

# APPLICATION FOR CERTIFICATE OF NEED

## HOSPITALS

1. Name of Facility \_\_\_\_\_
2. Address \_\_\_\_\_  
Street City County Zip
3. Person responsible for this project \_\_\_\_\_  
Telephone ( ) \_\_\_\_\_ FAX: \_\_\_\_\_

### DESCRIPTION OF PROJECT

4. Attach a narrative description of the proposed project.
5. For applicable items, indicate anticipated date for:
- Start of Construction \_\_\_\_\_
- Completion of Construction \_\_\_\_\_
- Offering of Services \_\_\_\_\_
6. Do you have a long-range development plan? Yes \_\_\_\_\_ No \_\_\_\_\_
- If Yes, attach a statement describing the relationship of the proposed project to the long-range plan, if any. Also attach a statement describing the procedure by which the long-range plan (was) or (is being) developed. Identify the participants.
7. Attach a forecasted capital budget for three years which includes the proposed project.
8. If the proposed project includes new construction, renovation or expansion, fill out Exhibit 1, indicating square footage of the functional area.
9. If the proposed project involves a change in beds, fill out Exhibit 2 indicating:
- A. Bed change by type of bed and type of service;
- B. Historical utilization statistics for each of the three most recent years; and

- C. Forecasted utilization statistics for each of the first three years after the service is offered.

### **NEED DETERMINATION**

10. Attach a statement describing what you consider to be the geographic service area for this project. Also attach a statement describing what you identify to be the existing or target patient population for this project in the area described.
11. If the proposed project involves an expansion, modernization, or replacement of an existing facility, attach a table indicating volume of admissions related to the proposed project by patient origin (county of residence) for each of the three most recent years.
12. Attach a statement describing the need for the proposed project. Specify the methodology, assumptions, and data used in your determination.
13. 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.
14. If the proposed project involves replacement of facilities and/or equipment, attach a statement describing the age, condition, life expectancy and intended disposition of the use of facilities and/or equipment being replaced.
15. On an attachment, list the names and addresses of other affected or potentially affected providers of the service similar to the one you are seeking a certificate of need and serving the patient population(s) identified in Question #10. For each of these providers, specify the following data and your efforts to obtain it. Or, if the following data could not be obtained, describe your efforts to obtain it (e.g., attach copies of letters of request for information):
  - A. Relevant historical utilization data for each of the three (3) most recent years; and
  - B. Relevant expected utilization data for each of the three years following initiation of the proposed service.
16. Attach a statement describing 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. Attach copies of any formal agreements.

### **AVAILABILITY OF PERSONNEL**

17. Attach a statement describing in detail any changes in staffing produced by this project and produced by related changes in any clinical, ancillary, and support service affected by this project.
18. If additional personnel will be needed as a result of the proposed project, attach a statement describing either what evidence there is that these personnel will be available, or the plans your facility has for recruiting them.
19. Attach a list of the medical staff associated with the department in which the proposed project will be located and with each clinical, ancillary or support service affected by the proposed project. If a change in beds is involved in the project, list the entire medical staff. On this list, provide the following information for each medical staff member:
  - A. Name
  - B. Specialty (Indicate whether Board certified, Board eligible or self declared)
  - C. Staff Status
  - D. Age
  - E. Total admissions and total patient days for each of the most recent two years.

### **FINANCIAL FEASIBILITY**

20. 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.
21. Does your facility plan to fund a depreciation account for this project?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
  
If Yes, attach a statement describing what will be the source of depreciation funds.  
If No, attach a statement of explanation.
22. Attach a statement listing new equipment (if any) for the proposed project and the manner of acquisition (purchase, lease, etc.).
23. Attach a schedule of leases, if any associated with the proposed project. Indicate the type of equipment, term of lease, yearly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.
24. Attach audited financial statements and notes to the financial statements for each of the most recent three years.
25. Attach a copy of your anticipated balance sheet for the year the proposed project will be completed.

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

<u>SOURCE OF FUNDS</u>	<u>Estimated Amount</u>
Cash on Hand	\$ _____
Borrowing *	_____
Federal Funds *	_____
State Funds *	_____
Gift and Contributions	_____
Lease	_____
Other *	_____
Total Source of Funds	\$ _____

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:

<u>Year</u> 1 <sup>st</sup> Payment / final payment	<u>Principal</u>	<u>Interest</u>	<u>Annual Debt Service</u>
---	------------------	-----------------	----------------------------

28. Attach a narrative statement indicating 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:

	<u>PRESENTLY</u>	<u>AFTER OFFERING OF SERVICE</u>
Private Pay	_____	_____
Medicare	_____	_____
Medicaid	_____	_____
BC/BS	_____	_____
Other Private Insurance	_____	_____
HMO's	_____	_____
Other	_____	_____
TOTAL		

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

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

Yes \_\_\_\_\_ No \_\_\_\_\_

First Year \$  
Second Year \$  
Third Year \$

Break even point in time, if any  
(if later than three years) \_\_\_\_\_

32. Attach a statement describing how your facility has allowed for start up 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 any studies that were done to support the need for and financial feasibility of the proposed project.

**OTHER CRITERIA**

35. Attach a statement describing 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.
36. Attach a statement providing 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.
37. Attach a statement describing 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, handicapped and the elderly.

**CERTIFICATION**

I, the undersigned, certify that:

I have read Chapter 135.61-83; Code of Iowa and the Administrative Rules (IAC 641-202 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 \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Email: \_\_\_\_\_



## EXHIBIT 2

### BED UTILIZATION STATISTICS

Bed                      Designed beds - Number of beds the facility was originally designed  
Definitions            for

Useable bed - Number of beds available for patient care excluding that  
 portion of the designed capacity which cannot be used as an inpatient  
 bed area by adding staff and./or moveable equipment

Exclude services provided by separately licensed facility, also exclude births and  
 bassinets. Newborn statistics should be indicated in the same format but separately if  
 applicable to project.

	Historical			Forecasted		
	199	199	199	199	199	199
<b>SERVICE</b>						
<u>Medical / Surgical</u>						
Designed Beds	_____	_____	_____	_____	_____	_____
Useable Beds	_____	_____	_____	_____	_____	_____
Staffed Beds	_____	_____	_____	_____	_____	_____
Admissions	_____	_____	_____	_____	_____	_____
Patient Days	_____	_____	_____	_____	_____	_____
Ave. Length of Stay	_____	_____	_____	_____	_____	_____
Percent of Occupancy	_____	_____	_____	_____	_____	_____
 <u>Intensive Care Unit</u>						
Designed Beds	_____	_____	_____	_____	_____	_____
Useable Beds	_____	_____	_____	_____	_____	_____
Staffed Beds	_____	_____	_____	_____	_____	_____
Admissions	_____	_____	_____	_____	_____	_____
Patient Days	_____	_____	_____	_____	_____	_____
Ave. Length of Stay	_____	_____	_____	_____	_____	_____
Percent of Occupancy	_____	_____	_____	_____	_____	_____
 <u>Coronary Care Unit *</u>						
Designed Beds	_____	_____	_____	_____	_____	_____
Useable Beds	_____	_____	_____	_____	_____	_____
Staffed Beds	_____	_____	_____	_____	_____	_____
Admissions	_____	_____	_____	_____	_____	_____
Patient Days	_____	_____	_____	_____	_____	_____
Ave. Length of Stay	_____	_____	_____	_____	_____	_____
Percent of Occupancy	_____	_____	_____	_____	_____	_____

\* If ICU and CCU beds are combined, include under ICU





**EXHIBIT 3**  
 Estimate Application of Funds  
 and  
 Estimate Depreciation

<u>Application of Funds</u>	<u>Estimated Amount</u>	<u>First Year (12 Months)</u>	
		<u>Estimated Average Useful Life</u>	<u>Estimated First Year Deprec.</u>
<b>Site Costs:</b>			
Site Acquisition	\$ _____		
Demolition of Existing Structures	_____		
Site Preparation	_____		
Other (Specify)	_____		
<b>Subtotal</b>	<b>\$ _____</b>		
Land Improvements (Specify)	\$ _____		
<b>Facility Costs:</b>			
General (Construction Shell)	\$ _____	_____	_____
Heating, Ventilating, A/C	_____	_____	_____
Plumbing	_____	_____	_____
Electrical	_____	_____	_____
Elevator	_____	_____	_____
Other Fixed Equipment	_____	_____	_____
Architectural	_____	_____	_____
Construction Management, Supervision, Engineering, Testing, Inspection	_____	_____	_____
Other (Specify)	_____	_____	_____
<b>Subtotal</b>	<b>\$ _____</b>	_____	_____
Movable Equipment	\$ _____	_____	_____
<b>Financing Costs:</b>			
Underwriters' Discount	_____		
Feasibility, Legal, Printing & Other	_____		
Interest Expense During Const.	_____		
Less Interest Earned During Const.	_____		
Other (Specify)	_____		
<b>Subtotal</b>	<b>\$ _____</b>		

**Total Project Costs**      \$ \_\_\_\_\_

**Other Applications:**

Debt Service Reserve Account    \$ \_\_\_\_\_

Other (Specify)                      \_\_\_\_\_

**Subtotal**                              \$ \_\_\_\_\_

**Total Application of Funds**    \$