TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control <u>4</u>			or Agency	State	Health	Planning	and	Developmen
Agency			d Review Bo	ard)				
Rule No		ppendix A						
Rule Title:	Applicat	ion for Ex	tension of Ce	rtificate of Nee	d			
	New	<u>X</u>	_Amend	Rep	eal	A	dopt b	y Reference
Would the abs	sence of the welfare, or	e proposed safety?	rule significa	intly harm or ei	ndanger th		NO	
Is there a reason protection of the	onable rela he public l	tionship be lealth, safe	etween the sta ty, or welfare	ite's police pow?	ver and the		YES	
Is there anothe adequately pro	er, less rest otect the pu	rictive me blic?	thod of regula	tion available t	hat could	and the second of the second o	NO	Parking the state of the state
Does the proporthe costs of an	osed rule h y goods or	ave the eff services in	ect of directly avolved and, i	or indirectly in ordinary	ncreasing egree?		NO	THE REAL PROPERTY OF THE PROPE
Is the increase that might resu	in cost, if alt from the	any, more e absence o	harmful to the of the propose	e public than thed rule?	e harm	Mark was a second as a second	NO	THE POST OF STREET STREET, STREET STREET, STRE
Are all facets of and so they ha	of the ruler ve, as their	naking pro primary e	cess designed ffect, the prot	I solely for the rection of the pr	purpose o ublic?		YES_	
* * * * * * * * * * Does the propo				* * * * * * * * * * * * * * * * * * *	* * * * * *	* * * * * * *	* * * * NO	*****
If the proposed note prepared i	d rule has a in accordar	n econom	ic impact, the obsection (f) o	proposed rule in Section 41-22	is required 2-23, <u>Cod</u>	l to be acco e of Alaban	mpanie na 197:	ed by a fiscal 5.
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Certification of	f Authoriz	ed Official						
Chapter 22, Tit the Administra	tle 41, <u>Cod</u> tive Proce	e of Alaba dure Divis	i <u>ma 1975,</u> and ion of the Leg	proposed in full I that it conforn gislative Refere	ns to all ap nce Servi	pplicable fil	e requi	rements of quirements of
		ficer	ibra m	1. Lam	lect			
Date 52	4-13							

DATE FILED (STAMP)



STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

100 NORTH UNION STREET, SUITE 870 MONTGOMERY, ALABAMA 36104

NOTICE OF INTENDED ACTION

AGENCY NAME:

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

(Certificate of Need Review Board)

RULE NO. & TITLE: Appendix A

Application for Extension of Certificate of Need

INTENDED ACTION:

The State Health Planning and Development Agency and the Certificate of Need Review Board propose to amend the Application for Extension of Certificate of Need.

SUBSTANCE OF PROPOSED ACTION:

This amendment to Application for Extension of Certificate of Need corrects formatting and typographical errors.

TIME, PLACE, MANNER OF PRESENTING VIEWS:

In response to this Proposed Amendment, all interested persons are invited to submit data, views, comments and/or arguments, orally or in writing. Any and all such data, comments, arguments and/or requests to orally address the Certificate of Need Review Board shall be made in writing on or before July 5, 2013, and shall be made to:

Nicole Horn, Executive Secretary State Health Planning and Development Agency P. O. Box 303025 Montgomery, Alabama 36130-3025

On July 17, 2013, at 10:00 a.m., the Certificate of Need Review Board shall conduct a public hearing in the State Capitol, Capitol Auditorium, 600 Dexter Avenue, Montgomery, Alabama, at which time it shall consider the Proposed Amendment, along with all written and oral submissions respecting the Proposed Amendment. Only those interested persons who have made timely written requests will be afforded the opportunity to speak.

Copies of the proposed changes are available for review at 100 North Union Street, RSA Union Building, Suite 870, Montgomery, Alabama. Phone (334) 242-4103 or visit the office Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding State holidays.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: July 5, 2013

CONTACT PERSON AT AGENCY:

Nicole Horn 100 North Union Street RSA Union, STE 870 Montgomery, AL 36104 (334) 242-4103

Alva M. Lambert, Executive Director

State Health Planning and Development Agency

Mailing address: Post Office Box 303025, Montgomery, Alabama 36130-3025 Street address: 100 North Union Street, Suite 870, Montgomery, Alabama 36104

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED

A filing fee in the amount of \$ has been submitted with this application.

1. APPLICATION. Application is her	eby made for	a twelve (12) r	nonth extension	of the Cert	ificate of Need	
issued for the health facility describ	ed below. (A	Il items must b	e completed in	full before e	extension of	
Certificate of Need can be considered	ed.)				ACCHISTON OF	
2. PROJECT	3. CERTIF	ICATE	4. CERTII	EICATE		
NUMBER	NUMBE		EXPIRI			
5. LEGAL NAME OF APPLICANT	TTOMBL					
3. LEGAL NAME OF APPLICANT		6. ADDRES	S OF APPLICA	ANT		
7. NAME OF PROPOSED FACILITY		8 LOCATIO	N OF PROPO	SEDEACH	ITV	
		o. Boerine	TOT TROTO	SED PACIL	1111	
9. TYPE OF FACILITY		10 ANTICH	ATED DATE	ON MARCI	T	
			TION IS EXPI			
11. ESTIMATED DATE CONSTRUC	TION	AND/OR	CONSTRUCT	ION STAR	TED	
IS SCHEDULED FOR COMPLET						
12. BED CAPACITY	ION					
Gen. Hosp.	Manain a II.	D	1	0.1		
Gen. Hosp.	Nursing Ho SK IC		ychiatric	Other	And the stronger philadesia	
Existing Bed	SK IC	Г				
Capacity						
Beds provided by				Management		
Naw Eagility						
Addition				***************************************		
D 1 1'						
	-	Tarkities Tarkities		A-100000	Market warmen and an artist of the second and artist of the second artist of the second and arti	
Replacement	***************************************	-				
Constant II						
Capacity Upon						
Completion	***************************************					
12 FOTD (1777)						
13. ESTIMATED COST OF THE PRO		14. PROPOS	SED FINANCI	NG OF THE	E PROJECT	
Construction \$		Total Es	imated Cost \$		The state of the s	
Fixed Equipment \$	***************************************	DHEW	Loan/Grant \$_			
Construction \$ Fixed Equipment \$ Movable Equipment \$		1 SBA Loa	an S			
Arch, & Eng. 8		FHA Mo	rtgage Insuran	ce \$		
one improvements 5		Private F	inancing \$			
Financing Charges \$		Other (S	pecify) \$		- Accepts	
Total Cost \$		1	· //		-	
13a. ATTACH COST ESTIMATE SIG	NED BY	14a. ATTAC	H STATEME	VT FROM F	INANCING	
PROJECT ARCHITECT (Required	l)	AGENCY(I	ES) OF	LOAN	FEASIBILITY	
		(Requir		201111	TAMBIDITALL	
15. SITE INFORMATION (Check One)		ECTURAL PF	OGRESS		
Acquired		Architec	Employed	CORESS		
		Schemat	Employed		Printered in the Contract of t	
Option Under Construction	***************************************	Working	c Drawings		A PART OF THE PART	
Not Acquired		Working DrawingsAdvertised for Bids				
1		Auvertis	LU TOI DIUS			
		l				

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED

17	DDIED DECORDEDATION OF SECTION	
17.	BRIEF DESCRIPTION OF PROPOSED WORK. change in the scope of the project as described in toriginal Application.	Include any proposed deletion, new or substantial he Program Narrative submitted in support of the
	S. S. S. F. F. C. S.	
1.0	DUDGET AND UTILIZATION OF THE	
18.	construction and/or operation of the facility (or if will be necessary to complete PART FIVE of the Part Five attached: Yes No	has been a material change in the estimated cost of the data were not submitted with the original application) it original application form.
19.	COST CONTAINMENT. Attach Cost Containm	ent Statement showing how the project will foster cost
	containment through improved efficiency and pro	ductivity, including promotion of cost-effective factors
	such as ambulatory care, preventive health care se	ervices, home health care, sharing of services with other
20	facilities, and design and construction economies.	
20.	In submitting this Application, the Applicant:	
	Understands that extension of the Certificate will A. Needs of the Area as set forth in the up-dated	Alabama State Health Plan
	B. 1. Site Procurement: Must have acquired or	holds option to purchase. Site must be inspected and
	approved.	-
	2. Architectural Progress: Must have approve	ed working drawings.
	3. Financial Status: Must present evidence t	hat appropriate and necessary financing is final and
	immediately available. 4. Program Narrative: Must be updated to sl	
		file and up-to-date. Maximum increase in costs and
	charges must be within Cost of Living Co	uncil guidelines
	6. Cost Containment: Satisfactory statement	must be on file.
	C. Understands that the Certificate if issued, will	expire not more than twelve (12) months from date of
	issuance and will not be subject to further ext	ension.
	the project is abandoned or is placed under co	ealth Planning and Development Agency, if and when
	E. The Certificate of Need, if issued, is not transf	erable and any action on the part of the Applicant to
	transfer or assign the Certificate of Need will	render the Certificate of Need null and void.
21.	SIGNATURE OF RESPONSIBLE OFFICER	22. TITLE OF OFFICER
23.	NAME OF RESPONSIBLE OFFICER	24. DATE
		Zii Billib
Atto	chments:	
rudi	Cost Estimate	
	Statement from Financing Agency	
	Part Five Budget and Utilization Data	
	Cost Containment Statement	

SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION

1. NAME OF APPLICAN	r			2.	NAME (OF FACII	JTY				
3. TYPE OF FACILITY				4.	LOCATI	ON OF F	ACILIT	Y		····	
5. HISTORICAL DATA: OCCUPANCY DATA	Give information	for last thre	e (3) years	for which	n complete	e data are	availab	le			
1. ACCOMMODATION OCCUPANCY	NUMBER O	F BEDS		ADMISSIONS OR DISCHARGES		TOTAL PATIENT DAYS			% OCCUPANCY		
	YR YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR
— PRIVATE MEDICINE AND SURGERY				***************************************			***				
SEMI-PRIVATE OBSTETRICS											
-WARD PEDIATRICS											
TOTALS PSYCHIATRY											
2. CLINICAL_SERVICES OTHER	NUMBER O			MISSIO DISCHAF			TOTAL TENT D		% + 0	CCUPA	NCY
TOTALS	-YR - YR	YR	-YR-	-YR	YR	-YR-	YR.	-YR	-YR-	-YR	-YR
—MEDICINE — AND SURGERY											
OBSTETRICS											
— PEDIATRICS											
— PSYCHIATRY								······································			
— OTHER		***************************************									
— TOTALS		· · · · · · · · · · · · · · · · · · ·									
B. SOURCE OF PAYMEN	Γ		PERCI	ENT OF (GROSS R	EVENUE	3	***************************************	I	W1.444	
		?			YR				YR		
BLUE CROSS											
OTHER INSURANCE											
MEDICARE											
MEDICAID								······································			
SELF-PAY											
FREE CARE											
OTHER						***************************************					
SUBTOTAL									····		
BAD DEBTS		***************************************	%	%				%			
TOTALS			100%			10	0%			10	00%

5. HISTORICAL DATA (Cont'd)

2.	NAME OF FACILITY	

C. Statement of Income and Expense (Give information for last — three (3) years for which complete data are available.)	20 Total	20 Total	20 Total	20 Per Diem
Revenue from Services to Patients	***			
Inpatient Services				
Routine (Nursing Service Areas) Other				
Onci				
Outpatient Services				
Emergency Services				
Other Operating Revenue				
Recoveries				
Other				
Gross Operating Revenue				
Deductions from Operating Revenue Contract Adjustments				
Discounts/Misc. Allowances	······································			
Provision for Charity Services				
Provision for Uncollectatbles				
Total Deductions	***************************************			
Net Operating Revenue				
Operating Expenses				
Salaries and Wages			***************************************	
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses	The second control of the second			
Total Operating Expenses				
Capital Expenditure Retirement of Principal				
Interest	***************************************			
Total Capital Expenditure				
Total Expenses (Operating and Capital)				
Operating Income (Loss)				
Other Revenue (Expense) - Net				
Net Income (Loss)				

SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION DATA

1. NAME OF APPLICANT				2. NAME OF FACILITY						
3. TYPE OF FACILITY				A LOCATION OF DAGINERY						
3. TIPE OF FACILITY				4. LOCATION OF FACILITY						
5. PROJECTED DATA: G	ive information	projected to	cover the firs	t two (2) ye	ears of	operation after	completion	n of project.		
A. OCCUPANCY DATA										
1.	NUMBER	OF BEDS	ADM OR DIS	IISSIONS SCHARGE	S		TOTAL PATIENT DAYS % OCC			
OCCUPANCY	1stst Year									
	Year Year	Znu - <u>Z</u>	2ndnd Yea	<u>15t</u> [rear	<u>Istst Year</u> <u>Year</u>	- 2ndnd	-1st st-Year nd-Year	<u>-2nd</u>	
—MEDICINE AND SURGERY			The state of the s							
-OBSTETRICS										
PEDIATRICS										
PSYCHIATRY							·			
OTHER							**************************************			
TOTALS										
		···					100000000000000000000000000000000000000			
		··········								
			PERCEN	T OF GRO	OSS R	EVENLIE				
B. SOURCE OF PAYMEN	T		YR	- OI OIK	20010	CYLINOL	7770	* * * * * * * * * * * * * * * * * * * 		
BLUE CROSS			11				YR			
OTHER INSURANCE										
MEDICARE										
MEDICAID										
SELF-PAY								21723		
FREE CARE		·····								
OTHER		······								
	SUBTOTAL									
BAD DEBTS	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							0/		
BAD DEBTS			<u>%</u>					<u>%</u>		
	<u>TOTALS</u>									
			100%	!			1	00%		
		YR				<u> </u>	/R	*	YR.	
		······								
—BLUE CROSS										

OTHER INSURANCE	
<u>MEDICARE</u>	
ACCOUNTY OF THE PROPERTY OF TH	
— MEDICAID	
— SELF-PAY	
J. D. T.	
FREE CARE	
— OTHER	
SUBTOTAL.	
BAD DEBTS 0/2 0/2	
BAD DEBTS %	0.
	<u>%</u>
100/0	10
	0%

Note: Include both inpatient and outpatient data

1. NAME OF APPLICANT	2. NAME OF FACILITY
3 TYPE OF FACILITY	4. LOCATION OF FACILITY
6. PROJECTED DATA: Give information projected to cov	ver the first two (2) years of operation after completion of project.
A. OCCUPANCY DATA	
1. ACCOMMO-DATION	ADMISSIONS TOTAL NUMBER OF BEDS OR DISCHARGESPATIENT DAYS
OCCUPANCY III	III I III I III III III III III III II
1 st VEAR	ORD ATTAR AND
PRIVATE	2 nd YEAR 1 st YEAR 2 nd YEAR 1 st YEAR 2 nd YEAR 1 st YEAR 2 nd YEAR
SEMI-PRIVATE	
WARD	
-TOTALS	
2. CLINICAL	A DA COCHONIC TOOM A
- SERVICES	ADMISSIONS TOTAL
OCCUPANCY III	NUMBER OF BEDS OR DISCHARGESPATIENT DAYS
- 1st YEAR	2 nd YEAR 1 st YEAR 2 nd YEAR 1ST YEAR 2ND YEAR
YEAR THE STATE OF	2 YEAR I YEAR 1ST YEAR 2ND YEAR 2ND YEAR 2ND YEAR
MEDICINE	ZINI YEAK
AND SURGERY	
OBSTETRICS	
PEDIATRICS	
PSYCHIATRY	
OTHER	
-TOTALS	
PERCENT OF GROSS REVENUE	
B. SOURCE OF PAYMENT	YR YR
——BLUE CROSS	
OTHER INSURANCE	
— MEDICARE	
MEDICAID	
SELF-PAY	
— FREE CARE	
— OTHER	
SUBTOTAL	0/ 0/0
— BAD DEBTS	
TOTAL	100% 100%
NOTE: Includ	le both inpatient and outpatien data.
	The second with our minimum and the second s

NAME OF FACILITY

6. PROJECTED DATArojected Data (Cont'd)

C. Statement of Projected Income and Expenses (First two (2) years after completion completion of project.)	20_		20		
	Total	Per Diem	Total	Per Diem	
Revenue from Services to Patients					
Inpatient Services Routine (Nursing Service Areas)			Tax Addition of the Control of the C		
Other					
Outpatient Services					
Emergency Services					
Other Operating Revenue Recoveries					
Other					
Gross Operating Revenue				THE PERSON NAMED AND ADDRESS OF THE PERSON NAMED AND ADDRESS O	
Deductions from Operating Revenue Contract Adjustments					
Discount/Misc. Allowances					
Provision for Charity Services					
Provision for Uncollectaibles					
Total Deductions				At the second of	
Net Operating Revenue				4477	
Operating Expenses Salaries and Wages					
Physician's Salaries and Fees					
Supplies					
Depreciation					
Interest (Other than Mortgage)				PROFILE OF THE AMERICAN AND AND AND AND AND AND AND AND AND A	
Other Expenses					
Total Operating Expenses Capital Expenditure					
Incurred Prior to this Project					
- Retirement of Principal					
- Interest This Project					
- Retirement of Principal					
- Interest					
Total Capital Expenditure					
Total Expenses (Operating & Capital)					
Operating Income (Loss)					
Other Revenue (Expense) – Net				The state of the s	

BUDGET AND UTILIZATION

7. INFORMATION REGARDING PROPOSED FINANCING
Total amount to be borrowed \$
Anticipated interest rate
Term of loanyears
Method of calculating interest and principal payments:
8. ATTACHMENTS
(1) Schedule of current charges.
(2) Schedule of proposed charges after completion of this project.
(3) State of existing capital indebtedness.
(4) Schedule showing projected annual depreciation for buildings, fixed equipment, and movable equipment.