DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
(202) 442-5875

FOR SHPDA USE ONLY
Date Received:_____

APPLICATION FOR CERTIFICATE OF NEED

Registration No._____

APPLICANT'S SUMMARY INFORMATION

PART ONE--QUANTITATIVE INFORMATION

1. Project Title _____

2. Brief Project Description

_____

_____

3. Applicant's Name and Mailing Address

_____

_____

_____

4. Name of Facility Operator (if different from #3)

_____

_____

5. Address of Facility where service is to be provided (if different from #3)

_____

_____

NOTE: **DO NOT ATTEMPT TO COMPLETE THIS APPLICATION WITHOUT FIRST CONSULTING WITH THE SHPDA STAFF PERSON ASSIGNED TO THIS PROJECT AND COMPLETING A "CERTIFICATE OF NEED APPLICATION CHECKLIST," WHICH SPECIFIES WHICH QUESTIONS MUST BE ANSWERED.**

6. Applicant's Chief Executive Officer or Administrator

_____

_____

7. Project Representative: Person to whom questions should be addressed (not the person identified in response to question six unless that person prepared the application)

_____ Telephone No: _____

Fax No: _____

8. Facility's Medicare Provider Number_____

9. Facility's Medicaid Provider Number_____

10. Category of Submission (check as applicable):

A. Qualifying Capital Expenditures and Acquisitions:

____ a. Capital expenditure over $2,000,000;
____ b. Other acquisitions (by lease, donation, etc.) which have fair market of value over $2,000,000;
____ c. Capital expenditure for major medical equipment over $1,300,000;
____ d. Other acquisitions (by lease, donation, etc.) of major medical, equipment which have fair market value of over $1,300,000.

B. Capital Expenditure in any amount to:

____ a. increase beds (as regulated by law);
____ b. decrease beds (as regulated by law);
____ c. relocate beds (as regulated by law);
____ d. redistribute beds among categories;
____ e. provide a new service; or
____ f. terminate a service.

____ C. Acquisition by individual provider or group practice of major medical equipment.

D. New institutional health service:

____ a. new health care facility;
____ b. new home health service;
____ c. other service not offered by the applicant on a regular basis within 12 months of the proposed offering date; or
____ d. increase, decrease or relocation of renal dialysis stations.

____ e. Acquisition of facility or equipment previously acquired under HMO exemption.

11. Type of Facility (check most appropriate)

a. Hospital (applying for inpatient services - specify license type)

____ 1. General license
____ 2. Special license (specify type)_____ ____

____ b. Hospital (applying for outpatient services)

____ c. Skilled Nursing Facility

____ d. HMO

____ e. Other Ambulatory Health Facility (free standing)

____ f. Home Health Agency (free standing)

____ g. Ambulatory Surgical Facility

____ h. Other, specify _____

12. Ownership of Facility:

A. All Proposals:

____ a. Non-Profit
____ b. For Profit
____ c. Government

____ B. HMO Proposals: (Complete this application only if the project is not exempt from CON Review. Consult with SHPDA staff for details.)

C. Type of Ownership:

____ a. Public
____ b. Individual Owner
____ c. Partnership (attach certified copy of partnership agreement)
____ d. Corporation (attach certified copy of corporate charter and articles of incorporation; if affiliated with other corporations, explain relationship in an attachment.)

13. Do you claim eligibility for:

____ a. Expedited Review

If you do claim eligibility for expedited review, attach an explanation of how the project meets the requirements outlined in the law.

CAPITAL EXPENDITURE

14. Cost for Pre-development (includes site acquisition cost, site preparation cost, architect and engineering fees, cost of permits, etc.) $ _____

15. Project Financing Costs and Other Cash Requirements: $ _____

A.	Loan Placement Fees	$ _____
B.	Bond Discount	$ _____
C.	Legal Fees, Printing, etc.	$ _____
D.	Consultant Fees	$ _____
E.	Liquidation of Existing Debt	$ _____
F.	Debt Service Reserve Fund	$ _____
G.	Principal Amortization Reserve Fund	$ _____
H.	Capitalized Construction Interest (Net)	$ _____
I.	Other (specify) _____ _____	$ _____
	TOTAL	$ _____

16. Physical Plant Costs (Estimate)

A.	Construction of New Facility	$ _____
B.	Expansion of Facility	$ _____
C.	Renovation of Facility	$ _____

D. Replacement of Facility $ _____

E. Lease of Existing Facility $ _____

a. Fair Market Value if Purchased $ _____
b. Annual Lease Cost $ _____ *
c. Number of Years _____

**** do not include in the total for Question 16***

F. Other Acquistion of Existing Facility

a. Fair market value of facility $ _____
b. How acquired?
___ i. simple purchase;
___ ii. stock transfer;
___ iii. donation;
___ iv. other (specify)
_____
_____

G. Closure of Facility $ _____

H. Other (specify) _____
_____ $ _____

TOTAL $ _____

17. Equipment Costs (check all that are applicable)

A. Type of Acquisition

____ a. New
____ b. Replacement
____ c. Addition to Current Equipment of Same Type

B. How Acquired

____ a. Purchased: Total Purchase Cost $ _____
____ b. Leased

i. If leased, enter Fair Market Value $ _____

ii. Lease Cost $ _____ *

iii. Number of Years _____

**** do not include in the total for Question 17.***

____ c. Donated (if donated give fair market value) $ _____

TOTAL $ _____

18. Costs Related to Change in Service Including Required Staff Training and Related Travel etc.

A. Type of Change in Service

____ a. New service $ _____

____ b. Expansion $ _____

____ c. Reduction $ _____

____ d. Termination $ _____

____ e. Consolidation $ _____

____ f. Relocation $ _____

____ g. Other (specify) _____ $ _____

B. Explain Costs Briefly

_____

_____

_____

TOTAL $_____

19. Contingency Costs (attach explanation) $_____

20. TOTAL CAPITAL EXPENDITURE
(Add Totals of Questions 14, 15, 16, 17, 18 and 19) $_____

21. Beds and Changes in Beds

Category of Beds	A. No. of Beds Two Years Before	B. Current No. of Beds	C. No. of Beds At Completion	D. Net Change B to C	E. Net Change A to C
A Medical Surgical					
B Coronary Care					
C OB/GYN (GYN)					
D OB/GYN Swing					
E Normal and Interm. Neonatal					
F Neonatal Intensive Care					
G Pediatrics					
H Psychiatric					
I Alcoholism, Chem. Dependency					
J Rehabilitation					
K Extended Acute Care					
L Medical-Surgical/Skilled Nursing Swing					
M Skilled Nursing (SNF)					
N Intermediate Care (ICF)					
TOTAL Number of Licensed Beds					

Attach explanation for any difference between current number of beds and current licensed number of beds. Also attach an explanation for any difference between this number and the number of operating beds reported to the State Health Planning and Development Agency.

22. Geographic Area to be Served _____

A. Attach a map showing location and proposed service area.

23. Location of the Project Site and Ownership

A. Site Address

_____

_____

B. Describe Site

_____

C. Is the site properly zoned?

____ a. Yes
____ b. No (If no, attach statement of zoning status)

D. a. Site Title Held by Applicant

____ i. Yes. If yes, state date acquired _____ .
____ ii. No

b. Option to Purchase held by applicant

____ i. Yes. If yes, state date acquired _____)
(aa) Date Option Expires _____
(bb) Terms of Option (attach additional sheets if necessary)

_____

_____

____ ii. No

E. Leasehold Interest for _____ years

F. Lease Renewable every _____ years.

G. Other (specify) _____

_____

24. Project Target Dates (may be expressed in terms of months following issuance of a Certificate of Need)

A. Financing Commitment _____

B. Bid Advertising _____

C. Contract Award _____

D. Begin Construction _____

E. Complete Construction _____

F. Project Completion _____

G. Attach a list of major construction milestones and dates.

25. Anticipated Types of Funding (check all that apply)

A. Non-Federal

_____ a. Tax-Exempt Bonds

_____ b. Other Non-Federal Funds

B. Federal (Specify source)

26. Source of Funds for Proposed Project

Indicate the source of funds for the proposed project (grant, loan, savings, securities, etc.). Attach confirmation of loans, grants, etc. received. Attach discussion of contingency plans if grants, loans, etc., applied for are not received.

Source of Funds	A. Total Amount of Funds	B. Funds In Hand	C. Funds Assured But Not In Hand Only	D. Funds Proposed or Requested
A. Cash (Retained Earnings)	$	$	$	$
B. Income from Future Operations	$	$	$	$
C. Pledges	$	$	$	$
D. Less Allowance for Uncollectible Funds	$	$	$	$
E. Gifts and Bequests	$	$	$	$
F. Interest Income	$	$	$	$
G. Bonds (see Quest. #28)	$	$	$	$
H. Mortgage	$	$	$	$
I. Loans (see Quest. #28)	$	$	$	$
J. Grants and Appropriations	$	$	$	$
a. Federal	$	$	$	$
b. DC Government	$	$	$	$
c. Other (specify)	$	$	$	$
d. Other (specify)	$	$	$	$

27. Complete the following for all borrowings (see Question 26-G, H, and I).

Lender/Bond Issue Issue	Amount	Rate of Interest	Annual Payment	Maturity Date
A.	$	%	$	
B.	$	%	$	
C.	$	%	$	
D.	$	%	$	
E.	$	%	$	
F.	$	%	$	

Attach a statement specifying condition(s) imposed or to be imposed by the lender, if any.

8. Revenue - Entire Facility or Agency

(In lieu of completing this form, subject to SHPDA approval, you may attach your own financial report and projections if they contain information similar to that required below.)
(Attach an explanation of your future years projection methodology.)

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19__	19__	19__	19__	19__	19__
A. Inpatient Services	$	$	$	$	$	$
B. Outpatient Services	+$	+$	+$	+$	+$	+$
C. Total Patient Service Revenues	$	$	$	$	$	$
D. Allowance for Bad Debts	-$	-$	-$	-$	-$	$
E. Contractual Allowances	-$	-$	-$	-$	-$	$
F. Allowance for free care for indigent	-$	-$	-$	-$	-$	$
G. Allowance for Professional or Admin. Courtesy	-$	-$	-$	-$	-$	-$
H. Net Patient Service Revenues (H=C-D-E-F-G)	$	$	$	$	$	$
I. Other Revenues	+$	+$	$	+$	+$	$
J. Total (J=+H+I)	$	$	$	$	$	$

9. (cont'd) Expenses, Entire Facility or Agency

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19__	19__	19__	19__	19__	19__
Miscellaneous (specify)						
Plant Operation & Maintenance						
A. Salaries & Benefits						
B. Electric, Gas, Water, etc.						
C. Exterminator						
D. Repairs						
E. Supplies						
F. Rental						
G. Other						
Total Plant Operation & Maintenance Expenses						
Miscellaneous (specify)						
A.	$	$	$	$	$	$
B.	$	$	$	$	$	$
C.	$	$	$	$	$	$
D.	$	$	$	$	$	$
Total Expenses	$	$	$	$	$	$

29.(cont'd) Expenses, Entire Facility or Agency

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19__	19__	19__	19__	19__	19__
Financial						
A. Interest on Current Debt						
B. Interest on Debt Related to this Project	XXXXXX	XXXXX	XXXXXX	XXXXX	XXXXX	XXXXX
C. Cross Current Depreciation						
D. Project Depreciation						
E. Current Amortization						
F. Project Amortization	XXXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX
G. Corporate Income Taxes						
Total Financial Expenses						
Housekeeping						
A. Salaries & Benefits						
B. Supplies						
C. Contract Services						
Total Housekeeping Expenses						

9. (Cont'd) Expenses, Entire Facility or Agency

dministration

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19__	19__	19__	19__	19__	19__
Health Care Services						
A. Salaries and Benefits	$	$	$	$	$	$
B. Professional Fees	$	$	$	$	$	$
C. Equipment Rental	$	$	$	$	$	$
D. Supplies	$	$	$	$	$	$
E. Drugs	$	$	$	$	$	$
F. Other	$	$	$	$	$	$
Total Health Care Expenses	$	$	$	$	$	$
Ancillary Services	$	$	$	$	$	$
A. Pharmacy	$	$	$	$	$	$
B. Physiotherapy	$	$	$	$	$	$
C. Laboratory	$	$	$	$	$	$
D. X-Ray	$	$	$	$	$	$
E. Occupational Therapy	$	$	$	$	$	$
Total Ancillary Expenses	$	$	$	$	$	$

29. Expenses, Entire Facility or Agency

In lieu of completing this form, subject to SHPDA approval, you may attach your own financial report and projections if they contain information similar to that requested below.)

(Attach an explanation of your future years projection methodology.)

Administration	19__	Three Most Recent Fiscal Years Ended 19__	19__	Current Year Projection 19__	First Two Years After Project Completion 19__	19__
A. Salaries and Benefits	$	$	$	$	$	$
B. Accounting	$	$	$	$	$	$
C. Advertising & Public Relations	$	$	$	$	$	$
D. Auto	$	$	$	$	$	$
E. Dues	$	$	$	$	$	$
F. Insurance	$	$	$	$	$	$
G. Legal	$	$	$	$	$	$
H. Office Supplies	$	$	$	$	$	$
I. Postage	$	$	$	$	$	$
J. Taxes	$	$	$	$	$	$
K. Telephone & Telegraph	$	$	$	$	$	$
L. Travel & Entertainment	$	$	$	$	$	$
M. Other	$	$	$	$	$	$
Total Administrative Expenses	$	$	$	$	$	$

30. Total facility patient mix by payment type (base these percentages on number of patients, not on percent of revenues):

		Most Recent Audited Year _____	% of Patients, Projected Year of Operation _____
A.	Medicare Patients	____%	____%
B.	Medicaid Patients	____%	____%
C.	Blue Cross Patients	____%	____%
D.	Other Insurance Patients	____%	____%
E.	HMO Patients	____%	____%
F.	Self-pay Patients	____%	____%
G.	Free Care Patients	____%	____%
H.	Other Patients (specify)		
	_____	____%	____%
	_____	____%	____%
	Total A through H equals	100 %	100%

31. Revenue Sources (total facility)

Percentage of Revenues

		Most Recent Audited Year*	First Year of Project Operation
A.	Patient Service Revenue	____%	____%
B.	Other Revenues	____%	____%
	Total A and B equals	100%	100%

- Specify date of end of fiscal year.

QUESTIONS 32 THROUGH 38, UTILIZATION STATISTICS

2. Number of Admissions (Attach an explanation of your future years projection methodology.)

rovide utilization statistics for your total facility or service (not project only). Attach a narrative justifying projections, including an explanation f your methodology. If the project is to be funded in whole or in part by income from operations during the period of project implementation see Question 26(b), also provide projections for all years until completion of the project.

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19__	19__	19__	19__	19__	19__
A. Medical Surgical						
B. Coronary Care						
C.OB/GYN						
D. OB/GYN Swing						
E. Norm & Intermed. Neonatal						
F. Neonatal Intensive						
G. Pediatrics						
H. Psychiatric						
I. Alcohol, Chem. Dependency						
J. Rehabilitation						
K. Extended Acute Care						
L. Medical-Surgical/Skilled Nursing Swing						
M. Skilled Nursing						
N. Intermediate Care						

33. Patient Days (Attach an explanation of your future years projection methodology.)

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19__	19__	19__	19__	19__	19__
A. Medical Surgical						
B. Coronary Care						
C.OB/GYN						
D. OB/GYN Swing						
E. Norm & Intermed. Neonatal						
F. Neonatal Intensive						
G. Pediatrics						
H. Psychiatric						
I. Alcohol, Chem. Dependency						
J. Rehabilitation						
K. Extended Acute Care						
L. Medical-Surgical/Skilled Nursing Swing						
M. Skilled Nursing						
N. Intermediate Care						
Total						

4. Average Length of Stay - In Days (Attach an explanation of your future years projection methodology.)

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion*	
	19__	19__	19__	19__	19__	19__
A. Medical Surgical						
B. Coronary Care						
C. OB/GYN						
D. OB/GYN Swing						
E. Norm & Intermed. Neonatal						
F. Neonatal Intensive						
G. Pediatrics						
H. Psychiatric						
I. Alcohol, Chem. Dependency						
J. Rehabilitation						
K. Extended Acute Care						
L. Medical-Surgical/Skilled Nursing Swing						
M. Skilled Nursing						
N. Intermediate Care						
Grand Mean Length of Stay						

* Specify month and day on line below.

35. Occupancy (Attach an explanation of your future years projection methodology.)

Occupancy Percentage	Three Most Recent Fiscal Years Ended 19__	19__	19__	Current Year Projection 19__	First Two Years After Project Completion 19__	19__
A. Medical Surgical	%	%	%	%	%	%
B. Coronary Care	%	%	%	%	%	%
C. OB/GYN	%	%	%	%	%	%
D. OB/GYN Swing	%	%	%	%	%	%
E. Norm & Intermed. Neonatal	%	%	%	%	%	%
F. Neonatal Intensive	%	%	%	%	%	%
G. Pediatrics	%	%	%	%	%	%
H. Psychiatric	%	%	%	%	%	%
I. Alcohol, Chem. Dependency	%	%	%	%	%	%
J. Rehabiliation	%	%	%	%	%	%
K. Extended Acute Care	%	%	%	%	%	%
L. Medical-Surgical/Skilled Nursing Swing	%	%	%	%	%	%
M. Skilled Nursing	%	%	%	%	%	%
N. Intermediate Care	%	%	%	%	%	%
Total Number of Licensed Beds						

6. Average Charge per Patient Day (Attach an explanation of your future years projection Methodology.)

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19__	19__	19__	19__	19__	19__
Average Charge	$	$	$	$	$	$

37. Newborn Nursery Utilization (Attach an explanation of your future years projection methodology.)

Newborn Nursery	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19__	19__	19__	19__	19__	19__
A. Number of Births						
B. Patient Days						
C. Average Length of Stay						
D. Number of Bassinets						

38. Non-Patient Utilization (Attach an explanation of your future years projection methodology.)

Non-Inpatient Visits	Three Most Recent Fiscal Years Ended 19__	19__	19__	Current Year Projection 19__	First Two Years After Project Completion* 19__	19__
A. Emergency						
B. Outpatient Dept.						
C. Home Health Care						
D. Hospice Home Care						
E. Chronic Kidney Disease Facility						
1. Outpatient staff assisted in facility Chronic Maintenance Hemodialysis						
2. Outpatient self care in facility Chronic Maintenance Hemodialysis						
3. Outpatient self care in facility Intermittent Periotoneal Dialysis, Including Training						
4. Training for Home Intermittent Peritoneal Dialysis						

OPERATING PROJECTIONS RELATED SPECIFICALLY TO PROPOSED PROJECT

9. Project-Related Utilization and Financial Information

(Attach an explanation of your future years projection methodology.)

	MOST RECENT FISCAL YEAR ENDED			ESTIMATED CURRENT FISCAL YEAR ENDING		
Unit of Service Delivery	Capacity	Actual Utilization	Average Charge Per Unit	Capacity	Estimated Utilization	Average Charge Per Unit
A.			$			$
B.			$			$
C.			$			$
D.			$			$
E.			$			$
F.			$			$
G.			$			$
H.			$			$
I.			$			$
J.			$			$
K.			$			$
L.			$			$
Project Related Total Revenue			$			$

3. Attach an explanation of the extent to which changes projected for the first two years operation are related.

40. Project-Service Related Expenses

(Audited financial reports may be attached in lieu of completing columns for the three most recent fiscal years if all requested information is supplied for the service under consideration. Also attach an explanation of your future years projection methodology.)

	Three Most Recent Fiscal Years Ended			Current Year Projection	First Two Years After Project Completion	
	19	19	19	19	19	19
A. Inpatient Services	$	$	$	$	$	$
B. Outpatient Services	$	$	$	$	$	$
C. Total Patient Service Revenues (C=A+B)	$	$	$	$	$	$
D. Allowance for Bad Debts	$	$	$	$	$	$
E. Contractual Allowances	$	$	$	$	$	$
F. Provision for Free or Reduced Cost Care	$	$	$	$	$	$
G. Net Patient Service Revenues (G=C-D-E-F)	$	$	$	$	$	$
H. Other Revenues	$	$	$	$	$	$
I. Total Net Revenues (I=G+H)	$	$	$	$	$	$

I. Project-Service Related Expenses

(Audited financial reports may be attached in lieu of completing columns for the three most recent fiscal years if all requested information is supplied for the service under consideration. Also attach an explanation of your future years projection methodology.)

	Three Most Recent Fiscal Years Ended			Current Year Project	First Two Years After Completion	
	19__	19__	19__	19__	19__	19__
A. Inpatient Services	$	$	$	$	$	$
B. Outpatient Services	$	$	$	$	$	$
C. Total Patient Service Revenues (C=A+B	$	$	$	$	$	$
D. Allowance for Bad Debts	$	$	$	$	$	$
E. Contractual Allowances	$	$	$	$	$	$
F. Provision for Free or Reduced Cost Care	$	$	$	$	$	$
G. Net Patient Service Revenues (G=C-D-E-F)	$	$	$	$	$	$
I. Project-Related Non-Operating Income	$	$	$	$	$	$
J. Total Project Related Surplus or (Deficit) (J=H+I)	$	$	$	$	$	$

3. Attach an explanation of the extent to which changes projected for the first two years operation are related to this project.

42. A. Project-Service Related Expenses

(Audited financial reports may be attached in lieu of completing columns for the three most recent fiscal years if all requested information is supplied for the service under consideration. Also attach an explanation of your future years projection methodology.)

	Three Most Recent Fiscal Years Ended			Current Year Project	First Two Years After Completion Projection	
	19__	19__	19__	19__	19__	19__
A. Salaries, wages, professional fees	$	$	$	$	$	$
B. Interest on Project Debt	$	$	$	$	$	$
C. Project Description	$	$	$	$	$	$
D. Project Amortization	$	$	$	$	$	$
E. Corporate Income Taxes	$	$	$	$	$	$
F. Supplies and Other Expenses	$	$	$	$	$	$
G. Total Project Operating Expenses (C=A+B+C+D+E+F)	$	$	$	$	$	$
H. Net Operating Income or (Loss) from Project (42.H=41.I-42.G)	$	$	$	$	$	$

B. Attach an explanation of the extent to which changes projected for the first two years of operation are related to this project.

43. A. Provide a list of the type and number of full-time equivalents (FTEs) and estimated annual salary of all personnel required to staff the new or expanded facility or service and identify the sources from which you intend to obtain the required personnel. Include current staff and volunteers if applicable.

	Personnel Category	Estimated Annual Salary	No. of FTEs	Source of Personnel*
Department	Job Title			
TOTALS	$			

* Currently on staff, new hire, contract personnel, etc.

44. B. In an attachment, describe the methodology (including the definition of FTE) used to determine the above staffing and cite any pertinent studies or programs upon which the staffing was based.

C. In an attachment, describe the sources available for recruiting additional personnel. Do you anticipate any difficulty in recruiting needed personnel? Why or why not?

45. List of Major Equipment (Fixed or Moveable)*

Qty.	Description	Addition or Replacement Donation?	Purchase Lease or Value	Fair Market	Annual Least Cost (if leased)

46. Current Major Equipment to be used in New Service in Facility*

Qty.	Description	Annual Lease Cost (if leased)**

Applicant may substitute his/her own list instead of completing this chart if all information requested in Question 46 is provided.

** Attach terms of lease (length and cost)

47. In an attachment, provide a general description and statement of the total value of any equipment not specified above in Questions 43 and 44.

PART TWO--NARRATIVE

Please respond to the following questions in a narrative format, with documentation and attachments as appropriate.

48. On a separate sheet, provide a reasonably full and detailed description of the facility, service(s) and equipment to be provided, as well as a justification and supporting evidence for establishing the service. This information will serve as an introduction to the proposal and to the specific questions below. The description may make reference to information supplied in response to specific questions throughout this application.

49. Explain in detail how the project is consistent or inconsistent with the Comprehensive Health Plan. If the project is inconsistent with the Plan, provide justification for the project in light of the inconsistency.

50. Does your facility have a long range plan? If so, explain the relationship of this project to the plan. If there, is no long range plan, explain how the project relates to the overall goals of the facility.

51. Discuss the need that the population to be served has for the services proposed to be offered or expanded. Explain how you reached the conclusion that there is unmet need. Include an analysis of the area and population to be served, the present and future utilization patterns of the proposed facility and service(s), and the impact of the proposal, if implemented, on the utilization of existing facilities and service(s) in the area. Use the methodology (if any) specified in the Comprehensive Health Plan. Demonstration of an unmet need is essential to approval of an application for a CON.

52. In the case of a reduction, elimination, or relocation of a service, discuss the need that the population presently served has for the service or facility, the extent to which that need can be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service or facility on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, other underserved groups and the elderly to obtain needed health care. Document with figures as much as possible.

53. Discuss the extent to which medically underserved populations (low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly) currently use your services in comparison to the percentage of the population in your service area which is in these categories. Discuss the extent to which the proposed project will affect the extent to which medically underserved populations can be expected to use your services if your application is approved.

54. Discuss your past performance in meeting your obligation, if any, under applicable federal- and District regulations requiring provision of uncompensated care, community service or access by minorities and handicapped persons to health programs, facilities and services (including the existence of any civil rights access complaints against you).

55. Discuss the range of means by which a person has or will have access to your services. NOTE: Regulations require that the SHPDA consider the accessibility of services to members of medically underserved groups. The regulations further specify that access to services can be through any of a variety of means including use of outpatient services, admission by house staff, admission by personal physician, etc. Please describe means of access in detail.

56. State the relationship of your proposed service to existing similar or related services provided by you or others and its impact on these services with respect to utilization, cost and resources (staff). Further, please list all providers of similar services in the proposed service are and/or surrounding area and the degree to which their service and equipment are being used to capacity. Note that these data may be available in the State Health Plan or from the SHPDA staff. Discuss competition in the supply of any service(s) proposed and any ways in which this proposal would foster competition in the financing or delivery of health care.

57. Describe the alternative methods (different equipment, floor plans, shared services, etc.) that have been explored, and explain how it was determined that the project as submitted represents the least costly and/or most effective method to provide the service in question. If the total project cost is more than $2,000,000, attach a copy of architects', consultants' or other (including those prepared by the applicant) report(s) concerning alternatives studied in terms of service to be provided, budget impact, cost effectiveness, etc. Compare the cost effectiveness of the selected alternative to the "do nothing" option.

58. Are there ancillary or support services existing to which the project relates or will relate? If so, please describe the expected relationship.

59. Discuss this proposal in relation to the special needs and circumstances, if any, of health maintenance organizations.

60. Discuss this proposal in relation to the special needs and circumstances, if any, of biomedical and behavioral research projects designed to meet a national need but for which local conditions offer special advantages.

61. Discuss the effect (if any) of the means proposed for the delivery of health services on the clinical need of health professional training programs.

62. If the proposed health services are available only in a limited number of facilities, discuss the extent to which health professional schools in the area will have access to the proposed services for training purposes.

63. If you claim to be an entity which provides a substantial portion of your services or resources, or both, to individuals not residing in the Washington Metropolitan Area, discuss your special needs and circumstances in relation to this project.

64. What would be the economic impact on the facility if the proposed project were not implemented?

65. What reviews, approvals, licenses, etc. are required by other governmental agencies for the implementation and operation of this project? What is the status of each of these reviews?

66. Discuss accessibility in relation to the proposed project (or in the case of indirect patient services, in relation to your direct patient services) in terms of the following:

    a. transportation patterns and resources for patients (and visitors if appropriate);

    b. hours and range of services provided;

    c. barriers to obtaining services (physical, cultural, economic); and

    d. physician referral and/or admitting patterns (if discussed in your response to question 55).

67. Describe the potential, if any, which the proposed service offers for a reduction in the use of inpatient care in the community, e.g., through alternatives to institutionalization or services of a preventive nature.

68. Have mechanisms been developed to consider consumer grievances, and to provide for consumer participation and rights. If so, specify.

69. Discuss any transfer or coordination agreements and any other appropriate linkages in the system to provide for consumer participation and rights. If so, specify.

70. State the relationship of the proposed services to the existing health care system in terms of:

    a. community health promotion and prevention;
    b. prevention and detection;

    c. diagnosis and treatment;

d. rehabilitation;
e. chronic maintenance;
f. support services;
g. enabling services.

71. Discuss the quality of any care currently provided (if any) and the care proposed to be provided. The following points, at least should be described and quality demonstrated:

a. organization and management;
b. certification and licensure;
c. medical direction;
d. staffing;
e. peer review, utilization review, medical audits;
f. continuing education for staff.

72. Discuss the costs and methods of any proposed construction in this project. Include a discussion of the method of energy provision and the methods used for energy conservation. Discuss the relationship of the selected construction type and method of energy provision to construction costs and future operating costs. Also discuss the methods used to estimate construction and equipment costs. Attach a copy of any available construction plans or drawings.

73. What steps have been taken to inform the affected Advisory Neighborhood Commission (ANCs) of this project and to solicit their views? Attach copies of any correspondence and ANC statements, if available.

74. Provide any other available evidence or documentation that the facility, program or service has or will have the support of the health consumers of the area (consumers include representative community organizations, patient groups, etc.) or state that no such evidence or documentation is available.

FEE: **Please note that the Agency is authorized to collect CON application fees. The fee is the greater of 1% of proposed capital expenditures or a minimum of $2,000, with a maximum of $25,000.**