Iowa Department of Public Health

APPLICATION FOR CERTIFICATE OF NEED

Organized Outpatient Health Facility/CMHC

READ THE ENTIRE APPLICATION FORM PRIOR TO COMPLETING THE QUESTIONS

1. Applicant Name ____

2. Name of Facility ____

3. Address ____
   Street City County Zip

4. Person responsible for this project ______________________________

   Telephone ______________________ FAX ______________________

   E-mail: ______________________

5. Type of ownership: Proprietary _____ Nonproprietary _____

6. Will the sponsor/owner be the operator? Yes _____ No _____

   If no, give name of operator or management firm: ______________________

7. 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.

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

   If yes, what equipment ____________________
   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.

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

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

10. Name of Administrator, Director or CEO:_____________________________________

DESCRIPTION OF PROJECT

11. Provide a narrative description of the proposed project (e.g., Does this involve constructing, remodeling, purchasing or leasing of a building? What are the services that will be provided? Etc.)

12. Fill out Exhibit 1 to indicate the total square footage of space planned and divide this into clinical patient treatment and exam areas, office, administration, and indirect service areas such as corridors and mechanical space.

    12a. Explain your rationale for the space allocated and why you believe it is adequate.
    12b. Provide a schematic of the facility

13. 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 physical building. With whom at these entities did you correspond? Provide copies of any correspondence with these entities.

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

15. Is there accreditation for the services provided by the proposed project? If so, identify the accreditation organization and state whether or not you will seek accreditation. What are the associated costs?

16. For applicable items, indicate anticipated date for:

Completion of Construction/Modification ________________________

Offering of Services ________________________

NEED DETERMINATION

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

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

19. On an attachment, provide for the proposed service and for relevant ancillary services:

    19a. Historical utilization statistics for each of the most recent three years, if applicable.

    19b. Expected utilization statistics for each of the first three (3) years after the proposal is operational (list assumptions used).

20. Describe what you consider to be the geographic service area for this project?

21. Describe what you identify to be the target patient population

22. Where are the area residents now receiving these services? Provide the names and addresses of other similar providers located in the geographic area noted in Q. 20. What volume of service are others providing?

23. What will be the impact of your proposal on the service volume of other providers? Please explain your assumptions.

24. State any other indicators of community need for this proposal.

25. As part of the public notice requirement, send a letter to each organized outpatient service provider 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.

PERSONNEL

26. Attach a list of the medical/professional staff, by specialty, who will supervise the operation of the project. If certain physicians/professionals have particularly relevant experience or interests, please elaborate. Which of these physicians/professionals will normally be on the premises during operating hours?

27. What arrangements between your program and other health care providers have been made or are being proposed to refer emergencies, share services, and provide backup? Attach a copy of any formal agreements.

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

Department		Current	Forecasted
Administrative		_______	_______
Physician(s)/Professional		_______	_______
Nursing:	RN	_______	_______

LPN	_______	_______
Aides/Orderlies	_______	_______
Therapists (specify type)	_______	_______
Other (specify)	_______	_______
TOTAL FTE'S	_______	_______

29. If new/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.

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

FINANCIAL FEASIBILITY

31. What do you propose to charge for services? What are the charges for similar services from other providers in your area? Please elaborate regarding comparability of service and any cost savings involved (i.e., if the physician fee is included in your charge it should be included in area wide charge comparisons).

32. Attach a budget for each of the first three years of operation. Project revenue and expenses, and comment on variable line items that could be cut if revenue does not meet expectations.

33. By source, indicate the percentage breakdown of total patient revenues for your facility.

Private Pay	______________
Medicare	______________
Medicaid	______________
BC/BS	______________
Other private insurance	______________
Other (specify)	______________
TOTAL	______________

34. Describe the liability insurance you propose to carry, along with any other information which substantiates that your project will either be financially viable or will have adequate subsidy to assure reasonable patient charges.

35. Fill out Exhibit 2 to itemize capital costs and anticipated depreciation. If your project does not expect to include depreciation and interest expense reimbursement through Medicare, Medicaid or other insurer, please explain briefly how this cost will be recovered (through patient charges, owner's income taxes, etc.)

36. What will be the source of capital funds? Attach a description of asterisked items.

	Estimated Amount
Cash on Hand	____________________
Borrowing*	____________________
Federal Funds*	____________________
State Funds*	____________________
Gifts/Contributions*	____________________
Lease**	____________________
Other (specify)	____________________
TOTAL	____________________

*For borrowed funds, please attach a letter from the bond consultant or the lender, indicating the probable terms. Also <u>attach an amortization schedule</u> for the life of the loan, showing the total debt service per year and the portion of each payment that is principal and which part is interest.

**Attach a copy of proposed lease.

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

38. 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				

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

40. 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) _____________

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

42. 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.

<u>OTHER CRITERIA</u>

43. 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.

44. 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.

45. 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.

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

47. 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:

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

2) 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 ______________________________

Telephone ______________________________

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
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	$__________