IOWA | Department of Inspections, Appeals, & Licensing

Application For Certificate of Need

BIRTHING CENTER

READ THE ENTIRE APPLICATION FORM PRIOR TO COMPLETING THE QUESTIONS

When complete, please return to Rebecca Swift at Rebecca.swift@dia.iowa.gov

1. Name of Applicant_____

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 _____
   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 _____
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.

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

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

11. Name of Administrator, Director or CEO:_____

DESCRIPTION OF PROJECT

12. Provide a narrative description of the proposed project.

13. 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.

    13a. Explain your rationale for the space allocated and why you believe it is adequate.

    13b. Provide a schematic of the facility.

14. Describe in detail your contact with entities such as the state fire marshal's office 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.

15. As applicable, describe how you will adhere to current Life Safety Codes and accreditation regulations or standards, such as the Commission for the Accreditation of Birthing Centers or the American Association of Birth Centers. Will you seek accreditation? What are the associated costs?

16. Indicate anticipated <u>date</u> 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. On an attachment, provide for the proposed service and for relevant ancillary services:

    18a. Historical utilization statistics for each of the most recent three years, if applicable.

    18b. Expected utilization statistics for each of the first three (3) years after the proposal is operational (list assumptions used).

19. What do you consider to be the geographic service area for this project?

20. Where are area residents now receiving these services? What other obstetric providers are located in this geographic area? What volume of service are others are providing?

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

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

PERSONNEL

23. Attach a list of the professional staff (e.g., Certified Nurse-Midwives, Certified Professional Midwives, Physicians, etc.) who will supervise the operation of the project. If certain staff have particularly relevant experience or interests, please elaborate. Which of these staff will normally be on the premises during operating hours?

24. 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.

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

Department	Current	Forecasted

Administrative		_____	_____
Physician(s)		_____	_____
Certified Nurse Midwives		_____	_____
Certified Professional Midwives		_____	_____
Licensed Midwives		_____	_____
Nursing:	Other ARNP	_____	_____
	RN	_____	_____
	LPN	_____	_____
	Aides/Orderlies	_____	_____
Other (specify)		_____	_____
TOTAL FTE'S		_____	_____

26. 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.

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

FINANCIAL FEASIBILITY

28. 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 a professional fee is included in your charge it should be included in area wide charge comparisons).

29. 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.

30. 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 _____

31. Provide a description of 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.

32. 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 and Blue Cross, please explain briefly how this cost will be recovered (through patient charges, owner's income taxes, etc.)

33. 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 attach an amortization schedule 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.

34. Attach audited financial statements and notes for each of the most recent years. Attach a balance sheet forecasting after three years of operation.

OTHER CRITERIA

35. 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.

36. 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.

37. 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.

38. Explain how existing facilities providing institutional services similar to those proposed are not being used in an efficient and appropriate manner, thus necessitating this project.

39. 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 _____

Organization _____

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)	$_____		
_____			
_____			
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)			
Annual Cost	$_____		
6. Land Lease			
Annual Cost	$_____		
7. Facility 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	$_____