Certificate of Need Program

GENERAL APPLICATION

FOR

CERTIFICATE OF NEED REVIEW

CON File Number: _____

(Assigned upon receipt of Letter of Intent)

Revised: March 2017

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 (CON) process or the applicability of any item on your project, feel free to contact the CON program staff.

2. As set forth in W.Va. Code § 16-2D-13(b)(1), a person proposing a proposed health service shall submit a Letter of Intent ten (10) days prior to submitting the CON application. In addition, W.Va. C.S.R. § 65-32-8.3 states that a CON application must be filed ten (10) days after the Letter of Intent.

3. PLEASE NOTE: The application will not be accepted if the information contained in the application does not match the Letter of Intent (e.g. capital expenditure, service area and case file name).

4. PLEASE NOTE: The appropriate CON filing fee, as set forth in W.Va. Code § 16-2D-13(b)(2), must be paid concurrently with the filing of the CON application. Checks shall be made payable to the "West Virginia Health Care Authority".

5. The applicant shall have the verifications attached to the CON application signed by the Chief Executive Officer and by the person who prepared the application.

6. An application will not be declared complete if the applicant is a health care facility subject to the financial disclosure provisions of W.Va. Code § 16-29B-24 or W. Va. C.S.R. § 65-13-1 et seq., and the health care facility has failed to file with the Health Care Authority all reports, records, data or other information required by the Code and rules promulgated pursuant to the Code.

7. The CON staff will review the application for completeness upon receipt and acceptance of the application. Within ten (10) days of acceptance, the application will either be declared complete or a request for additional information will be issued.

8. Any amendment to the application must be made in writing. If an amendment is deemed to be substantial by the CON staff, the application may be withdrawn and made subject to a new review cycle.

9. An applicant may withdraw its application at any time without prejudice. Applicants must notify the CON Program in writing of such action. PLEASE NOTE: Application fees are non-refundable.

10. The application must be assembled in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the section and page number. In the upper left hand corner of each page, repeat the facility name and case file number. Response to items should be provided repeating each question before providing your response.

11. Applicants must provide a signed original as well as one (1) copies of the entire application to:

Barbara Skeen, Director
Certificate of Need
West Virginia Health Care Authority
100 Dee Drive
Charleston, West Virginia 25311-1692

Submit the application in the following manner:

a. The original application must be in a three-ring, hard-back notebook with alphabetized section dividers.

b. One (1) copy is to be submitted unbound and unstapled.

12. Applicants must also provide one (1) copy of the entire application to:

Offices of the Insurance Commissioner
Attn: Consumer Advocacy Division
P.O. Box 11685
Charleston, West Virginia 25339-1685

For Hand Deliveries:
One Players Club Drive, Third Floor
Charleston, West Virginia 25301

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

14. Data and approved need methodologies will be provided by the Authority upon request only. CON Standards can be obtained on the Authority's website at www.hca.wv.gov under 'Certificate of Need'.

15. Certificate of Need law and legislative rules may be obtained by contacting:

Administrative Law Division
Secretary of State's Office
Building 1, Suite 157-K
Charleston, West Virginia 25305
Telephone: (304)-558-6000

WEST VIRGINIA HEALTH CARE AUTHORITY
PRIVACY NOTICE

Please do not submit any information that contains personally identifiable information (PII), including protected health information (PHI). PII is all information that identifies or can be used to identify, locate, or impersonate a particular individual. PHI is a subset of PII, held by HIPAA covered entities. PHI is individually identifiable health information. In some limited instances, the West Virginia Health Care Authority will request that you provide a name as part of your financial disclosure submission. If requested, this name must be provided. However, in compliance with the above directions, do not provide additional non-requested PII or PHI items, such as a social security number, home address, or medical record number. This data submission is public information, available to anyone on the Internet, and all non-requested PII and PHI must be removed prior to submission in order to protect an individual's privacy. The agency makes every effort to identify documents containing PII and PHI. Those documents identified as containing non-requested PII and PHI will not be accepted and are subject to being redacted, shredded or returned to the submitting agency. As a result, your facility may be declared out of compliance with financial disclosure and subject to all penalties up to and including fines and injunctive relief.

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 Applicant

Address of Applicant

City County State Zip Code

Name and Title of Chief Executive Officer Telephone

2.

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):

3. Person to contact regarding this application:

Name and Title

Organization

Address

City County State Zip Code

WORK Email: _____

4.

Type of Project: _____

5. Check the appropriate category, which describes the Applicant.

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
_____ Individual	_____ Corporation	_____ State
_____ Corporation	_____ Church	_____ County
_____ General Partnership	_____ Other (Specify)	_____ Other (Specify)
_____ Limited Partnership	_____	_____
_____ Limited Liability Partnership		
_____ Limited Liability Company		
_____ 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 there is no filing requirement with the Secretary of State, attach other proof of authorization to do business in the State.

7. List the current membership of the Board of Directors and principal officers of the corporation. If a partnership, provide the names of all general partners. Do not provide addresses or personally identifiable information.

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

SECTION B: AUTHORIZATION TO PURSUE THE PROJECT

1. Attach written authorization of the governing body's approval of the proposal and its written authorization 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 THE PROJECT

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

   - Specific services to be provided;
   - Proposed service area and population to be served;
   - Objectives of the project;
   - Components of the project;
   - General organization and management structure; and
   - Capital expenditures associated with the project.
     - Capital expenditure is defined at W.Va. Code § 16-2D-2(10).
     - Expenditure minimum is defined at W.Va. Code § 16-2D-2(15); the expenditure minimum is adjusted yearly on or before December 31 of each year and is posted on the Authority's website.

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 the following table regardless of the effect the project will have on the facility's bed capacity.

BED CLASSIFICATIONS	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						
Med/surg intensive care						
Cardiac intensive care						
Pediatric intensive care						
Neonatal intensive care						
Burn care						
Psychiatric intensive care						
Other special care (specify)						
Other intensive care (specify)						

Total Acute Care						
Skilled Nursing LTC						
Intermediate LTC						
Psychiatric LTC						
I/DD						
Personal care						
Respite						
Rehabilitation						
Chronic disease						
Chemical dependency						
Other (specify)						
Total Non-acute Care						
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. Moveable Equipment Cost

Provide a listing of movable equipment associated with the project. Major items of equipment valued under $100,000 may be grouped by department or services. 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, Lease or Donation:

EQUIPMENT DESCRIPTION	COST	INSTALLATION RENOVATION	FAIR MARKET VALUE	TOTAL COST
TOTAL				

b. Specify terms of maintenance agreement.

6. For construction projects, complete 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. Office of Health Facility Licensure and Certification (OHFLAC) 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 shows 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 proposed changes using the following format:

(A) SERVICE/ DEPT.	(B) EXISTING	PROPOSED PROJECT			TOTAL PROJECT (C-D-E)	TOTAL SERVICE/ DEPT (B-C-D-E)	COST
		(C) NEW	(D) RENOVATED	(E) DELETED			
TOTAL FACILITY							

9. Capital Cost of Project

Complete only those <u>sub-items</u> which apply to your project.

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

		Amount
a.	Site Acquisitions Costs:	
	1. Purchase Price	
	2. Closing Costs	
	3. Other (specify)	
	Subtotal (a)	
b.	Site Preparation Costs:	
	1. Demolition	
	2. Earthwork	
	3. Site Utilities	
	4. Road, Parking and Walks	
	5. Other (specify)	
	a.	
	b.	
	c.	
	Subtotal (b)	
c.	Architectural and Engineering:	
	1. Architectural Fees	
	2. Engineering Fees	
	Subtotal (c)	
d.	Consultant Fees:	
	1. CON Application Preparation Fees	

	2. CON Application Filing Fee	
	3. Other (Specify)	
	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.	Moveable Equipment Costs:	
	From Section C, Question 5	
	Subtotal (f)	
g.	For all types of financing, complete the applicable items:	
	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 area based:

_____

Estimate 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
Land (site) acquired	
Final plans and specifications submitted to the Office of Health Facility Licensure & Certification	
Financing arrangements completed	
Initial capital expenditure obligated	
Construction contract secured and signed	
Construction started	
Remaining capital expenditure obligated	
Equipment orders submitted	
Construction completed	
Request for substantial compliance review submitted to CON Program	
Project completed and in operation	

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

PLEASE NOTE that the Need Methodology of the applicable State Health Plan CON Standards (CON Standards) should be addressed under Section E.

1. Identify the study area or service area for the proposed project as defined in the applicable CON Standards. Please note that multiple Standards may apply. If the identified service area is not defined in the CON Standards, 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 Authority 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 methodology contained in the applicable CON Standards (Data provided by the Authority 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.

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

3. Describe how this proposal will result in the efficient and effective delivery of services.

4. In the case of new construction, what alternatives to new construction, such as modernization or sharing arrangements, have been considered and have been implemented to the maximum extent practicable.

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. Describe how patients will experience serious problems in obtaining care of the type proposed in the absence of the proposed new service.

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

SECTION I: RELATIONSHIP TO THE STATE HEALTH PLAN

1. Address the CON Standards applicable to the proposed project. Please note that multiple Standards may apply. The CON Standards are available on the Authority's website (www.hca.wv.gov).

2. In formatting your responses, please repeat each section of the CON Standards before providing your response.

PLEASE NOTE that the Need Methodology of the applicable CON Standards should be addressed under Section E of this application. All other sections of the applicable CON Standards are addressed under Section I.

SECTION J: 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 and operation 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 K: 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 and other federal, state and local inspection agencies.

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 L: 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 (check appropriate blanks)		**Total Amount**
☐ Lease		$
Land ___ Building ___ Equipment ___ Fair Market Value $_____		
☐ Cash		$
Source:		
☐ Conventional		$
Principal	$	
Interest	$	
Term		
☐ Bonds		$
Principal	$	
Interest	$	
Term		
Debt Service Reserve	$	
☐ Gifts		$
☐ Grants		$
☐ 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 sources(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 M: 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 to the types of employees who are associated with the proposal.

SECTION N: FINANCIAL FEASIBILITY

1. Submit audited financial reports for the most recent two (2) fiscal years. If audited financial reports are not prepared, submit the following financial statements: (1) statement of revenues and expenses; (2) balance sheet; (3) statement of changes in fund balances; and, (4) statement of cash flows for each of last two (2) fiscal years. If a Form 10-K is required to be submitted to the U.S. Securities and Exchange Commission by either the applicant or a related entity, submit the Form 10-K for the preceding two (2) years. The Form 10-K may be submitted on CD.

2. Provide a preliminary financial feasibility study including, at a minimum, pro forma financial statements to include a three (3) year projection of revenues and expenses for the project. If revenues do not equal expenses by the end of the third year, identify other sources of revenue or income which will subsidize the deficit. Applicants must demonstrate in their financial projections that all indigent persons can be served without jeopardizing the financial viability of the project. **Please note** that the applicant must address the criteria in the applicable CON Standards. 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.

3. Provide historical and projected utilization 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 three years of operation. 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 ____				
FY ____				
FY ____				
FY ____				
FY ____				
FY ____				
Inpatient discharges:				
FY ____				
FY ____				

FY ____				
FY ____				
FY ____				
FY ____				

b. AVERAGE LENGTH OF STAY	**PAYOR CLASSIFICATION**			
	MEDICARE	**MEDICAID**	**OTHER**	**TOTAL**
Inpatient days:				
FY ____				
FY ____				
FY ____				
FY ____				
FY ____				
FY ____				
Inpatient discharges:				
FY ____				
FY ____				
FY ____				
FY ____				
FY ____				
FY ____				

c. BEDS AND OCCUPANCY	**LICENSED BEDS**	**PERCENTAGE OCCUPANCY LICENSED**	**BEDS SET UP STAFFED**	**PERCENTAGE OCCUPANCY SET UP**
Inpatient days:				
FY ____				
FY ____				
FY ____				
FY ____				
FY ____				
FY ____				

d. UTILIZATION STATISTICS

Service	Value for Standard Units of Measure	FY	FY	FY	FY
Operating Rooms (General)	Surgery Minutes				
	Patients				
Operating Rooms (Ambulatory)	Surgery Minutes				
	Patients				
Operating Rooms (Open Heart)	Surgery Minutes				
	Patients				
Labor and Delivery Room	Births				
Outpatient					
Clinic	Patient Visits				
Emergency Room	Patient Visits				
Other ____	Patients				
Psychiatric	Patient Visits				
Cardiac Catheterization	Procedures				
Radiological	Procedures				
CT Scan	Procedures				
MRI scan	Procedures				
Kidney Transplant	Procedures				
Lithotripsy	Procedures				
Radiation Therapy	Procedures				
	Patients				
Home Health	Visits				
	Patients				

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

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 P: COMMUNITY SUPPORT

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 of Question 1 of Section A, 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. I further state that the applicant is in full compliance with the financial disclosure provisions of W.Va. Code § 16-29B-18, W.Va. Code § 16-5F-1 *et seq*. or W. Va. C.S.R. § 65-15-1 *et seq*.

_____

(Print Name)

_____

(Signature)

_____

(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____, 20___.

_____

Notary Public

(Notary stamp)

The following affidavit must be completed by the **person who prepared the application** identified in response of Question 3 of Section A, Page 2.

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.

_____

(Print Name)

_____

(Signature)

_____

(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____, 20___.

_____

Notary Public

(Notary stamp)