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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) |  |
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| 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.

|  |
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| **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.

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| **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.

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| **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.

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. Is the review competitive? Yes No

b. Is the total projected capital cost $5,000,000 or more? Yes No

c. Has the CON Section determined that a public hearing is in the public interest? Yes No

If **ALL** the answers above are **NO**, 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.**

**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).

**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 relocation of … dialysis stations from one licensed facility or campus to another, …* [or] *… any increase in the number of … 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 changing the scope of a project 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. It does **not** mean adding dialysis stations pursuant to a county or facility need during development of the original project or within 12 months after the original project was determined to be complete by the CON Section. **Please contact the CON Section if you have any question about whether the proposal is a change of scope of a previously approved application.**

**CMS**: The term “CMS” means the Centers for Medicare and Medicaid Services, a 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.”*

**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.

**Dialysis**: The term “dialysis,” which is defined in 10A NCAC 14C .2201(1), means *“the artificially aided process of transferring body wastes from a person's blood to a dialysis fluid to permit discharge of the wastes from the body.”*

**Dialysis facility:** The term “dialysis facility,” which is defined in 10A NCAC 14C .2201(2), means *“a kidney disease treatment center as defined in G.S. 131E-176(14e).”*

**Dialysis station**: The term “dialysis station,” which is defined in 10A NCAC 14C .2201(3), means *“the treatment area in a dialysis facility used to accommodate the equipment and supplies needed to perform hemodialysis on a single patient.”*

**End stage renal disease (ESRD)**: The term ESRD means a medical condition in which a person’s kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.

**Facility**: For the purpose of completing this application form, the term “facility” usually means a dialysis facility. For inpatient dialysis services it would mean an acute care hospital, a long-term care hospital, or an inpatient rehabilitation hospital. For home hemodialysis performed in a nursing home facility in collaboration with a dialysis provider it would mean a nursing home 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.

**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: in-center hemodialysis; home hemodialysis; peritoneal dialysis; and inpatient dialysis.

**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; … rehabilitation facility; nursing home facility; …* [or] *kidney disease treatment center, including freestanding hemodialysis units.”*

**Hemodialysis**: The term “hemodialysis,” which is defined in 10A NCAC 14C .2201(4), means *“the form of dialysis in which the blood is circulated outside the body through an apparatus which permits transfer of waste through synthetic membranes.”* This modality may be completed either “in-center” or in the patient’s home.

**Home hemodialysis**: The term “home hemodialysis,” which is defined in 10A NCAC 14C .2201(5), means *“hemodialysis performed in a location other than a dialysis facility by the patient after the patient is trained in a dialysis facility to perform the hemodialysis.”*

**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.

**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.”*

**In-center hemodialysis:** The term “in-center hemodialysis,” which is defined in 10A NCAC 14C .2201(6), means *“hemodialysis performed in a dialysis facility.”*

**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.

**Kidney disease treatment center**: The term “kidney disease treatment center,” which is defined in G.S. 131E-176(14e), means *“A facility that is certified as an end-stage renal disease facility by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 405.”*

**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.”*

**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.

**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 ($4,000,000) 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 ($4,000,000).*

*c. Any change in bed capacity.*

*d. The offering of dialysis 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.*

*…*

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

**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.”*

**Peritoneal dialysis**: The term “peritoneal dialysis,” which is defined in 10A NCAC 14C .2201(7), means *“the form of dialysis in which a dialysis fluid is introduced into the person's peritoneal cavity and is subsequently withdrawn. This form of dialysis is performed in a location other than a dialysis facility by the patient after the patient is trained in a dialysis facility to perform the peritoneal dialysis.”*

**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.

**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; or*

*(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.”*

**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.”*

**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>.

**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 dialysis facility, this should be the name as it appears in the CMS database. For new dialysis facilities, this should be the name as it will appear in the CMS database. For hospitals, this should be the name as it appears on the license. 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 or relocations of an entire existing facility this must be the same as the site address provided in Section K, Question 4.a. Please be as specific as possible.

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

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

|  |  |
| --- | --- |
| **Type of Health Service Facility** | **Internal Use Only** |
| **MFF** | **Access** |
|  | Dialysis Facility  | ESRD | ESRD |
|  | Acute Care Hospital | HL | HOSPITAL |
|  | Long-term Care Hospital | HL | HOSPITAL |
|  | Inpatient Rehabilitation Hospital | HL | HOSPITAL |
|  | Nursing Home Facility | NH | NH |

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

|  |  |
| --- | --- |
|  | In-center dialysis |
|  | Home hemodialysis training and support |
|  | Peritoneal dialysis training and support |
|  | Inpatient dialysis performed in an acute care hospital, LTCH, or inpatient rehabilitation hospital |
|  | Home hemodialysis performed in a nursing facility in collaboration with a dialysis provider |

c. Check **all** the following that apply to this proposal.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Change of scope for previously approved project(s) | Project ID #(s) |  |
|  | Cost overrun for previously approved project(s) | Project ID #(s) |  |
|  | Developing a new dialysis facility (excluding Policy ESRD-3) |
|  | Developing a new dialysis facility or dialysis stations pursuant to **Policy ESRD-3** |
|  | Developing new dialysis stations in response to a **county need** determination |
|  | Developing new dialysis stations in response to **Condition 1** of the facility need methodology |
|  | Developing new dialysis stations in response to **Condition 2** of the facility need methodology |
|  | Relocating existing dialysis stations to a new dialysis facility |
|  | Relocating existing dialysis stations to a previously approved dialysis facility |
|  | Relocating existing dialysis stations to an existing dialysis facility |
|  | Relocating the entire existing dialysis facility to a new site or campus |

d. **Dialysis Stations**: If the facility offers or will offer in-center dialysis or home hemodialysis training services, complete the following table.

|  |  |  |
| --- | --- | --- |
| **# of Stations** | **Description** | **Project ID #(s)** |
|  | Total # of **existing certified dialysis stations** at the dialysis facility identified in Section A, Question 4, as reported in Table 9A in the SMFP**\*** |  |
|  | # of dialysis stations to be **added** as part of **this proposal** |  |
|  | # of dialysis stations to be **deleted** as part of **this proposal** |  |
|  | # of dialysis stations **previously approved** to be **added** and are reported in Table 9A in the SMFP**\*** but not yet certified |  |
|  | # of dialysis stations **previously approved** to be **added** but are **not reported** in Table 9A in the SMFP**\*** |  |
|  | # of dialysis stations **previously approved** to be **deleted** and are reported in Table 9A in the SMFP**\*** but have not yet been relocated or deleted |  |
|  | # of dialysis stations **previously approved** to be **deleted** but are **not reported** in Table 9A in the SMFP**\*** and have not yet been relocated or deleted |  |
|  | # of dialysis stations **proposed** to be **added** in applications **still under review** as of the application deadline  |  |
|  | # of dialysis stations **proposed** to be **deleted** in applications **still under review** as of the application deadline  |  |
|  | Total # of dialysis stations upon completion of all proposals involving the dialysis facility identified in Section A, Question 4 |  |

**\*** If the application deadline is in January - June, use Table 9A in the signed SMFP; if the application deadline is in July - November, use Table 9A in the Proposed SMFP for the following year.

6. **Experience**

a. How many existing and approved dialysis facilities does the applicant or a related entity own, operate, or manage in North Carolina?

|  |
| --- |
|  |

How many of the facilities reported in Question 6.a provide only hemodialysis or peritoneal dialysis training and support services?

|  |
| --- |
|  |

b. If the applicant or a related entity does **not** currently own, operate, or manage any dialysis facilities in North Carolina, does the applicant or a related entity currently own, operate, or manage any dialysis facilities in other states?

|  |
| --- |
|  |

If you answered yes, how many dialysis facilities 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. Applications submitted in response to the **County Need Methodology**

|  |  |
| --- | --- |
| **County Need Methodology** | **Response** |
| County |  |
| Number of stations needed pursuant to the County Need Methodology |  |
| Number of stations proposed in this application |  |

2. Applications submitted in response to **Condition 2** of the **Facility Need Methodology**

|  |  |
| --- | --- |
| **Facility Need Methodology****Condition 2** | **Response** |
| Total number of stations needed as reported in Table 9D in the signed SMFP in effect as of the application deadline |  |
| Is this the first application submitted in this calendar year in response to this need determination (the limit is three)? |  |
| If you answered **no**, provide the Project ID #(s) for the application(s) submitted earlier this calendar year | Project ID # |  |
| Project ID # |  |
| Total number of stations that were previously applied for or approved in those applications? |  |
| Number of stations the applicant proposes to develop or add in this application |  |

3. Applications submitted in response to **Condition 1** of the **Facility Need Methodology** (New and Small Facilities Only) **\***

|  |  |
| --- | --- |
| **Facility Need Methodology****Condition 1 (New and Small Facilities Only)** | **Response** |
| Number of months the facility had been certified as of the data cut-off date in the SMFP **\***(Answer must be at least 9 and less than 21 for new facilities) **\*** |  |
| Number of stations in the facility as of the data cut-off date in the SMFP **\***(Answer must be 12 or less for small facilities) **\*\*** |  |
| According to Table 9A in the SMFP,**\*** the facility is designated as new, small, or new and small? |  |
| Number of stations proposed in this application(Answer must be 10 or less for new or small facilities applying pursuant to Condition 1) **\*\*** |  |
| Number of in-center patients per station as of the current reporting date(Answer must be 3.0 or greater for new or small facilities applying pursuant to Condition 1) **\*\*** |  |
| **Current Reporting Date** (Answer must be no more than 90 days before the date the application will be submitted) **\*\*** | mm/dd/yyyy |
| **Previous Reporting Date** (Answer must be six months before the current reporting date) **\*\*** | mm/dd/yyyy |
| 1 | Number of in-center patients as of the Current Reporting Date **\*\*** |  |
| 2 | Number of in-center patients as of the Previous Reporting Date **\*\*** |  |
| 3 | Subtract Line 2 from Line 1 (net in-center change for 6 months) |  |
| 4 | Divide Line 3 by Line 2 (6-month growth rate) |  |
| 5 | Multiply Line 4 by two (annual growth rate) |  |
| 6 | Multiply Line 5 by Line 1 (new patients) |  |
| 7 | Add Line 6 to Line 1 (total patients) |  |
| 8 | Divide Line 7 by 2.8 (total # of stations needed) |  |
| 9 | Number of stations as of the Application Deadline **^ \*\*** |  |
| 10 | Subtract Line 9 from Line 8 (additional stations needed) |  |

**\*** Use Table 9A inthe signed SMFP in effect as of the application deadline.

**^** Include all stations that were: 1) certified; 2) CON approved but not yet certified; and 3) proposed to be added in applications still under review as of the application deadline.

**\*\*** See Chapter 9 in the signed SMFP in effect as of the application deadline.

**Note: Rounding to the nearest whole number is allowed on Line 10, where fractions of 0.5 and greater shall be rounded to the next highest whole number.**

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

|  |  |  |
| --- | --- | --- |
|  | Policy ESRD-2 | Relocation of Dialysis Stations |
|  | Policy ESRD-3 | Development or Expansion of a Kidney Disease Treatment Center on a Hospital Campus |
|  | Policy GEN-4 | Energy Efficiency and Sustainability for Health Service Facilities |
|  | Policy GEN-5 | Access to Culturally Competent Healthcare |

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 ESRD-2: Relocation of Dialysis Stations**

*“Relocations of existing dialysis stations to contiguous counties are allowed. Certificate of need applicants proposing to relocate dialysis stations to a contiguous county shall:*

1. *Demonstrate that the facility losing dialysis stations or moving to a contiguous county is currently serving residents of that contiguous county; and*
2. *Demonstrate that the proposal shall not result in a deficit, or increase an existing deficit in the number of dialysis stations in the county that would be losing stations as a result of the proposed project, as reflected in the most recent North Carolina State Medical Facilities Plan, and*
3. *Demonstrate that the proposal shall not result in a surplus or increase an existing surplus of dialysis stations in the county that would gain stations as a result of the proposed project, as reflected in the most recent North Carolina State Medical Facilities Plan.”*

5. If the applicant proposes to relocate dialysis stations to a contiguous county, complete the following table:

|  |  |  |
| --- | --- | --- |
| Line 1 | County that will gain stations  |  |
| Line 2 | Projected station deficit for the county identified on Line 1 **\*** |  |
|  | Column A **\*\***Contiguous County 1 | Column B **\*\***Contiguous County 2 |
| Line 3 | Facility losing stations or moving to a contiguous county |  |  |
| Line 4 | County that will lose stations |  |  |
| Line 5 | Projected station surplus for the county identified on Line 4 **\*** |  |  |
| Line 6 | Number of stations to be relocated or moved from the facility identified on Line 3 |  |  |
| Line 7 | Subtract Line 6 from Line 5 |  |  |
| Line 8 | Number of residents of the county identified on Line 1 that were dialyzing at the facility identified on Line 3 **^**  |  |  |

\*As reported in Table 9B in the signed SMFP in effect as of the application deadline.

**\*\*** Add more columns if stations will be relocated from more than two contiguous counties.

**^** Provide supporting documentation, if any, in an Exhibit.

**Policy ESRD-3: Development or Expansion of a Kidney Disease Treatment Center on a Hospital Campus**

*“Licensed acute care hospitals (see stipulations in G.S. 131E-77 (e1)) may apply for a certificate of need to develop or expand an existing Medicare-certified kidney disease treatment center (outpatient dialysis facility) without regard to a county or facility need determination if all the following are true:*

1. *The hospital proposes to develop or expand the facility on any campus on its license where general acute beds are located.*
2. *The hospital must own the outpatient dialysis facility, but the hospital may contract with another legal entity to operate the facility.*
3. *The hospital must document that the patients it proposes to serve in an outpatient dialysis facility developed or expanded pursuant to this policy are inappropriate for treatment in an outpatient dialysis facility not located on a hospital campus.*
4. *The hospital must establish a relationship with a community-based outpatient dialysis facility to assist in the transition of patients from the hospital outpatient dialysis facility to a community-based facility wherever possible.*

*The hospital shall propose to develop at least the minimum number of stations allowed for Medicare certification by the Centers for Medicare and Medicaid Services (CMS). Certificate of need will impose a condition requiring the hospital to document that it has applied for Medicare certification no later than three (3) years from the effective date on the certificate of need.*

*The performance standards in 10A NCAC 14C .2203 do not apply to a proposal submitted by a hospital pursuant to this policy.”*

6. If a hospital proposes to develop or expand an outpatient dialysis facility on a hospital campus:

 a. Document that there are general acute care beds located on the campus where the outpatient dialysis facility is or will be located.

 b. Does the applicant certify that the hospital owns or will own the dialysis facility?

|  |
| --- |
|  |

 c. Document that the patients proposed to be served in the outpatient dialysis facility are inappropriate for treatment in an outpatient dialysis facility not located on a hospital campus.

 d. Document that the hospital has or will have a relationship with a community-based dialysis facility to assist in the transition of patients from the hospital outpatient dialysis facility to a community-based facility wherever possible.

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

*“Any person proposing a capital expenditure greater than $4 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.”*

7. If the proposed capital cost is $4 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 4. The plan shall not adversely affect patient or resident health, safety or infection control.

**Policy GEN-5: Access to Culturally Competent Healthcare** states:

*“A certificate of need (CON) applicant applying to offer or develop 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 provide culturally competent healthcare that integrates principles to increase health equity and reduce health disparities in underserved communities. The delivery of culturally competent healthcare requires the implementation of systems and training to provide responsive, personalized care to individuals with diverse backgrounds, values, beliefs, customs, and languages. A certificate of need applicant shall identify the underserved populations and communities it will serve, including any disparities or unmet needs of either, document its strategies to provide culturally competent programs and services, and articulate how these strategies will reduce existing disparities as well as increase health equity.”*

8. If the applicant is applying to develop dialysis stations pursuant to either a county or facility need determination in the SMFP:

a. Describe the demographics of the relevant service area with a specific focus on the medically underserved communities within that service area. These communities shall be described in terms including, but not limited to: age, gender, racial composition; ethnicity; languages spoken; disability; education; household income; geographic location and payor type.

b. Describe strategies it will implement to provide culturally competent services to members of the medically underserved community described in a. above.

c. Document how the strategies described in b. above reflect cultural competence.

1. Provide support (e.g., best-practice methodologies, evidence-based studies with similar communities) that the strategies described in b. and c. above are reasonable pathways for reducing health disparities, increasing health equity and improving the health outcomes to the medically underserved communities within the relevant service area.

e. Describe how the applicant will measure and periodically assess increased equitable access to healthcare services and reduction in health disparities in underserved communities.

Note: In approving an application, Certificate of Need shall impose a condition requiring the applicant to implement the described strategies in a manner that is consistent with the applicant’s representations in its CON application.

**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 and cost overrun proposals, skip to Section C, Question 8.

**Scope of the Project**

1. Identify and describe each health service**[[2]](#footnote-2)** included in the proposal. Your response should include but not be limited to describing the type and number of existing, approved, and proposed dialysis stations included in the proposal.

**Population to be Served**

2. **Historical Patient Origin** – Complete the following table for:

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

|  |  |
| --- | --- |
| **County** | **<Insert name of facility here> \*** |
| **Last Full FY****mm/dd/yyyy to mm/dd/yyyy** |
| **# of In-center Patients** | **% of Total** | **# of Home Hemodialysis Patients \*\*** | **% of Total** | **# of Peritoneal Dialysis Patients \*\*** | **% of Total** |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

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

**\*\*** This is **not** the number of patients trained in a year. Provide the total number of patients performing their hemodialysis or peritoneal dialysis in a location other than the dialysis facility.

3. **Projected Patient Origin**

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

b. Facilities proposing to offer inpatient dialysis services should change the header from # of In-center Patients to # of Inpatient Dialysis Patients.

|  |  |
| --- | --- |
| **County** | **<Insert name of facility here> \*** |
| **Second Full FY****mm/dd/yyyy to mm/dd/yyyy** |
| **# of In-center Patients** | **% of Total** | **# of Home Hemodialysis Patients \*\*** | **% of Total** | **# of Peritoneal Dialysis Patients \*\*** | **% of Total** |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

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

**\*\*** This is **not** the number of patients trained in a year. Provide the total number of patients performing their hemodialysis or peritoneal dialysis in a location other than the dialysis facility.

**Demonstration of Need**

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

Provide any supporting documentation in an Exhibit.

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

**Developing new dialysis stations in response to a county or facility need determination?** Include an explanation of why the patients projected to be served need the total number of existing, approved, and proposed in-center dialysis stations.

**Developing a new dialysis facility (excluding Policy ESRD-3) or replacing and relocating the entire existing dialysis facility to a new site?** Include an explanation of why the proposed site was selected as compared to other sites in the service area.

**Relocating existing dialysis stations to a different facility?** Include: 1) the identity of each existing dialysis facility that would lose dialysis stations as part of this proposal; and 2) an explanation of why the patients projected to be served need the stations at the facility identified in Section A, Question 4 as opposed to where they are currently located.

**Developing a new dialysis facility dedicated to home hemodialysis training?** Include an explanation of why the patients projected to be served: 1) need a new facility dedicated to home hemodialysis training; and 2) why those patients need the total number of existing, approved, and proposed home hemodialysis training stations.

**Expanding an existing dialysis facility dedicated to home hemodialysis training?** Include an explanation of why the patients projected to be served need the total number of existing, approved, and proposed home hemodialysis training stations.

**Replacing and relocating the entire existing dialysis facility to a different site?** Include an explanation of why the patients projected to be served need the dialysis facility to be replaced and relocated.

**Developing or expanding a dialysis facility pursuant to Policy ESRD-3?** Include an explanation of why the patients projected to be served: 1) need a dialysis facility on a hospital campus; and 2) why those patients need the total number of existing, approved, and proposed dialysis stations.

**Offering inpatient dialysis services?** Include an explanation of why the patients projected to be served need inpatient dialysis services.

**Performing home hemodialysis services in a nursing facility in collaboration with a dialysis provider?** Include an explanation of why the nursing home residents projected to be served need the services to be provided in the nursing home as opposed to at a freestanding dialysis facility.

5. **Utilization**

a. **Dialysis Facilities**

1) Complete Form C Utilization, which is found in Section Q.

* **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.
* **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 two 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.
* **Describe the assumptions and the methodology used to project utilization.** 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. While Form C only requests one year of historical data, 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 Form C. Provide any supporting documentation in an Exhibit.

2) If the dialysis facility offers or will offer **home hemodialysis or peritoneal training and support services**, complete the following table and describe the assumptions and methodology used for projected utilization. Add more rows if there are more than three Interim Full FYs. Delete the Partial FY row if there is no Partial FY.

|  |  |  |
| --- | --- | --- |
|  | **# of Home Hemodialysis Patients Trained \*** | **# of Peritoneal Dialysis Patients Trained \*** |
| Last Full FY |  |  |
| Interim Full FY |  |  |
| Interim Full FY |  |  |
| Interim Full FY |  |  |
| Partial FY |  |  |
| 1st Full FY of Operation |  |  |
| 2nd Full FY of Operation |  |  |

**\*** Report the total number of patients that started training during the year even if they did not complete training during the same year or never completed the training.

b. If the proposal includes offering **inpatient dialysis services**, complete the following table and describe the assumptions and methodology used for projected utilization.

|  |  |
| --- | --- |
|  | **# of Dialysis Patients** |
| Partial FY |  |
| 1st Full FY of Operation |  |
| 2nd Full FY of Operation |  |

c. If the proposal includes performing **home hemodialysis services in a nursing facility** in collaboration with a dialysis provider, complete the following table and describe the assumptions and methodology used for projected utilization.

|  |  |
| --- | --- |
|  | **# of Dialysis Patients** |
| Partial FY |  |
| 1st Full FY of Operation |  |
| 2nd Full FY of Operation |  |

**Access by Medically Underserved Groups**

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

 a. Briefly describe how the groups listed below will access the facility:

* 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 Second 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.”*

If the language of the rule in the application form differs from the language of the rule as promulgated, the language of the rule as promulgated controls. The language of the rule as promulgated can be found online at: <http://reports.oah.state.nc.us/ncac.asp>.

*10A ncac 14C .2203 PERFORMANCE STANDARDS*

*(a) An applicant proposing to establish a new dialysis facility for in-center hemodialysis services shall document the need for at least 10 dialysis stations based on utilization of 2.8 in-center patients per station per week as of the end of the first full fiscal year of operation following certification of the facility. An applicant may document the need for fewer than 10 stations if the application is submitted in response to an adjusted need determination in the State Medical Facilities Plan for fewer than 10 stations.*

*(b) An applicant proposing to increase the number of in-center dialysis stations in:*

*(1) an existing dialysis facility; or*

*(2) a dialysis facility that is not operational as of the date the certificate of need application is submitted but has been issued a certificate of need*

*shall document the need for the total number of dialysis stations in the facility based on 2.8 in-center patients per station per week as of the end of the first full fiscal year of operation following certification of the additional stations.*

*(c) An applicant proposing to establish a new dialysis facility dedicated to home hemodialysis or peritoneal dialysis training shall document the need for the total number of home hemodialysis stations in the facility based on training six home hemodialysis patients per station per year as of the end of the first full fiscal year of operation following certification of the facility.*

*(d) An applicant proposing to increase the number of home hemodialysis stations in a dialysis facility dedicated to home hemodialysis or peritoneal dialysis training shall document the need for the total number of home hemodialysis stations in the facility based on training six home hemodialysis patients per station per year as of the end of the first full fiscal year of operation following certification of the additional stations.*

*(e) The applicant shall provide the assumptions and methodology used for the projected utilization required by this 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**.

7. a. If proposing to **develop a** **new dialysis facility for in-center hemodialysis services**, document the need for at least 10 dialysis stations based on utilization of 2.8 in-center patients per station per week as of the end of the first full fiscal year of operation (unless the facility is proposed in response to an adjusted need determination in the SMFP).

b. If proposing to **add in-center dialysis stations** to an existing or approved dialysis facility, document the need for the total number of dialysis stations in the facility based on utilization of 2.8 in-center patients per station per week as of the end of the first full fiscal year of operation.

c. If proposing to **develop a new dialysis facility dedicated to home hemodialysis or peritoneal dialysis services**, document the need for the total number of home hemodialysis stations in the facility based on six home hemodialysis training patients per station per year as of the end of the first full fiscal year of operation.

d. If proposing to **add home hemodialysis training stations to a dialysis facility dedicated to home hemodialysis or peritoneal dialysis services**, document the need for the total number of home hemodialysis stations in the facility based on six home hemodialysis training patients per station per year as of the end of the first full fiscal year of operation.

e. Provide the assumptions and methodology used for the projected utilization.

**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), describe 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 table in Question 3 above, insert it below, and provide the response.

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.

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?

|  |
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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) Is any subpart of 10A NCAC 14C .2203 applicable to **this** proposal that was **not** applicable to the previously approved application(s)?

|  |
| --- |
|  |

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

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, handicapped persons, 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 4.

1. a. Does the proposal include **relocating the entire dialysis 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 include **eliminating home hemodialysis or peritoneal dialysis training and support services** at an existing dialysis facility?

|  |
| --- |
|  |

b. If you answered yes,

1) Explain how the needs of the patients currently receiving home hemodialysis or peritoneal dialysis services will be met following the elimination of those services;

2) Provide any supporting documentation in an exhibit; and

3) Describe the effect of the elimination of the home hemodialysis or peritoneal dialysis training and support services on the ability of each group listed below to obtain those services:

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

3. a. Does the proposal include **reducing or eliminating [[3]](#footnote-3)** **some but not all** the existing dialysis stations at a dialysis facility?

|  |
| --- |
|  |

b. If you answered yes, provide a **separate response** to this subpart for **each** facility that will lose dialysis stations.

1) Complete the following table.

|  |
| --- |
| **<Insert name of facility here>** |
| County where the facility is located |  |
| 1 | Total number of existing, approved, and proposed dialysis stations as of the application deadline |  |
| 2 | Number of existing dialysis stations to be reduced, relocated or eliminated in this proposal |  |
| 3 | Total number of dialysis stations upon completion of this project and all other projects involving this facility (you should be able to subtract Line 2 from Line 1; if you cannot, explain why not) |  |

2) Explain how the needs of the patients continuing to use the facility will be met following the reduction or elimination of stations. Your response should include but not be limited to discussion regarding the number of dialysis stations and patients that will remain where they are.

3) Describe the effect of the reduction or elimination of the dialysis stations on the ability of each group listed below to obtain dialysis services:

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

4) Complete Form D Utilization, which is found in Section Q.

* **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.
* **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** – 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.
* **Describe the assumptions and the methodology used to project utilization.** 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.

**Cost Overrun and Change of Scope Applications**

4. a. Do the changes proposed in this application now include **relocating the entire dialysis 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 eliminating **home hemodialysis or peritoneal dialysis training and support services** which was **not** proposed in the previously approved application(s)?

|  |
| --- |
|  |

If you answered yes, copy Question 2.b, insert it below, and provide a response for the home hemodialysis or peritoneal dialysis training and support services that will be eliminated as a result of this proposal.

c. Do the changes proposed in this application now include **reducing or eliminating dialysis stations** at an existing dialysis facility which was **not** proposed in the previously approved application(s)?

|  |
| --- |
|  |

If you answered yes, copy Question 3.b, insert it below, and provide a response for the dialysis stations 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. **Dialysis facilities**: Complete Forms F.2, F.3, and F.4 for the entire facility.

**All other facilities**: Complete Form F.2 and F.4 for the proposed health service. However, complete Form F.2 and Form F.4 for the entire facility if needed to show financial feasibility of the proposal.

Form F.2 Income Statement

Form F.3 Revenues

Form F.4 Operating Costs

* **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.
* **Historical** – Provide actual annual 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 full fiscal year 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 the first full fiscal year of projected annual data.

**Cost Overrun and Change of Scope Applications**

5. a. **Cost Overrun Proposals** – Copy Question 2, insert it below, and provide a new response for the difference between the 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. **In-center Dialysis Proposals**: Using Table 9A in the SMFP,**[[4]](#footnote-4)** complete the table below. In footnotes to the table, note any changes (new facilities, additional stations, stations relocated to a contiguous county) approved between the data cut-off date in the SMFP and the application deadline.

|  |
| --- |
| **<Insert the name of the county here>** |
| **<Insert the name of the facility here>** | **Certified Stations as of mm/dd/yyyy****\*** | **Number of In-center Patients as of mm/dd/yyyy****\*\*** | **Utilization by Percent as of mm/dd/yyyy****\*\*\*** | **Patients per Station as of mm/dd/yyyy** | **Number of Additional Stations Approved** **^** |
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| **Total** |  |  |  |  |  |

**\*** From Column K in Table 9A.

**\*\*** From Column L in Table 9A.

**\*\*\*** From Column M in Table 9A.

**^** The sum of Column G CON Issued/Not Certified and Column H Decision Rendered (Conditional Approval) in Table 9A.

 b. **All Other Proposals**: Identify all existing and approved health service facilities located in the proposed service area that provide the same health services proposed in this application.

2. **All Applicants**

a. Explain why the proposal will not result in an unnecessary duplication of the same existing or approved health services located in the proposed service area.

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 health services that were **not** included in the previously approved applications(s)?

|  |
| --- |
|  |

b. If you answered yes:

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

2) For each new health service included in this proposal, explain why this proposal will not result in an unnecessary duplication of the same existing or approved health services located in the proposed 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:

* + Dialysis facilities should complete the form for the entire facility.
* All other facilities should complete the form for the health service included in this proposal.

**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 for 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 two 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 two 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 and 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 and 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 Dialysis Facilities or Relocation of the Entire Existing Dialysis Facility**

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 cost overrun and 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 identified in Section A, Question 4; and
* Each facility from which existing dialysis stations will be relocated to the facility identified in Section A, Question 4.

**Last Full FY before Submission of Application**

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

|  |  |
| --- | --- |
| **Primary Payor Source at Admission** | **<Insert the name of facility identified in Section A, Question 4, here>** |
| **In-center Dialysis** | **Home Hemodialysis \*\*** | **Peritoneal Dialysis \*\*** |
| **# of Patients** | **% of Total** | **# of Patients** | **% of Total** | **# of Patients** | **% of Total** |
| Self-Pay |  | % |  | % |  | % |
| Insurance **\*** |  | % |  | % |  | % |
| Medicare **\*** |  | % |  | % |  | % |
| Medicaid **\*** |  | % |  | % |  | % |
| Other (**describe**) |  | % |  | % |  | % |
| Total |  | 100.0% |  | 100.0% |  | 100.0% |

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

**\*\*** This is **not** the number of patients trained in a year. Provide the total number of patients performing their hemodialysis or peritoneal dialysis in a location other than the dialysis facility.

**Last Full FY before Submission of Application**

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

|  |  |
| --- | --- |
| **Primary Payor Source at Admission** | **<Insert the name of facility from which stations will be relocated here>** |
| **In-center Dialysis** | **Home Hemodialysis \*\*** | **Peritoneal Dialysis \*\*** |
| **# of Patients** | **% of Total** | **# of Patients** | **% of Total** | **# of Patients** | **% of Total** |
| Self-Pay |  | % |  | % |  | % |
| Insurance **\*** |  | % |  | % |  | % |
| Medicare **\*** |  | % |  | % |  | % |
| Medicaid **\*** |  | % |  | % |  | % |
| Other (**describe**) |  | % |  | % |  | % |
| Total |  | 100.0% |  | 100.0% |  | 100.0% |

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

**\*\*** This is **not** the number of patients trained in a year. Provide the total number of patients performing their hemodialysis or peritoneal dialysis in a location other than the dialysis facility.

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

Complete the following tables for:

* The facility identified in Section A, Question 4; and
* Each facility from which existing dialysis stations will be relocated to the facility identified in Section A, Question 4.

|  |  |
| --- | --- |
| **<Insert the name of the facility identified in Section A, Question 4, 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 |  |  |

**^** All patients (in-center, home hemodialysis, and peritoneal dialysis).

**\*** 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 dialysis stations 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 identified in Section A, Question 4 **and** each facility from which existing dialysis stations will be relocated to that facility, respond to the following:

1) Is the facility 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 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 identified in Section A, Question 4, **and** each facility from which existing dialysis stations will be relocated to that facility. Describe the current status of each complaint.

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

a. Complete the following table for the facility identified in Section A, Question 4. Facilities proposing to offer inpatient dialysis services should change the heading from “In-center Dialysis” to “Inpatient Dialysis Services.”

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

**Projected Payor Mix during the 2nd Full FY**

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

|  |  |
| --- | --- |
| **Primary Payor Source at Admission** | **<Insert the name of facility identified in Section A, Question 4, here>** |
| **In-center Dialysis** | **Home Hemodialysis \*\*** | **Peritoneal Dialysis \*\*** |
| **# of Patients** | **% of Total** | **# of Patients** | **% of Total** | **# of Patients** | **% of Total** |
| Self-Pay |  | % |  | % |  | % |
| Insurance **\*** |  | % |  | % |  | % |
| Medicare **\*** |  | % |  | % |  | % |
| Medicaid **\*** |  | % |  | % |  | % |
| Other (**describe**) |  | % |  | % |  | % |
| Total |  | 100.0% |  | 100.0% |  | 100.0% |

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

**\*\*** This is **not** the number of patients trained in a year. Provide the total number of patients performing their hemodialysis or peritoneal dialysis in a location other than the dialysis facility.

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 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 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 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 proposal, describe the extent to which health professional training programs **in the area** have or will have access to the facility 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 proposal, 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 of the same type identified in response to Section A, Question 4.b 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 (not applicable to dialysis facilities in NC);
* Certified for participation in the Medicare Program;
* Certified for participation in the Medicaid Program; and
* Accredited (identify the accrediting body).

4. Document that the 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. 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. 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.

**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 |

|  |  |
| --- | --- |
| **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 |  |

\* Required

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. In-center hemodialysis, home hemodialysis training and support, peritoneal dialysis training and support, inpatient dialysis, or home hemodialysis performed in a nursing facility in collaboration with a dialysis provider. [↑](#footnote-ref-2)
3. Reducing or eliminating includes relocating dialysis stations to a different facility or campus. [↑](#footnote-ref-3)
4. If the application deadline falls in January to June, use Table 9A in the signed SMFP in effect as of the application deadline. If the application deadline falls in July to December, use Table 9A in the Proposed SMFP for the following year. [↑](#footnote-ref-4)