

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
APPLICATION FOR A CERTIFICATE OF NEED
(COST OVERRUN OR
CON AMENDMENT AND/OR ADDITIONAL CAPITAL EXPENDITURE)**

INSTRUCTIONS FOR COMPLETION OF APPLICATION

1. **Applicants are required to use this application format for submission of CON applications for CON amendment and/or cost overrun projects.** The CON Application is currently available on the Department's website at <http://www.msdh.ms.gov> under Certificate of Need, select Forms, (see "CON Application – Amendment/Cost Overrun")

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 Two Thousand, Five Hundred Dollars (\$2,500.00), 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.**

MSDH USE ONLY	
CON Review #:	_____
Date NOI Received	_____
Fee: \$ _____	Rec'd: Y N:

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

**APPLICATION FOR CON COST OVERRUN
CON AMENDMENT AND/OR ADDITIONAL CAPITAL EXPENDITURE**

Project Type:	<input type="checkbox"/> Amendment*	<input type="checkbox"/> Cost Overrun
Original Project Title		
CON Review Number		CON No.
Approved Capital Expenditure:	\$ _____	Additional Amount: \$ _____

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:		<input type="checkbox"/> Counsel <input type="checkbox"/> Consultant			
Firm:					
Address:					
City:		State:		Zip Code:	
Telephone:		Fax:			
E-mail Address:					

*Amendment projects are those projects that result in a change in sq. ft., project design, relocation, etc., and require an additional fee.

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

FACILITY				
Name:				
Address:				
City:		State:		Zip Code:
County:		Telephone:		

2. If the existing or proposed facility will be managed or operated by a different entity other than the Applicant, enter the entity information below.

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

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

TAX EXEMPT	<input type="checkbox"/> Not-for-Profit Corporation		
	<input type="checkbox"/> Public (Hospital or Government)		
TAX PAYING	<input type="checkbox"/> General Partnership	<input type="checkbox"/> Business Corporation	<input type="checkbox"/> Sole Proprietor
	<input type="checkbox"/> Limited Liability Partnership or Limited Partnership	<input type="checkbox"/> Limited Liability Company	
State of Incorporation or Organization:			

4. Describe any changes in the individual business or corporate officers and directors since the original CON approval.
- a. Enclose a copy of the Resolution adopted by the Board of Directors which is related to this project.
5. If it's a new entity or owner involved, provide evidence that the new entity/owner is authorized to do business in the State of Mississippi.

II. PROJECT DESCRIPTION

1. Provide a photocopy of the original Certificate of Need.
2. Describe all proposed changes not approved in the original CON application (e.g. changes in square footage, construction or renovation; changes in range, facilities served, or types of services, bed changes; equipment changes; etc.)
 - a. If the proposed project involves transfer of the CON from one (1) entity to another, provide a signed notarized copy of the transfer agreement.
 - b. If change of site, enclose proof of ownership/option to purchase, etc. of site of construction; (enclose plot plan of site and schematic drawings). Also, provide evidence that the Division of Licensure and Certification has approved the new site.
3. If the project is related in whole or in part to compliance with requirements of the Licensure and Certification Division of the MSDH, or any other certification or licensing authority, provide documentation.
4. If the project is related to a construction/expansion project, enclose a copy of the revised cost estimate signed by a licensed architect or licensed Mississippi building contractor.
 - a. Enclose a list of all bids received, if applicable, and names of respective companies. Was the lowest bid accepted? If not, explain.
5. If actual construction has not begun, give date it will begin and the reasons for the delay.
6. Provide evidence that the Division of Radiological Health has approved the plans for provision of radiation therapy services, if applicable.
7. If project involves the purchase/lease/change in vendor or manufacturer of major medical equipment, not included in the originally approved certificate of need project, provide the following:
 - a. Type of equipment, capacity and manufacturer;
 - b. Purchase price of equipment;
 - c. Purchase and installation date(s) of equipment; and
 - d. Explanation of cost variance from original quotes.
8. Will the amendment require any change in facility staffing? If so, identify changes in terms of personnel skills, number of personnel and indicate your recruitment plan which will obtain the services of these personnel.
9. List all transfer/referral/affiliation agreements between your facility and other providers of health care within your service area, which have changed since the original application was submitted or will change as a result of this amendment.
10. Provide the estimated date this project will be implemented/completed if the amendment/cost overrun is granted.

III. FINANCIAL ANALYSIS

1. Complete the enclosed Capital Expenditure Summary page.
2. Provide line-item justification for each increase (or decrease) in capital expenditure.
 - a. Document capital expenditure made to date and the percentage of completion.
3. Enclose a revised projected operating statement for the first full year of operation after completion of the project (for the proposed project/service only); include increased or decreased cost per day/procedure and charges per day/procedure.
4. Disclose the source of all financing (if debt attach creditor's letter).
 - a. Provide amount of loan/lease, interest rate, term of loan and payment/lease amount.
 - b. Enclose a loan amortization schedule for all loans.
5. Provide audited or un-audited financial statements for the past year.
6. Enclose a revised depreciation schedule for all assets.
7. Show effect of project on Medicaid patients, Medicare patients and other payers.

IV. COMPLIANCE WITH STATE HEALTH PLAN, POLICIES, AND PROCEDURES

1. Describe how the project complies with the health care needs addressed in the current *State Health Plan*. **Note: CON applications will be reviewed under the State Health Plan that is in effect at the time the application is received by the Department. However, amendment projects must continue to be in compliance with the Plan in effect at the time the original project was approval.**
2. Describe how the proposed project complies with the *Mississippi Certificate of Need Review Manual*, all adopted policies and procedures of the Mississippi State Department of Health, statute and federal regulations, if applicable.

V. CERTIFICATION

Complete and submit original notarized Certification Page for this project.

CAPITAL EXPENDITURE SUMMARY

APPLICANT: _____
 TYPE OF PROJECT: _____

	(1)	(2)	
	Original Approved Amount (\$)	Revised Amount* (\$)	Increase or (Decrease) (\$)
1. New Construction			
2. Construction / Renovation			
3. Land			
4. Site Work			
5. Fixed Equipment			
6. Non-Fixed Equipment			
7. Contingency			
8. Fees (Architectural, Consultant, etc)			
9. Capitalized Interest			
10. Capital Improvement			
Total Capital Expenditure			

Percentage Increase or Decrease _____
 Total Square Feet of Construction _____
 Total Square Feet of Renovation _____
 Percentage Complete _____

*Revised Capital Expenditure should include:
 (1) Original Amount Approved
 (2) Additional Requested Amount

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
CERTIFICATION**

APPLICANT: _____

TITLE OF PROPOSED PROJECT: _____

TOTAL CAPITAL EXPENDITURE: _____

I (we) swear or affirm on behalf of _____, after diligent research, inquiry, and study, that the information and material contained in the foregoing application for an amendment and/or cost overrun 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 cost overrun is approved or an amended Certificate of Need is issued based upon the evidence contained in this application, such approval or Certificate may be revoked, canceled, or rescinded if the Department of Health determines its findings were based on evidence, not true, not factual, inaccurate, and incorrect.

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 to the Department of Health a progress report on the proposal every six (6) months until the project is completed.**

Print or Type Name

Signature

Title

Facility Name (if Different)

STATE OF _____

COUNTY OF _____

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

Notary Public

My Commission Expires