APA-1
11/96

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 410 Department or Agency State Health Planning and Development Agency (Certificate of Need Review Board)
Rule No. Appendix A
Rule Title: Request for Determination of Exemption Status for Replacement of Existing Equipment
_____ New __X__ Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? NO

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? YES

Is there another, less restrictive method of regulation available that could adequately protect the public? NO

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? NO

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? NO

Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? YES

* *

Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

* *

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer Alva M. Lambert

Date 5-21-13

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 Request for Determination of Exemption Status for Replacement of Existing Equipment

INTENDED ACTION:
The State Health Planning and Development Agency and the Certificate of Need Review Board propose to amend the form for Request for Determination of Exemption Status for Replacement of Existing Equipment.

SUBSTANCE OF PROPOSED ACTION:
This amendment to Request for Determination of Exemption Status for Replacement of Existing Equipment will correct the fee calculation to conform to recent amendments to ALA. ADMIN. CODE r. 410-1-5-.04, as well as correcting formatting and typographical errors.

TIME, PLACE, MANNER OF PRESENTING VIEWS:
In response to this Proposed Rule, 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

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

Request # _____
Date Rec. _____
Received by: _____

REQUEST FOR DETERMINATION OF EXEMPTION STATUS FOR REPLACEMENT OF EXISTING EQUIPMENT

~~Instructions: Please submit an original and two (2) copies of this form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, 100 North Union Street, Suite 870, Montgomery, Alabama 36104 (Post Office Box 303025, 36130-3025).~~

~~Attached is a check~~ filing fee in the amount of: ~~—~~$_____ has been submitted with this application.

REQUESTER IDENTIFICATION (Check One) HOSPITAL (___) NURSING HOME (___)
OTHER (___) (Specify) _____

A. _____
Name of requester

_____
Address City County

_____
State Zip Phone

B. _____
Name of Facility/Organization (if different from A)

_____
Address City County

_____
State Zip Phone

C. _____
Name of Legal Owner (if different from A or B)

_____
Address City County

_____
State Zip Phone

D. _____
Name and Title of Person Representing Proposal and With Whom SHPDA Should Communicate

_____
Address City County

_____
State Zip Phone

DESCRIPTION OF EQUIPMENT TO BE REPLACED DESCRIPTION OF PROPOSED NEW EQUIPMENT

A. Manufacturer:

Serial #

B. Model:

C. Name of equipment:

D. Fair market value of equipment at present:

E. Cost of equipment (include written price quote):

F. Describe use of current equipment: ~~Describe use of proposed equipment:~~

Describe use of proposed equipment:

G. List any attachments or additional procedures associated with this equipment that could not be performed by old equipment:

H. Can any procedures be performed with the proposed new equipment that cannot be performed with the replaced equipment? If yes, describe in detail:

I. Location of existing equipment (include room #):

J. List specially trained or qualified personnel necessary for operation of equipment:

K. What use will be made of old equipment when replaced?
(Trade in on new equipment, used as back up, save for parts, etc.)

L. List job titles of any additional personnel that will be required to operate the new equipment.

M. Describe any renovation or new construction that will be necessary for the installation of the replacement equipment and cost.

N. Describe any new annual operating cost associated with this project such as maintenance contracts, salaries of new employees hired due to equipment, etc.

III. COST

A. Equipment costs
(Costs have to be supported by price quote on manufacturer's stationery or letterhead.) Cost of equipment only; do not list lease cost. $_____

B. Less trade-in of old equipment $_____

C. Total cost of equipment $_____

Calculation of fee for this determination:
~~Multiply dollar amount in III. C. (total cost of equipment) by .75%.~~
Multiply dollar amount in III.C. (total cost of equipment) ~~this sum~~ times 1~~2~~0% (the application fee for a Certificate of Need); 20% of this amount is ~~for~~ the application fee for non-rural hospitals.
For rural hospitals, ~~Multiply this sum times~~ the application fee is 25% of the application fee as calculated above for non-rural hospitals ~~if rural~~.

~~The maximum fee is $12,000 (indexed), or a maximum of $8,000 if the applicant has had an average daily census comprised of 50% or more Medicaid patients within the last year prior to the filing of this request. A rural hospital will not be required to submit a fee equal to 25% of the applicable fee.~~

Include manufacturer's literature on old equipment, if available, and on the new equipment.

Include any other information pertinent to the determination.

The Executive Director may request any other information which is relevant to his decision.

IV. CERTIFICATION

I certify that the information provided herein is true and correct and that there is no additional information which would be pertinent to this application which has not been provided. Further, I understand that any misrepresentation on this application or failure to include relevant information may void any favorable determination secured by such misrepresentation or omission.

_____
Signature of Applicant

_____
Applicant's Name and Title
(Type or Print)

Sworn to and subscribed before me this

_____ day of _____, 20 _____.

_____
Notary Public (affix seal on original)