Iowa Department of Public Health

IDPH
IOWA Department of PUBLIC HEALTH

APPLICATION FOR CERTIFICATE OF NEED

Health Care Facility – ICF/PMI

READ THE ENTIRE APPLICATION FORM PRIOR TO COMPLETING THE QUESTIONS

OVERVIEW

1. Applicant Name: ____

2. Name of Facility:____

3. Address:____
   Street City County Zip

4. Person responsible for this project:____

   Telephone:__________________________

   E-mail:____

5. Type of ownership: Proprietary _____ Nonproprietary _____

6. Attach a list of names and addresses of all persons holding ten (10) percent or more interest in the facility.

7. Provide an overview of the ownership structure of the facility, including the parent company/owner if applicable.

8. Describe the sponsoring or managing organization. What experience and expertise does it have in programming for people with mental illness?

9. Will the facility be leased? Yes _____ No _____

   If yes, to/from whom ___________________________
   Monthly Cost ___________
   Term ________
   Total cost of a one year lease__________

Attach a schedule of leases associated with the proposed project. Indicate the term of lease, monthly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.

10. Will any of the equipment be leased? Yes _____ No _____

If yes, what equipment (list) ________________
Monthly Cost ___________
Term ________
Total value of the lease including sales tax, delivery and installation__________

Attach a schedule of leases associated with the equipment. Indicate the term of lease, monthly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.

11. If the facility is incorporated, attach a list indicating name, address and position of each corporate officer.

12. Name of administrator: __________________________________

DESCRIPTION OF PROJECT

13. Provide a narrative description of the proposed project, including background information about the applicant.

14. Indicate anticipated date for:

Completion of Construction/Modification __________________

Offering of Services __________________

15. Do you have a long-range development plan? Yes _____ No_____

If yes, attach a copy and describe the relationship of the proposed project to the long-range plan.

16. Identify any agencies, organizations, groups, or individuals who provided consultation or other input into this project. Identify the impact of the input where appropriate.

17. If the proposed project involves a change in beds, specify:

	Present # of Licensed Beds	# to be Replaced	# of New Beds	Total # in Completed Project
ICF/PMI	______	______	______	______
TOTAL	______	______	______	______

18. If the proposed project involves new construction, renovation or expansion of the facility, fill out Exhibit 1, indicating square footage of the project by functional area.

    18a. Explain your rationale for the space allocated and why you believe it is adequate.
    18b. Provide a schematic of the facility.

19. Describe in detail your contact with such regulatory entities as the state fire marshal, Department of Inspections and Appeals, and city zoning commission for approval of your project. With whom at these entities did you correspond? Provide copies of any correspondence with these entities.

20. Describe how you will adhere to current Life Safety Codes.

NEED DETERMINATION

21. In detail, describe the need for the proposed project.

22. Describe what you consider to be the geographic service area for this proposed project. List the county (counties) of residence for the clients you expect to serve. In what MHDS region will your facility be located?

23. Describe what you identify to be the existing or target patient population for this project in the area described. (Do not provide any personally identifying information or personal health information.)

24. If you have identified specific people to become residents, indicate the number, their county of residence, their current living and care arrangements and the degree of certainty that they will actually move in. (Do not provide any personally identifying information or personal health information.)

25. If you have not identified specific people likely to become residents, please elaborate upon your prospective source of clients, why you feel certain that your facility will be fully utilized.

26. As applicable, attach copies of reports or citations received from regulatory agencies or accrediting bodies which indicate that the proposed project is necessary to enable your facility or service to achieve or maintain compliance with federal, state, or other appropriate licensing, certification, or safety requirements.

27. Describe the current conditions that favor the occupancy or sustainability of the proposed facility.

28. If applicable, report the dates of your last three inspections by the Department of Inspections and Appeals and state how many deficiencies were cited. Did any deficiencies result in citations? If so, briefly describe.

29. Fill out attached Exhibits 2-A and 2-B, specifying, by level of care and payment source, the following:

2-A. historical utilization statistics for each of the three most recent years (as applicable) and;
2-B. forecasted utilization statistics for each of the three years after the service is offered. Assumptions used in developing the forecast should also be listed and supported.

30. If the proposed project involves replacement of facilities and/or equipment, describe the age, condition, life expectancy and intended use or disposition of the facilities and/or equipment being replaced.

31. On an attachment, list the names and addresses of providers of the service similar to the one for which you are seeking approval and serving the geographic service area and patient population(s) identified in Q. 22 and Q. 23. Discuss the projected impact of the proposed project on each concerning utilization, market share and financial status.

32. As part of the public notice requirement, send a letter to each ICF/PMI service provider in your area stating that you are applying for a certificate of need and briefly describing your project. Attach a copy of the letter to this application.

33. Describe what arrangements between your facility and other health care facilities have been made or proposed to refer patients, share services, and coordinate programs related to the proposed project.

PERSONNEL

34. What is your intended staff to resident ratio? _____________

35. Specify your existing and forecasted full-time equivalents (FTEs):

Department		Current	Forecasted
Administrative		_______	_______
Psychiatric		_______	_______
Nursing:	RN	_______	_______
	LPN	_______	_______
	Aide's	_______	_______
Dietary		_______	_______
QMHP		_______	_______
Housekeeping/Laundry		_______	_______

Resident Aide's	_______	_______
Activities	_______	_______
Other (specify)	_______	_______
TOTAL FTE'S	_______	_______

36. If additional personnel will be needed as a result of the proposed project, describe either what evidence there is that these personnel will be available, or the plans your facility has for recruiting and employing them.

37. Describe plans for providing training and experience to new and existing personnel. Address legal limitations of professional practice.

FINANCIAL FEASIBILITY

37. List the daily rates presently charged and the proposed rates when service is offered.

Level of Care	Present Rate	Proposed Rate
ICF/PMI	________	________

38. Attach a statement indicating present and/or proposed charges for "add-ons" or miscellaneous. Attach a list specifying items and costs.

39. Fill out Exhibit 3, specifying estimated project costs and estimated depreciation. If the assets included in a line-item category are depreciated by differing lives, provide a footnote explanation of the useful lives being used.

40. Indicate the source of funds for the project costs.
(Attach a description of asterisked items.)

SOURCE OF FUNDS	Estimated Amount
Cash on Hand	$_________
Borrowing*	_________
Gifts and Contributions	_________
Lease	_________
Federal Funds*	_________
State Funds*	_________
Other*	_________

Total Source of Funds $_________

To support the debt portion, attach a letter from the lender or financial institution indicating the probable terms of the borrowing or from the underwriters or the bond financial consultants indicating the probable terms of the bond indenture.

41. Attach a table listing new equipment (if any) for the proposed project and the manner of acquisition (purchase, lease etc.).

42. Attach a description of existing debt. This description should include:

A. Terms of Debt

1. Face Amount
2. Interest
3. Payment period
4. Restrictions on additional debt
5. Prepayment
6. Other restrictions or requirements

B. Is the existing debt going to be refinanced? Yes_____ No_____
Is debt incurred to meet project costs going to be refinanced?
Yes _____ No _____ For Yes, attach statement describing:

1. Amount to be refinanced; and
2. Terms of refinancing.

C. Attach annual debt service schedules for: 1) debt incurred to meet project costs: and 2) any debt existing at completion of the proposed project. Use the following format:

	Year	Principal	Interest	Annual Debt Service
1st payment to final payment				

43. If applicable, attach audited financial statements and notes to the financial statements for the most recent three years.

44. Will there be an operating deficit as a result of the project?

Yes _____ No _____ If Yes, First Year $_________
Second Year $_________
Third Year $_________

Breakeven point in time, if any
(If later than three (3) years)____________

45. Describe how your facility has allowed for start-up funds.

46. On an attachment, provide a forecast of revenues and expenses for each year of the first three years after the service is offered. Include a list of assumptions used in the forecasts and support for the assumptions.

47. What will be the sources of this operating revenue and why do you feel assured of receiving it?

48. Describe the day programs your clients will use, and state what the cost per day is for those services. Attach a letter from these organizations stating they can absorb your clients.

OTHER CRITERIA

49. Explain how the proposed project will contribute to meeting the needs of the medically underserved, including persons in rural areas, low-income persons, racial and ethnic minorities, and persons with disabilities.

50. Describe what potentially less costly or more appropriate alternatives to the proposed project including but not limited to staffing, scheduling, design service sharing, etc., were considered and rejected. Specify the reasons therefor.

51. Describe what impact the proposed project will have on the distance, convenience, cost of transportation, and accessibility to health services for persons who live outside metropolitan areas.

52. Explain how existing facilities providing institutional services similar to those proposed are being used in an efficient and appropriate manner.

53. Describe how patients will experience serious problems obtaining care of the type proposed in the absence of the proposed service.

CERTIFICATION

I, the undersigned, certify that:

I have read chapter 135.61-83, Code of Iowa and the Administrative Rules (641 IAC 202 and 203) promulgated pursuant thereto, and

I have read this application, including all exhibits and attachments, and the information therein is, to the best of my knowledge and belief, accurate and true.

______________________________	______________________________
Signature of Owner or Chairperson, Board of Directors	Printed Name
______________________________	______________________________

Position or Title Date

If you wish to designate an official representative to act on your behalf, as addressee for written notifications and to speak for you before the Health Facilities Council, specify below:

Name ____

Agency ____

Address ____

Phone ____

Email ____

EXHIBIT 1

SQUARE FOOTAGE CHART

Name of Functional Area*	Present Square Feet	Square Feet to be Constructed/ Renovated	Total Square Feet
TOTALS			

*Examples of functional areas (nursing stations, lab, physician's office, lobby, medical records, etc.)

Exhibit 2-A

Facility Utilization - Historical

ICF/PMI	Year 20___			Year 20___			Year 20___		
	Pri.	St.	Total	Pri.	St.	Total	Pri.	St.	Total
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___

Exhibit 2-B

Facility Utilization – Forecasted

ICF/PMI	Year 20___			Year 20___			Year 20___		
	Pri.	St.	Total	Pri.	St.	Total	Pri.	St.	Total
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___

Pri. = Private Pay Residents

St. = State Assisted Residents

Exhibit 3
Estimate Application of Funds and Estimate Depreciation

Application of Funds	Estimated Amount	Estimated Average Useful Life	Estimated First Year Depreciation
1. Site Costs:			
Site Acquisition	$__________		
Demolition of Existing Structures	$__________		
Site Preparation	$__________		
Other (Specify)	$__________		
Subtotal	$__________		
2. Land Improvements (Specify)	$__________		

____
____

Application of Funds	Estimated Amount	Estimated Average Useful Life	Estimated First Year Depreciation
3. Construction Costs (all areas must meet current applicable Life Safety Codes):			
General (Construction Shell)	$__________	__________	__________
Heating, Ventilating, A/C	$__________	__________	__________
Plumbing	$__________	__________	__________
Electrical	$__________	__________	__________
Elevator	$__________	__________	__________
Other Fixed Equipment	$__________	__________	__________
Architectural	$__________	__________	__________
Construction Management, Supervision, Engineering, Testing, Inspection	$__________	__________	__________
Other (Specify)	$__________	__________	__________
Subtotal	$__________	__________	__________
4. Movable Equipment (list each item and its cost)	$__________	__________	__________

5. Equipment Lease (list each item and its cost)

Total value including sales tax, delivery and installation

Annual Cost $__________

6. Land Lease

Annual Cost $__________

7. Facility Lease

Total cost of a one year lease

Annual Cost $__________

8. Financing Costs:

Underwriters' Discount	$__________
Pricing Discount	$__________
Feasibility, Legal, Printing & Other	$__________

Interest Expense During Construction	$__________
Less Interest Earned During Construction	$__________
Other (Specify)	$__________
Subtotal	$__________
TOTAL PROJECT COSTS	$__________

Other Applications:

Debt Service Reserve Account	$__________
Other (Specify)	$__________
Subtotal	$__________
Total Application of Funds	$__________