

# APPLICATION FOR CERTIFICATE OF NEED

## ORGANIZED OUTPATIENT HEALTH FACILITY

### IDENTIFYING INFORMATION

1. Name of Facility \_\_\_\_\_
2. Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_
3. Person responsible for this project \_\_\_\_\_  
Telephone \_\_\_\_\_ FAX \_\_\_\_\_  
E-mail: \_\_\_\_\_
4. Type of ownership: Proprietary \_\_\_\_\_ Nonproprietary \_\_\_\_\_
5. Will the sponsor/owner be the operator? Yes \_\_\_\_\_ No \_\_\_\_\_  
If no, give name of operator or management firm: \_\_\_\_\_
6. Will the facility be leased? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, to whom? \_\_\_\_\_
7. Attach a list of the names and addresses of all persons holding a ten (10) percent or more equity in the facility.
8. If the facility is incorporated, attach a list giving the name, address and position of each corporate officer.
9. Name of Administrator, Director or CEO. \_\_\_\_\_

### DESCRIPTION OF PROJECT

10. Attach a brief narrative description of the proposed project (e.g. does this involve constructing, remodeling, purchasing or leasing of a building? What services will be provided?, etc.)
11. Fill out Exhibit 1 to indicate the total square footage of space planned, and divide this into clinical patient treatment and exam area, office, administration, and indirect service areas such as corridors and mechanical space.

**A. Explain your rationale for the space allocated and why you believe it is adequate.**

**B. Describe your contact with such entities as the fire marshal and city zoning commission for approval of your physical building.**

**12. For applicable items, indicate anticipated date for:**

**Land Purchase** \_\_\_\_\_

**Architectural Plans - Schematic Finalized** \_\_\_\_\_

**Architectural Plans Completed** \_\_\_\_\_

**Letting of Contracts** \_\_\_\_\_

**Start of Construction** \_\_\_\_\_

**Completion of Construction** \_\_\_\_\_

**Offering of Services** \_\_\_\_\_

**NEED DETERMINATION**

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

**A. Historical utilization statistics for each of the most recent three years, if applicable.**

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

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

**15. Where are the area residents now receiving these services?**

**What other providers are located in this geographic area?**

**What volume of service others are providing?**

**16. What will be the impact of your proposal on the service volume of other providers?**

**Please explain your assumptions.**

**17. State any other indicators of community need for this proposal.**

**18. Please send a form letter to other providers of similar service in the same geographic area, stating your plan and requesting their utilization history. Include with this application a list of people contacted, as well as any responses you have received.**

**PERSONNEL**

- 19. Attach a list of the medical staff, by specialty, who will supervise the operation of the project. If certain physicians have particularly relevant experience or interests, please elaborate. Which of these physicians will normally be on the premises during operating hours?
- 20. 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.
- 21. Specify your forecasted full-time equivalents (FTEs):

<u>Department</u>	<u>Forecasted FTEs</u>
Administrative	_____
Physician	_____
Nursing RN	_____
LPN	_____
Aides/Orderlies	_____
Therapists (specify type)	_____
Other (identify)	_____
TOTAL	_____

- 22. Describe plans for providing special personnel training needed and experiences to be required of applicants. Address legal limitations of professional practice.

**FINANCIAL FEASIBILITY**

- 23. 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 (e.g., if physician fee is included in your charge it should be included in area wide charge comparisons).
- 24. 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.

25. Indicate the percentages breakdown of total patient revenues for your facility, by source.

Private Pay	_____
Medicare	_____
Medicaid	_____
Wellmark	_____
Other private insurance	_____
Other (specify)	_____
TOTAL	=====

26. 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.

**CAPITAL EXPENSES**

27. 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.)

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

	<b><u>Estimated Amount</u></b>
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.**

- 29. Attach audited financial statements and notes for each of the most recent years. Attach a balance sheet forecasting after three years of operation.**
- 30. 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, handicapped persons and the elderly.**

**CERTIFICATION**

**I, the undersigned, certify that:**

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

**Telephone** \_\_\_\_\_

**Email** \_\_\_\_\_



## Exhibit 2

### Estimated Application of Funds and Estimated Depreciation

<u>Application of Funds</u>	<u>Estimated Amount</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)			
Subtotal	\$		
<b>Land Improvements (Specify)</b>	\$		
<b>Facility Costs:</b>			
General (Construction Shell)			
Heating, Ventilating, A/C			
Plumbing			
Electrical			
Elevator			
Other Fixed Equipment			
Architectural			
Construction Management, Engineering, Testing, Inspection			
Other (Specify)			
Subtotal	\$		
<b>Movable Equipment</b>	\$		
<b>Financing Costs:</b>			
Underwriters' Discount			
Pricing Discount			
Feasibility, Legal, Printing & Other			
Interest Expense			
During Construction			
Less Interest Earned			
During Construction			
Other (Specify)			
Subtotal	\$		
<b>Total Project Costs</b>	\$		