VR 355-30-000

220

COMMONWEALTH OF VIRGINIA

APPLICATION FOR EXPEDITED REVIEW

FOR

CERTIFICATE OF PUBLIC NEED

IN ACCORDANCE WITH

PART VI OF THE

VIRGINIA MEDICAL CARE FACILITIES

CERTIFICATE OF PUBLIC NEED RULES AND REGULATIONS

(VR 355-30-000.8)

June 15, 1994

EXPEDITED REVIEW PROCESS

This form is to be used to request an expedited review for certificate of public need (*"COPN"*) projects which may qualify for consideration in accordance with Part VI of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations (*"Regulations"*). The State Health Commissioner will issue a COPN for those projects which he determines meet the criteria for an expedited review within 45 days of the receipt of an application filed under the expedited review process. The appropriate application fee must accompany all requests for an expedited review as set forth in § 6.2.B. of the Regulations.

The applicant will be required to demonstrate to the satisfaction of the Commissioner that the project being proposed complies with the criteria for an expedited review. If the Commissioner denies a request for an expedited review of a project, the applicant may file an application for review of such project in the appropriate batch cycle in accordance with the process set forth in Part V of the Regulations. In cases when an expedited review is denied by the Commissioner, the project applicant will not be required to file a letter of intent or pay a second application fee to submit such application for review in the appropriate batch cycle. (See § 6.4.C. of the Regulations.)

CRITERIA FOR EXPEDITED REVIEW

Applicability - Projects of medical care facilities that satisfy the criteria set forth below as determined by the State Health Commissioner shall be subject to an expedited review process:

a. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another when the cost of such relocation is one million dollars or less.

b. The replacement at the same site by an existing medical care facility, of any medical equipment for the provision of cardiac catheterization, computed tomography (*"CT"*), lithotripsy, magnetic resonance imaging (*"MRI"*), open heart surgery, positron emission tomographic scanning (*"PET"*), radiation therapy, or single photon emission computed tomography (*"SPECT"*) when the medical care facility meets applicable standards for replacement of such medical equipment which are set forth in the State Medical Facilities Plan (*"SMFP"*).

c. The introduction into a medical care facility of any new SPECT service when the medical care facility currently provides non-SPECT nuclear medicine imaging services and meets the applicable standards for establishment of SPECT services which are set forth in the SMFP.

CONSIDERATION UNDER THE SECOND CATEGORY FOR EXPEDITED REVIEW

For the second and third categories for expedited review it will be necessary for the project applicant to obtain a copy of the SMFP and review

the relevant plan component that addresses the type of medical equipment which is being replaced. The SMFP provides specific criteria and standards for replacement of equipment within the individual plan components. A project must comply with the relevant SMFP criteria for replacement of equipment in order to qualify for expedited review under the second classification. Therefore, it is incumbent upon an applicant for expedited review to provide all appropriate data and information, as part of its application, to demonstrate that its project complies with the specific criteria in the SMFP. Copies of the SMFP are available from:

Virginia Department of Health
Office of Resources Development
1500 East Main Street, Suite 105
Richmond, Virginia 23219

APPLICATION FORM

Please complete the following form to apply for a COPN under the expedited review process in accordance with Part VI of the Regulations. One copy of the form should be filed with the appropriate regional health planning agency and two copies should be filed with the Department. The Office of Resources Development and the regional health planning agencies may be contacted for assistance and responses to questions concerning the COPN Program at the following addresses and telephone numbers:

Virginia Department of Health Office of Resources Development 1500 E. Main Street, Suite 105 Richmond, Virginia 23219	(804) 786-7463
Northwestern Virginia Health Systems Agency Blue Ridge Hospital Charlottesville, Virginia 22901	(804) 977-6010
Health Systems Agency of Northern Virginia 7245 Arlington Boulevard, Suite 300 Falls Church, Virginia 22042	(703) 573-3100
Southwest Virginia Health Systems Agency 3100A Peters Creek Road, N.W. Roanoke, Virginia 24019	(703) 362-9528
Central Virginia Health Planning Agency 1201 Broad Rock Boulevard Bldg. 507, Suite 317 No., Room 14 Richmond, Virginia 23249 MAIL: P.O. Box 24287 Richmond, Virginia 23224	(804) 233-6206
Eastern Virginia Health Systems Agency 18 Koger Executive Center, Suite 232 Norfolk, Virginia 23502	(804) 461-4834

SECTION I **FACILITY ORGANIZATION AND IDENTIFICATION**

A. _____
Official Name of Facility

_____
Address

_____
City State Zip Code

_____
Telephone Number

B. _____
Legal Name of Applicant

_____
Address

_____
City State Zip Code

C. Chief Administrative Officer

_____
Name

_____
Address

_____
City State Zip Code

_____
Telephone Number

D. Person(s) to whom questions regarding application should be directed.

_____
Name

_____
Address

_____
City State Zip Code

_____
Telephone Number

E. Type of Control and Ownership (Complete appropriate section for both owner and operator.)

Will the facility be operated by the owner? _____ Yes _____ No

Owner of Facility (Check one)	Proprietary	Operator of Facility (Check One)
(1) _____	(1) Individual	(1) _____
(2) _____	(2) Partnership - attach copy of Partnership Agreement and receipt showing that agreement has been recorded	(2) _____
(3) _____	(3) Corporate - attach copy of Articles of Incorporation and Certificate of Incorporation	(3) _____
(4) _____	(4) Other _____(Identify)	(4) _____
	Non-Profit	
(5) _____	(5) Corporation - attach copy of Articles of Incorporation and Certificate of Incorporation	(5) _____
(6) _____	(6) Other _____(Identify)	(6) _____
	Governmental	
(7) _____	(7) State	(7) _____
(8) _____	(8) County	(8) _____
(9) _____	(9) City	(9) _____
(10)_____	(10) City/County	(10)_____
(11)_____	(11) Hospital Authority or Commission	(11)_____
(12)_____	(12) Other _____(Identify)	(12)_____

F. Ownership of the Site (Check one and attach copy of document).

(1) _____ Fee simple title held by the applicant

(2) _____ Option to purchase held by the applicant

(3) _____ Leasehold interest for not less than _____ years

(4) _____ Renewable lease, renewable every _____ years

(5) _____ Other _____(Identify)

G. Attach a list of names and addresses of all owners or persons having a financial interest of five percent (5%) or more in the medical care facility.

(a) In the case of a proprietary corporation also attach:

(1) A list of the names and addresses of the board of directors of the corporation.

(2) A list of the officers of the corporation.

(3) The name and address of the registered agent for the corporation.

(b) In the case of a non-profit corporation also attach:

(1) A list of the names and addresses of the board of directors of the corporation.

(2) A list of the officers of the corporation.

(3) The name and address of the registered agent for the corporation.

(c) In the case of a partnership also attach:

(1) A list of names and addresses of all partners.

(2) The name and address of the general or managing partner.

(d) In the case of other types of ownership, also attach such documents as will clearly identify the owner.

H. List all subsidiaries wholly or partially owned by the applicant.

I. List all organizations of which the applicant is a wholly or partially owned subsidiary.

J. If the operator is other than the owner, attach a list of the name(s) and address(es) of the operator(s) of the medical care facility project. In the case of a corporate operator, specify the name and address of the Registered Agent. In the case of partnership operator, specify the name and address of the general or managing partner.

K. If the operator is other than the owner, attach an executed copy of the contract or agreement between the owner and the operator of the medical care facility.

SECTION II **PROJECT IDENTIFICATION**

A. Type of project for which a certificate of public need is being requested. (Check all that may be applicable).

(1) _____ Relocation at the same site of beds from one physical facility to another

(2) Replacement at the same site by an existing medical care facility of any medical equipment for the provision of

____ cardiac catheterization
____ computed tomography (CT)
____ lithotripsy
____ magnetic resonance imaging (MRI)
____ positron emission tomographic scanning (PET)
____ single photon emission computed tomography (SPECT)

B. Provide a full, but concise description of the proposed project. For equipment replacements, describe the specific equipment now available at the site and the type of equipment which is proposed to be acquired (include a copy of the manufacturer's quotation for new equipment).

C. For bed relocations:

1. Identify the present site of the beds to be relocated.

a. Site: _____ acres or square feet

b. Address or directions _____

_____

_____

2. Identify the proposed new location of the beds

   a. Site: _____ acres or square feet

   b. Address or directions _____

   _____

   _____

D. For equipment replacements:

1. Identify the location of the proposed equipment if the location is different is different from the present location of the existing equipment.

   a. Site: _____ square feet

   b. Address or directions _____

   _____

   _____

E. If the bed complement at the facility will change as a result of the project, complete the relevant portions of the following chart:

	Distribution of Existing Beds	Total Beds to be Lost or Removed from Service	Total Beds After Construction (Should equal sum of Columns 1 and 2)
Medical/Surgical			
Obstetrical			
Pediatric			
Psychiatric			
Rehabilitation			
Intensive/Coronary Care			
Long-Term/Extended Care			
Self Care			
Other (Specify)			
_____			
_____			
_____			
_____			
TOTAL			

SECTION III

For equipment purchases - Attach all documentation showing that the project complies with the relevant section of the State Medical Facilities Plan for "Replacement" of the medical equipment.

SECTION IV

Provide a timetable for completion of the project.

SECTION V **FINANCIAL DATA**

1. Direct Construction Costs $_____
2. Equipment not included in construction contract $_____
3. Site Acquisition Costs $_____
4. Site Preparation Costs $_____
5. Off Site Costs $_____
6. Architectural and Engineering Fees $_____
7. Other Consultant Fees $_____
8. Taxes During Construction $_____
9. HUD-232 Financing $_____
10. Industrial Development Authority Revenue & General Revenue Bond Financing $_____
11. Conventional Loan Financing $_____
12. Other (Specify) _____ $_____
13. **TOTAL CAPITAL COSTS (Add Lines 1 thru 12)** $_____
14. Percent of total construction costs to be financed _____
15. Dollar amount of long term mortgage $_____
16. Interest cost on long term financing
    a. HUD-232 Financing $_____
    b. Industrial Development Authority Revenue & General Revenue Bond Financing $_____
    c. Conventional Loan Financing $_____
    d. Other (Specify) _____ $_____
17. **TOTAL INTEREST COST ON LONG TERM FINANCING (Add Lines 16a, b, c, and d)** $_____
18. Anticipated Bond discount
    a. HUD-232 Financing $_____
    b. Industrial Development Authority Revenue & General Revenue Bond Financing $_____
    c. Conventional Loan Financing $_____
    d. Other (Specify) _____ $_____
19. **TOTAL ANTICIPATED BOND DISCOUNT (Add Lines 18a, b, c, and d)** $_____
20. **TOTAL PROJECT COST (Capital and Financing Costs) (Add Lines 13, 17, and 19)** $_____

SECTION VI **ASSURANCES**

I hereby assure and certify that the information included in this application is correct to the best of my knowledge and belief and that it is my intent to carry out the proposed project as described, to the extent it is approved and no more.

Signature of Authorizing Officer	Address Ln 1
Type or Print Name of Authorizing Officer	Address Ln 2
Title of Authorizing Officer	City, State and Zip
Date	Telephone Number

Copies of the request should be sent to:

A. Virginia Department of Health
Office of Resources Development
1500 E. Main Street, Suite 105
Richmond, Virginia 23219
(Send two copies)

B. The regional health planning agency which serves the area where the project will be located.
(Send one copy)