Iowa Department of Public Health

APPLICATION FOR CERTIFICATE OF NEED

Health Care Facility – NF/SNF

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. List 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. 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.

9. 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.

10. If the facility is incorporated, provide a list of the name, address and position of each corporate officer.

DESCRIPTION OF PROJECT

11. Provide a narrative description of the proposed project, including background information about the applicant and/or facility.

12. Indicate anticipated date for:

Completion of Construction/Modification _____

Offering of Services _____

13. Do you have a long-range development plan? Yes___ No___

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

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

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

	Present # of Licensed Beds	# to be Replaced	# of New Beds	Total # in Completed Project
SNF/NF	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

16. 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.

16a. Explain your rationale for the space allocated and why you believe it is adequate.
16b. Provide a schematic of the facility.

17. 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.

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

NEED DETERMINATION

19. In detail, describe the need for the proposed project and the methodology that was utilized.

20. Identify and discuss the factors which support the need for the proposed project.

21. Describe what you consider to be the geographic service area for the proposed project.

22. Describe what you identify to be the existing or target patient population (e.g., age range, average length of stay, abilities, etc.) for this project in the area described. As applicable, indict if you have a waiting list for beds (note how many are on the list) and how long the wait is.

23. Describe the other services available to the population you plan to serve, including, but not limited to, assisted living, hospice and home health, available in the geographic service area of the proposed project.

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

25. If the project includes an increase in beds in the service area, describe the methodology (beyond the State Bed Need formula) utilized to arrive at the number of beds to be added.

26. Will the facility be dually certified for Medicare and Medicaid? Yes _____ No _____
How many licensed beds are (or will be) certified for Medicaid? _____

27. If applicable, attach a table or statement indicating volume of admissions related to the proposed project by patient origin (county of residence) for each of the three (3) most recent years.

28. Does the proposed project conform to the State Bed Need formula?

    Yes _____ No _____

    If yes, how many beds remain under the current formula for the county in which the proposed project will be located and its contiguous counties? _____
    (Contact the Certificate of Need Program, 515-218-4969)

29. 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.

30. 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.

31. 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.

32. Attach a list of the names and addresses of facilities providing nursing or skilled nursing services and serving the geographic service area and patient population(s) identified in Q. 21 and Q. 22. Discuss the projected impact of the proposed project on them concerning utilization, market share and financial status.

33. As part of the public notice requirement, send a letter to each nursing facility in the county stating that you are applying for a certificate of need and briefly describing your project. Attach a copy of the letter to this application.

34. 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

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

Department		Current	Forecasted
Administrative		_____	_____
Nursing:	RN	_____	_____
	LPN	_____	_____
	Aide's	_____	_____
Dietary		_____	_____
Housekeeping		_____	_____
Laundry		_____	_____
Maintenance		_____	_____

Activities	_____	_____
Other (specify)	_____	_____
TOTAL FTE'S	_____	_____

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

FINANCIAL FEASIBILITY

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

Level of Care	Present Rate	Proposed Rate
Nursing	_____	_____

38. Indicate 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. What is the average cost per bed (turn key basis)? $_____
(Total Project Costs / Number of Increased Beds)

41. 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.

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

43. 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				

44. Attach audited financial statements and notes to the financial statements for the most recent three years.

45. 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) _____

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

47. 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.

OTHER CRITERIA

48. Describe 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, persons with disabilities and the elderly.

49. 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.

50. 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.

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

52. 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

Nursing	Year 20___ Pri.	St.	Total	Year 20___ Pri.	St.	Total	Year 20___ Pri.	St.	Total
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___

Exhibit 2-B

Facility Utilization – Forecasted

Nursing	Year 20___ Pri.	St.	Total	Year 20___ Pri.	St.	Total	Year 20___ 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)	$_____		
_____			
_____			
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	$_____