IOWA | Department of Inspections, Appeals, & Licensing

Application For Certificate of Need

INITIATION OF SERVICES

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

Select the type of service for which you are applying:

_____ Cardiac Catheterization
_____ Open Heart Surgery
_____ Organ Transplantation
_____ Radiation Therapy

OVERVIEW

1. Applicant Name
_____

2. Name of Facility_____

3. Address_____
Street City County
Zip

4. Person responsible for this project_____

Telephone_____

E-mail_____

5. Estimated Cost of the project (include all relevant equipment)
_____

6. Indicate the estimated date for:
Project Completion _____

Offering of Services _____

PROJECT DESCRIPTION

7. Provide a detailed description of the project, include background information about the applicant.

8. Do you have a long-range development plan? Yes _____ No _____

   If yes, describe the relationship of the proposed project to the long range plan. Provide a statement describing the procedure by which the long-range plan was developed.

9. If the proposed project includes new construction, renovation or expansion, fill out Exhibit 1.

   9a. Provide schematic drawings for the proposed project.

NEED DETERMINATION

10. Describe in detail the need for the proposed project, including the need of the population to be served by this project. Indicate the methodology, assumptions and data used in your determination.

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

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

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

14. List the names and addresses of facilities providing services similar to the one for which you are seeking a certificate of need and serving the geographical service area and patient population(s) identified in Questions #12 and #13.

15. Describe the relationship of your facility and the proposed service to the existing health care system of the area in which the new service is proposed to be provided.

16. 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.

17. If applicable, attach copies of any 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.

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

19. If applicable, thoroughly describe how the proposed new service 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.

20. As part of the public notice requirement, send a letter to each hospital and free standing facility in the county that is providing a similar service 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

21. Describe in detail the staffing needs produced by this project and by related changes in any clinical, ancillary, and support service affected by this project.

22. Provide a list of professional positions that will staff this project.

23. 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 them.

FINANCIAL FEASIBILITY

24. Attach a statement listing new equipment for the proposed project and the manner of acquisition (purchase, lease, etc.).

    24a. If applicable, attach a schedule of leases associated with the equipment for the proposed project. Indicate the type of equipment, term of lease; 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.

25. 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 other insurers, please explain briefly how this cost will be recovered (through patient charges, owner's income taxes, etc.).

26. Indicate the source of funds for project costs. Attach a description of asterisked items:

SOURCE OF FUNDS	Estimated Amount
Cash on Hand	_____
Borrowing *	_____
Federal Funds *	_____
State Funds *	_____
Gift and Contributions	_____
Lease	_____
Other *	_____
Total	_____

27. If debt is going to be used as a source of financing for the proposed project or if the cost of the proposed project will be equal to at least three (3) percent of the prior fiscal year's total operating revenues for your facility, 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 (e.g., reserves)

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/ final payment				

28. Describe what the patient charges for the proposed project will be (including room rates if applicable). Describe in detail what increases will be necessary, how charge determinations were made, and how the project will be cost effective. If no patient charge increases are contemplated, specify how all relevant costs will be covered.

29. Indicate the percentage breakdown by source of total patient revenue:

	Currently	After Offering of Service
Private Pay	_____	_____
Medicare	_____	_____
Medicaid	_____	_____
BC/BS	_____	_____
Other Private Insurance	_____	_____
Other	_____	_____
TOTAL	_____	_____

30. Attach a statement indicating the average cost per patient day for each of the three most recent years. In the case of a hospital-based service, use Medicare principles and derive figures from the Medicare Cost Statement.

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

Yes _____ No _____ If Yes: First Year $_____
Second Year $_____
Third Year $_____

Breakeven point, if any
(If later than three years) _____

32. Describe how your facility has allowed for startup funds.

33. On an attachment, provide, for the proposed service as well as for any clinical, ancillary, and support service affected by this project, forecasts of revenue and expense for each of the three years after the service is offered. Include a list of the assumptions used in the forecasts and support for the assumptions.

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

35. Attach any studies that were done to support the need for and financial feasibility of the proposed project.

OTHER CRITERIA

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. Provide data and arguments which will assist the reviewers in assessing the proposed project in terms of the impact of the project upon the distance, convenience, cost of transportation and accessibility to health services for persons who live outside metropolitan areas.

38. 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.

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

40. 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 hereto, 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: _____

Phone: _____

Email: _____

EXHIBIT I

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)			
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	$_____