



**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES PLANNING AND REVIEW BOARD
FORM 301C
Change of Scope Form and Waiver**

All persons who are requesting a change of scope or waiver of such under the requirements of New Hampshire General Statutes, Sections 151-C:12, IV-a must complete this form and submit 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

SECTION II. CONTACT INFORMATION

All applicants must complete the following.

Contact

Person: _____
Name Title/Position

Telephone: (_____) _____

Email: _____

SECTION III. CURRENT PROJECT INFORMATION

All applicants must complete the following. Use an additional sheet if necessary.

CON #: _____

Approved Cost Amount: \$ _____

Brief description of original project:

Project Commencement Date: _____

CON conditions, if any:

(1)

(2)

(3)

Implementation Report (s) Filed on:

Date: _____

Date: _____

Date: _____

Date: _____

CON # _____

SECTION IV. CHANGE OF SCOPE INFORMATION

All applicants must complete the following.

Description of the Change of Scope:

Revised Total Cost: \$ _____

Net Cost Difference: \$ _____

% Difference: \$ _____

For the following, choose **either** a Change of Scope or a Waiver, **but not both**. Select from one of the columns below and check all that apply in that column:

CHANGE OF SCOPE

WAIVER

- Total project cost will exceed the CON approved amount by more than 15% plus inflation
- Change in location of services/programs/equipment to a different service area or site
- Change of financing method due to cost overruns that exceed 15% plus inflation
- Change in applicant identity
- Additional or eliminated services, programs, or equipment from that previously identified

- Additional or eliminated services, programs, or equipment but:
 - No change to approved CON amount
 - No introduction of any new service/program/equipment to service area
 - No reduction of accessibility from that in original CON application

Complete all remaining sections of application.

Proceed to Section VII for completion of Waiver request.

CON # _____

SECTION V. CHANGE OF SCOPE DETAIL

PART A. NEED

- (1) Describe any anticipated changes affecting the need for the project as compared to the approved CON, with particular focus on:
 - Primary and secondary service areas,
 - Current and projected target populations;
 - Market share;
 - Bed need;
 - Utilization; and
 - Staffing.
- (2) Please address the potential for any detrimental impact of the proposed Change of Scope on any existing area services and programs in terms of new, additional or eliminated programs, services or equipment.
- (3) Please evaluate your project's ability to maintain or improve:
 - Quality of care;
 - Access and availability to health services; and
 - Cost effectiveness of health services provided
- (4) Please evaluate the impact of the proposed project, including the continued ability to:
 - Maintain quality services;
 - Provide essential community services;
 - Provide emergency services; and
 - Provide charity care.

PART B. HEALTH CARE SYSTEM

- (1) Please describe any new community service linkages that will result with the proposed change of scope that were not previously identified in the original CON application.
- (2) Please describe the new anticipated inter- and intra- facility benefits of integrating the change of scope into the existing CON application.

PART C. MEDICALLY UNDERSERVICED POPULATION

- (1) Please identify any new or additional medically underserved population which this Change of Scope is intended to affect from that identified in the original CON application, and explain how the proposal will affect such population. If no change, then please explain how the Change of Scope will be beneficial to the originally identified medically underserved population.
- (2) Please state whether the Change of Scope proposal will affect the nature or scope of the financial assistance plan originally submitted with the original CON application. Re-submit a copy of such plan as necessary.

PART D. QUALITY OF CARE

- (1) How will this Change of Scope affect quality of care from that identified in the original CON application? Please explain and include a copy of any amended quality assurance plan that reflects the Change of Scope proposal.
- (2) Please provide a copy of any updated inspection surveys and reports from State, Federal and accrediting agencies, as applicable for this proposed Change of Scope, that have been received since the filing of the original CON application. Include a copy of any resulting plan of corrective action.
- (3) Does the Change of Scope implement any new quality assurance initiatives? If so, please explain.
- (4) Does the Change of Scope reduce or change any quality assurance initiatives? If so, please explain.
- (5) Describe any construction/renovation requirements that will be amended to accommodate any additional needs to minimize excessive noise, dust, hazards or other problems which may be detrimental to patients, staff and visitors in terms of safety and comfort.

PART E: AFFORDABILITY

- (1) Are sources of funds changing as a result of this amendment? Yes No

If **YES**, please describe the changes and provide a before/after breakdown.

- (2) Please provide all financial statements since the original application was filed and continuing through 3 years after project completion;
- (3) Please provide documentation from the applicant's lender, underwriter or other anticipated source of capital, which includes the financed amount, the rate of interest and term of debt.
- (4) Please discuss the effect the change of scope will have on operating and capital expenses and income for the period immediately prior to, during and for 3 years after the adjusted project completion.
- (5) Please include in your application a financial study indicating that revenues shall be available in sufficient quantity to support the present operating levels, the added operating costs and, if applicable, the added debt service of your facility.
- (6) Please provide a study of the anticipated impact the proposed project will have on costs and charges on your facility by including:
 - (a) Your proposed charges for the project's services for a period of 3 years after project completion; and
 - (b) Your anticipated adjustments to charges for your other health care services as a direct result of the project through the end of the third year following project completion.

- (7) Please provide a schedule of all personnel since the original application was filed and continuing through 3 years after project completion. If the personnel schedule is being amended from that identified in the original CON application, provide a before and after breakdown of such changes.
- (8) Please describe any new or additional anticipated operational cost savings that may occur as a result of the change of scope due to:
- Consolidation of services;
 - Improved heating and maintenance costs;
 - Environmental design of the constructed or renovated space;
 - Space for future expansion; or
 - Other factors not listed above.

PART F: CONSTRUCTION COSTS

For any Change of Scope projects entailing additional construction and/or renovation, please address the criteria, as applicable, for the following:

- For fixed MRI proposals, rule section He-Hea 606.01;
- For comprehensive physical rehabilitation services, rule section He-Hea 703.01;
- For psychiatric inpatient services, rule section He-Hea 803.01;
- For long term care facilities, rule section He-Hea 903.01;
- For acute care facilities, rule section He-Hea 1004 (entire section);
- For adult cardiac catheterization services, rule section He-Hea 1103.01;
- For adult cardiac surgery services, rule section He-Hea 1106.01;
- For ambulatory surgical facilities, rule section He-Hea 1904.01;
- For fixed PET unit services, rule section He-Hea 2006.01;

PART G: PROJECT COSTS

Must be completed by ALL APPLICANTS unless the proposed Change of Scope costs = \$0

CATEGORY	Previously Approved Cost		Adjusted Cost		+/- Difference	
I. Fees						
1) Legal						
2) Consulting						
3) Financial Feasibility						
4) Other						
Total Fees						
II. Real Estate/Moving Costs						
1) Real Estate Acquisition						
2) Temporary Relocation Costs						
3) Moving Costs						
Total Real Estate/Moving Costs						
III. Construction Costs	New	Renovation	New	Renovation	New	Renovation
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. Major Movable Equipment						
1) Major Movable Equipment Costs						
VI. Financing Costs						
1) Bond Discount						
2) Debt Service Reserve						
Total Financing Costs						
VII. Total Project Cost						

PART H: TRAINING

- (1) Does the proposal entail services, programs, or equipment for which additional training may be offered or available for health professionals or health professional schools not previously identified in the application? Please explain.
- (2) Does the proposal remove any existing training opportunities previously identified in the original CON application? If so, please explain.

PART I. PROJECT SUPPORT

Does the proposal entail services, programs, or equipment for which support has not previously been expressed by other health care providers, business industry entities or other interested persons? If so, please supply additional letters of support for the proposal. If not, please explain why not.

SECTION VI. PROJECTED COMPLETION DATE

Projected Completion Date from approved CON or last Implementation Report: _____
month/year

New Anticipated Completion Date: _____
month/year

Does this CoS require an extension to either commence and/or complete? Yes No

If **YES**, a separate Extension Request must be submitted for HSPR Board consideration. See **RSA 151-C:12, IV**

SECTION VII. AFFIDAVIT

All applicants must complete the following.

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

of _____, being duly sworn, depose
Facility Name

and hereby state that said facility complies with all of the criteria described above.

Signature

Date

Subscribed and sworn to before me on _____
month/day/year

Notary Public/Commissioner of Superior Court

My commission expires: _____