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| **Section** | **Description** | **Statute Reference** | **Application Page #**  [Completed by the Applicant(s)] |
| A | Identification of Applicant(s) | G.S. 131E-182(b) |  |
| B | Criterion (1) | G.S. 131E-183(a)(1) |  |
| C | Criterion (3) and Rules | G.S. 131E-183(a)(3) and  G.S. 131E-183(b) |  |
| D | Criterion (3a) | G.S. 131E-183(a)(3a) |  |
| E | Criterion (4) | G.S. 131E-183(a)(4) |  |
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| M | Criterion (14) | G.S. 131E-183(a)(14) |  |
| N | Criterion (18a) | G.S. 131E-183(a)(18a) |  |
| O | Criterion (20) | G.S. 131E-183(a)(20) |  |
| P | Proposed Timetable | G.S. 131E-182(b) |  |
| Q | Excel Workbook / Assumptions for Workbook | |  |
| Exhibits – A through O | | Include all supporting documents for Sections A-O in the corresponding Exhibits A-O, which should be labeled as shown in the following example. Exhibit C.4 would include all documents provided to support the response in Section C, Question 4. Exhibit F.1 would include all documents provided to support the response in Section F, Question 1. | |

**Certification Page**

(Include this Certification Page as part of your application)

There are tables for up to three applicants. If there are more than three applicants, copy the first table, insert it below the third table, and change the 1s to 4s. Repeat this process if there are more than four applicants.

|  |  |
| --- | --- |
| **The undersigned hereby certifies that the information included in this application form is correct to the best of my knowledge and belief and that the applicant intends to develop and offer the proposed new institutional health service(s) within the timeframe proposed in Section P and as described in the application.** | |
| Legal Name of **Applicant 1** **\*** |  |
| Name of the Person Certifying for Applicant 1 (print/type name) |  |
| Title |  |
| Signature **\*\*** |  |
| Date Signed |  |

**\*** This should match the name provided in Section A, Question 1.

**\*\*** Inserting a picture of your signature is acceptable.

|  |  |
| --- | --- |
| **The undersigned hereby certifies that the information included in this application form is correct to the best of my knowledge and belief and that the applicant intends to develop and offer the proposed new institutional health service(s) within the timeframe proposed in Section P and as described in the application.** | |
| Legal Name of **Applicant 2** **\*** |  |
| Name of the Person Certifying for Applicant 2 (print/type name) |  |
| Title |  |
| Signature **\*\*** |  |
| Date Signed |  |

**\*** This should match the name provided in Section A, Question 1.

**\*\*** Inserting a picture of your signature is acceptable.

|  |  |
| --- | --- |
| **The undersigned hereby certifies that the information included in this application form is correct to the best of my knowledge and belief and that the applicant intends to develop and offer the proposed new institutional health service(s) within the timeframe proposed in Section P and as described in the application.** | |
| Legal Name of **Applicant 3** **\*** |  |
| Name of the Person Certifying for Applicant 3 (print/type name) |  |
| Title |  |
| Signature **\*\*** |  |
| Date Signed |  |

**\*** This should match the name provided in Section A, Question 1.

**\*\*** Inserting a picture of your signature is acceptable.

**Petition for Expedited Review**

(Include this Petition for Expedited Review as part of your application even if left blank)

Pursuant to G.S. 131E-185 and G.S. 131E-176(7b), the applicant(s) hereby petition that the review of the project identified below be expedited.

|  |  |
| --- | --- |
| Date |  |
| Legal Name of **Applicant 1** **\*** |  |
| Legal Name of **Applicant 2** **\*** |  |
| Legal Name of **Applicant 3** **\*** |  |
| Name of Health Service Facility **\*\*** |  |
| Project Description **^** |  |
| County |  |
| Total Projected Capital Expenditure **^^** |  |
| Name of Person Signing (print/type name) |  |
| Title |  |
| Company |  |
| Signature |  |

**\*** This should match the response provided in Section A, Question 1.

**\*\*** This should match the response provided in Section A, Question 4.a.

**^** This should match the response in Section A, Question 5.a.

**^^** This should match the responses in Section A, Question 3, and Form F.1a or Form F.1b.

In accordance with G.S. 131 E-176(7b), a request for an expedited review cannot be granted unless the Agency finds that all the following conditions are met:

a. The review is not competitive;

b. The proposed capital expenditure is less than five million dollars ($5,000,000);

c. The CON Section has not determined that a public hearing is in the public interest; and

d. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.

**Internal Use Only** (Assistant Chief or Team Leader)

Date: Project ID #: FID #:

a. The review is **not** competitive? Yes No

b. The total projected capital cost is **less than** $5,000,000? Yes No

c. The CON Section has **not** determined that a public hearing is in the public interest? Yes No

If **ALL** the answers above are **YES**, the petition is approved assuming no request for a public hearing is received during the written comment period.

Initials

**Instructions for Completing and Submitting the Application**

(Include these Instruction pages as part of your application)

Contact the CON Section at (919) 855-3873 if you have questions about this application form and ask for the project analyst assigned to the county where the proposal would be located. Project analyst county assignments are available online at: <https://info.ncdhhs.gov/dhsr/coneed/pdf/CountyAssignments.pdf>.

**Application**

1. Pursuant to 10A NCAC 14C .0203(e)(4), each applicant identified in Section A, Question 1, must sign the Certification Page.
2. The burden is on the applicant to demonstrate that its proposal is consistent with or not in conflict with all applicable statutory review criteria and CON rules. Each statutory review criterion is addressed in a separate section of the application form and the language of the statutory review criterion is provided at the beginning of the section. The questions that follow are designed to assist the applicant in providing the information that the CON Section needs in order to determine if the applicant has met its burden.
3. Answer every question. If you believe that a question is not applicable to your project, explain why you believe the question is not applicable. Failure to answer a question is not a basis for finding the application nonconforming if the necessary information is provided elsewhere in your application or exhibits but it is preferred that the information appear where it is requested.
4. Answer as many questions on a single page as space permits, but the first question of each section should begin on a new page.
5. Insert a tabbed divider between each section.
6. Do **not** change headers, footers, margins, font, font size, or page orientation in the Word document (Sections A - P) or the Excel spreadsheets in Section Q.
7. Do **not** bold entire questions. Do **not** bold entire responses. Applicants may use underlining or bold for emphasis in narrative responses.
8. There are page breaks in the blank Word document and Excel spreadsheets. The applicant may change the page breaks as necessary and is strongly encouraged to reset the page breaks and insert new ones so material that should be on the same page remains on the same page whenever possible (particularly tables).
9. Complete the tables in the Word document (Sections A - P) where they appear in the application form. Do **not** place them in an exhibit. Do not modify the tables except for: adding rows; deleting rows; adding dates or a facility name to a header; or making other edits specifically addressed in the instructions for the table.

**Exhibits**

1. Exhibits
   1. Paper versions– the exhibits should be bound together **separately** from the application form.
   2. Electronic versions – the exhibits should be saved as a **separate** pdf from the pdf of the application.
2. Provide a table of contents for the exhibits. If more than one volume of exhibits is submitted, place a complete table of contents at the beginning of each volume.
3. Insert a tabbed divider in front of each exhibit.
4. Do not submit originals of folded, stapled, or bound annual reports, brochures, or pamphlets as exhibits. Instead, such materials should be photocopied on 8.5” x 11” paper. Oversized line drawings, surveys and maps may be inserted in plastic sleeves bound in the application. All other oversized or undersized exhibits should be photocopied on 8.5” x 11” paper.
5. If you include more than one document in an exhibit, number the pages in the exhibit (the numbers may be handwritten) and reference both the letter and the page number of the exhibit when citing to the document in the application.

**Submitting the Application**

1. Pursuant to 10A NCAC 14C .0203(e), each volume of the application **must be bound together by punching holes in the left-hand margin and fastening the pages together with a metal paper fastener** (e.g., ACCO ® Paper Fasteners). Place a sturdy cover on the front and back to protect the first and last pages from damage. **Do not submit the application in a 3-ring binder or notebook.**
2. Pursuant to 10A NCAC 14C .0203(e), the applicant is required to submit a signed original and a copy of the application. The original application, including exhibits, must be printed, placed between a front and back cover, bound with metal fasteners, and submitted as a “hard copy.” The applicant may submit the **copy** of the application on a flash drive in lieu of a second paper copy. If the applicant chooses to submit the copy on a flash drive, the application and exhibits must be converted to PDF, saved on one flash drive, and shall not be encrypted or password protected. No more than one application, including exhibits, should be saved onto the same flash drive.
3. Submit the signed original and one copy of the completed application with the application fee to:

**Via US Postal Service: Healthcare Planning and Certificate of Need Section, DHSR, DHHS**

**2704 Mail Service Center**

**Raleigh NC 27699-2704**

**OR**

**Via Hand Delivery or Overnight [[1]](#footnote-1) Healthcare Planning and Certificate of Need Section, DHSR, DHHS**

**809 Ruggles Drive**

**Raleigh, NC 27603**

1. Pursuant to 10A NCAC 14C .0203(e), both the signed original, the copy of the completed application, **and the entire application fee** **must be received** by the CON Section by the application deadline which is **5:00 PM** on the **15th of the month prior to the beginning of the review period**, unless the 15th is on a weekend or holiday, then the application deadline is no later than **5:00 PM** on the next business day.
2. If you are requesting an **expedited review** pursuant to G.S. 131E-185(a2) and G.S. 131E-176(7b), complete the **Petition for Expedited Review** on page 3 of this application form.
3. Pursuant to 10A NCAC 14C .0203(j), an application will **not** be included in a scheduled review **unless it is received by the CON Section no later than 5:00 PM on the application deadline** shown in the SMFP for the review period.
4. **Once the application is received** bythe CON Section, pursuant to 10A NCAC 14C .0204 **it** **may not be amended**. Any additional information submitted to the CON Section related to the application after the application deadline that was **not** requested by the CON Section, may have the effect of amending the application. Therefore, do not state in the application that documents will be submitted later (e.g., letters of support, transfer or referral agreements, letters from health care providers agreeing to provide services, service contracts, letters from financial institutions or others regarding funding for the project, and options on property).
5. **All information submitted in an application** received by the CON Section is **public** information and is **subject to disclosure** upon written request and availability.

**Definitions for Terms Used in the Application Form**

(Include these Definitions pages as part of your application)

**If any definition in this section is not consistent with the definition of the same term found in the CON Law or Rules, the definition in the CON Law or Rules controls.**

**Adult care home (ACH)**: The term “ACH,” which is defined in G.S. 131E-176(1), means “*A facility with seven or more beds licensed under Part 1 of Article 1 of Chapter 131D of the General Statutes or under this Chapter that provides residential care for aged individuals or individuals with disabilities whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.”*

**Adults**: The term “adults” means individuals age 18 or older.

**Ambulatory surgical facility (ASF)**: The term “ASF,” which is defined in G.S. 131E-176(1b), means *“A facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional, or general anesthesia and a period of post‑operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room or gastrointestinal endoscopy room and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under Part 4 of Article 6 of this Chapter, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.”*

**Applicant**: For the purposes of completing this application form, the term “applicant” means each person, as that term is defined in G.S. 131E-176(19), who will:

* Incur an obligation for a capital expenditure to develop or offer the proposed new institutional health service(s); or
* Offer or develop the proposed new institutional health service(s).

**Application deadline**: The term “application deadline,” which is defined in 10A NCAC 14C .0202(2), means *“no later than 5:00 p.m. on the 15th day of the month preceding the month that the review period begins. If the 15th day of the month falls on a weekend or a State holiday as set forth in* *25 NCAC 01E .0901, which is hereby incorporated by reference including subsequent amendments and editions, the application deadline is the next business day.”*

**Application**: The term “application” means the application form as submitted, including any exhibits.

**Application form**: The term “application form” means the Microsoft Word document (Table of Contents, Certification Page, Petition for Expedited Review, Instructions, Definitions, and Sections A - P), and the Microsoft Excel file (Section Q).

**Bed capacity:** The term “bed capacity,” which is defined in G.S. 131E-176(2), means *“Space used exclusively for inpatient care, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage.”*

**Campus**: The term “campus,” which is defined in G.S. 131E-176(2c), means *“The adjacent grounds and buildings, or grounds and buildings not separated by more than a public right‑of‑way, of a health service facility and related health care entities.”*

**Capital cost**: The term “capital cost” has the same meaning as the term “capital expenditure” which is defined in G.S. 131E-176(2d) as *“An expenditure for a project, including but not limited to the cost of construction, engineering, and equipment which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance. Capital expenditure includes, in addition, the fair market value of an acquisition made by donation, lease, or comparable arrangement by which a person obtains equipment, the expenditure for which would have been considered a capital expenditure under this Article if the person had acquired it by purchase.”*

**Change in bed capacity**: The term “change in bed capacity,” which is defined in G.S. 131E-176(5), means *“Any of the following:*

*a. Any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another.*

*b. Any redistribution of health service facility bed capacity among the categories of health service facility bed.*

*c. Any increase in the number of health service facility beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.”*

**Change of scope**: For the purpose of completing this application form, the term “change of scope” means adding a new service component or changing a service component in a way that is not materially consistent with the representations made in the previously approved application (original project) if the change is proposed during development of the original project or within 12 months after the original project was determined to be complete by the CON Section. It also means a change of location which is not materially consistent with the representations made in the original project if proposed during development of the original project. **Please contact the CON Section if you have any question about whether the proposal is a change of scope of a previously approved application.**

**Chemical dependency (substance use disorder) treatment facility**: The term “substance use disorder treatment facility,” which is defined in G.S. 131E-176(5a), means “*A public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or a substance use disorder. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of individuals with chemical dependence or substance use disorders, and related services.”* This may be a unit in an acute care or psychiatric hospital, a freestanding unit licensed as part of an acute care hospital or psychiatric hospital, or a freestanding facility. This definition does not include detox beds, detox facilities, or halfway houses.

**Children/Adolescents**: The term “children/adolescents” means individuals from birth through age 17.

**Combination nursing facility**: The term “combination nursing facility,” defined in G.S. 131E-101(1a) as a “combination home,” means *“a nursing home offering one or more levels of care, including any combination of skilled nursing, intermediate care, and adult care home.”*

**CMS**: The term “CMS” means the Centers for Medicare and Medicaid Services, part of the U.S. Department of Health and Human Services.

**CON rules**: The term “CON rules” refers to the rules promulgated in 10A NCAC 14C (Subchapter 14C).

**CON Section**: The term “CON Section,” which is defined in 10A NCAC 14C .0202(4),” means *“the Healthcare Planning and Certificate of Need Section of the Division of Health Service Regulation.”*

**Continuing care retirement community (CCRC)**: The term “CCRC” means a retirement community or communities in which a provider undertakes to provide continuing care to an individual. The term “continuing care” is defined in G.S. 58-64-1(1) to mean “*The furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, under a contract approved by the Department* [of Insurance] *in accordance with … Article* [64 of Chapter 58 of the NC General Statutes] *effective for the life of the individual or for a period longer than one year.”*

**Cost overrun**: For the purpose of completing this application form, the term “cost overrun” means an increase of more than 115% of the approved capital expenditure for a project for which a certificate of need was issued (original project) if the increase is proposed during development of the original project or within 12 months after the original project was determined to be complete by the CON Section.

**Diagnostic center**: The term “diagnostic center,” which is defined in G.S. 131E-176(7a), means *“A freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000).”*

**Entire facility**: For the purpose of completing this application form, the term “entire facility” means all service components offered by a health service facility or all service components offered on all campuses on the same hospital license.

Some questions ask for information regarding either the **entire facility** or **campus**. Most applicants should provide a response for the entire facility. Depending on the nature of the project, **facilities with more than one campus on the same license** mayprovide a response for the campus identified in Section A, Question 4, not the entire facility unless a policy in the SMFP or a CON rule requires a response for the entire facility.

**Facility**: For the purpose of completing this application form, the term “facility” means a health service facility.

**Facility identification number (FID#)**: The term “FID#” means the unique 6-digit number assigned to each health service facility in the Division of Health Service Regulation’s databases.

**Full fiscal year (FY)**: The term “full FY,” which is defined in 10A NCAC 14C .0202(5), means *“the 12-month period used by the applicant to track and report revenues and operating expenses for the services proposed in the application.”* For the purpose of completing this application form, the term also means the 12-month period used by the applicant to track and report numbers of patients, cases, procedures, or treatments. Examples of typical full FYs are:

* January 1st to December 31st;
* July 1st to June 30th; or
* October 1st to September 30th.

**Gastrointestinal endoscopy room (GI endo room)**: The term “GI endo room,” which is defined in G.S. 131E-176(7d), means *“A room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.”*

**Health service**: The term “health service,” which is defined in G.S. 131E-176(9a), means *“An organized, interrelated activity that is medical, diagnostic, therapeutic, rehabilitative, or a combination thereof and that is integral to the prevention of disease or the clinical management of an individual who is sick or injured or who has a disability. ‘Health service’ does not include administrative and other activities that are not integral to clinical management.”*

For the purposes of completing this application form, the term health service includes but is not limited to the following services: hospital;**[[2]](#footnote-2)** adult care home; bone marrow transplantation; burn intensive care; cardiac catheterization; GI endoscopy; home health; hospice home care; hospice inpatient; hospice residential; inpatient psychiatric; inpatient rehabilitation; intermediate care for persons with intellectual disabilities; long-term care hospital; medical equipment; neonatal intensive care; nursing home facility; open heart; solid organ transplantation; substance use disorder treatment; and surgical (ORs).

**Health service facility**: For the purpose of completing this application form, the term “health service facility,” which is defined in G.S. 131E-176(9b), means *“A* *hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; … intermediate care facility for individuals with intellectual disabilities; home health agency office; chemical dependency treatment facility; diagnostic center; hospice office,**hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.”*

**Health service facility bed**: The term “health service facility bed,” which is defined in G.S. 131E-176(9c), means *“A bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) psychiatric beds; (iii) rehabilitation beds; (iv) nursing home beds; (v) intermediate care beds for individuals with intellectual disabilities; (vi) chemical dependency treatment beds; (vii) hospice inpatient facility beds; (viii) hospice residential care facility beds; (ix) adult care home beds; and (x) long-term care hospital beds.”*

**Health system**: For the purpose of completing this application form, the term “health system” has the same meaning as that term is defined in Chapter 6 in the State Medical Facilities Plan (SMFP) in effect at the time the review begins. The SMFP can be obtained at no cost on the Division’s website at: <https://info.ncdhhs.gov/dhsr/ncsmfp/index.html>.

**Home health agency**: The term “home health agency,” which is defined in G.S. 131E-176(12), means *“A private organization or public agency, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services.”*

**Home Health Definitions**

**Duplicated clients**: For home health agency proposals, the term “duplicated clients” means the total number of home health clients served or projected to be served during a given fiscal year by each staff discipline. If the client is seen by more than one discipline, the related client visits should be counted under each staff discipline.

**Unduplicated clients**: For home health agency proposals, the term “unduplicated clients” means the total number of home health clients served or projected to be served during a given fiscal year. Each home health client should be counted only once regardless of the number of times the clients are admitted during the given fiscal year.

**Staff discipline**: For home health agency proposals, the term “staff discipline” means nursing (RN or LPN), physical therapy, occupational therapy, speech therapy, medical social worker, or home health aide.

**Visits**: For home health agency proposals, the term “visits” means direct care visits provided to the client by home health staff members or by others under contract with the home health agency for which the home health agency bills the client.

**Hospice**: The term “hospice,” which is defined in G.S. 131E-176(13a), means *“Any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.”*

**Hospice Home Care Definitions**

**Days of care**: For hospice home care proposals, the term “days of care” means the number of days hospice services were provided by a hospice office during a given fiscal year. Count or include all days for each episode for patients with multiple episodes of care during the same fiscal year.

**New (unduplicated) admissions:** For hospice home care proposals, the term “new (unduplicated) admissions” means patients admitted or projected to be admitted to the facility for the first-time during a given fiscal year. Patients admitted or projected to be admitted multiple times within the same fiscal year should only be included or counted once. Patients carried over from the previous fiscal year should not be included or counted.

**Patients served**: For hospice home care proposals, the term “patients served” includes patients carried over from the previous fiscal year and new (unduplicated) admissions during a given fiscal year. However, patients admitted more than once during the same fiscal year should be counted or included only once.

**Hospice inpatient facility:** The term “hospice inpatient facility,” which is defined in G.S. 131E-176(13b), means *“A freestanding licensed hospice facility or a designated inpatient unit in an existing health service facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in an inpatient setting.”*

**Hospice residential care facility**: The term “hospice residential care facility,” which is defined in G.S. 131E-176(13c), means *“A* *freestanding licensed hospice facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in a group residential setting.”*

**Hospital**: The term “hospital,” which is defined in G.S. 131E-176(13), means *“A public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. The term includes all facilities licensed pursuant to G.S. 131E‑77, except long-term care hospitals.”*

For the purpose of completing this application form, the term refers to acute care hospitals.

**Hospital services**: For the purpose of completing this application form, the term “hospital services” refers to services provided by acute care hospitals, long-term care hospitals, and inpatient rehabilitation hospitals. It includes but is not limited to the following services: nursing (general med/surg, intensive care, neonatal, pediatric, obstetric, etc.); emergency; laboratory; radiology (imaging and interventional); pharmacy; physical, occupational and speech therapies; cardiopulmonary therapy; GI endoscopy; and surgical (ORs).

**Immediate jeopardy**: The term “immediate jeopardy,” which is defined in 42 CFR Part 489.3, means *“a situation in which the provider’s … non-compliance with one or more requirements, conditions of participation, conditions for coverage, or conditions for certification has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient.”*

**Initial operating costs**: For the purpose of completing this application form, the term “initial operating costs” means the difference between:

1. total cash outflow (operating costs) during the initial operating period for the entire facility; and
2. total cash inflow (revenues) during the initial operating period for the entire facility.

**Initial operating period**: For the purpose of completing this application form, the term “initial operating period” means the number of months, if any, during which cash outflow (operating costs) for the entire facility exceeds cash inflow (revenues) for the entire facility.

**Intermediate care facility for individuals with intellectual disabilities (ICF/IID)**: The term “ICF/IID,” which is defined in G.S. 131E-176(14a), means *“Facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.”*

**Inpatient rehabilitation bed**: The term “inpatient rehabilitation bed” means a bed licensed as an inpatient rehabilitation bed and included in the inventory of inpatient rehabilitation beds in the SMFP.

**Local management entity/Managed care organization (LME/MCO)**: The term “LME/MCO,” which is defined in G.S. 122C-3(20c), means *“a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act or to operate a BH IDD tailored plan.”*

**Long-term care hospital (LTCH)**: The term “LTCH,” which is defined in G.S. 131E-176(14k), means *“A hospital that has been classified and designated as a long-term care hospital by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 412.”*

**Main campus**: For the purpose of completing this application form, the term “main campus” means the campus of a facility with more than one campus on the same license where the facility provides clinical patient services and exercises financial and administrative control over the entire facility. **The term as used in this application form is similar to but not identical to the same term as defined in G.S. 131E-176(14n)**.

**Major medical equipment**: The term “major medical equipment,” which is defined in G.S. 131E-176(14o), means *“A single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than seven hundred fifty thousand dollars ($750,000).”* The term as used in this application form does NOT include: cardiac catheterization equipment; gamma knives; heart‑lung bypass machines; linear accelerators; lithotriptors; MRI scanners; PET scanners; or simulators.

**Medical equipment**: For the purpose of completing this application form, the term “medical equipment” means equipment used to diagnose and treat patients, including the following:

* + Cardiac catheterization equipment, gamma knives, heart‑lung bypass machines, linear accelerators, lithotriptors, MRI scanners, PET scanners, or simulators;
  + Major medical equipment as that term is defined in G.S. 131E-176(14o); and
  + For diagnostic center proposals, any unit of diagnostic medical equipment costing $10,000 or more.

**Medically indigent**: For the purpose of completing this application form, the term “medically indigent” means patients with no health insurance; inadequate health insurance; or low-income patients with health insurance plans with high deductibles, co-pays or coinsurance provisions.

**Medically underserved**: For the purpose of completing this application form, the term “medically underserved” means the types of patients described in G.S. 131E-183(a)(13), including medically indigent or low-income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and persons with disabilities.

**Multispecialty ambulatory surgical program**: The term “multispecialty ambulatory surgical program,” which is defined in G.S. 131E-176(15a), means *“A formal program for providing on a same‑day basis surgical procedures for at least three of the following specialty areas: gynecology, otolaryngology, plastic surgery, general surgery, ophthalmology, orthopedic, or oral surgery.”*

**New institutional health service**: The term “new institutional health service,” which is defined in G.S. 131E-176(16), means *“Any of the following:*

*a. The construction, development, or other establishment of a new health service facility.*

*b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding two million dollars ($2,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds two million dollars ($2,000,000).*

*c. Any change in bed capacity.*

*d. The offering of … home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.*

*e. A change in a project that was subject to certificate of need review and for which a certificate of need was issued, if the change is proposed during the development of the project or within one year after the project was completed. For purposes of this subdivision, a change in a project is a change of more than fifteen percent (15%) of the approved capital expenditure amount or the addition of a health service that is to be located in the facility, or portion thereof, that was constructed or developed in the project.*

*f. The development or offering of a health service as listed in this subdivision by or on behalf of any person:*

*1. Bone marrow transplantation services.*

1. *Burn intensive care services.*

*2a. Cardiac catheterization services, except cardiac catheterization services provided on equipment furnished by a person authorized to operate the equipment in North Carolina pursuant to either a certificate of need issued for mobile cardiac catheterization equipment or a settlement agreement executed by the Department for provision of cardiac catheterization services.*

*3. Neonatal intensive care services.*

*4. Open‑heart surgery services.*

*5. Solid organ transplantation services.*

*f1. The acquisition by purchase, donation, lease, transfer, or comparable arrangement of any of the following equipment by or on behalf of any person:*

*1. Air ambulance.[[3]](#footnote-3)*

*2. Repealed.*

*3. Cardiac catheterization equipment.*

*4. Gamma knife.*

1. *Heart‑lung bypass machine.*

*5a. Linear accelerator.*

*6. Lithotriptor.*

*7. Magnetic resonance imaging scanner.*

1. *Positron emission tomography scanner.*
2. *Simulator.*

*g.to k. Repealed.*

*l. The purchase, lease, or acquisition of any health service facility, or portion thereof, or a controlling interest in the health service facility or portion thereof, if the health service facility was developed under a certificate of need issued pursuant to G.S. 131E‑180* [Health Maintenance Organizations]*.*

*m. Any conversion of nonhealth service facility beds to health service facility beds.*

*n. The construction, development or other establishment of a hospice, hospice inpatient facility, or hospice residential care facility.*

*o. The opening of an additional office by an existing home health agency* ***or*** *hospice within its service area as defined by rules adopted by the Department; or the opening of any office by an existing home health agency or hospice**outside its service area as defined by rules adopted by the Department.*

*p. The acquisition by purchase, donation, lease, transfer, or comparable arrangement by any person of major medical equipment.*

*q. The relocation of a health service facility from one service area to another.*

*r. The conversion of a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program.*

*s. The furnishing of mobile medical equipment to any person to provide health services in North Carolina, which was not in use in North Carolina prior to the adoption of this provision, if the equipment would otherwise be subject to review in accordance with sub-subdivision f1. of this subdivision or sub-subdivision p. of this subdivision if it had been acquired in North Carolina.*

*t. Repealed.*

1. *The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right‑of‑way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.*
2. *The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility’s license in effect as of January 1, 2005.”*

**Nursing Home Facility (NF)**: The term “NF,” which is defined in G.S. 131E-176(17b), means “*A health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds.”*

**Operating room (OR)**: The term “OR,” which is defined in G.S. 131E-176(18c), means “*A room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room.”*

**OR Need Methodology**: For the purpose of completing this application form, the term “OR Need Methodology” means the methodology for projecting OR need as described in Chapter 6 in the SMFP in effect on the date the review begins. The SMFP can be obtained at no cost on the Division’s website at: <https://info.ncdhhs.gov/dhsr/ncsmfp/index.html>.

**Person**: The term “person,” which is defined in G.S. 131E-176(19), means *“An individual; a trust or estate; a partnership; a corporation, including associations, joint stock companies, and insurance companies; the State; or a political subdivision or agency or instrumentality of the State.”*

**Proposal**: For the purposes of completing this application form, the term “proposal,” which is defined in 10A NCAC 14C .0202(9), means the new institutional health service(s) proposed in this application form.

**Psychiatric bed**: The term “psychiatric bed” means a bed licensed as a psychiatric bed and included in the inventory of psychiatric beds in the SMFP.

**Psychiatric facility**: The term “psychiatric facility,” which is defined in G.S. 131E-176(21), means *“A public or private facility licensed pursuant to Article 2 of Chapter 122C of the General Statutes and which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of individuals with mental illness.”*

**Rehabilitation facility:** The term “rehabilitation facility,” which is defined in G.S. 131E-176(22), means *“A public or private inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of individuals with disabilities through an integrated program of medical and other services which are provided under competent, professional supervision.”* In this application form, this type of facility is referred to as an inpatient rehabilitation hospital.

**Related entity:** The term “related entity,” which is defined in 10A NCAC 14C .0202(10), means *“a person that:*

*(a) shares the same parent corporation or holding company with the applicant;*

*(b) is a subsidiary of the same parent corporation or holding company as the applicant; or*

*(c) participates with the applicant in a joint venture that provides the same type of health services proposed in the application.”*

**Satellite campus**: For the purpose of completing this application form, the term “satellite campus” means any campus on the license of a health service facility with more than one campus on the same license other than the main campus.

**Service area**: The term “service area,” which is defined in G.S.131E-176(24a), means *“The area of the State, as defined in the State Medical Facilities Plan* [SMFP] *or in rules adopted by the Department, which receives services from a health service facility.”* If neither the SMFP nor the CON Rules define the service area, the service area is the same as the projected patient origin reported in Section C, Question 3.

**Service component**: For the purpose of completing this application form, the term “service component” means each type of the following included in the proposal:

* Health service facility bed;
* Health service;
* Hospital service; or
* Medical equipment.

**Special care unit (SCU)**: The term “SCU” means either:

1. ACH *“a wing or hallway within an adult care home, or a program provided by an adult care home, that is designated especially for residents with Alzheimer's disease or other dementias, a mental health disability, or other special needs disease or condition as determined by the Medical Care Commission.”* [G.S.131D-4.6(a)] or
2. NF *“a wing or hallway within a nursing home, or a program provided by a nursing home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Commission, which may include mental disabilities.”* [G.S. 131E-114(e)]

**Specialty ambulatory surgical program**: The term “specialty ambulatory surgical program,” which is defined in G.S. 131E-176(24f), means *“A formal program for providing on a same‑day basis surgical procedures for only the specialty areas identified on the ambulatory surgical facility's 1993 Application for Licensure as an Ambulatory Surgical Center and* [or] *authorized by its certificate of need.”*

**Start-up costs**: For the purpose of completing this application form, the term “start-up costs” means costs that are:

* not capital costs based on generally accepted accounting principles;
* necessary in order to offer the proposed new institutional health service; and
* incurred prior to offering the proposed new institutional health service.

**State Medical Facilities Plan (SMFP)**: For the purpose of completing this application form, the term “SMFP,” which is defined in G.S. 131E-176(25), means the annual SMFP signed by the Governor that is in effect as of the application deadline. The SMFP can be obtained at no cost on the Division’s website at: <https://info.ncdhhs.gov/dhsr/ncsmfp/index.html>.

**Substandard quality of care**: For the purpose of completing this application form, the term “substandard quality of care” refers to Level 4 (immediate jeopardy) CMS survey deficiencies in a **nursing home facility** if the requirement that is not met falls under:

* 42 CFR 483.13 Resident Behavior and Facility Practices;
* 42 CFR 483.15 Quality of Life; or
* 42 CFR 483.25 Quality of Care.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Severity** | | **Scope** | | |
| **Isolated** | **Pattern** | **Widespread** |
| **Level 4** | Immediate jeopardy to resident health or safety | J | K | L |
| **Level 3** | Actual harm that is not immediate jeopardy | G | H | I |
| **Level 2** | No actual harm with potential for more than minimal harm that is not immediate jeopardy | D | E | F |
| **Level 1** | No actual harm with potential for minimal harm | A | B | C |

**Section A - Identification**

1. **Applicant(s):** There are tables for up to three applicants. See the definitions for who should be identified as an applicant. If there are more than three applicants, copy the first table, insert it below the third table, and change the 1 to a 4. Repeat this process if there are more than four applicants.

|  |  |  |
| --- | --- | --- |
| **Applicant 1** | | |
| Business ID # (Internal Use Only) | |  |
| Legal Name (do NOT include a d/b/a) | |  |
| Street or Post Office Box | |  |
| City | |  |
| State | |  |
| ZIP Code | |  |
| Name of parent or holding company | |  |
| Is this an existing legal entity? |  | If not an existing legal entity, briefly explain in the cell below |
|  | | |

|  |  |  |
| --- | --- | --- |
| **Applicant 2** | | |
| Business ID # (Internal Use Only) | |  |
| Legal Name (do NOT include a d/b/a) | |  |
| Street or Post Office Box | |  |
| City | |  |
| State | |  |
| ZIP Code | |  |
| Name of parent or holding company | |  |
| Is this an existing legal entity? |  | If not an existing legal entity, briefly explain in the cell below |
|  | | |

|  |  |  |
| --- | --- | --- |
| **Applicant 3** | | |
| Business ID # (Internal Use Only) | |  |
| Legal Name (do NOT include a d/b/a) | |  |
| Street or Post Office Box | |  |
| City | |  |
| State | |  |
| ZIP Code | |  |
| Name of parent or holding company | |  |
| Is this an existing legal entity? |  | If not an existing legal entity, briefly explain in the cell below |
|  | | |

2. **Contact Individual**: The **one** individual to whom all correspondence regarding this application should be directed by the CON Section. The individual should be able to provide clarifying or supplemental information regarding this application if requested by the CON Section during the review. If a certificate of need is issued for the project, the certificate holder(s) may designate a different individual to be the contact individual to whom all correspondence related to progress reports will be directed by the CON Section. The Agency Decision and Required State Agency Findings for your application will be mailed and emailed to the Contact Individual.

|  |  |
| --- | --- |
| **Contact Individual** | |
| Individual ID # (Internal Use Only) |  |
| Name (First, Middle, Last) **\*** |  |
| Title |  |
| Street or Post Office Box **\* ^** |  |
| City **\*** |  |
| State **\*** |  |
| ZIP Code **\*** |  |
| Direct Telephone Number **\*** |  |
| Email Address **\*** |  |

**\*** Required

**^** Provide the address where mail is received.

3. **Total Projected Capital Cost \***

|  |
| --- |
| **$** |

**\*** The total projected capital cost must equal the total capital cost reported in Form F.1a Capital Cost or Form F.1b Capital Cost for Cost Overrun or Change of Scope, both of which are found in Section Q.

4. **Health Service Facility:** Respond for the facility or campus where the proposal will be developed or offered.

a. **Name and Site Address**

|  |  |
| --- | --- |
| Name **\*** |  |
| Street Address **^** |  |
| City **^** |  |
| State | North Carolina |
| ZIP Code **^** |  |
| County |  |
| FID # **\*\*** |  |
| License Number |  |
| Provider Number |  |

**\*** If the proposal will be developed or offered at an existing facility, this should be the name as it appears on the facility’s current license or signage. For new facilities, this should be the name as it will appear on the facility’s license or signage. The name should not include any of the following: Inc., Incorporated, Corp., LLC, PA, etc. unless those terms are actually part of the d/b/a name.

**^** For new facilities, relocations of an entire existing facility, or new campuses of a facility with multiple campuses on the same license, this must be the same as the site address provided in Section K, Question 4.a. Please be as specific as possible.

**\*\*** The FID # can be found on the license along with the license number. To obtain the FID # for an existing diagnostic center, contact the Project Analyst for the county where the diagnostic center is located.

b. **Type of Health Service Facility** (Do **NOT** check more than one type)

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Health Service Facility** | | **Internal Use Only** | |
| **MFF** | **Access** |
|  | Adult Care Home (ACH) | HA | ACH |
|  | Ambulatory Surgical Facility (ASF) | AS | ASC |
|  | Diagnostic Center | DIA | DXCTR |
|  | Home Health Agency | HC | HC |
|  | Hospice Home Care | HOS | HOSPICE |
|  | Hospice Inpatient / Residential Care | HOS | HOSPICE |
|  | Hospital | HL | HOSPITAL |
|  | ICF/IID | MHL | MHL |
|  | Inpatient Rehabilitation Hospital | HL | HOSPITAL |
|  | Long-term Care Hospital (LTCH) | HL | HOSPITAL |
|  | Nursing Facility (NF) | NH | NF |
|  | Psychiatric Facility (10A NCAC 27G .6000) | MHH | MHH |
|  | Psychiatric Unit (or Campus) on a Hospital License | HL | HOSPITAL |
|  | Substance Use Disorder (SUD) (10A NCAC 27G .3400) | MHL | MHL |

c. If the type of health service facility selected in Question 4.b is an **ASF**, complete the following table by checking **each** surgical specialty that will be offered at the facility upon completion of this project. **Do not change or add any other specialties**. The specialties listed below are the only ones listed in the definition of multispecialty ambulatory surgical program found in G.S. 131E-176(15a) and the Definitions section of the application form.

|  |  |
| --- | --- |
|  | Gynecology |
|  | Otolaryngology |
|  | Plastic Surgery |
|  | General Surgery |
|  | Ophthalmology |
|  | Orthopaedic |
|  | Oral Surgery |

d. If the type of health service facility selected in Question 4.b is a **hospital, LTCH, or rehabilitation hospital**, indicate in the following table whether the facility does or will consist of multiple campuses on the same license. If the facility does or will consist of multiple campuses on the same license, identify all existing, approved, and proposed campuses by name and indicate which campus is the main campus. Add more rows if necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| Does or will the facility consist of multiple campuses on one license? | |  | |
| If you answered yes, identify all existing, approved, and proposed campuses that are or would be on the same license and identify which one is or will be the main campus. | | | |
| **Name of Campus** | **Existing, Approved or Proposed?** | | **Main Campus?** |
|  |  | |  |
|  |  | |  |
|  |  | |  |

e. **Ownership and Operation**

|  |  |
| --- | --- |
| **Building** | |
| Does or will an applicant own the building? |  |
| If not, identify the owner of the building |  |
| **Land** | |
| Does or will an applicant own the land? |  |
| If not, identify the owner of the land |  |
| **Operator** | |
| Does or will an applicant operate the facility? |  |
| If not, identify the operator of the facility |  |

5. **Proposal**

a. **Description**: Provide a brief, one or two sentence description of the proposal in the table below.

|  |
| --- |
|  |

b. Check **all** the following that describe this proposal.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Acquiring equipment (Complete 5.f below) | | |
|  | Change of scope for previously approved project(s) | Project ID #(s) |  |
|  | Cost overrun for previously approved project(s) | Project ID #(s) |  |
|  | Developing a new campus of <insert name of hospital here>, an existing acute care hospital **\*** | | |
|  | Developing a new health service facility **\*** | | |
|  | Developing a satellite emergency department (ED) of <insert name of hospital here> | | |
|  | Developing or offering a service component in response to a need determination in the SMFP | | |
|  | Physically expanding the existing health service facility on the same campus | | |
|  | Relocating a service component to a new, existing or previously approved facility or campus | | |
|  | Relocating the entire existing health service facility to a new campus **\*** | | |
|  | Renovating the existing health service facility on the existing campus | | |

**\*** Developing a new campus of an existing facility with multiple campuses on the same license or relocating the entire health service facility to a new campus is **not** the development of a **new** health service facility.

c. **Health Services**: Check **each** health service included in this proposal.

|  |  |
| --- | --- |
|  | Adult care home |
|  | Bone marrow transplantation |
|  | Burn intensive care |
|  | Cardiac catheterization |
|  | GI endoscopy |
|  | Home health |
|  | Hospice home care |
|  | Hospice inpatient |
|  | Hospice residential |
|  | Hospital (Complete 5.d below) |
|  | Inpatient psychiatric |
|  | Inpatient rehabilitation (Complete 5.d below) |
|  | Intermediate care for persons with intellectual disabilities |
|  | Long-term care hospital (Complete 5.d below) |
|  | Medical equipment (Complete 5.f below) |
|  | Neonatal intensive care |
|  | Nursing home facility |
|  | Open heart |
|  | Solid organ transplantation |
|  | Substance use disorder treatment |
|  | Surgical |
|  | Other (**describe**) |

d. **Hospital Services**: If the facility is an acute care hospital, LTCH, or inpatient rehabilitation hospital and the proposal includes hospital services, complete the following table by checking **each** hospital service included in this proposal.

|  |  |
| --- | --- |
|  | Nursing (general med/surg, intensive care, neonatal, pediatric, obstetric, etc.) |
|  | Emergency |
|  | Laboratory |
|  | Radiology (imaging and interventional) |
|  | Pharmacy |
|  | Physical therapy |
|  | Occupational therapy |
|  | Speech therapy |
|  | Cardiopulmonary therapy |
|  | GI endoscopy |
|  | Surgical |
|  | Other (**describe**) |

e. **Health Service Facility Beds**: Complete the table **only** for the **types of health service facility beds included in this proposal**. Facilities with more than one campus on the same license, should provide the information for the entire facility (i.e., all campuses on that license).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Health Service Facility Bed** | **Currently Licensed** | **Previously Approved to be Added or (Deleted)** | **Proposed as Part of this Project** | **Total Upon Completion of all Projects** |
| Acute Care Hospital |  |  |  |  |
| Burn Intensive Care Unit (BICU) |  |  |  |  |
| Neonatal Intensive Care Unit (NICU) \* |  |  |  |  |
| Long-term Care Hospital |  |  |  |  |
| Inpatient Rehabilitation |  |  |  |  |
| Nursing Facility |  |  |  |  |
| Adult Care Home |  |  |  |  |
| Hospice Inpatient |  |  |  |  |
| Hospice Residential |  |  |  |  |
| Adult Psychiatric |  |  |  |  |
| Child/Adolescent Psychiatric |  |  |  |  |
| Adult Substance Use Disorder (SUD) |  |  |  |  |
| Child/Adolescent SUD |  |  |  |  |
| ICF/IID |  |  |  |  |

**\*** If the NICU beds are also new acute care beds pursuant to a need determination in Chapter 5, in addition to completing this line, also provide the total number of acute care beds on the license on the Acute Care Hospital line.

f. **Medical** **Equipment**: Complete the table **only** for the **types of medical equipment included in this proposal**. Facilities with more than one campus on the same license should provide the information for the entire facility (i.e., all campuses on that license).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Medical Equipment** | **Number of Units** | | | |
| **Existing** | **Previously Approved to be Added or (Deleted)** | **Proposed as Part of this Project** | **Total upon Completion of All Projects** |
| Cardiac catheterization equipment |  |  |  |  |
| CT scanner |  |  |  |  |
| Gamma knife |  |  |  |  |
| Heart-lung bypass machine |  |  |  |  |
| Linear accelerator |  |  |  |  |
| Lithotriptor |  |  |  |  |
| Major medical equipment **\*** |  |  |  |  |
| MRI scanner |  |  |  |  |
| PET scanner |  |  |  |  |
| Simulator |  |  |  |  |
| Other (**describe**) **\*\*** |  |  |  |  |

**\*** Excluding the medical equipment listed separately in the table.

**\*\*** This is relevant to a diagnostic center proposal where the medical equipment costs more than $10,000 but less than $750,000. It is also relevant to a proposal to develop a new hospital or a new hospital campus which includes acquisition of X-ray, ultrasound, mammography, C-arms, etc. that cost more than $10,000 but less than $750,000.

6. **Experience**

a. How many existing and approved facilities of the type reported in Question 4.b does the applicant or a related entity own, operate, or manage in North Carolina?

|  |
| --- |
|  |

b. If the applicant or a related entity does **not** currently own, operate, or manage any facilities of the type reported in Question 4.b in North Carolina, does the applicant or a related entity currently own, operate, or manage any such facilities in other states?

|  |
| --- |
|  |

If you answered yes, how many facilities of the type reported in Question 4.b in does the applicant or a related entity currently own, operate, or manage in other states?

|  |
| --- |
|  |

**Section B - Criterion (1)**

G.S. 131E-183(a)(1)

*“The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.”*

**1.** a. **Applications submitted in response to a need determination in the SMFP** – Identify the need determination in the table below (For example: 2016 SMFP, Orange County, 84 acute care beds).

|  |
| --- |
|  |

b. **Applications submitted in response to a need determination for acute care beds in Chapter 5 of the SMFP** – Document that the applicant meets all the requirements of a “qualified applicant,” which are as follows:

1) Does the hospital or will the hospital provide a 24-hour emergency department?

|  |
| --- |
|  |

2) Does the hospital or will the hospital provide inpatient medical services to both surgical and non-surgical patients?

|  |
| --- |
|  |

3) If proposing a new hospital, will the hospital provide medical and surgical services daily within at least five of the major diagnostic categories as recognized by the Centers for Medicare and Medicaid Services (CMS) which are listed in Chapter 5 of the SMFP under Qualified Applicants?

|  |
| --- |
|  |

4) Provide supporting documentation in an Exhibit.

**2.** Check **each** policy below, from Chapter 4 of the SMFP, which is applicable to this proposal:

|  |  |  |
| --- | --- | --- |
|  | Policy AC-3 | Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects |
|  | Policy AC-4 | Reconversion to Acute Care |
|  | Policy AC-5 | Replacement of Acute Care Bed Capacity |
|  | Policy AC-6 | Heart-Lung Bypass Machines for Emergency Coverage |
|  | Policy NH-2 | Plan Exemption for Continuing Care Retirement Communities |
|  | Policy NH-5 | Transfer of Nursing Home Beds from State Psychiatric Hospital Nursing Facilities to Community Facilities |
|  | Policy NH-6 | Relocation of Nursing Facility Beds |
|  | Policy NH-8 | Innovations in Nursing Facility Design |
|  | Policy LTC-1 | Plan Exemption for Continuing Care Retirement Communities – Adult Care Home Beds |
|  | Policy LTC-2 | Relocation of Adult Care Home Beds |
|  | Policy LTC-3 | Certification of Beds for Special Assistance |
|  | Policy MH-1 | Linkages between Treatment Settings (this policy will always be applicable to proposals involving psychiatric, substance use disorder, and ICF/IID beds or facilities) |
|  | Policy PSY-1 | Transfer of Beds from State Psychiatric Hospitals to Community Facilities |
|  | Policy ICF/IID-5 | Transfer of ICF/IID Beds from State Operated Developmental Centers to Community-Based Facilities |
|  | Policy TE-1 | Conversion of Fixed PET Scanners to Mobile PET Scanners |
|  | Policy TE-2 | Intraoperative Magnetic Resonance Scanners |
|  | Policy TE-3 | Plan Exemption for Fixed Magnetic Resonance Imaging Scanners |
|  | Policy GEN-3 | Basic Principles |
|  | Policy GEN-4 | Energy Efficiency and Sustainability for Health Service Facilities |

The language of each policy follows in the same order as listed above. Following each policy are questions that should be answered if the policy is applicable to this proposal. If a policy is not applicable, delete the language of the policy and the questions related to that policy. However, do not renumber any following questions.

**If the language of the policy in the application form differs from the language in the SMFP, the language in the SMFP controls.**

**If there is a policy in the SMFP that is not listed in the table above and that policy is applicable to the proposal, the policy in the SMFP controls. Please add that policy to your application at the end of this section and provide a response.**

**Policy AC-3: Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects** states:

*“Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. The Healthcare Planning and Certificate of Need Section shall designate as an academic medical center teaching hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:*

1. *serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate and postgraduate education;*
2. *houses extensive basic medical science and clinical research programs, patients and equipment; and*
3. *serves the treatment needs of patients from a broad geographic area through multiple medical specialties.*

**[Note: The following paragraph is the second paragraph referenced in the questions that follow this policy.]**

*Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by academic medical center teaching hospitals designated prior to January 1, 1990 provided the projects are necessary to meet one of the following unique academic medical needs:*

1. *necessary to complement a specified and approved expansion of the number or types of students, residents or faculty that are specifically required for an expansion of students or residents, as certified by the head of the relevant associated professional school; the applicant shall provide documentation that the project is consistent with any relevant standards, recommendations or guidance from specialty education accrediting bodies; or*
2. *with respect to the acquisition of equipment, is necessary to accommodate the recruitment or retention of a full-time faculty member who will devote a majority of his or her time to the combined activities of teaching (including teaching within the clinical setting), research, administrative or other academic responsibilities within the academic medical center teaching hospital or medical school; or*
3. *necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; and including, to the extent applicable, documentation pertaining to grants, funding, accrediting or other requirements, and any proposed clinical application of the asset; or*
4. *necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*

*A project submitted by an academic medical center teaching hospital under this policy that meets one of the above conditions shall demonstrate that the academic medical center teaching hospital’s teaching or research need for the proposed project cannot be achieved effectively at any non-academic medical center teaching hospital provider which currently offers and has capacity within the service for which the exemption is requested and which is within 20 miles of the academic medical center teaching hospital.*

*The academic medical center teaching hospital shall include in its application an analysis of the cost, benefits and feasibility of engaging that provider in a collaborative effort that achieves the academic goals of the project as compared with the certificate of need application proposal. The academic medical center teaching hospital shall also provide a summary of a discussion or documentation of its attempt to engage the provider in discussion regarding its analysis and conclusions.*

*The academic medical center teaching hospital shall include in its application a discussion of any similar assets within 20 miles that are under the control of the applicant or the associated professional school and the feasibility of using those assets to meet the unique teaching or research needs of the academic medical center teaching hospital.*

*For each of the first five years of operation the approved applicant shall submit to Certificate of Needa detailed description of how the project achieves the academic requirements of the appropriate section(s) of Policy AC-3, paragraph 2 (items 1 through 4) as proposed in the certificate of need application.*

*Applicants who are approved for Policy AC-3 projects after January 1, 2012 shall report those Policy AC-3 assets (including beds, operating rooms and equipment) on the appropriate annual license renewal application or registration form for the asset. The information to be reported for the Policy AC-3 assets shall include: (a) inventory or number of units of AC-3 Certificate of Need-approved assets (including all beds, operating rooms and equipment); (b) the annual volume of days, cases or procedures performed for the reporting year on the Policy AC-3 approved asset; and (c) the patient origin by county. Except for operating rooms, neither the assets under (a) above nor the utilization from (b) above shall be used in the annual State Medical Facilities Plan need determination formulas, but both the assets and the utilization will be available for informational purposes to users of the State Medical Facilities Plan. Operating rooms approved under Policy AC-3 and their utilization shall be reported on the license renewal application and included in the inventory, regardless of the date of Certificate of Need approval.*

*This policy does not apply to a proposed project or the portion thereof that is based solely upon the inability of the State Medical Facilities Plan methodology to accurately project need for the proposed service(s), due to documented differences in patient treatment times that are attributed to education or research components in the delivery of patient care or to differences in patient acuity or case mix that are related to the applicant’s academic mission. However, the applicant may submit a petition pursuant to the State Medical Facilities Plan Petitions for Adjustments to Need Determinations process to meet that need or portion thereof (see Chapter 2).*

*Policy AC-3 projects are required to materially comply with representations made in the certificate of need application regarding academic based need. If an asset originally developed or acquired pursuant to Policy AC-3 is no longer used for research and/or teaching, the academic medical center teaching hospital shall surrender the certificate of need.”*

3. a. Document that the hospital was designated an academic medical center teaching hospital by the CON Section prior to January 1, 1990.

b. Identify each unique academic medical need which qualifies for an exemption as listed in the second paragraph of the policy (i.e., Subparagraphs 1-4) that is relevant to this proposal and provide the documentation required by each relevant Subparagraph.

c. Identify all non-academic medical center teaching hospitals located within 20 miles of the academic medical center teaching hospital which currently offer and have capacity within the service(s) proposed in this application.

d. For each hospital identified in response to 3.c., document that the need for the project cannot be achieved effectively at that hospital.

e. For any hospital identified in response to 3.c. where the need for the project could be achieved effectively:

1) Provide an analysis of the cost, benefits and feasibility of engaging in a collaborative effort with that hospital; and

2) Document the attempts to discuss the analysis and conclusions with that provider.

f. Identify any similar assets within the control of the applicant or the associated professional school located within 20 miles of the academic medical center teaching hospital and discuss the feasibility of using those assets to meet the unique academic medical need.

g. Does the applicant commit to providing a detailed description of how the project achieves the academic requirements of the appropriate section(s) of Policy AC-3, paragraph 2, as proposed in the certificate of need application, for each of the first five years of operation?

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h. Does the applicant commit to surrender the certificate of need if an asset originally developed or acquired pursuant to Policy AC-3 is no longer used for research and/or teaching?

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**Policy AC-4: Reconversion to Acute Care** states:

*“Facilities that have redistributed beds from acute care bed capacity to psychiatric, rehabilitation, nursing home, or long-term care hospital use, shall obtain a certificate of need to convert this capacity back to acute care. Applicants proposing to reconvert psychiatric, rehabilitation, nursing home, or long-term care hospital beds back to acute care beds shall demonstrate that the hospital’s average annual utilization of licensed acute care beds as calculated using the most recent days of care as provided to Healthcare Planning by The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill is equal to or greater than the target occupancies shown below, but shall not be evaluated against the acute care bed need determinations shown in Chapter 5 of the North Carolina State Medical Facilities Plan. In determining utilization rates and average daily census, only acute care bed “days of care” are counted.*

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| ***Facility Average Daily Census*** | ***Target Occupancy of Licensed Acute Care Beds*** |
| *1 – 99* | *66.7%* |
| *100 – 200* | *71.4%* |
| *Greater than 200* | *75.2%”* |

4. a. Provide projected acute care bed days of care for the total number of licensed acute care beds on the hospital’s license (including all acute care beds located on every campus) following completion of the project.

b. Describe all assumptions and the methodology used to project acute care bed days of care in response to 4.a. and provide any supporting documentation in an Exhibit.

**Policy AC-5: Replacement of Acute Care Bed Capacity** states:

*“Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant’s hospital in relation to utilization targets found below. For hospitals* ***not*** *designated by the Centers for Medicare & Medicaid Services as Critical Access Hospitals, in determining utilization of acute care beds, only acute care bed days of care shall be counted. For hospitals designated by the Centers for Medicare & Medicaid Services as Critical Access Hospitals, in determining utilization of acute care beds, only acute care bed days of care* ***and*** *swing bed days (i.e., nursing home facility days of care) shall be counted in determining utilization of acute care beds. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application. Additionally, if the hospital is a Critical Access Hospital and swing bed days are proposed to be counted in determining utilization of acute care beds, the hospital shall also propose to remain a Critical Access Hospital and must demonstrate the need for maintaining the swing bed capacity proposed within the application. If the Critical Access Hospital does not propose to remain a Critical Access Hospital, only acute care bed days of care shall be counted in determining utilization of acute care beds and the hospital must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*

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| ***Facility Average Daily Census*** | ***Target Occupancy of Licensed Acute Care Beds*** |
| *1 – 99* | *66.7%* |
| *100 – 200* | *71.4%* |
| *Greater than 200* | *75.2%”* |

**Note: This policy applies if the applicant proposes to construct new space to replace existing beds on any campus on the hospital license, including constructing new space for existing beds to be relocated to a new campus.**

5. a. **Acute Care** **Hospitals not designated as Critical Access**: Provide projected acute care bed days of care for the total number of licensed acute care beds on the hospital’s license (including **all** acute care beds located on every campus on the same license) following completion of the project.

b. **Critical Access Acute Care Hospitals**:

1) Does the applicant certify that the acute care hospital will remain designated as a critical access hospital?

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2) Provide projected acute care bed days of care and swing bed days of care (i.e., nursing facility days of care) for the total number of licensed acute care beds on the hospital’s license following completion of the project.

3) Document the need to maintain swing bed capacity.

c. **Describe all assumptions and the methodology used to project acute care bed days of care** in response to 5.a. or 5.b. and provide any supporting documentation in an Exhibit.

**Policy AC-6: Heart-Lung Bypass Machines for Emergency Coverage** states:

*“To protect cardiac surgery patients, who may require emergency procedures while scheduled procedures are underway, a need is determined for one additional heart-lung bypass machine whenever a hospital is operating an open-heart surgery program with only one heart-lung bypass machine. The additional machine is to be used to assure appropriate coverage for emergencies and in no instance shall this machine be scheduled for use at the same time as the machine used to support scheduled open-heart surgery procedures. A certificate of need application for a machine acquired in accordance with this provision shall be exempt from compliance with the performance standards set forth in 10A NCAC 14C .1703.”*

6. a. Does the applicant certify that the hospital operates an open-heart surgery program with only one heart-lung bypass machine?

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b. Does the applicant certify that the proposed heart-lung bypass machine will not be scheduled for use at the same time as the existing heart-lung bypass machine?

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c. Provide supporting documentation in an Exhibit.

**Policy NH-2: Plan Exemption for Continuing Care Retirement Communities** (CCRCs) states:

*“Qualified continuing care retirement communities (CCRC) may include from the outset or add or convert bed capacity for nursing care without regard to the nursing home bed need shown in Chapter 10: Nursing Care Facilities. To qualify for such exemption, the applicant shall document that the proposal meets all the following requirements:*

1. *will only be developed concurrently with or subsequent to construction on the same site of facilities for both of the following levels of care:*
   1. *independent living accommodations (apartments and homes) for people who are able to carry out normal activities of daily living without assistance; such accommodations may be in the form of apartments, flats, houses, cottages and rooms;*
   2. *licensed adult care home beds for use by people who, because of age or disability, require some personal services, incidental medical services and room and board to assure their safety and comfort.*
2. *will be used exclusively to meet the needs of people with whom the facility has continuing care contracts (in compliance with the North Carolina Department of Insurance statutes and rules) who have lived in a non-nursing unit of the continuing care retirement community for a period of at least 30 days. Exceptions shall be allowed when one spouse or sibling is admitted to the nursing unit at the time the other spouse or sibling moves into a non-nursing unit, or when the medical condition requiring nursing care was not known to exist or be imminent when the individual became a party to the continuing care contract.*
3. *reflects the number of nursing home facility beds required to meet the current or projected needs of residents with whom the facility has an agreement to provide continuing care after making use of all feasible alternatives to institutional nursing care.*
4. *will not be certified for participation in the Medicaid program.*

*One hundred percent of the nursing home facility beds developed under this exemption shall be excluded from the inventory and the occupancy rate used to project nursing home bed need for the general population. Certificates of need issued under policies analogous to this policy in the North Carolina State Medical Facilities Plans subsequent to the 1985 State Medical Facilities Plan are automatically amended to conform to the provisions of this policy at the effective date of this policy. Certificates of need awarded pursuant to the provisions of Chapter 920, Session Laws 1983 or Chapter 445, Session Laws 1985 shall not be amended.”*

7. If the applicant is proposing to develop new Policy NH-2 beds:

a. Document that the proposed NF beds will be developed concurrently or subsequent to construction on the same site of independent living accommodations or units (ILUs) and licensed ACH beds.

b. Does the applicant certify that the proposed NF beds will be used exclusively by people with whom the CCRC has contracts for continuing care?

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c. Document that the number of proposed NF beds reflects the number required to meet the current or projected need of the residents of the CCRC.

d. Explain how the CCRC will ensure that it has made use of all feasible alternatives to institutional nursing care.

e. Does the applicant certify that the proposed NF beds will not be certified for participation in the Medicaid program?

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**Policy NH-5: Transfer of Nursing Home Facility Beds from State Psychiatric Hospital Nursing Facilities to Community Facilities** states:

*“Beds in state psychiatric hospitals that are certified as nursing home facility beds may be relocated to licensed nursing home facilities. However, before nursing home facility beds are transferred out of the state psychiatric hospitals, services shall be available in the community. State psychiatric hospital nursing home facility beds that are relocated to licensed nursing home facilities shall be closed within 90 days following the date the transferred beds become operational in the community.*

*Licensed nursing facilities proposing to operate transferred nursing home facility beds shall commit to serve the type of residents who are normally placed in nursing home facility beds at the state psychiatric hospitals. To help ensure that relocated nursing home facility beds will serve those people who would have been served by state psychiatric hospitals in nursing home facility beds, a certificate of need application to transfer nursing home facility beds from a state hospital shall include a written memorandum of agreement between the director of the applicable state psychiatric hospital, the director of the North Carolina Division of State Operated Healthcare Facilities, the secretary of the North Carolina Department of Health and Human Services, and the person submitting the proposal.*

*This policy does not allow the development of new nursing home facility beds. Nursing home facility beds transferred from state psychiatric hospitals to the community pursuant to Policy NH-5 shall be excluded from the inventory.”*

8. If the applicant is proposing to relocate existing NF beds from a state psychiatric hospital:

a. Document that services are or will be available in the community.

b. Does the applicant certify that the relocated NF beds will be used to serve people who would have been served by a state psychiatric hospital in a NF bed?

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c. Provide a written memorandum of agreement between the following:

* Director of the applicable state psychiatric hospital;
* Director of the North Carolina Division of State Operated Healthcare Facilities;
* Secretary of the North Carolina Department of Health and Human Services; and
* Applicant.

**Policy NH-6: Relocation of Nursing Home Facility Beds** states:

*“Relocations of existing licensed nursing home facility beds to another service area are allowed. Certificate of need applicants proposing to relocate licensed nursing home facility beds to another service area shall:*

1. *demonstrate that the proposal shall not result in a deficit, or increase an existing deficit in the number of licensed nursing home facility beds in the county that would be losing nursing home facility beds as a result of the proposed project, as reflected in the North Carolina State Medical Facilities Plan in effect at the time the certificate of need review begins; and*
2. *demonstrate that the proposal shall not result in a surplus or increase an existing surplus of licensed nursing home facility beds in the county that would gain nursing home facility beds as a result of the proposed project, as reflected in the North Carolina State Medical Facilities Plan in effect at the time the certificate of need review begins.”*

9. If the applicant proposes to relocate NF beds to another service area (county):

a. Document that the proposal would not result in a deficit or increase an existing deficit in the number of licensed NF beds in the county that would be losing NF beds as a result of the proposal.

b. Document that the proposal would not result in a surplus or increase an existing surplus in the number of licensed NF beds in the county that would gain NF beds as a result of the proposal.

c. If the NF beds are to be relocated to another county explain:

1) Why the NF beds need to be relocated;

2) Why the proposed county was selected as compared to other counties; and

3) How the number of NF beds to be relocated was determined.

d. Provide any supporting documentation for your responses to Section B, Question 9, in an Exhibit.

**Policy NH-8: Innovations in Nursing Home Facility Design** states:

*“Certificate of need applicants proposing new nursing home facilities and replacement nursing home facilities shall pursue innovative approaches in environmental design that address quality of care and quality of life needs of the residents. These plans could include innovative design elements that encourage less institutional, more home-like settings, privacy, autonomy and resident choice, among others.”*

10. If the applicant proposes to develop a new or replacement nursing facility:

a. Describe the innovative approaches in environmental design included as part of the proposal; and

b. Explain how these innovative approaches address the quality of care and quality of life needs of the residents.

**Policy LTC-1: Plan Exemption for Continuing Care Retirement Communities – Adult Care Home Beds** states:

*“Qualified continuing care retirement communities may include from the outset or add or convert bed capacity for adult care without regard to the adult care home bed need shown in Chapter 11: Adult Care Homes. To qualify for such exemption, applications for certificates of need shall document that the proposal meets all the following requirements:*

1. *will only be developed concurrently with, or subsequent to, construction on the same site of independent living accommodations (apartments and homes) for people who are able to carry out normal activities of daily living without assistance; such accommodations may be in the form of apartments, flats, houses, cottages, and rooms.*
2. *will provide for the provision of nursing services, medical services or other health related services as required for licensure by the North Carolina Department of Insurance.*
3. *will be used exclusively to meet the needs of people with whom the facility has continuing care contracts (in compliance with the North Carolina Department of Insurance statutes and rules) who have lived in a non-nursing or adult care unit of the continuing care retirement community for a period of at least 30 days. Exceptions shall be allowed when one spouse or sibling is admitted to the adult care home unit at the time the other spouse or sibling moves into a non-nursing or adult care unit, or when the medical condition requiring nursing or adult care home care was not known to exist or be imminent when the individual became a party to the continuing care contract.*
4. *reflects the number of adult care home beds required to meet the current or projected needs of residents with whom the facility has an agreement to provide continuing care after making use of all feasible alternatives to institutional adult care home care.*
5. *will not participate in the Medicaid program or serve State-County Special Assistance recipients.*

*One hundred percent of the adult care home beds developed under this exemption shall be excluded from the inventory used to project adult care home bed need for the general population. Certificates of need issued under policies analogous to this policy in the North Carolina State Medical Facilities Plans subsequent to the North Carolina 2002 State Medical Facilities Plan are automatically amended to conform with the provisions of this policy at the effective date of this policy.”*

11. If the applicant is proposing to develop new Policy LTC-1 beds:

a. Document that the proposed ACH beds will be developed concurrently or subsequent to construction on the same site of independent living accommodation or units (ILUs).

b. Explain how nursing services, medical services or other health related services will be provided.

c. Does the applicant certify that the proposed ACH beds will be used exclusively by people with whom the CCRC has contracts for continuing care?

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d. Document that the number of proposed ACH beds reflects the number required to meet the current or projected need of the residents of the CCRC.

e. Does the applicant certify that the proposed ACH beds will not be certified for participation in the Medicaid program or serve State-County Special Assistance recipients?

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**Policy LTC-2: Relocation of Adult Care Home Beds** states:

*“Relocations of existing licensed adult care home beds to another service area are allowed. Certificate of need applicants proposing to relocate licensed adult care home beds to another service area shall:*

1. *demonstrate that the proposal shall not result in a deficit, or increase an existing deficit in the number of licensed adult care home beds in the county that would be losing adult care home beds as a result of the proposed project, as reflected in the North Carolina State Medical Facilities Plan in effect at the time the certificate of need review begins; and*
2. *demonstrate that the proposal shall not result in a surplus or increase an existing surplus of licensed adult care home beds in the county that would gain adult care home beds as a result of the proposed project, as reflected in the North Carolina State Medical Facilities Plan in effect at the time the certificate of need review begins.”*

12. If the applicant proposes to relocate ACH beds to another service area (county):

a. Document that the proposal would not result in a deficit or increase an existing deficit in the number of licensed ACH beds in the county that would be losing ACH beds as a result of the proposal.

b. Document that the proposal would not result in a surplus or increase an existing surplus in the number of licensed ACH beds in the county that would gain ACH beds as a result of the proposal.

c. If the ACH beds are to be relocated to another county explain:

1) Why the ACH beds need to be relocated;

2) Why the proposed county to receive beds was selected as compared to other counties; and

3) How the number of ACH beds to be relocated was determined.

d. Provide any supporting documentation for your responses in an Exhibit.

**Policy LTC-3: Certification of Beds for Special Assistance** states:

*“Certificate of need applicants proposing to develop new adult care home beds pursuant to a need determination shall demonstrate that the proposed beds will be certified for special assistance and that at least 5% of the projected days of care in the third full fiscal year of operation shall be provided to residents receiving State-County Special Assistance.”*

13. If the applicant proposes to develop new ACH beds pursuant to a need determination:

a. Document that the proposed ACH beds will be certified for special assistance; and

b. Document that at least 5% of the projected days of care in the third full fiscal year of operation shall be provided to residents receiving State-County Special Assistance.

**Policy MH-1: Linkages between Treatment Settings** states:

*“An applicant for a certificate of need for psychiatric, substance use disorder or intermediate care facilities for individuals with intellectual disabilities (ICF/IID) beds shall document that the affected local management entity-managed care organization has been contacted and invited to comment on the proposed services.”*

14. a. Identify the affected LME/MCO.

b. Document that the affected LME/MCO has been contacted and invited to comment on the proposed services.

c. Provide any comments received from the affected LME/MCO in an Exhibit.

**Policy PSY-1: Transfer of Beds from State Psychiatric Hospitals to Community Facilities** states:

*“Beds in the state psychiatric hospitals used to serve short-term psychiatric patients may be relocated to community facilities through the certificate of need process. However, before beds are transferred out of the state psychiatric hospitals, services and programs shall be available in the community. State psychiatric hospital beds that are relocated to community facilities shall be closed within 90 days following the date the transferred beds become operational in the community.*

*Facilities proposing to operate transferred beds shall submit an application to Certificate of Need of the North Carolina Department of Health and Human Services and commit to serve the type of short-term patients normally placed at the state psychiatric hospitals. To help ensure that relocated beds will serve those people who would have been served by the state psychiatric hospitals, a proposal to transfer beds from a state hospital shall include a written memorandum of agreement between the local management entity-managed care organization serving the county where the beds are to be located, the secretary of the North Carolina Department of Health and Human Services, and the person submitting the proposal.”*

15. a. Document that psychiatric services and programs are available in the community.

b. Document that the applicant is committed to serving the type of short-term patients normally placed at state psychiatric hospitals.

c. Provide a copy of a written memorandum of agreement between the following:

* LME/MCO serving the county where the beds are to be located;
* Secretary of the North Carolina Department of Health and Human Services; and
* Person submitting the proposal.

**Policy ICF/IID-5: Transfer of ICF/IID Beds from State Operated Developmental Centers to Community-Based Facilities**

*“Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) beds in state operated developmental centers may be relocated to existing community-based facilities through the certificate of need process. This policy covers the relocation of beds only and does not provide for or preclude transfer of residents with the beds. State operated developmental center ICF/IID beds that are relocated to a community-based facility shall be closed upon licensure of the transferred beds.*

*Applicants proposing to relocate beds from a state operated developmental center shall be required to submit a certificate of need application. The application shall include a written agreement signed by all the following:*

1. *director of the local management entity/managed care organization serving the county where the community-based facility is or will be located;*
2. *director of the state operated developmental center transferring the beds;*
3. *director of the North Carolina Division of State Operated Healthcare Facilities;*
4. *secretary of the North Carolina Department of Health and Human Services; and*
5. *operator of the community-based facility.*

*The maximum number of beds in the facility upon project completion shall not exceed 15 beds.*

*The project shall not result in more than three facilities housing a combined total of 18 people being developed on contiguous pieces of property.”*

16. If the applicant proposes to transfer beds from a state operated developmental center pursuant to Policy ICF/IID-5:

a. Provide a copy of a written agreement between the following:

* Director of the LME/MCO serving the county where the community-based facility is or will be located;
* Director of the state operated developmental center transferring the beds;
* Director of the North Carolina Division of State Operated Healthcare Facilities;
* Secretary of the North Carolina Department of Health and Human Services; and
* Operator of the community-based facility.

b. Document that the maximum number of beds in the facility upon project completion shall not exceed 15 beds.

c. Document that the project will not result in more than three facilities housing a combined total of 18 people being developed on contiguous pieces of property.

**Policy TE-1: Conversion of Fixed Pet Scanners to Mobile Pet Scanners** states:

*“Facilities with an existing or approved fixed PET scanner may apply for a Certificate of Need (CON) to convert the existing or approved fixed PET scanner to a mobile PET scanner if the applicant(s) demonstrates in the CON application that the converted mobile PET scanner:*

1. *shall continue to operate as a mobile PET scanner at the facility, including satellite campuses, where the fixed PET scanner is located or was approved to be located;*
2. *shall be moved at least weekly to provide services at two or more host facilities; and*
3. *shall not serve any mobile host site that is not owned by the PET certificate holder or an entity related to the PET certificate holder such as a parent or subsidiary that is**located in the county where any existing or approved fixed PET scanner is located, except as required by subpart (1).*

*There will be one certificate of need application filing opportunity each calendar year.”*

**Note: Applications proposing to convert a mobile PET scanner to fixed can only be filed in the July 1 Review Cycle.**

17. If the applicant proposes to convert a fixed PET scanner to a mobile PET scanner:

a. Document that the proposed mobile PET scanner will operate at the facility, including satellite campuses, where the fixed PET scanner is located or was approved to be located.

b. Document the proposed mobile PET scanner will be moved at least weekly to provide services at two or more host sites.

c. Document that the proposed mobile PET scanner will not serve at any host site not owned by the PET certificate holder or an entity related to the PET certificate holder such as a parent or subsidiary that is located in the county where any existing or approved fixed PET scanner is located, except as required by subpart (1) of the Policy.

**Policy TE-2: Intraoperative Magnetic Resonance Scanners** states:

*“Qualified applicants may apply for an intraoperative Magnetic Resonance Scanner (iMRI) to be used in an operating room suite.*

*To qualify, the health service facility proposing to acquire the iMRI scanner shall demonstrate in its certificate of need application that it is a licensed acute care hospital which:*

1. *performed at least 500 inpatient neurosurgical cases during the 12 months immediately preceding the submission of the application; and*
2. *has at least two neurosurgeons that perform intracranial surgeries currently on its Active Medical Staff; and*
3. *is located in a metropolitan statistical area as defined by the US Census Bureau with at least 350,000 residents.*

*The iMRI scanner shall not be used for outpatients and may not be replaced with a conventional MRI scanner.*

*The performance standards in 10A NCAC 14C .2703 would not be applicable.*

*Intraoperative procedures and inpatient procedures performed on the iMRI shall be reported separately on the Hospital License Renewal Application.*

*These scanners shall not be counted in the inventory of fixed MRI scanners; the procedures performed on the iMRI will not be used in calculating the need methodology and will be reported in a separate table in Chapter 17.”*

18. If the applicant proposes to acquire an intraoperative MRI scanner:

a. Document that the health service facility is a licensed North Carolina acute care hospital.

b. Document the hospital performed at least 500 inpatient neurosurgical cases during the 12 months immediately preceding the submission of the application.

c. Document that there are at least two neurosurgeons that perform intracranial surgeries on the hospital’s Active Medical Staff.

d. Document that the hospital is located in a metropolitan statistical area as defined by the US Census Bureau with at least 350,000 residents.

**Policy TE-3: Plan Exemption for Fixed Magnetic Resonance Imaging Scanners** states:

*“Qualified applicants may apply for a fixed magnetic resonance imaging scanner (MRI). To qualify, the health service facility proposing to acquire the fixed MRI scanner shall demonstrate in its certificate of need application that it is a licensed North Carolina acute care hospital with emergency care coverage 24 hours a day, seven days a week and that does not currently have an existing or approved fixed MRI scanner as reflected in the inventory in the applicable State Medical Facilities Plan.*

*The applicant shall demonstrate that the proposed fixed MRI scanner will perform at least 850 weighted MRI procedures during the third full operating year.*

*The performance standards in 10A NCAC 14C .2703 would not be applicable.*

*The fixed MRI scanner must be located on the hospital’s ‘main campus’ as defined in G.S. 131E-176(14n)a.”*

19. If the applicant proposes to acquire a fixed MRI scanner pursuant to Policy TE-3:

a. Document that the health service facility is a licensed North Carolina acute care hospital with emergency care coverage 24 hours a day, seven days a week.

b. Document that the hospital does not currently have an existing or approved fixed MRI scanner as reflected in the applicable SMFP.

c. Document that the proposed fixed MRI scanner will be located on the hospital’s “main campus” as that term is defined in G.S. 131E-176(14n)a.

d. Document that the proposed fixed MRI scanner will perform at least 850 weighted MRI procedures during the third full operating year following completion of the project. Provide any supporting documentation in an Exhibit.

**Policy GEN-3: Basic Principles** states:

*“A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area.”*

20. If the applicant is applying to develop or offer a new institutional health service based on a need determination in the SMFP:

a. Document how the project will promote safety and quality in the delivery of the proposed services.

b. Document how the project will promote equitable access in the delivery of the proposed services.

c. Document how the project will maximize healthcare value for resources expended in the delivery of the proposed services.

d. Document how projected utilization incorporates the concepts of safety, quality, access, and maximum value for resources expended in meeting the need identified in the SMFP.

**Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities** states:

*“Any person proposing a capital expenditure greater than $2 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178 shall include in its certificate of need application a written statement describing the project’s plan to assure improved energy efficiency and water conservation.*

*In approving a certificate of need proposing an expenditure greater than $5 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178, Certificate of Need shall impose a condition requiring the applicant to develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan must be consistent with the applicant’s representation in the written statement as described in paragraph one of Policy GEN-4.*

*Any person awarded a certificate of need for a project or an exemption from review pursuant to G.S. 131E-184 is required to submit a plan for energy efficiency and water conservation that conforms to the rules, codes and standards implemented by the Construction Section of the Division of Health Service Regulation. The plan must be consistent with the applicant’s representation in the written statement as described in paragraph one of Policy-GEN 4. The plan shall not adversely affect patient or resident health, safety or infection control.”*

21. If the proposed capital cost is $2 million or greater, provide a written statement describing the project’s plan to assure improved:

a. Energy efficiency; and

b. Water conservation.

Note: Once a certificate of need is approved, if the proposed capital cost of the project is $5 million or greater, a condition will be imposed requiring the applicant to submit an Energy Efficiency and Sustainability Plan to the Agency’s Construction Section that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes and is consistent with the applicant’s written statement in Section B, Question 11. The plan shall not adversely affect patient or resident health, safety or infection control.

**Section C - Criterion (3)**

G.S. 131E-183(a)(3)

*“The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, … persons* [with disabilities]*, the elderly, and other underserved groups are likely to have access to the services proposed.”*

For change of scope or cost overrun proposals, skip to Section C, Question 8.

**Scope of the Project**

1. Identify and describe each service component included in this proposal. Your response should include but not be limited to describing the type and number of existing, approved, and proposed health service facility beds, health services, hospital services, or medical equipment included in this proposal.

**Population to be Served**

2. **Historical Patient Origin**

a. **Service Component(s)** – Complete the following table for each service component included in this proposal for:

* The facility or campus identified in Section A, Question 4; and
* Each facility from which existing service components will be relocated as part of this proposal.

|  |  |  |
| --- | --- | --- |
| **<Identify the service component here>** | **<Insert name of facility here> \*** | |
| **Last Full FY**  **mm/dd/yyyy to mm/dd/yyyy** | |
| **County or other geographic area such as ZIP code** | **Number of Patients** | **% of Total** |
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| **Total** |  |  |

**\*** This should match the name provided in Section A, Question 4.

b. **Entire Facility or Campus**

* **Facilities with more than one campus on the same license**: Complete the following table for: 1) the entire facility if the proposal involves relocating the entire facility to another site or developing a new satellite campus; or 2) the campus identified in Section A, Question 4, if the proposal involves relocating an existing campus of a facility with multiple campuses to another site.
* **All other applicants**: Complete the following table for the entire facility. If historical patient origin for the service component and the entire facility are the same, the applicant **should explain why that** **is the case** and is not required to complete the following table.

|  |  |  |
| --- | --- | --- |
| **Entire Facility or Campus** | **<Insert name of facility here> \*** | |
| **Last Full FY**  **mm/dd/yyyy to mm/dd/yyyy** | |
| **County or other geographic area such as ZIP code** | **Number of Patients** | **% of Total** |
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| **Total** |  |  |

**\*** This should match the name provided in Section A, Question 4.

3. **Projected Patient Origin**

a. Describe the **assumptions and methodology used** to project the number of patients by county or other geographic area of origin.Provide any supporting documentation in an Exhibit.

b. **Service Component(s)** – Complete the following table for each service component included in this proposal for the facility or campus identified in Section A, Question 4.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **<Identify the service component here>** | **<Insert name of facility here> \*** | | | | | |
| **1st Full FY** | | **2nd Full FY** | | **3rd Full FY** | |
| **mm/dd/yyyy to mm/dd/yyyy** | | **mm/dd/yyyy to mm/dd/yyyy** | | **mm/dd/yyyy to mm/dd/yyyy** | |
| **County or other geographic area such as ZIP code** | **Number of Patients \*\*** | **% of Total** | **Number of Patients \*\*** | **% of Total** | **Number of Patients \*\*** | **% of Total** |
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| **Total** |  |  |  |  |  |  |

**\*** This should match the name provided in Section A, Question 4.

**\*\*** Home health agencies should report the number of unduplicated clients.

c. **Entire Facility or Campus**

* + - **Facilities with more than one campus on the same license**: Complete the following table for: 1) the entire facility if the proposal involves developing a new facility or relocating the entire facility to another site; or 2) the campus identified in Section A, Question 4 if the proposal involves developing a new campus of an existing facility or relocating an existing campus of a facility with multiple campuses to another site.
    - **All other applicants**: Complete the following table for the entire facility. If projected patient origin for the service component and the entire facility is the same, the applicant **should explain why that is the case** and is not required to complete the following table.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Entire Facility or Campus** | **<Insert name of facility here> \*** | | | | | |
| **1st Full FY** | | **2nd Full FY** | | **3rd Full FY** | |
| **mm/dd/yyyy to mm/dd/yyyy** | | **mm/dd/yyyy to mm/dd/yyyy** | | **mm/dd/yyyy to mm/dd/yyyy** | |
| **County or other geographic area such as ZIP code** | **Number of Patients \*\*** | **% of Total** | **Number of Patients \*\*** | **% of Total** | **Number of Patients \*\*** | **% of Total** |
|  |  |  |  |  |  |  |
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| **Total** |  |  |  |  |  |  |

**\*** This should match the name provided in Section A, Question 4.

**\*\*** Home health agencies should report the number of unduplicated clients.

**Demonstration of Need**

4. Explain why the patients projected to be served by the facility or campus identified in Section A, Question 4, need the proposal. If the proposal involves multiple service components, explain why those patients need each proposed service component.

Provide any supporting documentation in an Exhibit.

The response should include but not be limited to the following as applicable:

**Developing a New Facility or Campus?** Include an explanation of why the patients projected to be served: 1) need a new facility or campus; and 2) why the proposed site was selected as compared to other sites in the service area.

**Relocating Existing Service Components?** Include: 1) the identify of each facility that would lose service components as part of this proposal; 2) a description of each service component (i.e., specific type and number if applicable) that will be relocated as part of this proposal; and 3) an explanation of why the patients projected to be served need the service components at the facility identified in Section A, Question 4, as opposed to where they are currently located.

**Replacing and Relocating the Entire Facility?** Include an explanation of why the patients projected to be served: 1) need the facility to be replaced and relocated; and 2) why the proposed site was selected as compared to other sites in the service area.

**Developing or Expanding a Special Care Unit** **(nursing home facilities or adult care home facilities)?** Include an explanation of why the patients projected to be served need the new or expanded SCU.

**Acquiring Major Medical Equipment** **or Developing or Expanding a Diagnostic Center** **(excluding CT scanners, MRI scanners, PET scanners, and cardiac catheterization equipment)?** Include: a description of: 1) the annual maximum capacity per unit for each type of major medical equipment included in the proposal; and 2) the assumptions and methodology used to determine maximum capacity per unit.

**Acquiring Mobile Medical Equipment?** Include: 1) the identity of the proposed host sites by name, owner, type (e.g., hospital, physician office, diagnostic center, etc.) and physical location (i.e., street address, city and county) and 2) a description of the applicant’s efforts to contact the proposed host sites.

5. **Utilization**

a. **Complete the applicable forms listed below**. The forms are found in Section Q.

**Health Service Facility Bed Utilization**

Form C.1a (Prior Full FY and up to 7 Interim Full FYs)

Form C.1b (Partial FY and 1st 3 Full FYs)

**Facilities with more than one campus on the same license**: Provide utilization for the campus identified in Section A, Question 4. However, also provide utilization for the entire facility if a CON rule or SMFP policy applies and requires utilization for the entire facility. If the proposal includes adding neonatal beds (Levels II, III, or IV), provide neonatal utilization for all three levels for the entire facility.

**All other health service facilities with licensed beds**: Provide utilization for the entire facility.

**All applicants**: Also provide utilization for the entire facility for the other facilities owned by the applicant or a related entity located in the same service area if a CON rule is applicable and requires historical or projected utilization for those other facilities.

**Medical Equipment Utilization**

Form C.2a (Prior Full FY and up to 7 Interim Full FYs)

Form C.2b (Partial FY and 1st 3 Full FYs)

**Diagnostic centers**: Provide utilization for all the types medical equipment (existing, approved, and proposed) operated by the facility.

**All other facilities proposing to acquire medical equipment**: Provide utilization for each type of medical equipment (existing, approved, and proposed) included in the proposal for the campus identified in Section A, Question 4. However, also provide utilization for the entire facility if a CON rule or SMFP policy requires utilization for the entire facility.

Provide utilization for all the types of medical equipment (existing, approved, and proposed) operated by the facility if the proposal involves: 1) developing a new facility; 2) developing a new campus of an existing facility and the new campus will be on the same license; or 3) relocating a facility to a new campus.

**All applicants**: Also provide utilization for the entire facility for the other facilities owned by the applicant or a related entity located in the same service area if a CON rule is applicable and requires historical or projected utilization for those other facilities.

**OR and GI Endo Room Utilization**

Form C.3a (Prior Full FY and up to 7 Interim Full FYs)

Form C.3b (Partial FY and 1st 3 Full FYs)

**Ambulatory Surgical Facilities**: Provide utilization for the entire facility.

**Hospitals**: Provide utilization for the campus identified in Section A, Question 4. However, also provide utilization for the entire facility if: 1) a CON rule requires utilization for the entire facility; or 2) developing a new facility.

**All applicants**: Also provide utilization for the entire facility for the other facilities owned by the applicant or a related entity located in the same service area if a CON rule is applicable and requires historical or projected utilization for those other facilities.

**Other Hospital Services Utilization**

Form C.4a (Prior Full FY and up to 7 Interim Full FYs)

Form C.4b (Partial FY and 1st 3 Full FYs)

Provide utilization for those Other Hospital Services included in the proposal for the campus identified in Section A, Question 4. However, if the proposal includes developing a new facility, provide utilization for all Other Hospital Services for the entire facility. If the proposal includes developing a new campus of an existing facility and the new campus will be on the same license, provide utilization for all Other Hospital Services for the campus identified in Section A, Question 4.

**Home health agencies** should use Form C.5, not Forms C.4a and C.4b.

**Home Health Utilization**

Form C.5 (Partial FY and 1st 3 Full FYs)

**Hospice Utilization**

Form C.6 (Partial FY and 1st 3 Full FYs)

**Instructions for All Forms:**

* **DO NOT CHANGE** the font, font size, row height, column width, margins, borders, shading, footnotes, or the orientation from landscape to portrait. The spreadsheets are set up to fit all columns on one page. If the applicant must copy a form (original) and paste it into a new blank spreadsheet, the applicant should use Paste Special All and then format the new spreadsheet as follows:

Font: Calibri

Font Size: 10 pt

Row Height: as close to the original as possible

Column Width: as close to the original as possible

Top Margin: 1

Bottom Margin: 0.5

Left Margin: 0.5

Right Margin: 0.5

Orientation: Landscape

Left footnote: Calibri (body), 9 pt, type: “CON Application Form”

Center footnote: Calibri (body), 9 pt, type: “Page,” then select “Insert Page Number”

Right footnote: Calibri (body), 9 pt, type: “Date of Last Revision” (use the date on the original)

Scaling: Fit all columns on one page

* **Historical** – Provide actual annual utilization data for the last full fiscal year prior to the submission of the application. If a full year of utilization data is not available, annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include annualized utilization data, specify the number of months for which actual utilization data is available, provide the total actual utilization data for those months and describe the method used to annualize the partial year of actual utilization data.
* **Interim** – Provide projected annual utilization data for each full fiscal year starting with the first full fiscal year following the last full fiscal year prior to submission of the application until the project is complete. One year of annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include one year of annualized utilization data, specify the number of months for which actual utilization data is available, provide the total actual utilization data for those months and describe the method used to annualize the partial year of actual utilization data.
* **Projected** – Provide projected annual utilization data for the first three full fiscal years after completion of the proposed project. A partial fiscal year of projected utilization data following completion of the project may be necessary and is permissible. If it is necessary to include a partial fiscal year of projected utilization data, specify the number of months included in the partial fiscal year. Then include three full fiscal years of projected annual utilization data.

b. **Describe the assumptions and the methodology used to complete the forms in 5.a**. The description should be done in Microsoft Word or similar software and placed in Section Q, immediately following the completed form to which it relates. The applicant has the burden to demonstrate in the application as submitted that projected utilization is based on reasonable and adequately supported assumptions. Forms C.1a, C.2a, C.3a, and C.4a only request one year of historical data. However, an applicant may need to provide more years of historical data in its assumptions and methodology in order to meet its burden. If the applicant does provide more years of historical data in its assumptions and methodology, do **not** add those earlier years to the forms. Provide any supporting documentation in an Exhibit.

c. 1) **Operating Room Proposals –** Complete **only one** of the following tables.

|  |  |
| --- | --- |
| **Existing Facility to be Expanded \*** | |
| **<Insert name of facility here>** | |
| **Group Assignment** | |
| Provide the Group Assignment as reported in Table 6A in the SMFP in effect on the application deadline |  |
| Are you proposing that the Group Assignment will change as a result of this project? |  |
| If you answered yes, what is the new Group Assignment? |  |
| Explain why it is appropriate in the cell below and provide any supporting documentation in an Exhibit | |
|  | |
| **Standard hours per OR per year \*\*** |  |
| **Case Times \*\*\*** | |
| Final inpatient case time |  |
| Final outpatient case time |  |

**\*** Includes a new proposed campus of an existing facility if the new campus will be on the same license with other campuses.

**\*\* Standard Hours per OR per Year** – Based on the Group Assignment and Step 3 in the OR Need Methodology in Chapter 6 of the SMFP.

**\*\*\* Case Times** – From Table 6B in the SMFP. Use these case times to project surgical hours for this facility.

|  |  |
| --- | --- |
| **New Facility \*** | |
| **<Insert name of facility here>** | |
| **Group Assignment** | |
| Provide the proposed Group Assignment |  |
| Explain why it is appropriate in the cell below and provide any supporting documentation in an Exhibit | |
|  | |
| **Standard hours per OR per year \*\*** |  |
| **Case Times \*\*\*** | |
| Average final inpatient case time |  |
| Average final outpatient case time |  |

**\*** Does not include a new proposed campus of an existing facility if the new campus will be on the same license with other campuses.

**\*\* Standard Hours per OR per Year** – Based on the Group Assignment and Step 3 in the OR Need Methodology in Chapter 6 of the SMFP.

**\*\*\* Case Times** – Based on the Group Assignment and Step 4 in the OR Need Methodology in Chapter 6 of the SMFP. Use these case times to project surgical hours for this facility.

2) **Health System** – Identifyall licensed or approved facilities with ORs **located in the same service area** as the facility or campus identified in response to Section A, Question 4 that are or would be part of the applicant’s health system, as that term is defined in Chapter 6 of the signed SMFP in effect as of the application deadline, by completing the following tables.

* Use the facility’s final case times as reported in Chapter 6 of the signed SMFP in effect as of the application deadline to project estimated surgical hours in Form C.3. If the facility does not have final case times in Chapter 6, use the average final case times for the Group.
* All campuses on one hospital license should be reported on one line as they are in Tables 6A and 6B in Chapter 6 in the SMFP.

**Number of Operating Rooms**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Health Service Facility** | **# of Dedicated C-Section ORs** | **# of Inpatient ORs** (excluding dedicated C-Section ORs) | **# of Shared ORs** | **# of Dedicated Ambulatory ORs** | **# of Exclusions \*** | **Total # of ORs less Exclusions\*** |
|  |  |  |  |  |  |  |
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\* Exclude all dedicated C-Section ORs, 1 OR for each Level I or Level II Trauma Center, and 1 additional OR for each designated Burn Intensive Care Unit.

**Group Assignments, Standard Hours per OR per Year, and Case Times**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health Service Facility** | **Group Assignment** | **Standard Hours per OR per Year** | **Case Times** | |
| **Inpatient** | **Outpatient** |
|  |  |  |  |  |
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**Access by Medically Underserved Groups**

6. For the facility or campus identified in Section A, Question 4:

a. Briefly describe how the groups listed below will access the service components proposed in this application form:

* Low income persons;
* Racial and ethnic minorities;
* Women;
* Persons with disabilities;
* Persons 65 and older;
* Medicare beneficiaries; and
* Medicaid recipients.

b. Provide an estimated percentage of total patients for each group listed in the following table. If an applicant is unable to provide an estimate for any group, explain.

|  |  |
| --- | --- |
| **Group** | **Estimated Percentage of Total Patients**  **during the Third Full Fiscal Year** |
| Low income persons |  |
| Racial and ethnic minorities |  |
| Women |  |
| Persons with disabilities |  |
| Persons 65 and older |  |
| Medicare beneficiaries |  |
| Medicaid recipients |  |

**CON Rules:** *“The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.”*

7. a. The CON Rules which may be applicable are listed below. Check each one that applies to this proposal. Copies of the rules may be obtained online at: <http://reports.oah.state.nc.us/ncac.asp>.

|  |  |  |
| --- | --- | --- |
|  | 10A NCAC 14C .1102 | Criteria and Standards for Nursing Facility or Adult Care Home Services **\*** |
|  | 10A NCAC 14C .1403 | Criteria and Standards for Neonatal Services |
|  | 10A NCAC 14C .1603 | Criteria and Standards for Cardiac Catheterization Equipment and Cardiac Angioplasty Equipment |
|  | 10A NCAC 14C .1703 | Criteria and Standards for Open-Heart Surgery Services and Heart-Lung Bypass Machines |
|  | 10A NCAC 14C .1903 | Criteria and Standards for Radiation Therapy Equipment |
|  | 10A NCAC 14C .2003 | Criteria and Standards for Home Health Services |
|  | 10A NCAC 14C .2103 | Criteria and Standards for Surgical Services and Operating Rooms |
|  | 10A NCAC 14C .2303 | Criteria and Standards for Computed Tomography Equipment |
|  | 10A NCAC 14C .2403 | Criteria and Standards for Intermediate Care Facilities for Individuals with Intellectual Disabilities **\*** |
|  | 10A NCAC 14C .2503 | Criteria and Standards for Substance Use Disorder (Chemical Dependency Treatment) Beds **\*** |
|  | 10A NCAC 14C .2603 | Criteria and Standards for Psychiatric Beds **\*** |
|  | 10A NCAC 14C .2703 | Criteria and Standards for Magnetic Resonance Imaging Scanner |
|  | 10A NCAC 14C .2803 | Criteria and Standards for Rehabilitation Services **\*** |
|  | 10A NCAC 14C .3703 | Criteria and Standards for Positron Emission Tomography Scanner |
|  | 10A NCAC 14C .3803 | Criteria and Standards for Acute Care Beds |
|  | 10A NCAC 14C .3903 | Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities |
|  | 10A NCAC 14C .4003 | Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Care Facilities **\*** |

**\*** CON rules with an asterisk have specific questions in 7.c.

b. If you checked a CON rule in the table above that does **not** have an asterisk, copy the rule, insert it here, and document that the proposal is consistent with that rule.

c. If you checked a CON rule in the table above that **has** an asterisk, copy the rule, find the relevant subpart below, insert the rule right below the bolded title, respond to the specific question(s) and document that the proposal is consistent with the rule.

It is permissible to state that the response can be found in another part of Section C or Section Q. In that case, identify the specific Question or Form where the response to the CON rule can be found. **However, be sure that the response in that section is consistent with the requirements of the CON rule**. Some rules require that historical utilization be provided for a 6-month or 9-month period and that projected utilization be provided quarterly or for a 6-month period while the Questions and Forms do not.

Applicants may delete any of the following subparts that are **not applicable**. However, if any of the subsequent subparts are applicable, do **not** change the number for the applicable subpart.

1) **10A NCAC 14C .1100 Criteria and Standards for Nursing Facility or Adult Care Home Services**

**Existing facilities that propose to add beds** – Provide actual days of care during the last nine (9) months immediately preceding submittal of the application by completing the following table.

|  |  |  |  |
| --- | --- | --- | --- |
| **From:** | mm/dd/yyyy | **All Nursing Facility Beds, including those in a SCU** | **All Adult Care Home Beds, including those in a SCU** |
| **To:** | mm/dd/yyyy |
| # of Existing Beds | |  |  |
| Month 1 | |  |  |
| Month 2 | |  |  |
| Month 3 | |  |  |
| Month 4 | |  |  |
| Month 5 | |  |  |
| Month 6 | |  |  |
| Month 7 | |  |  |
| Month 8 | |  |  |
| Month 9 | |  |  |
| Total Days of Care | |  |  |
| Occupancy Rate **\*\*** | |  |  |

**\*\*** Occupancy Rate = Total Days of Care / (# of Existing Beds times 273.7 days). If you use the formula available in a Microsoft Word Table to add up the Total Days of Care in the table above, make sure you did **not** include the cell that includes the # of Existing Beds in the formula.

2) **10A NCAC 14C .2400 Criteria and Standards for Intermediate Care Facilities for Individuals with Intellectual Disabilities**

a) **Existing facilities that propose to add beds** – Provide actual days of care during the last six (6) months immediately preceding submittal of the application by completing the following table.

|  |  |
| --- | --- |
| **From:** | mm/dd/yyyy |
| **To:** | mm/dd/yyyy |
| # of Existing ICF/IID Beds |  |
|  | **Days of Care** |
| Month 1 |  |
| Month 2 |  |
| Month 3 |  |
| Month 4 |  |
| Month 5 |  |
| Month 6 |  |
| Total Days of Care |  |
| Occupancy Rate **\*** |  |

**\*** Occupancy Rate = Total Days of Care / (# of Existing ICF/IID Beds times 182.5 days).

b) **All applicants** – Document that no more than three ICF/IID facilities housing a combined total of 18 persons shall be developed on contiguous pieces of property.

3) **10A NCAC 14C .2500 Criteria and Standards for Substance Use Disorder (Chemical Dependency Treatment) Beds**

a) **Existing** **facilities that propose to add beds** – Provide actual days of care during the last nine (9) months immediately preceding submittal of the application by completing the following table.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **From:** | mm/dd/yyyy | **Child / Adolescent SUD Beds** | **Adult SUD Beds** | **Total SUD Beds** |
| **To:** | mm/dd/yyyy |
| # of Existing SUD Beds | |  |  |  |
| Month 1 | |  |  |  |
| Month 2 | |  |  |  |
| Month 3 | |  |  |  |
| Month 4 | |  |  |  |
| Month 5 | |  |  |  |
| Month 6 | |  |  |  |
| Month 7 | |  |  |  |
| Month 8 | |  |  |  |
| Month 9 | |  |  |  |
| Total Days of Care | |  |  |  |
| Occupancy Rate **\*** | |  |  |  |

**\*** Occupancy Rate = Total Days of Care / (# of Existing SUD Beds times 273.7 days). If you use the formula available in a Microsoft Word Table to add up the Total Days of Care in the table above, make sure you did **not** include the cell that includes the # of Existing Beds in the formula.

b) **All Applicants**

i) Complete the following table:

|  |  |
| --- | --- |
| Projected average length of stay |  |
| Projected recidivism rate |  |

ii) Describe how the average length of stay was determined.

iii) Describe how the recidivism rate was determined.

iv) Provide any supporting documentation in an Exhibit.

4) **10A NCAC 14C .2600 Criteria and Standards for Psychiatric Beds**

**Existing facilities that propose to add** **beds** – Provide actual days of care during the last six (6) months immediately preceding submittal of the application by completing the following table.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **From:** | mm/dd/yyyy | **Child / Adolescent Psychiatric Beds** | **Adult Psychiatric Beds** | **Total Psychiatric Beds** |
| **To:** | mm/dd/yyyy |
| # of Existing Psychiatric Beds | |  |  |  |
| Month 1 | |  |  |  |
| Month 2 | |  |  |  |
| Month 3 | |  |  |  |
| Month 4 | |  |  |  |
| Month 5 | |  |  |  |
| Month 6 | |  |  |  |
| Total Days of Care | |  |  |  |
| Occupancy Rate **\*** | |  |  |  |

**\*** Occupancy Rate = Total Days of Care / (# of Existing Psychiatric Beds times 182.5 days). ). If you use the formula available in a Microsoft Word Table to add up the Total Days of Care in the table above, make sure you did **not** include the cell that includes the # of Existing Beds in the formula.

5) **10A NCAC 14C .2800 Criteria and Standards for Rehabilitation Services**

**Existing facilities that propose to add beds** – Provide actual days of care during the last nine (9) months immediately preceding submittal of the application by completing the following table.

|  |  |
| --- | --- |
| **From** | mm/dd/yyyy |
| **To** | mm/dd/yyyy |
| # of Beds |  |
|  | **Days of Care** |
| Month 1 |  |
| Month 2 |  |
| Month 3 |  |
| Month 4 |  |
| Month 5 |  |
| Month 6 |  |
| Month 7 |  |
| Month 8 |  |
| Month 9 |  |
| Total Days of Care |  |
| Occupancy Rate **\*** |  |

**\*** Occupancy Rate = Total Days of Care / (# of Beds times 273.7 days).

6) **10A NCAC 14C .4000 Criteria and Standards for** **Hospice Inpatient Facilities and Hospice Residential Care Facilities**

a) **Existing facilities that propose to add beds** – Provide actual days of care during the last nine (9) months immediately preceding submittal of the application by completing the following table.

|  |  |  |
| --- | --- | --- |
| **From** | mm/dd/yyyy | |
| **To** | mm/dd/yyyy | |
| Level of Care | **Inpatient** | **Residential** |
| # of Beds |  |  |
| **Days of Care** | | |
| Month 1 |  |  |
| Month 2 |  |  |
| Month 3 |  |  |
| Month 4 |  |  |
| Month 5 |  |  |
| Month 6 |  |  |
| Month 7 |  |  |
| Month 8 |  |  |
| Month 9 |  |  |
| Total Days of Care |  |  |
| Occupancy Rate **\*** |  |  |

**\*** Occupancy Rate = Total Days of Care / (# of Beds times 273.7 days).

b) **All applicants** – Provide projected days of care during each of the last six (6) months of the first full fiscal year of operation by completing the following table.

**First Full FY**

|  |  |
| --- | --- |
| **From** | mm/dd/yyyy |
| **To** | mm/dd/yyyy |
| # of Beds |  |
| **Days of Care** | |
| Month 7 |  |
| Month 8 |  |
| Month 9 |  |
| Month 10 |  |
| Month 11 |  |
| Month 12 |  |
| Total Days of Care |  |
| Occupancy Rate **\*** |  |

**\*** Occupancy Rate = Total Days of Care / (# of Beds times 182.5 days).

c) **Proposals to develop new hospice residential care beds** – Identify each existing hospice residential care facility located in the hospice service area (as defined in Chapter 12 of the applicable SMFP) and provide actual days of care during the 12-month period as reported in each facility’s most recent Licensure Renewal Application (LRA) form on file with the Division as of the application deadline.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Facility** | **# of Residential Beds** | **Total Days of Care** | **Occupancy Rate \*** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**\*** Occupancy Rate = Total Days of Care / (# of Beds times 365 days).

**Change of Scope and Cost Overrun Applications**

8. a. Does this proposal involve a **change of scope** for a previously approved proposal(s)?

|  |
| --- |
|  |

If you answered yes:

1) Compare the scope of this proposal with the scope of the previously approved proposal(s), identify each proposed change, and explain the need the patients to be served have for each proposed change; and

2) Provide any supporting documentation in an Exhibit.

b. Does this proposal involve a **cost overrun** for a previously approved proposal(s)?

|  |
| --- |
|  |

If you answered yes:

1) Complete Form F.1b Capital Cost for Cost Overrun, which is found in Section Q;

2) Compare the new capital cost with the previously approved capital cost, identify each line item that has increased or decreased, and explain why each change is necessary; and

3) Provide any supporting documentation in an Exhibit.

c. **Projected** **Patient Origin** – Isprojected patient origin expected to be different from what was projected in the previously approved application(s) as a result of this proposal?

|  |
| --- |
|  |

1) If you answered yes:

a) Copy the tables in Question 3 above, insert them below, and provide the responses;

b) Describe the assumptions and methodology used to project the new patient origin, including but not limited to explaining why it is expected to change as a result of this proposal; and

c) Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

d. **Projected Utilization** – Is projected utilization expected to be different from what was projected in the previously approved application(s) as a result of this proposal?

|  |
| --- |
|  |

1) If you answered yes, provide the new projected utilization in Section Q, including the assumptions and methodology used (see Question 5 above).

2) If you answered no, explain why not.

e. **Access by Medically Underserved Groups** – Is access by medically underserved groups expected to be different from what was projected in the previously approved application(s) as a result of this proposal?

|  |
| --- |
|  |

1) If you answered yes:

a) Copy the table in Question 6, insert it below, and provide the response;

b) Describe the changes and explain why access by medically underserved groups is expected to change as a result of this proposal; and

c) Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

f. **CON** **Rules**

1) Are there any CON rules applicable to **this** proposal that were **not** applicable to the previously approved application(s)?

|  |
| --- |
|  |

2) If you answered yes, identify the CON rule(s) applicable to **this** proposal, copy each rule, insert it below, and document that this proposal is consistent with that rule.

3) Provide any supporting documentation in an Exhibit.

**Section D - Criterion (3a)**

G.S. 131E-183(a)(3a)

*“In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, … persons* [with disabilities]*, and other underserved groups and the elderly to obtain needed health care.”*

For cost overrun and change of scope applications, skip to Section D, Question 3.

1. a. Does the proposal in this application involve **relocating the entire facility** to another location or campus?

|  |
| --- |
|  |

b. If you answered yes:

1) Explain how the needs of the patients currently using the facility will be met following the relocation of the facility;

2) Provide any supporting documentation in an Exhibit; and

3) Describe the effect of the relocation of the facility on the ability of each group listed below to obtain the services provided by the facility:

* + - Low income persons;
    - Racial and ethnic minorities;
    - Women;
    - Persons with disabilities;
    - Persons 65 and older;
    - Medicare beneficiaries; and
    - Medicaid recipients.

2. a. Does the proposal in this application involve **reducing or eliminating** **[[4]](#footnote-4) some but not all** the service components at a health service facility?

|  |
| --- |
|  |

b. If you answered yes, provide a **separate response** to this subpart for **each** facility that will lose service components as a result of this proposal.

1) Complete the following table. Add more rows if needed.

|  |  |  |
| --- | --- | --- |
| **<Insert name of facility here>** | | |
| **Service Component to be Reduced or Eliminated** | **Number to be Reduced or Eliminated \*** | **Number Remaining** |
|  |  |  |
|  |  |  |

\* Provide the number of health service facility beds by type, ORs by type (shared, dedicated outpatient, dedicated C-section, or other dedicated inpatient), GI endo rooms, or medical equipment by type to be reduced or eliminated. For some health services or hospital services, there would not be a number.

2) Explain how the needs of the patients continuing to use the facility will be met following the reduction or elimination of the existing service components. Your response should include but not be limited to discussion regarding the type and number of health service facility beds, health services, hospital services, or medical equipment that will remain where they are.

3) Describe the effect of the reduction or elimination of the existing service components on the ability of each group listed below to obtain services:

* + - Low income persons;
    - Racial and ethnic minorities;
    - Women;
    - Persons with disabilities;
    - Persons 65 and older;
    - Medicare beneficiaries; and
    - Medicaid recipients.

4) If the proposal involves reducing or eliminating **Operating Rooms,** complete the following table.

|  |  |
| --- | --- |
| **<Insert name of facility here> \*** | |
| **Group Assignment** | |
| Provide the Group Assignment as reported in Table 6A in the SMFP in effect at the time the review begins |  |
| Are you proposing that the Group Assignment will change as a result of this project? |  |
| If you answered yes, what is the new Group Assignment? |  |
| Explain why it is appropriate in the cell below and provide any supporting documentation in an Exhibit. | |
|  | |
| **Standard hours per OR per year \*\*** |  |
| **Case Times \*\*\*** | |
| Final inpatient case time |  |
| Final outpatient case time |  |

**\*** Includes all campuses on one license.

**\*\* Standard Hours per OR per Year** – Based on the Group Assignment and Step 3 in the OR Need Methodology in Chapter 6 of the SMFP.

**\*\*\* Case Times** – Based on Step 4 in the OR Need Methodology in Chapter 6 of the SMFP. Use these case times to project surgical hours for this facility.

5) Complete the applicable forms listed below for the facility that will lose existing health service facility beds, health services, hospital services, or medical equipment. The forms can be found in Section Q

Form D.1 Historical and Projected Health Service Facility Bed Utilization

Form D.2 Historical and Projected Medical Equipment Utilization

Form D.3 Historical and Projected ORs and GI Endo Room Utilization

Form D.4 Historical and Projected Other Hospital Services Utilization

**Describe the assumptions and the methodology used to complete the forms**. The description should be done in Microsoft Word or similar software and placed in Section Q, immediately following the completed form to which it relates. Provide any supporting documentation in an Exhibit.

**Instructions for All Forms:**

* **DO NOT CHANGE** the font, font size, row height, column width, margins, borders, shading, footnotes, or the orientation from landscape to portrait. The spreadsheets are set up to fit all columns on one page. If the applicant must copy a form (original) and paste it into a new blank spreadsheet, the applicant should use Paste Special All and then format the new spreadsheet as follows:

Font: Calibri

Font Size: 10 pt

Row Height: as close to the original as possible

Column Width: as close to the original as possible

Top Margin: 1

Bottom Margin: 0.5

Left Margin: 0.5

Right Margin: 0.5

Orientation: Landscape

Left footnote: Calibri (body), 9 pt, type: “CON Application Form”

Center footnote: Calibri (body), 9 pt, type: “Page,” then select “Insert Page Number”

Right footnote: Calibri (body, 9 pt, type: “Date of Last Revision” (use the date on the original)

Scaling: Fit all columns on one page

* **Historical** – Provide actual annual utilization data for the last full fiscal year prior to the submission of the application. If a full year of utilization data is not available, annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include annualized utilization data, specify the number of months for which actual utilization data is available, provide the total actual utilization data for those months and describe the method used to annualize the partial year of actual utilization data.
* **Interim** – Provide projected annual utilization data for each full fiscal year starting with the first full fiscal year following the last full fiscal year prior to submission of the application until the project is complete. One year of annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include one year of annualized utilization data, specify the number of months for which actual utilization data is available, provide the total actual utilization data for those months and describe the method used to annualize the partial year of actual utilization data.
* **Projected** – Provide projected annual utilization data for the first full fiscal year after completion of the proposed project. A partial fiscal year of projected utilization data following completion of the project may be necessary and is permissible. If it is necessary to include a partial fiscal year of projected utilization data, specify the number of months included in the partial fiscal year. Then include the first full fiscal year of projected annual utilization data.

**Cost Overrun and Change of Scope Applications**

3. a. Do the changes proposed in this application now include relocating the entire health service facility to another location or campus which was **not** proposed in the previously approved application(s)?

|  |
| --- |
|  |

If you answered yes, copy Question 1.b, insert it below, and provide a response.

b. Do the changes proposed in this application now include reducing or eliminating service components at an existing health service facility which were **not** proposed to be reduced or eliminated in the previously approved application(s)?

|  |
| --- |
|  |

If you answered yes, copy Question 2.b, insert it below, and provide a response for the service components that will be reduced or eliminated as a result of this proposal.

**Section E - Criterion (4)**

G.S. 131E-183(a)(4)

*“Where alternative methods of meeting the needs for the proposed project exist, the applicant shall* *demonstrate that the least costly or most effective alternative has been proposed.”*

1. Are there any alternative methods of meeting the need for the proposal available to the applicant?

|  |
| --- |
|  |

2. If you answered yes:

a. Describe each alternative method available to the applicant to meet the need for the proposal;

b. For each alternative method **not** selected, explain how that alternative would be more costly or less effective for the applicant than the selected alternative; and

c Provide any supporting documentation in an Exhibit.

3. If you answered no:

a. Explain why there is no alternative method available to the applicant of meeting the need for the proposal; and

b. Provide any supporting documentation in an Exhibit.

**Section F - Criterion (5)**

G.S. 131E-183(a)(5)

*“Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.”*

For cost overrun and change of scope applications, skip to Section F, Question 5.

**Capital Cost and Availability of Funds for the Capital Cost**

1. a. Complete Form F.1a Capital Cost, which is found in Section Q.

b. Describe the **assumptions** used to project the capital cost.

* The description should be done in Word or similar software.
* Include it in Section Q immediately following the completed form to which it relates.
* Provide any supporting documentation in an Exhibit.

2. a. All applicants complete the following table(s).

* Add the name of each applicant in the blank cell in the first row of each table. The name should match the name in Section A, Question 1.
* Add additional tables if there are more than 3 applicants that will incur an obligation for any portion of the capital cost.
* The sum of the dollar amounts in the row labeled “**Total to be Incurred by Applicant …**” in each table should equal Line 14 on Form F.1a or Form F.1b.

|  |  |  |
| --- | --- | --- |
| **Applicant 1** |  | |
| Loans | | $ |
| Cash and Cash Equivalents, Accumulated Reserves, or Owner’s Equity | | $ |
| Bonds | | $ |
| Other (**Describe**) | | $ |
| **Total to be Incurred by Applicant 1** | | **$** |

|  |  |  |
| --- | --- | --- |
| **Applicant 2** |  | |
| Loans | | $ |
| Cash and Cash Equivalents, Accumulated Reserves, or Owner’s Equity | | $ |
| Bonds | | $ |
| Other (**Describe**) | | $ |
| **Total to be Incurred by Applicant 2** | | **$** |

|  |  |  |
| --- | --- | --- |
| **Applicant 3** |  | |
| Loans | | $ |
| Cash and Cash Equivalents, Accumulated Reserves, or Owner’s Equity | | $ |
| Bonds | | $ |
| Other (**Describe**) | | $ |
| **Total to be Incurred by Applicant 3** | | **$** |

b. Loans – If financing any portion of the capital cost with a loan, document that the prospective lending institution(s) would consider financing the proposed project. The documentation for each loan should be provided in an Exhibit and should include the:

* Proposed borrower;
  + Note: if the borrower is **not** the applicant, document that the borrower is willing to commit the proceeds of the loan for the capital cost of the project.
* Purpose of the loan;
* Proposed interest rate;
* Proposed term (period of the loan);
* Proposed amount of the loan; and
* Amortization schedule.

c. Cash and Cash Equivalents, Accumulated Reserves, or Owner’s Equity – If financing any portion of the capital cost with cash and cash equivalents, accumulated reserves, or owner’s equity:

1) Identify each legal entity that will provide cash and cash equivalents, accumulated reserves, or owner’s equity for any portion of the capital cost of the project;

2) Document that each legal entity is willing to commit cash and cash equivalents, accumulated reserves, or owner’s equity for the capital cost of the project; and

3) For each legal entity identified in response to Question 2.a, document that the cash and cash equivalents, accumulated reserves, or owner’s equity that will be used to finance the capital cost are reasonably likely to be available when needed.

d. Other Forms of Financing – If financing any portion of the capital cost through bonds or some other form of financing:

1) Describe the source of the financing; and

2) Document that the source of the financing is reasonably likely to make the funds available for the project.

**Working Capital and Availability of Funds for Working Capital**

3. a. **All applicants**

|  |  |  |
| --- | --- | --- |
| **Start-up Costs \*** | Will the applicant incur any start-up costs? |  |
| **Initial Operating Costs \*** | Will the applicant incur any initial operating costs? |  |

**\*** The term is defined in the Definitions Section of the application form.

1) If you answered no to either question, explain why not.

2) If you answered yes to either question, respond to the remainder of Question 3.

b. **Start‑up costs**

|  |  |
| --- | --- |
| Total estimated start-up costs | $ |

Identify the types of costs included in the total estimated start-up costs by checking **all** that apply in the following table.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Utilities |  | Hiring Staff |
|  | Mortgage or Rent |  | Training Staff |
|  | Purchasing Equipment |  | Fees |
|  | Purchasing Supplies |  | Other (**describe**) |
|  | Marketing or Advertising |  | Other (**describe**) |

c. **Initial operating costs**

|  |  |
| --- | --- |
| Initial operating period **\*** |  |
| Total estimated initial operating costs during the initial operating period | $ |

**\*** The term is defined in the Definitions Section of the application form.

d. **Total working capital** **\***

|  |
| --- |
| $ |

**\*** Should equal the sum of the total estimated start‑up costs in Question 3.b and the total estimated initial operating costs in Question 3.c.

e. Describe the **assumptions** used to estimate the:

1) Initial operating period;

2) Start-up costs; and

3) Initial operating costs.

f. **Sources of Financing for Working Capital**

* Add the name of each applicant in the blank cell in the first row of each table. The name should match the name in Section A, Question 1.
* Add additional tables if there are more than 3 applicants that will incur an obligation for any portion of the working capital.
* The sum of the dollar amounts in the row labeled “**Total to be Incurred by Applicant …**” in each table should equal the amount reported in Question 3.d.

|  |  |  |
| --- | --- | --- |
| **Applicant 1** |  | |
| Loans | | $ |
| Cash or Cash Equivalents, Accumulated Reserves or Owner’s Equity | | $ |
| Lines of credit | | $ |
| Bonds | | $ |
| **Total to be incurred by Applicant 1** | | $ |

|  |  |  |
| --- | --- | --- |
| **Applicant 2** |  | |
| Loans | | $ |
| Cash or Cash Equivalents, Accumulated Reserves or Owner’s Equity | | $ |
| Lines of credit | | $ |
| Bonds | | $ |
| **Total to be incurred by Applicant 2** | | $ |

|  |  |  |
| --- | --- | --- |
| **Applicant 3** |  | |
| Loans | | $ |
| Cash or Cash Equivalents, Accumulated Reserves or Owner’s Equity | | $ |
| Lines of credit | | $ |
| Bonds | | $ |
| **Total to be incurred by Applicant 3** | | $ |

g. Loans – If financing any portion of the working capital with a loan, document that the prospective lending institution(s) would consider financing the working capital. The documentation for each loan should be provided in an Exhibit and should include the:

* Proposed borrower;
  + Note: if the borrower is **not** the applicant, document that the borrower is willing to commit the proceeds of the loan for the working capital.
* Purpose of the loan(s);
* Proposed interest rate(s);
* Proposed term (period of the loan(s));
* Proposed amount of the loan(s); and
* Amortization schedule.

h. Cash or Cash Equivalents, Accumulated Reserves or Owner’s Equity – If financing any portion of the working capital with cash or cash equivalents, accumulated reserves or owner’s equity:

1) Identify each legal entity that will provide cash or cash equivalents, accumulated reserves or owner’s equity for any portion of the working capital;

2) Document that each legal entity is willing to commit cash or cash equivalents, accumulated reserves or owner’s equity for the working capital; and

3) For each legal entity identified in response to Question 2.a, document that the cash or cash equivalents, accumulated reserves or owner’s equity that will be used to finance the working capital are reasonably likely to be available when needed.

i. Other Forms of Financing – If financing any portion of the working capital through a line of credit, bonds or some other form of financing:

1) Describe the source of the financing; and

2) Document that the source of the financing is reasonably likely to make the funds available for the working capital.

**Financial Feasibility – Availability of Funds for Operating Needs and Projected Costs and Charges**

4. a. **Describe the** **assumptions and methodology used to complete each form in 4.b**. The forms are found in Section Q.

The description of the assumptions and methodology used for each form should be done in Microsoft Word or similar software and should address each line item on that form. Include the description in Section Q, immediately following the completed form to which it relates.

b. **All Applicants** should complete the following Revenues and Operating Costs forms as instructed below.

* Form F.2a Historical and Interim Revenues and Net Income
* Form F.2b Projected Revenues and Net Income upon Project Completion
* Form F.3a Historical and Interim Operating Costs
* Form F.3b Projected Operating Costs upon Project Completion

**ASFs** should complete the revenues and operating costs forms for ORs, GI endo rooms, procedure rooms, and the entire facility.

**Combination nursing home facilities** should complete the revenues and operating costs forms for NF beds, ACH beds, and the entire facility.

**CCRCs** should complete the revenues and operating costs forms for NF beds, ACH beds, and the entire health service facility. Provide projected revenues and operating costs for the independent living units only if required to demonstrate the financial feasibility of the proposal.

**Diagnostic Centers** should complete the revenues and operating costs forms for each service component and the entire facility.

**Hospice inpatient facilities that also have hospice residential care beds** should complete the revenues and operating costs forms for hospice inpatient beds, hospice residential care beds, and the entire facility.

**Hospitals** should complete the revenues and operating costs forms for each hospital service included in this proposal. Also complete these forms for the entire facility **if** the proposal involves:

* + Developing a new facility;
  + Developing a new campus of an existing facility; and
  + Projected revenues and operating costs for the entire facility are necessary to demonstrate financial feasibility of the proposal.

**All other applicants** should complete the revenues and operating costs forms for the entire facility.

**General Instructions for the Revenues and Operating Costs forms**

* **Historical** – Provide actual revenues and operating costs for the last full fiscal year prior to the submission of the application. If a full year of data is not available, annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include annualized data, specify the number of months for which actual data is available, provide the total actual data for those months and describe the method used to annualize the partial year of actual data.
* **Interim** – Provide projected annual revenues and operating costs for each full fiscal year starting with the first full fiscal year following the last full fiscal year prior to submission of the application until the project is complete. One year of annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include one year of annualized data, specify the number of months for which actual data is available, provide the total actual data for those months and describe the method used to annualize the partial year of actual data.
* **Projected** – Provide projected annual revenues and operating costs for the first three full fiscal years after completion of the proposed project. A partial fiscal year of projected data following completion of the project may be necessary and is permissible. If it is necessary to include a partial fiscal year of projected data, specify the number of months included in the partial fiscal year. Then include three full fiscal years of projected annual data.

**NFs and ACHs** should also completeForm F.4 Charges and Reimbursement Rates (Partial FY and 1st 3 Full FYs).

**Home Health Agencies** should also complete Form F.5 Charges, Costs, and Reimbursement Rates per Visit (Partial FY and 1st 3 Full FYs).

**Hospice Home Care Agencies** should also complete Form F.6 Charges and Reimbursement Rates per Visit (Partial FY and 1st 3 Full FYs).

**General Instructions for All Forms**

**DO NOT CHANGE** the font, font size, margins, borders, shading, footnotes, or the orientation from landscape to portrait. The spreadsheets are set up to fit all columns on one page. If the applicant must copy a form (original) and paste it into a new blank spreadsheet, the applicant should use Paste Special All and then format the new spreadsheet as follows:

Font: Calibri

Font Size: 10 pt

Row Height: as close to the original as possible

Column Width: as close to the original as possible

Top Margin: 1

Bottom Margin: 0.5

Left Margin: 0.5

Right Margin: 0.5

Orientation: Landscape

Left footnote: Calibri (body), 9 pt, type: “CON Application Form”

Center footnote: Calibri (body), 9 pt, type: “Page,” then select “Insert Page Number”

Right footnote: Calibri (body, 9 pt, type: “Date of Last Revision” (use the date on the original)

Scaling: Fit all columns on one page

c. **Professional Fees**

Will the facility identified in Section A, Question 4, bill the patient for any professional fees such as interpretation of radiological studies by a radiologist or review of specimens by a pathologist?

|  |
| --- |
|  |

If you answered yes, include the cost of professional fees in Form F.3. Each type of professional fee should be on its own separate line and should not be combined with other professional fees (additional rows may be inserted). For example, do not combine professional fees for interpretation of radiological studies on the same line with professional fees for review of specimens by a pathologist.

**Cost Overrun and Change of Scope Applications**

5. a. **Cost Overrun Proposals** – Copy Question 2, insert it below, and provide a response for the difference between the previously approved capital cost and the new projected capital cost.

b. **Change of Scope or Cost Overrun Proposals**

1) Do the proposed changes to the scope or the cost overrun result in changes to **total** **working capital** from the previously approved application(s)?

|  |
| --- |
|  |

a) If you answered yes:

i) Complete the following table;

|  |  |  |
| --- | --- | --- |
| **Line 1** | New total estimated start-up costs | $ |
| **Line 2** | New total estimated initial operating costs during initial operating period | $ |
| **Line 3**  (Line 1 + Line 2) | New total working capital | $ |
| **Line 4** | Previously approved total working capital | $ |
| **Line 5**  (Line 3 – Line 4) | Difference | $ |

ii) Explain why total working capital is expected to change as a result of this proposal; and

iii) If total working capital has **increased**, provide documentation of the availability of the additional funds needed in an Exhibit.

b) If you answered no, explain why not.

2) Do the proposed changes to the scope or the cost overrun result in different **revenue and operating cost** projections from the previously approved application?

|  |
| --- |
|  |

a) If you answered yes:

i) Describe the changes and explain why projected revenues are expected to change during the first three full fiscal years of operation as a result of this proposal;

ii) Describe the changes and explain why projected operating costs are expected to change during the first three full fiscal years of operation as a result of this proposal; and

iii) Provide new proformas in Section Q (see Question 4 above).

b) If you answered no, explain why not.

**Section G - Criterion (6)**

G.S. 131E-183(a)(6)

*“The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.”*

For cost overrun and change of scope applications, skip to Section G, Question 3.

1. a. Identify all existing and approved health service facilities located in the proposed service area that provide the same service components proposed in this application.

b. If available from the SMFP or license renewal application forms on file with the Division of Health Service Regulation, for each existing facility identified above, provide the total annual utilization for each service component proposed in this application during the last full fiscal year prior to the application deadline.

2. a. Explain why the proposed project will not result in an unnecessary duplication of the existing or approved health service facilities located in the proposed service area that provide the same service components proposed in this application.

b. Provide any supporting documentation for your response in an Exhibit.

**Cost Overrun and Change of Scope Applications**

3. a. Do the proposed changes to the scope or the cost overrun include adding service components that were **not** included in the previously approved applications(s)?

|  |
| --- |
|  |

b. If you answered yes:

1) Identify the new service components included in this proposal that were **not** included in the previously approved application(s); and

2) For each new service component included in this proposal, explain why this proposal will not result in an unnecessary duplication of the same existing or approved service component located in the service area.

c. If you answered no, explain why not.

**Section H - Criterion (7)**

G.S. 131E-183(a)(7)

*“The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.”*

For cost overrun and change of scope applications, skip to Section H, Question 4.

1. **Staffing** – Complete Form H Staffing, which is found in Section Q, as follows:

* + Acute care hospitals should complete the form for the service components included in this proposal. However, if the proposal involves developing a new hospital or developing a new campus of an existing hospital, the applicant should complete the form for the entire facility or new campus.
* All other applicants should complete the form for the entire facility.

**Instructions:**

* **DO NOT CHANGE** the font, font size, margins, borders, shading, footnotes, or the orientation from landscape to portrait. The spreadsheets are set up to fit all columns on one page. Applicants may add rows for position types not listed and may delete rows for position types that are not relevant to the type of facility identified in Section A, Question 4.b.
* For each staff position, which **includes employees, contract employees and temporary employees**, provide the **average annual salary** for one full-time equivalent (FTE) position (2,080 hours per year per FTE).
* For current staffing, identify the position types and the number of FTEs as of a specific date as close as possible to the date the application is expected to be submitted.
* For projected staffing, **describe the assumptions and methodology used to project:**
* The type of positions included;
* The number of FTE positions for each type; and
* The average annual salary for each position type.
* The description of the assumptions should be done in Microsoft Word or similar software and placed in Section Q, immediately following the completed spreadsheet to which they relate.

2. **Staff Recruitment** – Describe the methods used or to be used by the facility identified in response to Section A, Question 4, to recruit or fill vacant or new positions.

3. **Staff Training** – Describe the training programs and continuing education programs currently in place or to be used in the facility identified in response to Section A, Question 4.

**Cost Overrun and Change of Scope Applications**

4. a. Do the proposed changes to the scope or the cost overrun result in changes to projected staffing during the first three full fiscal years of operation?

|  |
| --- |
|  |

b. If you answered yes:

1) Describe the changes and explain why staffing is projected to change during the first three full fiscal years of operation as a result of this proposal; and

2) Complete a new Form H in Section Q (See Question 1 above).

c. If you answered no, explain why not.

**Section I - Criterion (8)**

G.S. 131E-183(a)(8)

*“The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.”*

For cost overrun and change of scope applications, skip to Section I, Question 3.

1. **Ancillary and Support Services**

a. Check each ancillary and support service in the table below that the applicant would need to provide or contract for in order to be able to offer the health services proposed in this application.

|  |  |
| --- | --- |
|  | Administration / Management |
|  | Billing / Finance Office / Insurance Claims Filing |
|  | Marketing |
|  | Human Resources / Staff Recruitment and Retention |
|  | Staff Training / Continuing Education |
|  | Information Technology |
|  | Building Maintenance / Grounds Keeping |
|  | Equipment Maintenance |
|  | Purchasing / Materials Management / Central Sterile Supply |
|  | Dietary |
|  | Housekeeping / Linen |
|  | Medical Records |
|  | Social Services |
|  | Discharge Planning |
|  | Other (**describe**) |

b. 1) For each ancillary or support service checked in the table above, briefly explain why it is necessary and how it is or will be made available.

2) For each ancillary or support service **not** checked in the table above, briefly explain why it is not necessary.

3) Provide any supporting documentation in an Exhibit.

2. **Coordination with Existing Health Care System**

a. **Existing Facilities** – Describe the facility’s existing and proposed relationships with other local health care and social service providers and provide any supporting documentation in an Exhibit.

b. **New Facilities** – Describe the efforts made by the applicant(s) to develop relationships with other local health care and social service providers and provide any supporting documentation in an Exhibit.

**Cost Overrun and Change of Scope Applications**

3. a. **Ancillary and Support Services** – Do the proposed changes to the scope or the cost overrun result in changes to the provision of necessary ancillary and support services?

|  |
| --- |
|  |

1) If you answered yes:

* Describe the changes to provision of necessary ancillary and support services and explain why each change is necessary; and
* Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

b. **Coordination with Existing Health Care System** – Do the proposed changes to the scope or the cost overrun result in changes to coordination with the existing health care system?

|  |
| --- |
|  |

1) If you answered yes:

* Describe the changes to coordination with the existing health care system and explain why each change is necessary; and
* Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

**Section J - Criterion (9)**

G.S. 131E-183(a)(9)

*“An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.”*

Note: Criterion (9) applies only if a “substantial portion” of the patients expected to utilize the service components proposed in this application reside in a “health service area” (i.e., HSA) that is not adjacent to the HSA where the facility is located. The following table identifies the non-adjacent HSAs for each HSA.

|  |  |
| --- | --- |
| **HSA** | **Non-adjacent HSAs** |
| I | IV, V and VI |
| II | VI |
| III | IV and VI |
| IV | I and III |
| V | I |
| VI | I, II and III |

“Substantial portion” is not defined in the CON Law but some of the synonyms for “substantial” are big, considerable, large and sizable. Thus, it would have to be a relatively large percentage of the total number of patients projected to utilize the service components proposed in this application in order to be considered a “substantial portion.”

1. What portion of each service component proposed in this application does the applicant project will be utilized by individuals **not** residing in the Health Service Area (HSA) in which the project is located **or** in **adjacent** HSAs?

2. If a **substantial** portion of any of the service components proposed in this application will be utilized by individuals **not** residing in the HSA in which the project is located **or** in **adjacent** HSAs, document the special needs and circumstances that warrant service to these individuals.

**Section K - Criterion (12)**

G.S. 131E-183(a)(12)

*“Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.”*

For cost overrun and change of scope applications, skip to Section K, Question 5.

1. **Construction of New Space**

|  |  |
| --- | --- |
| Does the proposal include construction of new space? |  |
| If yes, provide the total number of square feet to be constructed: |  |
| Briefly describe the proposed construction in the cell below | |
|  | |

Provide legible line drawings (no larger than 11” x 17”) that identify all new construction in an Exhibit. The use of each room or space should be labeled.

2. **Renovation of Existing Space**

|  |  |
| --- | --- |
| Does the proposal include renovation of existing space? |  |
| If yes, provide the total number of square feet to be renovated: |  |
| Briefly describe the proposed renovation in the cell below | |
|  | |

Provide legible line drawings (no larger than 11” x 17”) that identify all existing spaces to be renovated in an Exhibit. Include drawings that show the “before” and “after” renovation. The use of each room or space should be labeled.

3. a. Explain how the cost, design and means of construction (including renovating space) represents the most reasonable alternative for the proposal and provide any supporting documentation in an Exhibit.

b. Explain why the project will not unduly increase the costs to the applicant of providing the proposed services or the costs and charges to the public for the proposed services and provide any supporting documentation in an Exhibit.

c. Identify any applicable energy saving features incorporated into the construction / renovation plans and provide any supporting documentation in an Exhibit.

**New Facilities, Relocation of the Entire Existing Facility, or a New Campus of an Existing Acute Care Hospital**

G.S. 131E-181(a) states:

*“A certificate of need shall be valid only for the defined scope,* ***physical location****, and person named in the application.”* (Emphasis added)

Thus, assuming a certificate of need is issued for this project, it will be valid only for the physical location of the proposed site as described below.

4. **Proposed Site**

a. **Site Address** **\***

|  |  |
| --- | --- |
| Street Address (be as specific as possible) |  |
| City |  |
| State | North Carolina |
| ZIP Code |  |
| County |  |

**\*** This should be the same as the address provided in Section A, Question 4.

b. **Ownership**

1) Identify the legal entity that currently holds fee simple title to the proposed site (this is usually available on the county’s website).

2) If the applicant is not the current owner in fee simple, provide documentation that the site is available for acquisition by purchase or lease.

c. **Zoning and Special Use Permits**

1) Describe the current zoning at the proposed site and provide any supporting documentation in an Exhibit.

2) If the proposed site will require rezoning, describe how the applicant anticipates having it rezoned and provide any supporting documentation in an Exhibit.

3) If the proposed site will require a special use permit, describe how the applicant anticipates obtaining the special use permit and provide any supporting documentation in an Exhibit.

d. **Water** – Describe how water will be provided at the proposed site and include any supporting documentation in an Exhibit.

e. **Sewer and Waste Disposal** – Describe how sewer and waste disposal services will be provided at the proposed site and include any supporting documentation in an Exhibit.

f. **Power** – Describe how power will be provided at the proposed site and include any supporting documentation in an Exhibit.

**Cost Overrun and Change of Scope Applications**

5. a. Do the changes to the scope or the cost overrun result in changes to the cost, design, and means of construction?

|  |
| --- |
|  |

1) If you answered yes:

i) Copy Questions 1 through 3, insert them below, and provide responses;

ii) Identify each proposed change and explain the need for each proposed change; and

iii) Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

b. If proposing to change the site, copy Question 4, insert it below, and provide a response.

**Section L - Criterion (13)**

G.S. 131E-183(a)(13)

*“The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and … persons* [with disabilities]*, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:*

*(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;*

*(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and … persons* [with disabilities] *to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;*

*(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and*

*(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.”*

For change of scope applications, skip to Section L, Question 6.

1. a. **Historical Payor Sources during the Last Full FY before Submission of Application**

Complete the following tables for:

* The facility or campus identified in Section A, Question 4; and
* Each facility from which service components will be relocated to the facility or campus identified in Section A, Question 4.

**Last Full FY before Submission of Application**

**mm/dd/yyyy to mm/dd/yyyy**

|  |  |
| --- | --- |
| **<Insert the name of the facility here>** | |
| **Payor Source** | **Percentage of Total Patients Served** |
| Self-Pay | % |
| Charity Care | % |
| Medicare **\*** | % |
| Medicaid **\*** | % |
| Insurance **\*** | % |
| Workers Compensation | % |
| TRICARE | % |
| Other (**describe**) | % |
| Total | 100.0% |

**\*** Including any managed care plans.

**Last Full FY before Submission of Application**

**mm/dd/yyyy to mm/dd/yyyy**

|  |  |
| --- | --- |
| **<Insert the name of the facility from which service components will be relocated here>** | |
| **Payor Source** | **Percentage of Total Patients Served** |
| Self-Pay | % |
| Charity Care | % |
| Medicare **\*** | % |
| Medicaid **\*** | % |
| Insurance **\*** | % |
| Workers Compensation | % |
| TRICARE | % |
| Other (**describe**) | % |
| Total | 100.0% |

**\*** Including any managed care plans.

b. **Comparison with the Percentages of the Population of the Service Area**

Complete the following tables for:

* The facility or campus identified in Section A, Question 4; and
* Each facility from which service components will be relocated to the facility or campus identified in Section A, Question 4.

|  |  |  |
| --- | --- | --- |
| **<Insert the name of the facility here>** | **Last Full FY before Submission of the Application** | |
| **Percentage of Total Patients Served** | **Percentage of the Population of the Service Area \*** |
| Female |  |  |
| Male |  |  |
| Unknown |  |  |
| 64 and Younger |  |  |
| 65 and Older |  |  |
| American Indian |  |  |
| Asian |  |  |
| Black or African-American |  |  |
| Native Hawaiian or Pacific Islander |  |  |
| White or Caucasian |  |  |
| Other Race |  |  |
| Declined / Unavailable |  |  |

**\*** The percentages can be found online using the United States Census Bureau’s QuickFacts which is at: <https://www.census.gov/quickfacts/fact/table/US/PST045218>. Just enter in the name of the county.

|  |  |  |
| --- | --- | --- |
| **<Insert the name of the facility from which service components will be relocated here>** | **Last Full FY before Submission of the Application** | |
| **Percentage of Total Patients Served** | **Percentage of the Population of the Service Area \*** |
| Female |  |  |
| Male |  |  |
| Unknown |  |  |
| 64 and Younger |  |  |
| 65 and Older |  |  |
| American Indian |  |  |
| Asian |  |  |
| Black or African-American |  |  |
| Native Hawaiian or Pacific Islander |  |  |
| White or Caucasian |  |  |
| Other Race |  |  |
| Declined / Unavailable |  |  |

**\*** The percentages can be found online using the United States Census Bureau’s QuickFacts which is at: <https://www.census.gov/quickfacts/fact/table/US/PST045218>. Just enter in the name of the county.

2. **Uncompensated Care, Community Service, Access by Minorities & Persons with Disabilities, and Patient Civil Rights Complaints**

a. For the facility or campus identified in Section A, Question 4 **and** each facility from which existing health services will be relocated to that facility, respond to the following:

1) Is the facility or campus obligated under any applicable federal regulations to provide uncompensated care, community service, or access by minorities and persons with disabilities?

|  |
| --- |
|  |

2) If you answered yes, describe how the facility or campus has fulfilled or is fulfilling its requirement.

b. Identify each **patient** civil rights equal access complaint filed in the 18 months immediately preceding the application deadline against the facility or campus identified in Section A, Question 4, **and** each facility from which existing health services will be relocated to that facility or campus. Describe the current status of each complaint.

3. **Projected Payor Sources during the Third Full FY of Operation following Completion of the Project.**

a. Complete the following tables for:

* The facility or campus identified in response to Section A, Question 4; and
* Each service component included in the proposal.

b. **Describe the assumptions used to project each payor source**.

**Projected Payor Mix during the 3rd Full FY**

**mm/dd/yyyy to mm/dd/yyyy**

|  |  |
| --- | --- |
| **<Insert the name of the facility here>** | |
| **Payor Source** | **Percentage of Total Patients Served** |
| Self-Pay | % |
| Charity Care | % |
| Medicare **\*** | % |
| Medicaid **\*** | % |
| Insurance **\*** | % |
| Workers Compensation | % |
| TRICARE | % |
| Other (**Describe**) | % |
| Total | 100.0% |

**\*** Including any managed care plans.

|  |  |
| --- | --- |
| **<Identify the service component here>** | |
| **Payor Source** | **Percentage of Total Patients Served** |
| Self-Pay | % |
| Charity Care | % |
| Medicare **\*** | % |
| Medicaid **\*** | % |
| Insurance **\*** | % |
| Workers Compensation | % |
| TRICARE | % |
| Other (**Describe**) | % |
| Total | 100.0% |

**\*** Including any managed care plans.

4. **Charity and Reduced Cost Care**

a. Will the facility or campus identified in Section A, Question 4, provide care to medically indigent or low-income patients at no cost to the patient (i.e., charity care)?

|  |
| --- |
|  |

If you answered yes, provide estimates of the total number of charity care patients to be served by the entire facility in the each of the first three full FYs of operation. **Describe how the number was estimated**.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **1st Full FY** | **2nd Full FY** | **3rd Full FY** |
| Estimated # of Charity Care Patients |  |  |  |

b. Will the facility or campus identified in Section A, Question 4, provide care to medically indigent or low-income patients at a reduced cost to the patient?

|  |
| --- |
|  |

If you answered yes, provide estimates of the total number of patients to be served by the entire facility at a reduced cost to the patient in the each of the first three full FYs of operation. **Describe how the number was estimated**.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **1st Full FY** | **2nd Full FY** | **3rd Full FY** |
| Estimated # of Patients to be Served at a Reduced Cost to the Patient |  |  |  |

c. Provide copies of the facility’s existing or proposed policies regarding charity and reduced cost care.

5. Indicate the means by which a person will have access to the services proposed in this application (e.g., physician referral, self-admission, etc.).

**Cost Overrun and Change of Scope Applications**

6. Do the proposed changes to the scope or the cost overrun result in changes to projected access by medically underserved groups?

|  |
| --- |
|  |

a. If you answered yes:

1) Copy Questions 3 and 4, insert them below, and provide responses;

2) Explain what would change and why; and

3) Provide any supporting documentation in an Exhibit.

b. If you answered no, explain why not.

**Section M - Criterion (14)**

G.S. 131E-183(a)(14)

*“The* *applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.”*

For cost overrun and change of scope applications, skip to Section M, Question 3.

1. a. If applicable to the proposed service components, describe the extent to which health professional training programs **in the area** have or will have access to the facility or campus identified in Section A, Question 4, for health professional training purposes.

b. Document the efforts made by the applicant to establish relationships with these training programs.

2. If not applicable to the proposed service components, briefly explain why not.

**Cost Overrun and Change of Scope Applications**

3. Do the changes proposed to the scope or the cost overrun result in changes to accommodating the clinical needs of area health professional training programs?

a. If you answered yes:

1) Explain what would change and why; and

2) Provide any supporting documentation in an Exhibit.

b. If you answered no, explain why not.

**Section N - Criterion (18a)**

G.S. 131E-183(a)(18a)

*“The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.”*

For cost overrun and change of scope applications, skip to Section N, Question 3.

1. Describe the expected effects of the proposal on competition in the proposed service area.

2. Will the proposal have a positive impact on cost-effectiveness, quality, and access by medically underserved groups to the proposed services?

|  |
| --- |
|  |

a. If your answer was **yes**, discuss how the proposal will have a positive impact on:

1) Cost effectiveness of the proposed services;

2) Quality of the proposed services; and

3) Access by medically underserved groups to the proposed services.

b. If your answer was **no**, explain why the proposal is a service on which competition will not have a favorable impact on cost-effectiveness, quality and access by medically underserved groups.

**Cost Overrun and Change of Scope Applications**

3. a. Do the changes proposed to the scope or the cost overrun result in changes to the expected effects of the proposal on competition in the proposed service area from what was stated in the previously approved application(s)?

|  |
| --- |
|  |

1) If you answered yes, explain why and provide any supporting documentation in an exhibit.

2) If you answered no, explain why not.

b. Do the changes proposed to the scope or the cost overrun result in changes to the impact of enhanced competition on the cost effectiveness, quality and access by medically underserved groups from what was stated in the previously approved application(s)?

|  |
| --- |
|  |

1) If you answered yes, explain why and provide any supporting documentation in an exhibit.

2) If you answered no, explain why not.

**Section O - Criterion (20)**

G.S. 131E-183(a)(20)

*“An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.”*

1. Identify all existing and approved facilities providing the same service components included in this proposal that are owned, operated or managed by the applicant or a related entity in North Carolina by completing Form O Facilities, which is found in Section Q.

2. Describe the methods used or to be used by the facility identified in response to Section A, Question 4 to ensure and maintain quality of care.

3. If the facility identified in Section A, Question 4 is an existing facility, provide supporting documentation in an Exhibit to document that the facility is currently:

* Licensed;
* Certified for participation in the Medicare Program;
* Certified for participation in the Medicaid Program; and
* Accredited (identify the accrediting body).

If any of the above are not applicable to the existing facility, briefly explain why it is not applicable.

4. **All Applicants** – Document that the health service facilities identified in Form O have provided quality care during the 18 months immediately preceding submission of the application (18 month look-back period).

5. **Hospitals, LTCHs, Inpatient Rehabilitation Hospitals, Psychiatric Units in Hospitals, ASFs, Home Health Agencies, Hospice Home Care Agencies, and Hospice Inpatient or Hospice Residential Care Facilities**

a. Of the facilities identified in Form O, identify each facility that was determined by the Division of Health Service Regulation to have had any situations resulting in a finding of immediate jeopardy during the 18 month look-back period (determination). Include only those facilities that did not challenge the determination or where a challenged determination was subsequently upheld.

b. For each facility identified in response to Question 5.a:

* + Briefly summarize each situation that resulted in the determination;
  + Indicate the number of patients, if any, affected by each situation;
  + State whether the facility is now back in compliance; and
  + If the facility is not back in compliance as of the application deadline, estimate when it will be back in compliance.

6. **Nursing Facilities**

a. Of the facilities identified in Form O, identify each facility that was found by the Division of Health Service Regulation or CMS to have had any situations resulting in a finding of substandard quality of care (Level 4) during the 18 month look-back period (determination). Include only those facilities that did not challenge the determination or where a challenged determination was subsequently upheld.

b. For each facility identified in response to Question 6.a:

* + Briefly summarize each situation that resulted in the determination.
  + Indicate the number of patients, if any, affected by each situation.
  + State whether the facility is now back in compliance.
  + If the facility is not back in compliance as of the application deadline, estimate when it will be back in compliance.

7. **Adult Care Homes, Psychiatric Facilities\*, Substance Use Disorder Facilities\*\*, and Intermediate Care Facilities for Individuals with Intellectual Disabilities**

a. Of the facilities identified in Form O, identify each facility that had a situation which resulted in any of the following during the 18 month look-back period. Do not include facilities where an appeal of any associated fine due to the violation, the summary suspension of license, the revocation of license is pending, or was rescinded or reversed.

State Administrative Action:

* + Imposition of a Type A or an unabated violation;
  + Summary suspension of license; or
  + Revocation of license.

b. For each facility identified in response to Question 7.a:

* + Briefly summarize each situation that resulted in the state administrative action.
  + Indicate the number of patients, if any, affected by each state administrative action.
  + State whether the facility is now back in compliance.
  + If the facility is not back in compliance as of the application deadline, estimate when it will be back in compliance.

**\*** Facilities licensed pursuant to G.S. 122C and 10A NCAC 27G .6000.

**\*\*** Facilities licensed pursuant to G.S. 122C and 10A NCAC 27G .3400.

**Section P – Proposed Timetable**

The proposed timetable determines:

* The deadline by which the project must be developed.
* The times at which the Agency will request the progress reports.

Therefore, the dates provided in Section P should reflect the date each milestone is anticipated to be completed. Please note:

* Dates **MUST** be provided in the following format: **mm/dd/yyyy;**
* A date **MUST** be provided for **#14 Services Offered**;
* Use **ONLY** the milestones listed below;
* Do **NOT** change the descriptions;
* Do **NOT** add other milestones; and
* Do **NOT** change the order in which the milestones appear.

Assume for the purposes of projecting milestone completion dates that the date of the decision will be 150 days from the first date of the review and that the certificate of need will be issued 35 days from the projected decision date. Projected milestone completion dates should be calculated from the 1st date the certificate may be issued.

|  |  |
| --- | --- |
| 1st Day of Review Cycle (this is always the 1st Day of the Month) |  |
| 150 Days from 1st Day of Review (Projected Decision Date) |  |
| 35 Days from Projected Decision Date (1st date certificate may be issued) |  |

|  |  |
| --- | --- |
| Fiscal Year for the Facility Identified in Section A, Question 4 | **mm/dd** to **mm/dd** |

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| **Milestone** | | **Date**  **mm/dd/yyyy** |
| 1 | Financing Obtained |  |
| 2 | Drawings Completed |  |
| 3 | Land Acquired |  |
| 4 | Construction / Renovation Contract(s) Executed |  |
| 5 | 25% of Construction / Renovation Completed (25% of the cost is in place) |  |
| 6 | 50% of Construction / Renovation Completed |  |
| 7 | 75% of Construction / Renovation Completed |  |
| 8 | Construction / Renovation Completed |  |
| 9 | Equipment Ordered |  |
| 10 | Equipment Installed |  |
| 11 | Equipment Operational |  |
| 12 | Building / Space Occupied |  |
| 13 | Licensure Obtained |  |
| **14** | **Services Offered \*** |  |
| 15 | Medicare and / or Medicaid Certification Obtained |  |
| 16 | Facility or Service Accredited |  |
| 17 | First Annual Report Due **\* ^** |  |

**\*** Required

**^** Assuming the proposal is approved, the following condition will be imposed:

No later than three months after the last day of each of the first three full fiscal years of operation following initiation of the services authorized by this certificate of need, the applicant shall submit, on the form provided by the CON Section, an annual report containing the:

* Payor mix for the services authorized in this certificate of need;
* Utilization of the services authorized in this certificate of need;
* Revenues and operating costs for the services authorized in this certificate of need;
* Average gross revenue per unit of service;
* Average net revenue per unit of service; and
* Average operating cost per unit of service.

1. The US Postal Service will not deliver overnight packages to 809 Ruggles Drive. Instead, the US Postal Service delivers all mail, including overnight packages, to the Mail Service Center, which may or may not deliver the package to 809 Ruggles Drive the day after the applicant put it in the mail. [↑](#footnote-ref-1)
2. See the definition of the term “hospital services.” [↑](#footnote-ref-2)
3. Pursuant to an Order of Permanent Injunction issued by the United States District Court for the Eastern District of North Carolina Western Division on October 15, 2008, the North Carolina Department of Health and Human Services is prohibited from requiring that any person obtain a certificate of need before acquiring an air ambulance. [↑](#footnote-ref-3)
4. Reducing or eliminating includes relocating health service facility beds, health services, hospital services, or medical equipment to a different facility or campus. [↑](#footnote-ref-4)