IOWA | Department of Inspections, Appeals, & Licensing

Application For Certificate of Need

ACQUISITION OF EQUIPMENT

READ THE ENTIRE APPLICATION FORM PRIOR TO COMPLETING THE QUESTIONS.
When complete return to Rebecca Swift at rebecca.swift@dia.iowa.gov

** Please note: If you are initiating Cardiac Catheterization Services, or Radiation Therapy Services applying ionizing radiation for the treatment of malignant disease using megavoltage external beam equipment, complete the "Initiation of Services" application form.

Check one:

_____ New Unit (including mobile to stationary)

_____ Additional Unit

_____ Replacement Unit

OVERVIEW

1. Applicant Name:_____

2. Name of Facility:_____

3. Address:_____
   Street City County
   Zip

4. Person responsible for this project:_____

   Telephone:_____ FAX:_____

   Email:_____

5. Describe the type of equipment, including anticipated manufacturer and model, and its estimated cost, including any construction or facility modifications needed and associated costs.

6. If the applicant is a group or partnership (or a member of one), attach a list of the names of the members and specialties of each. Identify those members who will be directly involved in the professional use of the proposed piece of equipment.

DESCRIPTION OF THE PROJECT

7. Provide a narrative description of the proposed project, including the effect the unit will have on the quality of care provided patients. Include information about any construction or facility modification that will be necessary to accommodate the equipment.

8. If applicable, describe the manufacturer, age, condition, life expectancy and intended use or disposition of the equipment being replaced.

9. If applicable, describe the technological advances provided by the replacement or additional unit. Also describe any new capabilities the replacement or additional equipment will provide.

10. Indicate the anticipated start date for the offering of services utilizing the equipment.

NEED DETERMINATION

11. Describe what you consider to be the geographic service area for this project, including population estimates for that area.

12. Describe whom you identify to be the target patient population for this project in the area described in Question #11.

13. Describe how patient satisfaction and outcomes would be improved as a result of the acquisition of equipment.

14. Describe the need for the proposed project, include specific community problems or unmet needs this project would address. Indicate the methodology, assumptions and data used in your determination.

15. NEW EQUIPMENT - Attach a table or statement indicating the projected number of patients related to the service to be provided by the proposed project, by county of residence, for each of the three years after the service is offered. Include a list of assumptions used in this forecast and support for the assumptions.

16. ADDITIONAL OR REPLACEMENT EQUIPMENT - On an attachment, provide the following information related to the use of the equipment.

    16a. Relevant historical utilization data for each of the three (3) most recent years; and

    16b. Relevant expected utilization data for each of the three (3) years following the acquisition of the equipment.

17. On an attachment, list the names and addresses of facilities using equipment similar to that for which you are seeking a certificate of need and serving the geographical service area and patient population(s) identified in Questions #11 and #12.

18. 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.

19. Describe how the acquisition of this equipment relates to your facility's long term development plan.

20. Thoroughly describe how the proposed equipment conforms to the relevant standards in 641 IAC 203 (Standards for Certificate of Need review). See https://idph.iowa.gov/cert-of-need for more information. Add an attachment if needed.

21. For additional units, document compliance with the utilization standard. If not achieved, provide documentation to justify the additional unit.

22. As part of the public notice requirement, send a letter to each hospital or free standing facility (or other entity) in the county that is using similar equipment stating that you are applying for a certificate of need and briefly describing your project. Attach a copy of the letter to this application.

AVAILABILITY OF PERSONNEL

23. Describe in detail any changes in staffing produced by this project.

24. 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 you have for recruiting them.

25. Describe the training and experience of the personnel who will make professional use of the proposed piece of equipment.

FINANCIAL FEASIBILITY

26. Indicate the manner of acquisition, the estimated purchase price of the equipment or fair market value if leased, and the estimated useful life.

27. Will the equipment be leased? Yes _____ No _____

27a. If the equipment will be leased, attach a schedule of the lease associated with the proposed project. Indicate the term of lease; the total value of the lease including sales tax, delivery and installation; any prepayments; and if the lease is renewable and/or if there is a purchase option.

28. Indicate the amounts for project financing by the following breakdown. Attach a description of asterisked items.

Source of Funds	Estimated Amount
Cash on Hand	_____
Borrowing *	_____
Gifts and Contributions	_____
Lease	_____
Other *	_____

Total Source of Funds _____

To support the debt portion, attach a letter, if applicable, from the lender indicating the probable terms of the borrowing.

29. Fill out Exhibit 1, 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.

30. Provide a narrative statement indicating what the patient charges for the proposed project will be. Describe in detail what increases will be necessary, how charge determinations were made, and how the proposed project will be cost effective. If no patient charge increases are contemplated, specify how all relevant costs will be covered.

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

Yes _____ No_____ If Yes, First Year $_____
Second Year $_____
Third Year $_____

Break-even point in time, if any (if later than 3 years) _____

32. If applicable, attach a copy of your most recent balance sheet.

OTHER CRITERIA

33. 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.

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

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

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

37. 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/or to speak for you before the Health Facilities Council, specify below:

Name _____

Agency _____

Address _____

Phone _____

Email _____

EXHIBIT I

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	$_____