For internal staff use:

MARYLAND HEALTH CARE COMMISSION

____

MATTER/DOCKET NO.

____

DATE DOCKETED

APPLICATION FOR CERTIFICATE OF NEED: HOSPICE SERVICES

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

REQUIRED FORMAT:

TABLE OF CONTENTS. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. The Table of Contents must include:

- Responses to PARTS I, II, III and IV of the following application form
- Attachments, Exhibits, or Supplements

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6.)

SUBMISSION FORMAT:
We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1]. All subsequent correspondence should also be submitted as *searchable PDFs*.

- **Microsoft Word:** The application responses and responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

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[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Hospice Provider : ______________________________

Address:

____
Street | City | Zip | County

Name of Owner (if differs from applicant):

____

2. OWNER

Name of owner: ______________________________

3. APPLICANT. *If the application has a co-applicant, provide the detail in section 3 and 4 as an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee):

____

Address:

____
Street | City | Zip | State | County

Telephone: ____________________

Name of Owner/Chief Executive: ______________________________

Is this applicant one of the following? (Circle or highlight description that applies.)

Licensed and Medicare certified general hospice in Maryland
Licensed and Medicare certified hospice in another state
Licensed hospital in Maryland/ other state
Licensed nursing home in Maryland/other state
Licensed and Medicare certified home health agency in Maryland/other state
Limited license hospice in Maryland
IF NONE OF THE ABOVE, NOT ELIGIBLE TO APPLY (See COMAR 10.24.13.04A.)
DO NOT COMPLETE REMAINDER OF APPLICATION

4. LEGAL STRUCTURE OF LICENSEE

Check ☑ or fill in one category below.

A. Governmental ☐
B. Corporation
   (1) Non-profit ☐
   (2) For-profit ☐
C. Partnership
   General ☐
   Limited ☐
   Other (Specify): ________
D. Limited Liability Company ☐
E. Other (Specify): ________

5. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: ______________________________

Mailing Address:

____

Street | City | Zip | State

Telephone: ______________________________

E-mail Address (required): ______________________________

Fax: ______________________________

B. Additional or alternate contact: ______________________________

____

Mailing Address:

____

Street | City | Zip | State

Telephone: ______________________________

E-mail Address (required): ______________________________

Fax: ______________________________

6. Brief Project Description (for identification only; see also item #13):

____

____

____

____

7. Project Services (check applicable description):

Service	(check if description applies)
Establish a general hospice	
Establish a General Inpatient Unit (GIP)	
Add beds to a GIP	

8. Current Capacity and Proposed Changes:

A) List the jurisdictions in which the applicant is currently authorized to provide general hospice services. (If services provided in other state(s), list them.)

____

____

____

B) Jurisdiction applicant is applying to be authorized in:

____

____

9. Project Location and Site Control *(Applies only to applications proposing establishment or expansion of a GIP unit):*

A. Site Size ______ acres

B. Have all necessary State and Local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO _____ (If NO, describe below the current status and timetable for receiving necessary approvals.)

____

____

____

____

____

C. Site Control and utilities:

(1) Title held by: ____

(2) Options to purchase held by: ____

(i) Expiration Date of Option _________________

(ii) Is Option Renewable? __________ If yes, Please explain

____

____

(iii) Cost of Option ____

(3) Land Lease held by: ____

(i) Expiration Date of Lease __________________________________

(ii) Is Lease Renewable _______________ If yes, please explain

____

____

(iii) Cost of Lease ____

(4) Option to lease held by: ____

(i) Expiration date of Option __________________________________

(ii) Is Option Renewable?____________ If yes, please explain

____

____

(iii) Cost of Option ____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained.

____

____

(6) Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

____

____

(INSTRUCTION: IN COMPLETING THE APPLICABLE OF ITEMS 10, 11 or 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

10. For new construction or renovation projects.

Project Implementation Target Dates

A. Obligation of Capital Expenditure _________months from approval date.
B. Beginning Construction ________________months from capital obligation.
C. Pre-Licensure/First Use ________________months from capital obligation.
D. Full Utilization ___________________________months from first use.

11. For projects not involving construction or renovations.

Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure ________ months from CON approval date.
B. Pre-Licensure/First Use ___________________ months from capital obligation.
C. Full Utilization ___________________________ months from first use.

12. For projects not involving capital expenditures.

Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget ________ months from CON approval date.
B. Pre-Licensure/First Use ___________________ months from CON approval.
C. Full Utilization ___________________________ months from first use.

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13. PROJECT DESCRIPTION

Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

14. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For projects involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

15. FEATURES OF PROJECT CONSTRUCTION:

A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS and COSTS"** (next page) describing the applicable characteristics of the project, if the project involves new construction.

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.
____
____

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.____
____

PART II - PROJECT BUDGET: COMPLETE TABLE 1 - PROJECT BUDGET

PART III - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)

10.24.01.08G(3)(a). The State Health Plan.

Applicant must address each standard from the applicable chapter of the State Health Plan (10.24.13 .05); these standards are excerpted below. (All applicants must address standards A. through O. Applicants proposing a General Inpatient facility must also address P.)

Please provide a direct and concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application. Copies of the State Health Plan are available on the Commission's web site
http://mhcc.dhmh.maryland.gov/shp/Pages/default.aspx

10.24.13 .05 Hospice Standards. The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new general hospice program, expand an existing hospice program to one or more additional jurisdictions, or to change the inpatient bed capacity operated by a general hospice.

A. Service Area. An applicant shall designate the jurisdiction in which it proposes to provide services.

B. **Admission Criteria**. An applicant shall identify:
(1) Its admission criteria; and
(2) Proposed limits by age, disease, or caregiver.

C. **Minimum Services**.
(1) An applicant shall provide the following services directly:
(a) Skilled nursing care;
(b) Medical social services;
(c) Counseling (including bereavement and nutrition counseling);

(2) An applicant shall provide the following services, either directly or through contractual arrangements:
(a) Physician services and medical direction;
(b) Hospice aide and homemaker services;
(c) Spiritual services;
(d) On-call nursing response
(e) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management);
(f) Personal care;
(g) Volunteer services;
(h) Bereavement services;
(i) Pharmacy services;
(j) Laboratory, radiology, and chemotherapy services as needed for palliative care;
(k) Medical supplies and equipment; and
(l) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services.

(3) An applicant shall provide bereavement services to the family for a period of at least one year following the death of the patient.

D. **Setting**. An applicant shall specify where hospice services will be delivered: in a private home; a residential unit; an inpatient unit; or a combination of settings.

E. **Volunteers**. An applicant shall have available sufficient trained caregiving volunteers to meet the needs of patients and families in the hospice program.

F. **Caregivers**. An applicant shall provide, in a patient's residence, appropriate instruction to, and support for, persons who are primary caretakers for a hospice patient.

G. **Impact**. An applicant shall address the impact of its proposed hospice program, or change in inpatient bed capacity, on each existing general hospice authorized to serve each jurisdiction affected by the project. This shall include projections of the project's impact on future demand for the hospice services provided by the existing general hospices authorized to serve each jurisdiction affected by the proposed project.

H. **Financial Accessibility**. An applicant shall be or agree to become licensed and Medicare-certified, and agree to accept patients whose expected primary source of payment is Medicare or Medicaid.

I. **Information to Providers and the General Public.**
(1) General Information**.** An applicant shall document its process for informing the following entities about the program's services, service area, reimbursement policy, office location, and telephone number:
(a) Each hospital, nursing home, home health agency, local health

department, and assisted living provider within its proposed service area;
(b) At least five physicians who practice in its proposed service area;
(c) The Senior Information and Assistance Offices located in its proposed service area; and
(d) The general public in its proposed service area.

(2) Fees. An applicant shall make its fees known to prospective patients and their families before services are begun.

J. **Charity Care and Sliding Fee Scale**. Each applicant shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to hospice services regardless of an individual's ability to pay and shall provide hospice services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

(1) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospice shall make a determination of probable eligibility.

(2) Notice of Charity Care Policy. Public notice and information regarding the hospice's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the population in the hospice's service area, and in a format understandable by the service area population. Notices regarding the hospice's charity care policy shall be posted in the business office of the hospice and on the hospice's website, if such a site is maintained. Prior to the provision of hospice services, a hospice shall address any financial concerns of patients and patient families, and provide individual notice regarding the hospice's charity care policy to the patient and family.

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each hospice's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income patients who do not qualify for full charity care, but are unable to bear the full cost of services.

(4) Policy Provisions. An applicant proposing to establish a general hospice, expand hospice services to a previously unauthorized jurisdiction, or change or establish inpatient bed capacity in a previously authorized jurisdiction shall make a commitment to provide charity care in its hospice to indigent patients. The applicant shall demonstrate that:
(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and
(b) It has a specific plan for achieving the level of charity care to which it is committed.

K. Quality.
(1) An applicant that is an existing Maryland licensed general hospice provider shall document compliance with all federal and State quality of care standards.

(2) An applicant that is not an existing Maryland licensed general hospice provider shall document compliance with federal and applicable state standards in all states in which it, or its subsidiaries or related entities, is licensed to provide hospice services or other applicable licensed health care services.

(3) An applicant that is not a current licensed hospice provider in any state shall demonstrate how it will comply with all federal and State quality of care standards.

(4) An applicant shall document the availability of a quality assurance and improvement program consistent with the requirements of COMAR 10.07.21.09.

(5) An applicant shall demonstrate how it will comply with federal and State hospice quality measures that have been published and adopted by the Commission.

L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient hospice care will be provided to patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

(2) An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance Programs, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

M. Respite Care. An applicant shall document its system for providing respite care for the family and other caregivers of patients.

N. Public Education Programs. An applicant shall document its plan to provide public education programs designed to increase awareness and consciousness of the needs of dying individuals and their caregivers, to increase the provision of hospice services to minorities and the underserved, and to reduce the disparities in hospice utilization. Such a plan shall detail the appropriate methods it will use to reach and educate diverse racial, religious, and ethnic groups that have used hospice services at a lower rate than the overall population in the proposed hospice's service area.

O. Patients' Rights. An applicant shall document its ability to comply with the patients' rights requirements as defined in COMAR 10.07.21.21.

P. Inpatient Unit: In addition to the applicable standards in .05A through O above, the Commission will use the following standards to review an application by a licensed general hospice to establish inpatient hospice capacity or to increase the applicant's inpatient bed capacity.

(1) Need. An applicant shall quantitatively demonstrate the specific unmet need for inpatient hospice care that it proposes to meet in its service area, including but not limited to:

(a) The number of patients to be served and where they currently reside;
(b) The source of inpatient hospice care currently used by the patients identified in subsection (1) (a); and
(c) The projected average length of stay for the hospice inpatients identified in subsection (1) (a).

(2) Impact. An applicant shall quantitatively demonstrate the impact of the establishment or expansion of the inpatient hospice capacity on existing general hospices in each jurisdiction affected by the project, that provide either home-based or inpatient hospice care, and, in doing so, shall project the impact of its inpatient unit on future demand for hospice services provided by these existing general hospices.

(3) Cost Effectiveness. An applicant shall demonstrate that:

(a) It has evaluated other options for the provision of inpatient hospice care, including home-based hospice care, as well as contracts with existing hospices that operate inpatient facilities and other licensed facilities, including hospitals and comprehensive care facilities; and

(b) Based on the costs or the effectiveness of the available options, the applicant's proposal to establish or increase inpatient bed capacity is the most cost-effective alternative for providing care to hospice patients.

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

10.24.01.08G(3)(d). Viability of the Proposal.

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

10.24.01.08G(3)(e). <u>Compliance with Conditions of Previous Certificates of Need</u>.

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1995, and their status.

10.24.01.08G(3)(f). <u>Impact on Existing Providers</u>.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

As part of this criterion, complete Table 5, and provide:

1. **an assessment of the sources available for recruiting additional personnel;**
2. **recruitment and retention plans for those personnel believed to be in short supply;**
3. **(for existing facilities) a report on average vacancy rate and turnover rates for affected positions,**

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identity and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

____
____
____
____
____

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement.

____
____
____
____

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

____
____
____
____

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

____
____
____
____

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

____
____
____
____

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

____
Signature of Owner or Authorized Agent of the Applicant

____
Print name and title

Date:____________________________________

Hospice Application: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE FACILITY

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

TABLE 5: MANPOWER INFORMATION

TABLE 1: Project Budget

Instructions: All estimates for 1a- d; 2a- f; and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. Inflation from date of submission of project completion should only be included on the Inflation line 1e. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. USE OF FUNDS	
1. CAPITAL COSTS (if applicable):	
a. New Construction	
1) Building	$
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc)	
a. SUBTOTAL New Construction	**$**
b. Renovations	
1) Building	$
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc.)	
b. SUBTOTAL Renovations	**$**
c. Other Capital Costs	
1) Movable Equipment	
2) Contingency Allowance	
3) Gross Interest During Construction	
4) Other (Specify)	
c. SUBTOTAL Other Capital Cost	**$**
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	**$**
Non-Current Capital Cost	
d. Land Purchase Cost or Value of Donated Land	$
e. Inflation (state all assumptions, including time period and rate	$
TOTAL PROPOSED CAPITAL COSTS (sum of a - e)	**$**
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	$
b. Bond Discount	
c. CON Application Assistance	
c1. Legal Fees	
c2 Other (Specify and add lines as needed)	
d. Non-CON Consulting Fees	
d1. Legal Fees	
d2. Other (Specify and add lines as needed)	
e. Debt Service Reserve Fund	
f. Other (Specify)	
TOTAL (a - e)	**$**
3. WORKING CAPITAL STARTUP COSTS	**$**
TOTAL USES OF FUNDS (sum of 1 - 3)	**$**

B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	
2. Pledges: Gross ___________,less allowance for uncollectables ___________= Net	
3. Gifts, bequests	
4. Authorized Bonds	
5. Interest income (gross)	
6. Mortgage	
7. Working capital loans	
8. Grants or Appropriation	
a. Federal	
b. State	
c. Local	
9. Other (Specify)	
TOTAL SOURCES OF FUNDS (sum of 1-9)	**$**
ANNUAL LEASE COSTS (if applicable)	
• Land	
• Building	
• Moveable equipment	
• Other (specify)	

Instructions: Complete Table 2A for the Entire General Hospice Program, including the proposed project, and **Table 2B** for the proposed project only using the space provided on the following pages. **Only existing facility applicants should complete Table 2A. All Applicants should complete Table 2B. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).**

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE Hospice Program

	Two Most Current Actual Years		**Projected years – ending with first year at full utilization**			
CY or FY (circle)			20__	20__	20__	20__
Admissions						
Deaths						
Non-death discharges						
Patients served						
Patient days						
Average length of stay						
Average daily hospice census						
Visits by discipline						
Skilled nursing						
Social work						
Hospice aides						
Physicians - paid						
Physicians - volunteer						
Chaplain						
Other clinical						
Licensed beds						
Number of licensed GIP beds						
Number of licensed Hospice House beds						
Occupancy %						
GIP(inpatient unit)						
Hospice House						

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

	Projected years – ending with first year at full utilization			
CY or FY (circle)	20__	20__	20__	20__
Admissions				
Deaths				
Non-death discharges				
Patients served				
Patient days				
Average length of stay				
Average daily hospice census				
Visits by discipline				
Skilled nursing				
Social work				
Hospice aides				
Physicians - paid				
Physicians - volunteer				
Chaplain				
Other clinical				
Licensed beds				
Number of licensed GIP beds				
Number of licensed Hospice House beds				
Occupancy %				
GIP(inpatient unit)				
Hospice House				

TABLE 3: REVENUES AND EXPENSES - ENTIRE Hospice Program (including proposed project)

(INSTRUCTIONS: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Recent Years -- Actual		**Current Year Projected**	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20-___
1. Revenue							
a. a. Inpatient services							
b. Hospice house services							
c. Home care services							
d. Gross Patient Service Revenue							
e. Allowance for Bad Debt							
f. Contractual Allowance							
g. Charity Care							
h. Net Patient Services Revenue							
i. Other Operating Revenues (Specify)							
j. Net Operating Revenue							
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)							
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies							
j. Other Expenses (Specify)							
k. Total Operating Expenses							
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							

d. Income Taxes							
e. Net Income (Loss)							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
4. Patient Mix							
A. As Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Other Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Other Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTIONS: Each applicant should complete this table for the proposed project only)

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
1. Revenue				
a. Inpatient services				
b. Hospice House services				
c. Home care services				
d. Gross Patient Service Revenue				
e. Allowance for Bad Debt				
f. Contractual Allowance				
g. Charity Care				
h. Net Patient Services Revenue				
i. Other Operating Revenues (Specify)				
j. Net Operating Revenue				
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)				
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				
j. Other Expenses (Specify)				
k. Total Operating Expenses				
3. Income				
a. Income from Operation				
b. Non-Operating Income				
c. Subtotal				
d. Income Taxes				
e. Net Income (Loss)				

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	20___	20___	20___	20___
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Other Commercial Insurance				
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Other Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%

TABLE 5. MANPOWER INFORMATION

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Administration					
Direct Care					
Nursing					
Social work/services					
Hospice aides					
Physicians-paid					
Physicians-volunteer					
Chaplains					
Bereavement staff					
Other clinical					
Support					
Other support					
				Benefits*	___________
				TOTAL	___________

* Indicate method of calculating benefits cost

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Updated June 2016.