

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
APPLICATION FOR A CERTIFICATE OF NEED**

INSTRUCTIONS FOR COMPLETION OF APPLICATION

1. **Applicants are required to use this application format for submission of Certificate of Need (CON) applications.** The financial analysis section for a CON Application is a separate document entitled “CON Application: Financial Analysis Spreadsheet”. Please make sure to complete the Excel Financial spreadsheets and submit them along with the CON application. The CON Application and CON Application: Financial Analysis Spreadsheet is currently available on the Mississippi State Department of Health (MSDH)’s website at <http://www.msdh.ms.gov/> under Certificates of Need, Forms, (see “CON Application – Substantive Review”) “CON Application – Financial Analysis.”)
2. One (1) original CON application must be mailed, or hand delivered to the Mississippi State Department of Health, and a complete copy of the application and attachments should be emailed to HPRD@msdh.ms.gov. Be sure to include the following words in the subject line of the e-mail: **CON application submission**. Please provide a Table of Contents referencing the Exhibits along with dividers or tabs to distinguish the appropriate Exhibit documentation. The original application and Certification Page including attachments with the filing fee should be mailed or hand delivered to the following address:

Division of Health Planning and Resource Development
Mississippi State Department of Health - Office of Health Protection
143-B Le Fleur’s Square
Jackson, MS 39211

Note: (CONFIDENTIAL Information)

If the CON Application contains information deemed CONFIDENTIAL, please submit a statement (*the statement must provide an explanation as to why the applicant considers the information specified to be deemed CONFIDENTIAL*); clarifying why the allocated information is deemed CONFIDENTIAL.

CONFIDENTIAL information must be submitted under a separate cover, isolated from the CON application.

3. **Please include the filing fee calculated at (CON Fee = 0.50 x 1% of proposed capital expenditure). The minimum fee shall not be less than Five Thousand Dollars (\$5,000.00), and the maximum fee shall not exceed Twenty-Five Thousand Dollars (\$25,000.00). All checks or money orders must be made payable to the Mississippi State Department of Health.**

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
CERTIFICATION**

APPLICANT: _____

TITLE OF PROPOSED PROJECT: _____

TOTAL CAPITAL EXPENDITURE: _____

LOCATION: _____

I (we) swear or affirm on behalf of _____,

After diligent research, inquiry and study, the information and material contained in the attached application for a Certificate of Need is true, accurate, and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi State Department of Health will rely on this information and material in making its decision as to the issuance of a Certificate of Need, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth or accuracy, the Department may refrain from further review of the application and consider it rejected. It is further understood that if a Certificate of Need is issued based upon evidence contained in this application, such Certificate may be revoked, canceled, or rescinded if the Department of Health determines its findings were based on evidence, not true, factual, accurate, and correct.

I (we) certify that no revision or alteration of the proposal submitted will be made without obtaining prior written consent of the Department of Health. Furthermore, I (we) will furnish the Department of Health a progress report and/or request a six-month extension on the proposal every six (6) months until the project is completed.

Type or Print Name

Signature

Title

Facility (if different than above)

STATE OF _____

COUNTY OF _____

Sworn to and subscribed to before me, this the _____ day of _____, 20____.

Notary Public

My Commission Expires

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
APPLICATION FOR A CERTIFICATE OF NEED**

SUBSTANTIVE REVIEW

TITLE OF PROPOSED PROJECT:	
LOCATION:	
CAPITAL EXPENDITURE:	\$

I. APPLICANT/FACILITY INFORMATION

APPLICANT					
Applicant Legal Name:					
d/b/a (if applicable):					
Address:					
City:		State:		Zip Code:	
County:		Telephone:			
Parent Organization (if applicable):					
E-mail Address:		Fax:			
PRIMARY CONTACT PERSON					
Name:			Title or Position:		
Firm:					
Address:					
City:		State:		Zip Code:	
Telephone:				Fax:	
E-mail Address:					
LEGAL COUNSEL/CONSULTANT (if applicable)					
Name:				() Attorney	() Consultant
Firm:					
Address:					
City:		State:		Zip Code:	
Telephone:				Fax:	
E-mail Address:					

1. If the name of the existing or proposed facility is different than the Applicant's legal name, provide the facility information.

FACILITY					
Facility Name:					
Facility Address:					
City:		State:		Zip Code:	
County:		Phone:			

2. Will the existing or proposed facility be operated by a different Management Entity other than the Applicant? If yes, provide the following information and submit any existing or proposed management agreements.

MANAGEMENT / OPERATING ENTITY					
Organization Name:					
Address:					
City:		State:		Zip Code:	
Telephone:		Fax:			

3. Select the type of ownership for the present or proposed facility.

TAX EXEMPT	☐ Not-for-Profit Corporation		
	☐ Public (Hospital or Government)		
TAX PAYING	☐ General Partnership	☐ Business Corporation	☐ Sole Proprietor
	☐ Limited Liability Partnership or Limited Partnership	☐ Limited Liability Company	
State of Incorporation / Organization:			

4. Please provide documentation of the organizational and legal structure as indicated in the table below.

ORGANIZATIONAL STRUCTURE	
Not-for-Profit Corporation	▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State
Public	▪ All Governing Authority Approvals for this Project
Sole Proprietor	▪ County Business Authorization Documents, if available
General Partnership	▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Partnership Agreement
Limited Liability Partnership or Limited Partnership	▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Letter of Good Standing from Secretary of State
Business Corporation	▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State
Limited Liability Company	▪ Name of Each Member and Managing Member, Officers, and/or Directors ▪ Letter of Good Standing from Secretary of State

II. PROJECT DESCRIPTION

Project Type (select as many as applicable)

- ☐ Construction, development or other establishment of a new health care facility
- ☐ Renovation and/or expansion of an existing health care facility
- ☐ Offering of health services
- ☐ Relocation of health services
- ☐ Acquisition of major medical equipment
- ☐ Relocation of health care facility or major medical equipment
- ☐ Change in bed complement
- ☐ Change of ownership

1. Describe in detail ALL the characteristics of the proposed project.
2. Provide the anticipated date for obligation of capital expenditure (_____) and the anticipated date the project will be complete (_____). No project will be deemed complete without this information.
3. Provide evidence that the Division of Licensure and Certification has approved the site of construction or new service. No project will be approved unless the site has been approved. (If site approval is not necessary, provide a statement from the Division of Licensure and Certification stating that site approval is not necessary for this project.)
4. Describe the final objectives of the proposed project.
5. Describe and/or provide the following components of the proposed project:
 - a. Facility
 - i. Number of licensed beds by category.

	Current Beds			
	Licensed	Setup & Staffed	Beds Proposed	Total Beds at Completion
Short-Term Acute Care Beds				
Swing Beds				
Long-Term Acute Care Beds				
Rehabilitation Beds				
Adult Psychiatric Beds				
Adolescent Psychiatric Beds				
Adult Chemical Dependency Beds				
Adolescent Chemical Dependency Beds				
Psychiatric Residential Treatment Beds				
Long-Term Care Beds				
TOTAL:				

ii. Facility Type (select one).

☐ Hospital-Based ☐ Freestanding ☐ Not Applicable

b. Equipment

- i. If any single item of equipment costs in excess of \$150,000, enter the equipment information below & attach copies of any equipment leases or rental agreements, if applicable.

Fixed or Non-Fixed	Description	Manufacturer	Proposed Installation Date

6. If the proposed project involves New Construction and/or Renovation:

- a. Describe the new construction and/or renovation (including but not limited to site work, grounds work, drainage, parking, fencing, mechanical and electrical systems). Also state square footage requirements and identify current and/or proposed use of all space.
- b. Enclose plot plan of site. If proposed project includes construction, modernization, or alteration of the physical plant, enclose schematic drawings (8½" x 11" format).
- c. Describe any capital expenditure projects completed within the past two years in excess of \$200,000.
- d. Describe any outstanding Certificates of Need.
- e. Provide documentation that the applicant will or has complied with state and local building codes, zoning ordinances, and/or appropriate regulatory authority.
- f. Affirm that applicant will comply with all applicable State statutes and regulations for the protection of the environment, including: 1) approved water supplies; 2) sewage and water disposal; 3) hazardous waste disposal; 4) water pollution control; 5) air pollution control; and 6) radiation control.
- g. If the project involves the renovation of an existing facility and the facility has licensure code or accreditation standard deficiencies, enclose a copy of the most recent report or survey from the licensing authority or accreditation program citing deficiencies.
- h. Provide evidence that the Division of Radiological Health has approved the plans for provision of radiation therapy services, and other services if applicable.

III. CERTIFICATE OF NEED CRITERIA AND STANDARDS

A. STATE HEALTH PLAN

1. Document the proposed project's compliance with each of the applicable standards. The application must have narrative sections corresponding to each item of the policy statements, and general and/or service specific criteria and standards in the current State Health Plan. (A list of projects with service specific criteria and standards is at the end of this format).
2. If the proposed project is to provide a new institutional service which is based on physician referrals, provide affidavits of commitment from the referring physicians that include the actual number of referrals from the prior year, the projected number of referrals and/or the number of procedures or treatments to be rendered.

B. CERTIFICATE OF NEED (CON) MANUAL

Criterion 1 – State Health Plan: All projects will be reviewed for consistency with the State Health Plan in effect at the time of submission. See discussion above.

Criterion 2 - Long Range Plan: Describe how the proposed project is consistent with the applicant's long-range plans. Include a discussion of the planning process which preceded submission of this application.

Criterion 3 - Availability of Alternatives: Identify alternative approaches to the project which were considered.

- a. Describe the advantages and disadvantages of each alternative as well as the reason(s) they were not chosen.
- b. For new construction projects, modernization of existing facilities should be considered as an alternative, and the rejection of this alternative by the applicant should be justified.
- c. Demonstrate in specific terms how the option selected most effectively benefits the health care system.
- d. If an effective and less costly alternative for the proposed project is currently available in the area, demonstrate:
 - i. Why the proposed project is not an unnecessary duplication of services.
 - ii. Why the proposed project is a more efficient solution to the identified need.
- e. State how your proposed project fosters improvements or innovations in the financing or delivery of health services or promotes health care quality assurance or cost effectiveness.
- f. Explain the relevancy of the proposed project in relation to changing trends in service delivery and community health care needs of the foreseeable future.

Criterion 4 - Economic Viability:

- a. Discuss both the proposed charges for the service and the profitability of the proposed service compared to other similar services in the service area or state. Document how the proposed charges were calculated.
- b. Discuss whether projected levels of utilization are reasonably consistent with those experienced by similar facilities in the service area and/or state and whether the projected utilization level is consistent with the need level of the service area.
- c. If the capital expenditure of the proposed project is \$2,000,000.00 or more, submit a financial feasibility study prepared by an accountant, CPA, or the facility's financial officer. The study must include the financial analyst's opinion of the ability of the facility to undertake the obligation and the probable effect of the expenditure on present and future operating costs. In addition, the report must be signed by the preparer.
- d. Fully explain and justify any financial forecasts which deviate significantly from the financial statements of the three-year historical period.
- e. Describe how the applicant will cover expenses incurred by the proposed project in the event that the project fails to meet projected revenues.
- f. Discuss the impact of the proposed project on the cost of health care. This discussion should include the proposed project's impact on gross revenues and expenses per patient day or per procedure as well as the impact on Medicaid, if applicable.

Criterion 5 - Need for the Project:

- a. Discuss the need that the population served or to be served has for the services proposed to be offered or expanded and the extent to which all residents of the area - in particular low-income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups, and the elderly - are likely to have access to those services.
- b. In the case of the relocation of a facility or service, discuss the need that the population presently served has for the service and the extent to which that need will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the 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.
 - i. If a replacement facility, what is the proposed disposition for the existing facility? Also, explain the financial impact the disposition will have on this proposed project?
 - ii. If relocation of services, explain how the existing space will be utilized after the relocation.
- c. Discuss the current and projected utilization of like facilities or services within the proposed service area and the justification for the need for additional facilities or services.

- d. Discuss the probable effect of the proposed facility or service on existing facilities providing similar services to those proposed. When the service area of the proposed facility or service overlaps the service area of an existing facility or service, then the effect on the existing facility or service may be considered. The applicant or interested party must clearly present the methodologies and assumptions upon which any proposed project's impact on utilization in affected facilities or services is calculated. Also, discuss the appropriate and efficient use of existing facilities/services.
- e. Document the community reaction to the facility. Submit letters of comment from: 1) physicians; 2) health care facilities; 3) consumers and 4) health related community agencies in your health planning area. Also include letters of comment from city, county, or area government officials, if applicable.

Criterion 6 - Access to the Facility or Service:

- a. Discuss the extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved and the extent to which medically underserved populations are expected to use the proposed services if approved.
 - 1. Do all residents of the health planning service area, hospital service area or patient service area, including Medicaid recipients, charity/medically indigent patients, racial and ethnic minorities, women, handicapped persons and the elderly have access to the services of the existing facility?

☐ Yes ☐ No ☐ Not Applicable
 - 2. Will these residents have access to the proposed services and/or facility as described in this application?

☐ Yes ☐ No
 - 3. Provide the percentage of gross patient revenue and actual dollar amount of health care provided to medically indigent and charity care patients for the last two (2) years as well as the projected amount for the two (2) years following completion of the proposed project. Medically indigent patients should include only those patients for whom there is no expectation of payment upon admission and should not include bad debt. Discuss any significant changes between historical and projected utilization. Be sure to identify what years are the historical years.

Gross Patient Revenue				
	Medically Indigent (%)	Charity Care (%)	Medically Indigent (\$)	Charity Care (\$)
Historical Year 20				
Historical Year 20				
Projected Year 1				
Projected Year 2				

- b. Does your facility have existing obligations under any federal regulation requiring provision of uncompensated care, community service, or access by minority/handicapped persons?

☐ Yes ☐ No

i. Describe the remaining obligation.

- c. The extent to which the unmet needs of Medicare, Medicaid, and medically indigent patients are proposed to be served by the applicant; and
- d. The extent to which the applicant offers a range of means by which a person will have access to the proposed facility or services.
- e. Address the following access issues:
- i. Transportation and travel time to the facility.
 - ii. Restrictive admissions policies. Provide a copy of the current or proposed admissions policy.
 - iii. Access to care by medically indigent patients.
 - iv. Provide the hours per week the proposed service and/or facility will be manned and operating:
 1. Regular operation.
 2. Emergency only operation.

Criterion 7 - Information Requirement: Affirm that you will record and maintain, at a minimum, the following information regarding charity care, care to the medically indigent, and Medicaid populations and make it available to the Department within fifteen (15) business days of request:

- Utilization data, e.g., number of indigent, Medicaid, and charity admissions, and patient days of care.
- Age, race, sex, zip code, and county of origin of patient.
- Cost/charges per patient day and/or cost/charges per procedure, if applicable; and

- Any other data pertaining directly or indirectly to the utilization of services by medically indigent, Medicaid, or charity patients which may be requested, i.e., discharge diagnosis, service provided, etc.

Criterion 8 - Relationship to Existing Health Care System:

- Identify any existing, comparable services within your service area and describe any significant differences in population served or service delivery. If there are no existing, comparable services in the area, describe how the target population currently accesses the proposed service(s).
- State how the proposed project will affect existing health services available in the region or statewide, if applicable. Describe how each proposed new or expanded service will:
 - Complement existing services.
 - Provide an alternative or unique service.
 - Provide a service for a specific target population.
 - Provide services for which there is an unmet need.
- Describe any adverse impact to the existing health care system that may result from failure to implement the proposed project.
- Provide a list of transfer/referral/affiliation agreements between the current or proposed facility and other providers of health care within your health planning service area that are directly related to the proposed project.

Criterion 9 - Availability of Resources:

- Document the availability of new personnel required to staff the proposed service and/or facility. If applicable, demonstrate that sufficient physicians are available to ensure proper implementation of the proposed project. Describe your plan for recruiting any new personnel required.
- List all clinically related contractual services purchased by type of service, name of contractor, and term of contract.
- If the applicant owns existing facilities or services, demonstrate a satisfactory staffing history.
- Identify alternative uses of resources for the provision of other health services that were considered.

Criterion 10- Relationship to Ancillary or Support Services:

- Demonstrate that all necessary support and ancillary services for the proposed project are available.
- Describe any change in costs or charges as a result of this proposed project.

- c. Describe how you plan to accommodate any change in costs or charges.

Criterion 11 - Discuss the effect of the proposed service and/or facility on the clinical needs of health professional training programs in the service area.

Criterion 12 - Access by Health Professional Schools: State how your proposed project will meet the clinical needs of health professional training programs. (Optional)

Criterion 13 - If the applicant proposes to provide service(s) to individuals not residing in the service area, document any special needs or circumstances that should be considered.

Criterion 14 - Construction Projects: *Included in Economic Viability.*

Criterion 15 - Competing Applications: (Should competing applications be received; the Department will contact the applicant for any additional required information).

Criterion 16 - Quality of Care:

- a. If the project involves existing services or facilities, describe how the applicant has demonstrated past quality of care.
- b. Describe how the proposed project will improve the quality of care being delivered to the target population.
- c. List any accreditation and/or certifications held.

IV. FINANCIAL FEASIBILITY:

CON Application Financial Analysis (Excel spreadsheet) consists of seven (7) tables that must be completed and submitted along with application.

Copies of financial statements are required with each application. Please provide audited financial statements when possible. Audited financial statements to be submitted must include, at a minimum, balance sheet, operating statement, and cash flow statement. Be sure financial information for the last three (3) years is included.

Submit a Depreciation Schedule.

V. UTILIZATION

Use the table on the following page to list utilization statistics for the past two (2) years, current year, and the first three (3) years following project completion. Be sure to identify the corresponding calendar year for each column. Only include data that is relevant to the proposed project. The data provided for the past two (2) years should be consistent with the data submitted in the Annual Survey of Hospitals for the respective years. See Project Description, question 3a for a list of bed types. Service types include but may not be limited to: 1) magnetic resonance imaging; 2) positron emission tomography; 3) digital angiography; 4) extracorporeal shock wave lithotripsy; 5) adult open-heart surgery; 6) pediatric open-heart

surgery; 7) adult cardiac catheterization; and 8) pediatric cardiac catheterization. (Add additional pages if necessary).

- 1. Clearly identify the methodology and any assumptions used to project utilization.**
- 2. Discuss the specific reasons for increases and/or decreases in the various categories.**

		Prior two years		Current year	Three years after project completion		
		Year 20	Year 20	Year 20	Year 1	Year 2	Year 3
Bed Type:							
# Licensed Beds							
# Setup Beds							
Admissions							
Inpatient Days							
Outpatient Days							
Discharges							
Discharge Days							
Average Length of Stay							
Average Daily Census							
Occupancy Rate							
Bed Type:							
# Licensed Beds							
# Setup Beds							
Admissions							
Inpatient Days							
Outpatient Days							
Discharges							
Discharge Days							
Average Length of Stay							
Average Daily Census							
Occupancy Rate							
Service Type:							
# Procedures/Treatments							
Service Type							
#Procedures/Treatment							

VI. ESRD Projects ONLY

1. Project for the development or expansion of an end-stage renal disease (ESRD) facility.

a. Complete the following table.

Type of Station	Current Number	Proposed Number
Home Training		
Self-Care Hemodialysis		
Self-Care Peritoneal Dialysis		
Staff Assisted Hemodialysis		
Staff Assisted Peritoneal Dialysis		
Other (specify)		
Other (specify)		

b. If the proposed project involves the expansion of an existing ESRD facility, describe the types of ancillary services provided.

c. If the proposed project involves the expansion of an existing ESRD facility, complete the following table.

Number of Transplants in the Past Three (3) Years:	
Name of Transplant Facility:	
Location of Transplant Facility:	
Projected number of patients who will be candidates for transplantation during the first three (3) years of operation:	

d. Provide the name and address of all nephrologists and other physicians who will serve the patients of the facility.

e. List all existing ESRD facilities in your service area and approximate distance from your proposed facility.

f. Submit letters of comment from any other ESRD facilities, hospitals, physicians, community agencies or political entities in your ESRD service area.

Attachment 1

The following table documents the service-specific criteria currently used by the Department of Health as provided by the current State Health Plan. Carefully review this table and place an “X” in the box provided for any and all service-specific review criteria that apply to your proposed project.

SERVICE-SPECIFIC CRITERIA			
	Service	State Health Plan Chapter	Mark if Applicable
Long-Term Care	Nursing Home Care Services	Chapter 1	
	Nursing Home Care Services for Mentally Retarded and Other Developmentally Disabled Individuals	Chapter 2	
	Pediatric Skilled Nursing Facility	Chapter 2	
Mental Health	Acute Psychiatric, Chemical Dependency, and/or Psychiatric Residential Treatment Facility Beds/Services	Chapter 3	
Perinatal Care	Obstetrical Services	Chapter 4	
	Neonatal Special Care Services	Chapter 4	
Habilitation & Rehabilitation	Comprehensive Medical Rehabilitation Beds/Services	Chapter 6	
Other	Ambulatory Surgery Services	Chapter 7	
	Home Health Agency and/or Home Health Services	Chapter 7	
	End Stage Renal Disease (ESRD) Facilities	Chapter 7	
Acute Care	General Acute Care Hospitals & Beds	Chapter 5	
	Swing-Bed Services	Chapter 5	
	Therapeutic Radiation Equipment and/or Services (other than Stereotactic Radiosurgery)	Chapter 5	
	Stereotactic Radiosurgery Equipment/Services	Chapter 5	
	Magnetic Resonance Imaging (MRI) Equipment and/or Services	Chapter 5	
	Digital Angiography (DA)	Chapter 5	
	Positron Emission Tomography (PET) Scanner & Related Equipment	Chapter 5	
	Long-Term Care Hospitals/ Beds	Chapter 5	
	Cardiac Catheterization Equipment and/or Services	Chapter 5	
	Open-Heart Surgery Equipment and/or Services	Chapter 5	