed by the project. For example, identify whether this project is for (a) a new service; (b) an expanded service; or (c) an upgrade of an existing service.

2. Describe whether (and how) this project (a) addresses an unmet community need; (b) satisfies an increasing demand for services; (c) follows a national trend in providing this type of service; or (d) meets a higher quality or efficiency standard.

3. Describe any internal deficiencies of the facility that will be corrected, and document which of these deficiencies have been noted by regulatory authorities. Note any deficiencies that will not be corrected by this project, what efforts have been taken to correct the deficiencies, and how this project will affect the deficiencies. Attach any pertinent inspection records and other relevant reports as an appendix to the application.

4. Identify the target population to be served by this project. The "target population" is the population that is or may reasonably be expected to be served by a specific service at a particular site. Explain whether this is a local program, or a program that serves a population outside of the proposed service area. Use the most recent Alaska Department of Labor and Workforce Development statistics for population data and projections. Explain and document any variances from those projections. The population may be defined in one or more ways:

   a. Document the service area by means of a patient origin analysis.

   b. Justify the customary geographical area served by the facility using trade and travel pattern information. Indicate the number and location of individuals using services who live out of the primary service area.

   c. Use Alaska Department of Labor and Workforce Development information, including current census data on cities, municipalities, census areas, or census sub-areas, to describe trends, age/sex breakdowns, and other characteristics pertinent to the determination of need.

d. The population to be served can be defined according to the unique needs of patients requiring specialized or tertiary care (e.g. heart, cancer, kidney, alcoholism, etc.) or the needs of under-served groups.

5. Describe the projected utilization of the proposed services and the method by which this projection was derived. Do not annualize utilization data. It must include the last complete year of operation (indicate if it is a calendar year or fiscal year) and as many prior years as is feasible to show trends. If graphs are used to depict this information, and they do not include the actual utilization numbers, numerical charts must be included. In providing this information:

a. Include evidence of the number of persons from the target population who are currently using these services and who are expected to continue to use the service, including individuals served out of the service area or out of state;

b. Include evidence of the number of persons who will begin to use any new services that are not now available, accessible, or acceptable to the target population.

c. Provide annual utilization data and demand trends for the five most recent years and monthly utilization data for the most recent incomplete year prior to the application for each existing facility offering a similar service in the service area. Provide projections for utilization for three years (or the appropriate planning horizon set out in the review standards related to this project) after construction, and show methodology used to determine use, including the math.

d. If the project is an acquisition of a new piece of major equipment or a new service, provide utilization data for similar services, existing equipment, or older technology. Indicate whether similar existing equipment will continue to be used and the project's effect on utilization of similar services. If this service or equipment was not in place in the service area, compare the expected utilization with other similar communities in Alaska or in other states.

e. If an increase in utilization is projected, list the factors that will affect the increase. Provide annual utilization projections for three to five years in the future, as applicable, for each specific service in the proposal (in general, equipment projections are for three years, and new beds and facility construction are for five years). Include each of the following data when applicable:

(1) number of admissions/discharges
(2) number of patient days
(3) average length of stay
(4) percent occupancy
(5) average daily census
(6) number of licensed beds
(7) number of beds set up
(8) number of inpatient and outpatient surgeries and surgery minutes
(9) number of existing surgery suites in the service area

(10) number of procedures
(11) number of treatment rooms
(12) number of patients served
(13) number of outpatient visits
(14) number of laboratory tests
(15) number of x-rays
(16) number of ER visits
(17) number of CT, MRI, PET or PET/CT scanners

f. If any services will be reduced, indicate how the proposed reduction will affect the service area needs and patient access.

g. Provide any other information that may be pertinent to establishing the need for this project.

h. Attach letters of support from local and regional agencies, other health care facilities, individuals, governmental bodies, etc.

6. Include your calculations of numerical need for each proposed activity for your service area. If the proposed project is expected to have a larger capacity than that projected by (and available from) the department, explain the rationale and provide documentation to support the larger capacity.

C. AVAILABILITY OF LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

1. Describe the different alternatives considered in developing this project. Explain why the particular alternative for providing the services proposed by this application was selected. Include as an alternative a discussion of the effect of doing nothing.

2. Describe any special needs and circumstances. Special needs may include special training, research, Health Maintenance Organizations (HMOs), managed care, access issues, or other needs.

D. THE RELATIONSHIP OF THE PROPOSED PROJECT TO EXISTING HEALTH CARE SYSTEM AND TO ANCILLARY OR SUPPORT SERVICES

1. Identify any existing comparable services within the service area and describe any significant differences in population served or service delivery. If there are no existing comparable services in the area, describe the unmet need and how the target population currently accesses the services. Describe significant factors affecting utilization, including cost, accessibility, and acceptability.

2. Describe the probable effect on other community resources, including any anticipated impact on existing facilities offering the same/similar services or alternatives locally or statewide if applicable. Describe how each proposed new or expanded service will:

a. complement existing services
b. provide an alternative or unique service
c. provide a service for a specific target population
d. provide needed competition

3. Identify existing working relationships the applicant has with hospitals, nursing homes, and other resources serving the target population in the service area. Include a discussion of cooperative planning activities, shared services (i.e. agreements assigning services such as emergency or obstetrics), and patient transfer agreements. If other organizations provide ancillary or support services to your facility, describe the relationship. Attach copies of relevant agreements in an appendix in the application. If a service requires support from another agency but does not have an agreement, explain why.

E. FINANCIAL FEASIBILITY

1. Demonstrate how the project will ensure financial feasibility, including long-term viability, and what the financial effect will be on consumers and the state, region, or community served.

2. Discuss how the project construction and operation is expected to be financed. Demonstrate access to sufficient financial resources and the financial stability to build and operate this project.

3. Provide a description and estimate of:

a. the probable impact of the proposal on the annual increase on the overall costs of the health services to the target population to be served;

b. If applying to build a residential psychiatric treatment centers, nursing homes, or additional nursing home beds the annual increase to Medicaid required to support the new project, and the projected cost of and charges for providing the health care services in the first year of operation (per diem rate, scan, surgery etc);

c. the immediate and long-term financial feasibility of continuing operations of the proposal.

F. ACCESS TO SERVICE BY THE GENERAL POPULATION AND UNDER-SERVED GROUPS

1. Provide information on service needs and access of under-served groups of people such as low-income persons, racial and ethnic minorities, women, and persons with a disability. Discuss any plans to overcome language and cultural barriers of groups to be served.

2. Indicate the annual amount of charity care provided in each of the last five years with projections for the next three years. Include columns for revenue deductions, contractual allowances, and charity care.

3. Address the following access issues:

a. transportation and travel time to the facility;

b. special architectural provisions for the aged and persons with a disability;

c. hours of operation; and

d. the institution's policies for nondiscrimination in patient services.

Section V. Consideration of Quality, Effectiveness, Efficiency, and Benefits of the Applicant's Services

Please discuss the following in narrative form:

1. ACCREDITATION AND LICENSURE: The current status, source, date, length, etc., of the applicant's license and certification. Include information on Medicaid and Medicare Certification.

2. QUALITY CONTROL: How the applicant plans to ensure high quality service.

3. PERSONNEL: Plans for optimum utilization and appropriate ratios of professional, sub-professional and ancillary personnel.

4. APPROPRIATE UTILIZATION: Development of programs such as ambulatory care, assisted living, home health services, and preventive health care that will eliminate or reduce inappropriate use of inpatient services

5. NEW TECHNOLOGY AND TREATMENT MODES: Plans to use modern diagnostic and treatment devices to enhance the accuracy and reliability of diagnostic and treatment procedures.

6. LABOR SAVING DEVICES AND EFFICIENCY: The employment of labor-saving equipment and programs to provide operating economies.

7. PROGRAM EVALUATION: Future plans for evaluation of the proposed activity to ensure that it fulfills present expectations and benefits.

8. ORGANIZATIONAL STRUCTURE: Include an organizational chart, descriptions of major position requirements and board representation; show representation from community economic and ethnic groups.

9. STAFF SKILLS: Provide descriptions of major position requirements, appropriate staff-to-patient ratios to maintain quality, and the minimal level of utilization that must be maintained to ensure that staff skills are maintained. Provide a source for the staffing standards.

10. ECONOMIES OF SCALE: The minimum and maximum size of facility or unit required to ensure optimum efficiency. If the planned project is significantly smaller or larger, explain the effect and why the size was chosen.

Section VI. Narrative Description of How Project Meets Applicable Review Standards

Describe in this section of the application how the proposed project meets each review standard applicable to all activities, and each specific review standard applicable to the proposed activity. *Some of this information will duplicate information required elsewhere in the application packet; that duplication is intentional.*

Section VII. Construction Data

A. Please check appropriate boxes:

1. Construction type	☐ New	☐ Expansion	☐ Renovation
2. Basement	☐ Full	☐ Partial	☐ None

B. Project Development Schedule **Date**

1. Estimated completion of final drawings and specifications
2. Estimated construction begun by
3. Estimated construction complete by
4. Estimated opening of proposed services

C. Facility site data: Provide the following as attachments (referenced by the subsection and item number):

1. A legal description and area of the proposed site. Is the site now owned by the facility? If not, how secure are the arrangements to acquire the site?

2. Diagrammatic plan showing:
    a. dimensions and location of structures, easements, rights-of-way or encroachments;
    b. location of all utility services available to the site; and
    c. Location of service roads, parking facilities, and walkways within site boundaries.

3. Document clearances regarding zone restrictions, fire protection, sewage, and other waste disposal arrangements (under special circumstances, it is acceptable to present evidence of conditional approvals from local government and regulatory agencies).

4. An architectural master plan including long-range concept and development of total facility.

5. Schematic floor plan drawings (or conceptual drawings) of proposed activity, including functional use of various rooms.

D. Describe the plan for completing construction and the effect (disruption) construction activities will have on existing services.

Section VIIIA. Financial Data - Acquisitions

1. Acquisition type: (Please check applicable boxes)

☐ Lease ☐ Rent ☐ Donation ☐ Purchase ☐ Stock Transaction

2. Cost data (Omit cents)

a. Total acquisition cost*	$
b. Amount to be financed	$
c. Difference between items (a) and (b) (list available resources to be used, e.g. available cash, investments, grants, etc.)	$
d. Anticipated interest rate ___% , term ___ years.	
e. Total anticipated interest amount	$
f. Total of (a) and (e)	$
g. Estimated annual debt service requirements	$

3. Describe how you expect to finance the project.

Note: Acquisition costs must include (as appropriate):

- Total purchase price of land and improvements (if donated, the fair market value**)
- "Goodwill" or "purchase of business" costs
- The net present value of the lease calculated on the total lease payments over the useful life of the asset as set out in the 2004 version of *Estimated Useful Lives of Depreciable Hospital Assets*, published by the American Hospital Association.
- Consultant or brokers fees paid by person acquiring the facility
- Other pre-development costs to date.

*Site acquisition should be stated as "book" value, i.e. actual purchase price plus costs of development. If desired, the applicant may elect to state the acquisition as "fair market value"** (in which case, give reason and basis).

** A form for use in calculating fair market value is included on page 31 of this packet. Include your calculations as part of this section of your application.

Section VIIIB. Financial Data – Construction Only

1. Construction Method (Please check)

a. ☐ Conventional bid ☐ Contract management ☐ Design and build

b. ☐ Phased ☐ Single project ☐ Fast Track

2. Construction Cost (New Activity) (Omit cents)

a. Site acquisition (Section VIIIA.2.f) $

b. Estimated general construction** $

c. Fixed equipment, not included in a** $

d. Total construction costs (sum of items a, b, and c)** $

e. Major movable equipment** $

f. Other cost:**

(1) Administration expense $

(2) Site survey, soils investigation, and materials testing $

(3) Architects and engineering fees $

(4) Other consultation fees (preparation of application included) $

(5) Legal fees $

(6) Land development and landscaping $

(7) Building permits and utility assessments (including water, sewer, electrical, phones, etc.) $

(8) Additional inspection fees (clerk of the works) $

(9) Insurance (required during construction period) $

g. Total project cost (sum of items d, e, f) $

h. Amount to be financed $

i. Difference between 2.g and 2.h (list, as Schedule 1, available resources to be used, e.g., available cash, investments, grants funds, community contributions, etc.) $

j. Anticipated long-term interest rate _____%

k. Anticipated interim (construction) interest rate _____%

l. Anticipated long-term interest amount $

m. Anticipated interim interest amount $

n. Total items g, l, and m $

o. Estimated annual debt service requirement $

p. Construction cost per sq. ft. $

q. Construction cost per bed $

r. Project cost per sq. ft. $

s. Project cost per bed (if applicable) $

*Site acquisition should be stated as "book" value, i.e., actual purchase price (or estimate of value if donated) plus costs of development. If desired, the applicant may elect to state as "fair market value" (in which case, so indicate). A form for use in calculating fair market value is included on page 31 of this packet. Include your calculations as part of this section of your application.

** Items must be certified estimates from an architect or other professional. Major medical equipment may be documented by bid quotes from suppliers.

Section IX. Financial Data – All Proposed Activities

Provide an accompanying narrative explanation for each of the schedules below if there are any significant trends or significant changes in any item or group of items from year to year.

Note: Indicate whether you are using a calendar year or other fiscal year period.

A. Attach Schedule I - Facility Income Statement

1. For the most recent five prior full fiscal or calendar years
2. Projections during construction or implementation period (if applicable)
3. Projection for three years following completion of construction, or implementation of the proposed activity.

B. Attach Schedule II - Facility Balance Sheet

1. For the most recent five prior fiscal or calendar years.
2. Current fiscal or calendar year to date

C. Attach Schedule III - Average Patient Cost Per Day (Per Diem Rate if applicable) and Revenue Amounts

Provide revenue and expense data FOR EACH SERVICE THAT IS IDENTIFIED AS CHANGING.

1. For the most recent five prior full fiscal or calendar years (information may be obtained on total patient load, directly from your respective years' Medicare Cost Reports)
2. Current fiscal or calendar year to date
3. Projection for five years following completion of construction or implementation.

D. Attach Schedule IV – Operating Budget

Current and projected line item capital and operating budgets for the proposed activity. Describe what alternative plans have been made if deficits occur.

E. Attach Schedule V – A. Debt Service Summary, and B. New Project Debt Service Summary

A debt service cash flow schedule over the life of the debt, if applicable, for all long-term debt of the facility. Identify each debt, including the proposed activity, and break out interest, principal, and other costs.

F. Attach Schedule VI - Reimbursement Sources

Showing reimbursement sources for the facility for the previous five full years and projected for three years after implementation.

G. Attach Schedule VII – Depreciation Schedule

Showing a depreciation schedule for all items acquired through the proposed project. Note that the straight-line method must be used. Indicate on the depreciation schedule or separately which major movable equipment is being purchased for the project (see Section VIIIB, Item 2e). Also, on a separate page, include a list of all equipment to be purchased through this project and the costs.

Schedule I. Facility Income Statement					
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion					
Gross Patient Revenue:	FY	FY	FY	FY	FY
Inpatient Routine					
Inpatient Ancillary					
Outpatient					
Long-Term Care					
Swing Beds					
Other					
Total Patient Revenue					
Less Deductions					
Charity Care					
Contractual Allowances					
Bad Debts					
Total Deductions					
Net Operating Revenues					
All Other Revenues					
EXPENSES:					
Salaries					
Benefits					
Supplies					
Utilities					
Property Tax					
Rent					
Lease					
Other Expenses					
Depreciation					
Interest					
Total Expenses					
Excess (Shortage) of Revenue Over Expenditures					

Note: Use one copy of this form for the previous five years, another for the construction or development period, and five years after the project opens

Schedule II. Facility Balance Sheet					
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion					
CURRENT ASSETS	FY	FY	FY	FY	FY
Cash & Cash Equivalent					
Net Patient Accounts Receivable					
Other Accounts Receivable					
Inventories					
Prepaid Expenses					
Other					
Total Current Assets					
Property and Equipment					
Land & Improvements					
Building/Fixed Equipment					
Major Movable Equipment					
Accumulated Depreciation					
Net Property & Equipment					
Other Assets					
TOTAL ASSETS					
LIABILITIES/FUND BALANCE					
Current Liabilities					
Accounts Payable					
Accrued Expenses					
Accrued Compensation					
Other Accruals					
Total Current Liabilities					
Long Term Liabilities					
Long Term Debt					
Other					
Total Long Term Liabilities					
Fund Balance					
Total Liabilities & Fund Balance					

Note: Use one copy of this form for the previous five years, another for the construction or development period, and five years after the project opens

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and Revenue Amounts					
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion					
	FY	FY	FY	FY	FY
Revenues					
Expenses					
Patient Days					
Revenue Per Patient Day					
Operating & Capital Budget Summary:					
Gross Revenues					
Deductions from Revenue					
Net Revenue					
Direct Expense					
Indirect Expense					
Net Income Projected					
Rate Computation					
Annual Medicaid Rate					
Base Year Cost					
Less Ancillary					
Plus Admin. Overhead					
Cost Basis for Rate					
Base Year Patient Days					
Cost per Patient Day					

Years 1 and 2 are equivalent to State of Alaska swing-bed rate.
Facility Medicaid Rate is figured from Year 3 onward.

Schedule IV. Operating Budget					
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion					
Description:	FY	FY	FY	FY	FY
Number of Beds					
Days in a year	365	365	365	365	365
Available bed days					
Resident bed days					
Percent growth					
Occupancy					
Average length of stay					
Patient Bed Days					
Number of Residents					
Daily Room and Board Rate*					
Nursing Revenue					
Nursing Services					
Payer Mix:					
Medicaid					
Medicare					
Other					
Ancillary Revenue					
Total Revenue					
Rate Computation					
Annual Medicaid Rate					
Base Year Cost					
Less Ancillary					
Plus Admin. Overhead					
Cost Basis for Rate					
Base Year Patient Days					
Cost per Patient Day					

Years 1 and 2 are equivalent to State of Alaska swing-bed rate.
Facility Medicaid Rate is figured from Year 3 onward.

Schedule V-A. Debt Service Summary					
Provide Current Debt Data and Projections For the Next Three Years					
Existing Debt:	FY	FY	FY	FY	FY
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
Total Existing Debt					
Principal					
Interest					
Estimated Debt – New Project					
Principal					
Interest					

Schedule V-B. New Project Debt Service Summary					
Attach a debt service cash flow schedule over the life of the debt for the new project. Break out principal, interest, and other.					
Year	Item	Principal	Interest	Other	Total

Schedule VI. Reimbursement Sources

Show reimbursement sources for the previous five years and projections for three years after the new project opens.

Fiscal Year				
Reimbursement Source	**Number of Patients**	**Gross Patient Charges**	**Deductions**	**Net Patient Revenues**
Medicaid				
Medicare				
Private Insurance				
Self Pay				
Charity				
Other				
Total				

Fiscal Year				
Reimbursement Source	**Number of Patients**	**Gross Patient Charges**	**Deductions**	**Net Patient Revenues**
Medicaid				
Medicare				
Private Insurance				
Self Pay				
Charity				
Other				
Total				

Fiscal Year				
Reimbursement Source	**Number of Patients**	**Gross Patient Charges**	**Deductions**	**Net Patient Revenues**
Medicaid				
Medicare				
Private Insurance				
Self Pay				
Charity				
Other				
Total				

Schedule VII. Depreciation Schedule			
Use the straight-line method. Provide a separate schedule for any pieces of major moveable equipment.			
Equipment Description	Cost	AHA Life	Depreciation Per Year

FAIR MARKET VALUE – HOW TO CALCULATE

Fair market value is the price that the property would sell for on the open market. It is the price that would be agreed on between a willing buyer and a willing seller, with neither being required to act, and both having reasonable knowledge of the relevant facts.

To determine the fair market value of equipment, using the formula below, first determine the number of years of estimated useful life of the equipment, as described in the AHA publication *Estimated Useful Lives of Depreciable Hospital Assets* to achieve an annual depreciation amount. Include your calculations as part of this section of your application.

Determining Fair Market Value of Equipment		
1	Purchase price of equipment (round to nearest dollar)	$
2	AHA estimated useful life of equipment (in years)	
3	Annual Depreciation Expense (ADE) [Divide #1 by #2]	$
4	Multiply ADE by age of equipment (new = 0)	$
5	Fair Market Value (Subtract #4 from #1)	$

The fair market value of land or buildings is the value contained in a current appraisal of the land or building from a licensed real estate appraiser who has no financial or other interest in the transaction. Attach the appraisal as an appendix to the application.

APPLICATION FEE – DETERMINATION AND CERTIFICATION OF AMOUNT

How to Determine the Amount of the Application Fee Required Under 7 AAC 07.079

(1) For a project that does not include a lease of a facility or equipment, the value of the project is:

A. the amount listed on page 20 of this packet under Section VIIIA, Financial Data – Acquisitions, subsection (2), item "a" (total acquisition cost of land and buildings): $_____

plus

B. the amount listed on page 21 of this packet under Section VIIIB, Financial Data – Construction Only, item "g" (total project cost, which is the sum of items d, e, and f): $_____

Estimated Value of the Activity for (1) (sum of A & B above) $_____

(2) For a project that has a component that is leased, the fair market value of the leased equipment, facility, or land must be considered in addition to the acquisition cost. See the form on page 31 of this packet for how to determine fair market value.

Estimated Fair Market Value for (2): $_____

Estimated Value for (1) from above: $_____

Total Estimated Value of the Activity (sum of (1) and (2): $_____

Amount of Application Fee submitted with this application (see 7 AAC 07.079 to calculate amount due): $_____

Certification of Individual Determining Application Fee

I certify that, to the best of my knowledge, as of this date, the estimated value and fee for this certificate of need activity are accurate.

Date:
Facility Name and Address:
Name and Title of Person Determining Application Fee:

_____
Signature of Certifying Officer of the Organization

REQUEST FOR MODIFICATION OF A CERTIFICATE OF NEED

Name of Facility

Mailing Address

Street Address

Project Authorized in Certificate of Need dated:

APPLICANT INFORMATION

If the owner, applicant organization, or contact person has changed since the certificate of need was issued, please provide the new name, title, and address.

REASON FOR MODIFICATION (Describe each applicable reason in detail)

☐ Change in scope of authorized activity

☐ Change in cost of authorized activity

☐ Change in time schedule of authorized activity

CERTIFICATION

I certify that all of the information contained in this request, including any supporting documents, is true to the best of my knowledge and belief.

Name

Title:

Date:

Signature:

NOTE: A current periodic progress report must be submitted with this request.

PERIODIC PROGRESS REPORT

Name and Address of Applicant or Certificate Holder:

Project Description:

Date Certificate of Need Issued:

Approved Cost:

All persons who have requested an exemption or have been issued a certificate of need are required to submit periodic reports until the project has been completed or terminated, as required under 7 AAC 07.105. Submittal dates are on or before January 1 and July 1 each year.

Please respond to the following questions. If the question is not applicable, please state why.

1. Is the project fully obligated? (An obligation is defined as an enforceable contract for acquisition, construction, or lease of a capital asset; or, in the case of donated property, the date on which the gift is completed in accordance with applicable state law.) If not, explain. If yes, indicate the nature and date of all obligations incurred to date. If the project is not fully obligated, indicate the cost and the date those obligations will be incurred.

2. What are all expenditures by category (e.g., land fees, construction, etc.) made to date on the project? Attach an expense sheet that compares the proposed costs to the expenses for the reporting period, as well as all expenses since the certificate of need was issued.

3. What is the anticipated completion date (operational date)? How does this differ from the project schedule submitted in the certificate of need application? Please explain any significant differences in the schedules. How will future milestones in the schedule be affected?

4. In the case of construction projects, has the construction started and what has been completed to date (e.g., footings, foundations, etc.)? What percentage of total construction is complete?

5. Are construction/project activities progressing in conformance with the scope of the project approved by the Commissioner? Explain any variations (e.g., in size or type of construction).

6. Is the projected final project cost currently within the limits approved by the Commissioner? If the project is complete, please submit a final capital budget. Include a documentation of expenses that has been certified by a general contractor, equipment supplier, and/or other authorized representative who can objectively confirm the expenses.

7. Are there any changes in the services or programs from those that were originally proposed and approved? If so, please indicate those changes.

I hereby certify that the statements made in this report are correct to the best of my knowledge and belief.

Signature of Certifying Officer:

Title:

Telephone:

Date:

Send to:
Certificate of Need Program
Health Planning and Systems Development
Department of Health and Social Services
P.O. Box 110660
Juneau, Alaska. 99811-0660