



**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES PLANNING AND REVIEW BOARD**

**Form 301A Instructions
Not Subject to Review/Exemption Application**

All persons who are requesting an NSR/Exemption from the Certificate of Need process under the requirements of New Hampshire RSA Sections 151-C:5 and 151-C:13 must complete Form 301A. Form 301A consists of eight sections that should provide the Office of Health Services Planning and Review ("HSPR") with sufficient information to determine if the proposal meets the requirements for an NSR/exemption determination. The eight sections are:

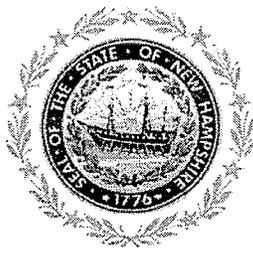
Section I	Identifying Information
Section II	Contact Information
Section III	Project Information
Section IV	Project Costs
Section V	Cost Information
Section VI	Replacement Equipment
Section VII	Additional Information
Section VIII	Affidavit

All portions of Sections I – VIII **must be completed as required**. If any portion is incomplete the application will be returned to you for completion. HSPR recognizes that some of the information requested might not be pertinent to your proposal. If this is the case, please indicate that the question is "Not Applicable."

HSPR requires an original and 15 copies of your completed Form 301A. All pages must be consecutively numbered. Please submit the completed Form 301A to:

Office of Health Services Planning and Review
29 Hazen Drive
Concord, NH 03301-6504

If you have any questions concerning this form, please contact Cynthia Carrier at (603) 271-4606.



For Office Use Only NSR # _____

**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES PLANNING AND REVIEW BOARD
FORM 301A
Not Subject to Review/Exemption Application**

All persons who are requesting an NSR/Exemption from the Certificate of Need process under the requirements of New Hampshire General Statutes, Sections 151-C:5 or 151-C:13, must complete this form and submit it to:

Office of Health Services Planning and Review
29 Hazen Drive
Concord, NH 03301-6504

SECTION I. APPLICANT INFORMATION

All applicants must complete the following.

Full Legal Name: _____

Doing Business
As: _____

Name of Parent
Corporation: _____

Mailing Address: _____
Street City/State/Zip

List of Officers, Managers,
Directors, Trustees and Affiliates: _____
(Attach separate sheet if necessary)

SECTION II. CONTACT INFORMATION

All applicants must complete the following.

Contact Person: _____
Name Title/Position

Telephone: (_____) _____

Email: _____

SECTION III. PROJECT INFORMATION

All applicants must complete the following.

Project Description and Reason for NSR Request:

Check as applicable

<p>(A) <input type="checkbox"/> Project cost does not exceed threshold</p> <p>\$ _____</p> <p>(Indicate facility type)</p> <p><input type="checkbox"/> Acute Care Hospital</p> <p><input type="checkbox"/> Specialty Hospital</p> <p><input type="checkbox"/> Nursing Home</p> <p><input type="checkbox"/> Ambulatory Surgery Center</p> <p><input type="checkbox"/> Outpatient Clinic/Urgent Care</p> <p><input type="checkbox"/> Medical Office Building (MOB)</p> <p><input type="checkbox"/> Non-Health Care Related Project</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>Is this facility currently licensed with the Bureau of Health Facilities Administration?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is/will this facility be leased?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If yes, complete and submit Form 301W)</p>	<p>(B) <input type="checkbox"/> Equipment cost does not exceed threshold</p> <p>\$ _____</p> <p>(Indicate equipment type)</p> <p><input type="checkbox"/> Magnetic Resonance Imaging (MRI)</p> <p><input type="checkbox"/> Positron Emission Tomography (PET)</p> <p><input type="checkbox"/> Radiation Therapy (RT)</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>Is this equipment:</p> <p><input type="checkbox"/> New</p> <p><input type="checkbox"/> Replacement (Also complete Section VI)</p> <p><input type="checkbox"/> Additional</p> <p>Is/will this equipment be leased?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If yes, complete and submit Form 301W)</p>
<p><input type="checkbox"/> Owner of real estate:</p>	
<p><input type="checkbox"/> Date real estate acquired:</p>	
<p>(C) <input type="checkbox"/> Transfer of beds/Transfer of Ownership</p> <p>#Beds Transferred: _____</p> <p>Transfer Cost per Bed: \$ _____</p> <p>Total Transfer Cost: \$ _____</p> <p>Name of Facility Receiving Beds:</p> <p>_____</p> <p>Address: _____</p> <p>_____</p> <p>Does this facility currently have SNF Beds?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>(D) Exemptions:</p> <p>(1) <input type="checkbox"/> Exemption under RSA 151-C:13, I, (a), (b), (c), (d), (g), (i), or (j)</p> <p style="text-align: center;">--OR--</p> <p>(2) <input type="checkbox"/> Not an institutional health service</p>

SECTION IV. COST INFORMATION

CATEGORY	COST	
	New	Renovation
I. Fees		
1) Legal		
2) Consulting		
3) Financial Feasibility		
4) Other		
Total Fees		
II. Real Estate/Moving Costs		
1) Real Estate Acquisition		
2) Value of Leased Property from Form 301W		
3) Temporary Relocation Costs		
4) Moving Costs		
Total Real Estate/Moving Costs		
III. Construction Costs		
1) Architect and Engineering Fees		
2) Site Preparation		
3) Utilities		
4) Soil Survey/Evaluation		
5) Labor/Materials/Fixed Equipment		
6) Insurance Costs during Construction		
7) Interest Cost during Construction		
Total Construction Costs		
IV. Other Construction Costs		
1) Demolition Costs		
2) Contingency Costs		
Total Other Construction Costs		
V. Non-Regulated Equipment Costs		
Non-Regulated Equipment (provide itemized list)		
Total Non-Regulated Equipment Costs		
VI. Financing Costs		
1) Bond Discount		
2) Debt Service Reserve		
Total Financing Costs		
VII. Regulated Equipment Costs		
*Regulated equipment pursuant to RSA 151-C:5, II(d)(1) (Include Value of Leased Equipment from Form 301W)		
* If any single piece exceeds \$400,000 a CON may be required. Contact HSPR for additional information.		

+ TOTAL ALL PROJECT COSTS** \$ _____
 (NOT including regulated equipment costs):

+ (check here if applicable) If a current license holder AND project costs are less than 25% of the current statutory threshold no further sections are required for completion.

** If cost exceeds 75% of current statutory threshold also complete Section VII.

SECTION V. PREVIOUS CAPITAL EXPENDITURES

(within the past 36 months, including equipment acquisition)

Description:	Cost:
(1)	\$
(2)	\$
(3)	\$

SECTION VI. REPLACEMENT EQUIPMENT

Check to confirm.

- Replacement equipment is substantially similar to replaced equipment
- Replacement equipment will be used in the same facility
- Replaced equipment will be removed from service from this facility or that owned by any affiliate

Original value of replaced equipment: \$ _____ Date of Acquisition: _____

Annual new/increased operating costs: \$ _____
(specify/itemize and use additional sheet as necessary)**SECTION VII. ADDITIONAL INFORMATION****For projects exceeding 75% of the statutory threshold, check the following and supply with this form:**

- A comparison of project costs to Marshall Valuation Services, Sections 15, 98 and 99, where applicable, for the proposed class and type of construction, and adjusted for inflation, labor and materials.
- A copy of contracts and/or agreements between the requestor (or authorized representative) and the person(s) performing the services or selling identified equipment and supplies.
- A statement of certification by an architect or contractor stating that the project cost estimate is accurate to the best of that person's knowledge and belief.
- Any stated reasons as to why certain costs are not considered capital expenditures, including the reasons associated with generally accepted accounting principles (GAAP).

SECTION VIII. AFFIDAVIT

To be completed by each applicant.

I, _____, _____,
Name of the authorized representative *Title*

of _____, being duly sworn, depose and state that said facility
Facility Name

complies with all of the criteria described above.

Signature

Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____