

Craig P. Tanio, M.D.  
CHAIR



Ben Steffen  
EXECUTIVE DIRECTOR

*For internal staff use:*

**MARYLAND  
HEALTH  
CARE  
COMMISSION**

\_\_\_\_\_  
MATTER/DOCKET NO.

\_\_\_\_\_  
DATE DOCKETED

**INSTRUCTIONS: GENERIC APPLICATION FOR CERTIFICATE OF NEED (CON)**

**Note: Specific CON application forms exist for hospital, comprehensive care facility, home health, and hospice projects. This form is to be used for any other services requiring a CON.**

***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 this application form**
- **Responses to PART IV must include responses to the standards in the State Health Plan chapter that apply to the project being proposed..**
  - All Applicants must respond to the Review Criteria listed at 10.24.01.08G(3)(b) through 10.24.01.08G(3)(f) as detailed in the application form.
- **Identification of each Attachment, Exhibit, or Supplement**

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. However, a replacement exhibit that merely replaces an

exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

### **SUBMISSION FORMATS:**

We require submission of application materials and the applicant's responses to completeness questions 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.<sup>1</sup> All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.
- **Microsoft Word:** Responses to the questions in the application and the applicant's 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.

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](mailto:ruby.potter@maryland.gov) and [kevin.mcdonald@maryland.gov](mailto:kevin.mcdonald@maryland.gov).

**Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.**

*A pre-application conference will be scheduled by Commission Staff to cover this and other topics. Applicants are encouraged to contact Staff with any questions regarding an application.*

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<sup>1</sup> 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 Facility:** \_\_\_\_\_

**Address:**

\_\_\_\_\_  
Street                      City                      Zip                      County

**2. Name of Owner**

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

**3. APPLICANT.** *If the application has a co-applicant, provide the following information in an attachment.*

**Legal Name of Project Applicant (Licensee or Proposed Licensee):** \_\_\_\_\_

**Address:**

Street				
	City	Zip	State	County
Telephone:				

**4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:**

\_\_\_\_\_

**5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).**

Check  or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

- A. Governmental
- B. Corporation
- (1) Non-profit
- (2) For-profit
- (3) Close  State & Date of Incorporation
- C. Partnership
- General
- Limited
- Limited Liability Partnership
- Limited Liability Limited Partnership
- Other (Specify): \_\_\_\_\_
- D. Limited Liability Company
- E. Other (Specify): \_\_\_\_\_
- To be formed:
- Existing:

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

**A. Lead or primary contact:**

**Name and Title:**

**Company Name** \_\_\_\_\_

**Mailing Address:**

Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_

**Telephone:**

**E-mail Address (required):**

**Fax:**

If company name is different than applicant briefly describe the relationship

**B. Additional or alternate contact:**

Name and Title: \_\_\_\_\_

Company Name \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail Address (required): \_\_\_\_\_

Fax: \_\_\_\_\_

If company name is different than applicant briefly describe the relationship

**7. TYPE OF PROJECT**

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

- (1) A new health care facility built, developed, or established
- (2) An existing health care facility moved to another site
- (3) A change in the bed capacity of a health care facility
- (4) A change in the type or scope of any health care service offered by a health care facility
- (5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at:   
[http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs\\_con/documents/con\\_capital\\_threshold\\_20140301.pdf](http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf)

**8. PROJECT DESCRIPTION**

**A. 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

**B. Comprehensive Project Description:** The description should include details regarding:

- (1) Construction, renovation, and demolition plans
- (2) Changes in square footage of departments and units
- (3) Physical plant or location changes
- (4) Changes to affected services following completion of the project
- (5) Outline the project schedule.

**9. Current Capacity and Proposed Changes:**

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	___/___		
ICF-C/D	Beds	___/___		
Residential Treatment	Beds	___/___		
Ambulatory Surgery	Operating Rooms			
	Procedure Rooms			
Home Health Agency	Counties	___/___		
Hospice Program	Counties	___/___		
Other (Specify)				
TOTAL				

**10.** Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

**11. REQUIRED APPROVALS AND SITE CONTROL**

- A. Site size: \_\_\_\_\_ acres
- B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained?  
YES \_\_\_\_\_ NO \_\_\_\_\_ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

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C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

- (1) Owned by: \_\_\_\_\_
- (2) Options to purchase held by: \_\_\_\_\_  
Please provide a copy of the purchase option as an attachment.
- (3) Land Lease held by: \_\_\_\_\_  
Please provide a copy of the land lease as an attachment.
- (4) Option to lease held by: \_\_\_\_\_  
Please provide a copy of the option to lease as an attachment.
- (5) Other: \_\_\_\_\_  
Explain and provide legal documents as an attachment.

## 12. PROJECT SCHEDULE

(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)

### **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.

### **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.

### **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.

## 13. 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, 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. Specify dimensions and square footage of patient rooms.



#### 14. FEATURES OF PROJECT CONSTRUCTION

- A. If the project involves new construction or renovation, complete **Tables C and D of the Hospital CON Application Package**
- B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

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#### PART II - PROJECT BUDGET

##### Complete Table E of the Hospital CON Application Package

**Note:** Applicant should include a list of all assumptions and specify what is included in each budget line, as well as the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.).

#### PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

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2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

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3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, 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, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

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4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

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5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

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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 Board-designated official of 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Owner or Board-designated Official

\_\_\_\_\_  
Position/Title

\_\_\_\_\_  
Printed Name

## PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR

### 10.24.01.08G(3):

**INSTRUCTION:** Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

***An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.***

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and to the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

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

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services<sup>2</sup>. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

**Please provide a direct, 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 as an exhibit.**

*(Insert relevant State Health Plan standards here.)*

#### **10.24.01.08G(3)(b). Need.**

***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.***

**INSTRUCTIONS:** 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. If the relevant chapter of the State Health Plan includes a need standard or need projection methodology, please reference/address it in your response. For applications proposing to address the need of special population groups, please specifically identify those populations that are underserved and describe how this Project will address their needs.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area

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<sup>2</sup> [1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here: [http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs\\_shp/hcfs\\_shp](http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp)

population. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. List all assumptions made in the need analysis regarding demand for services, utilization rate(s), and the relevant population, and provide information supporting the validity of the assumptions.

Complete Tables 1 and/or 2 below, as applies.

**[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]**

**TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY**

CY or FY (Circle)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__	20__	20__	20__	20__	20__
<b>1. Admissions</b>							
a. ICF-MR							
b. RTC-Residents							
Day Students							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
<b>2. Patient Days</b>							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__		20__	20__	20__	20__
<b>3. Average Length of Stay</b>							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
<b>4. Occupancy Percentage*</b>							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
<b>5. Number of Licensed Beds*</b>							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
<b>6. Home Health Agencies</b>							
a. SN Visits							
b. Home Health Aide							
c. Other Staff							
d.							
e. Total patients srvd.							

Table 1 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__
<b>7. Hospice Programs</b>							
a. SN visits							
b. Social work visits							
c. Other staff visits							
d.							
e. Total patients srvd.							
<b>8. Ambulatory Surgical Facilities</b>							
a. Number of operating rooms (ORs)							
• Total Procedures in ORs							
• Total Cases in ORs							
• Total Surgical Minutes in ORs**							
b. Number of Procedure Rooms (PRs)							
• Total Procedures in PRs							
• Total Cases in PRs							
• Total Minutes in PRs**							

\*Number of beds and occupancy percentage should be reported on the basis of licensed beds.

\*\*Do not include turnover time.

**TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT  
(INSTRUCTION: All applicants should complete this table.)**

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
<b>1. Admissions</b>				
a. ICF-MR				
b. RTC-Residents				
Day Students				

c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
<b>2. Patient Days</b>				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
<b>3. Average Length of Stay</b>				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
<b>4. Occupancy Percentage*</b>				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				

Table 2 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
<b>5. Number of Licensed Beds</b>				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				

6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)				
● Total Procedures in ORs				
● Total Cases in ORs				
● Total Surgical Minutes in ORs**				
b. Number of Procedure Rooms (PRs)				
● Total Procedures in PRs				
● Total Cases in PRs				
● Total Minutes in PRs**				

\*Do not include turnover time

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

***The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.***

**INSTRUCTIONS:** Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing



facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

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

***The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.***

**INSTRUCTIONS:** Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete Tables 3 and/or 4 below, as applicable. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item.
- Complete Table L (Workforce) from the Hospital CON Application Table Package.
- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.
- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.
- Describe and document relevant community support for the proposed project.
- Identify the performance requirements applicable to the proposed project (see question

12, "Project Schedule") and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

**TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY** (including proposed project)

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

CY or FY (Circle)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__	20__	20__	20__	20__	20__
1. Revenue							
a. Inpatient services							
b. Outpatient services							
c. Gross Patient Service Revenue							
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue							
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue							

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

**TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT**

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

CY or FY (Circle)	Projected Years (Ending with first full year at full utilization)			
	20__	20__	20__	20__
<b>1. Revenues</b>				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Services Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
h. Total Net Operating Revenue				
<b>2. Expenses</b>				
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				

**10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.**

***An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.***

**INSTRUCTIONS:** List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

**10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.**

***An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.***

**INSTRUCTIONS:** Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

- a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;
- b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.
- c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);
- d) On costs to the health care delivery system.

If the applicant is an existing facility or program, provide a summary description of the impact of the proposed project on the applicant's costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.