|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Virginia Department of Health | | | | | | | | | | | |
| **Division of Certificate of Public Need** | | | | | | | | | | | |
|  |  | | | | |  | | | | | |
| **Report of Compliance**  **Certificate of Public Need Indigent Care and Primary Care Conditions** | | | | | | | | | | | |
|  |  | | | | |  | | | | | |
| Reporting period: |  | | | | | - | | | | | |
|  | Calendar Year | | | | | Fiscal Year | | | | | |
|  |  | | |  | |  | | |  | | |
| Name of conditioned facility: | | |  | | | | | | | | |
|  |  | | |  | |  | | |  | | |
| Conditioned facility address: | | |  | | | | | | | | |
|  | |  | |  | |  | | |  | | |
| Conditioned service: | |  | | | | | | | | | |
|  | | **Report only ONE service per form**, e.g. CT, MRI, cardiac catheterization, surgery, etc… | | | | | | | | | |
|  | |  | |  | |  | | |  | | |
| COPN number(s): | |  | |  | |  | | |  | | |
|  | |  | |  | |  | | |  | | |
| Gross patient revenue from the conditioned service: | | | | | | A | $ |  | | | |
|  |  | | |  | |  |  | |  | | |
| Total dollar value required by the condition: | | | | | | B | $ |  | | | |
| (total conditioned service gross patient revenue x conditioned percent) | | | | | |  |  | |  | | |
|  |  | | |  | |  | | |  | | |
| Total dollar value of charity care provided this period: | | | | | | C | $ |  | | | |
|  |  | | |  | |  |  | |  | | |
| Total number of patients served by conditioned service: | | | | | |  |  | |  | | |
|  |  | | |  | |  |  | |  | | |
| Total number of patients who received charity care: | | | | | |  |  | |  | | |
|  |  | | |  | |  |  | |  | | |
| Conditioned *service* shortfall or (excess): | | | | | | B-C | $ |  | | | |
|  |  | | | | |  |  | |  | | |
| Contributions and/or expenditures made to facilitate the development and operation of primary care: | | | | | | D | $ |  | | | |
|  | | | |
| Per paragraph I.B.1.b. or paragraph I.B.1.c.of the Compliance with Conditions on Certificates of Public Need Guidance Document | | | | | |  |  | |  | | |
|  |  | | |  | |  | | |  | | |
| ***Provide, on a separate sheet, a detailed explanation of qualifying contributions and/or expenditures including the dollar value of each, the date each was made, and to what facility or organization it was made.*** | | | | | | | | | | | |
|  |  | | |  | |  | | |  | | |
| Total value of indigent and primary care contribution: | | | | | | C+D | $ |  | | | |
|  | | | | | |  |  | | | | |
| Total shortfall or (excess) conditioned contribution: | | | | | B-(C+D) | | $ |  | | | |
|  |  | | |  | |  | | |  | | |
| Organization/facility to which contributions and/or expenditures were made: | | | |  | | | | | | | |
|  | | | | | | | |
|  |  | | |  | |  | | |  | | |
| Have the terms of the condition been met? | | | | | | 🞐 | YES | | 🞐 | | NO |
|  | | | | | | | | |  | | |
|  | | |
| Signature: |  | | | | | | | |  |  | |
|  | Company Officer, Managing Partner or Manager, Auditor or Owner | | | | | | | | Date | | |
|  |  | | |  | |  | | |  | | |
| Report of Compliance |  | | |  | |  | | | Revised 2/2/04 | | |