



11. 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: \_\_\_\_\_  
Other: \_\_\_\_\_

12. Do you have a long-range development plan? If yes, describe.

13. If the proposed project involves a change in beds, specify:

	<u>Present # of Licensed Beds</u>	<u># to be Replaced</u>	<u>New Beds</u>	<u>Total # in Completed Project</u>
Nursing	_____	_____	_____	_____
Residential	_____	_____	_____	_____
ICF/ID	_____	_____	_____	_____
RCF/ID	_____	_____	_____	_____

14. Has the Health Facilities Division of the Dept. of Inspections and Appeals indicated tentative approval of your preliminary plans? With whom in that division did you discuss the physical structure requirements for licensure?

### NEED DETERMINATION

15. How many beds are needed in your district for this level of care according to the bed need formula for ID beds? (Contact the Certificate of Need Program, 515/281-4344).

16. What is the geographic service area for this program? List the county (counties) of residence for the clients you expect to serve.

17. Attach a letter from the local office of the Department of Human services in which the person responsible for placements estimates the number of residents of the county who would be appropriately cared for in the setting being proposed and where those clients are currently being served.

18. If you have identified specific people to become residents, indicate the number, their county of residence, their current living and care arrangement and indicate degree of certainty that they will actually move in (i.e. have DHS, Glenwood, Woodward personnel indicated the persons eligible for placement and appropriate to transfer? Have parents agreed?) What degree of intellectual disability will you accept?
19. If you have not identified specific people likely to become residents, please elaborate upon your prospective source of clients, why you feel certain that your facility will be fully utilized and degree of intellectual disability of clients.
20. Attach copies of 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.
21. Fill out Exhibits 2-A and 2-B, specifying, by level of care and payment source the following:
  - A. Historical utilization statistics for each of the three (3) most recent years (if the proposed project involves the expansion, modernization, or replacement of an existing facility); and
  - B. Forecasted utilization statistics for each of the three (3) years after the service is offered. This forecast should reflect a start up period needed to fill the facility to the desired occupancy. Assumptions used in developing the forecast should be listed and supported.
22. If the proposed project involves replacement of facilities and/or equipment, attach a statement describing the age, condition, life expectancy and intended use or disposition of the facilities and/or equipment being replaced.
23. As part of the public notice requirement, send a form letter to each provider in your district who is licensed as you are applying to be licensed, stating that you are applying for a certificate of need and briefly describing your project. Attach to this application a copy of this letter and a list of people to whom you sent it.

### **PERSONNEL**

24. What is your intended staff to resident ratio?

Specify your existing and forecasted full-time equivalents (FTE)?

<u>Department</u>	<u>Current FTEs</u>	<u>Forecasted FTEs</u>
Administrative	_____	_____
Nursing: RN/LPN	_____	_____
Therapy	_____	_____
Aides	_____	_____
Dietary	_____	_____
Housekeeping/Laundry	_____	_____
QMRP	_____	_____
Resident Aides	_____	_____
Activities weekends, evenings	_____	_____
Other (specify)	_____	_____
TOTAL FTE'S	_____	_____

25. 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 and employing them.

**FINANCIAL FEASIBILITY**

26. Fill out exhibit 1. If the project will purchase an existing building indicate only the total square footage, approximately, and indicate that the Fire Marshall and Dept. of Inspection and Appeals, health facilities division, are indicating willingness to license the structure.
27. Indicate the amounts for projects financing by the following breakdown. Attach a description of asterisked items.

<u>Source of Funds</u>	<u>Estimated Amount</u>
Cash on hand	\$ _____
Borrowing*	\$ _____
Federal Funds*	\$ _____
State Funds*	\$ _____

Gifts & Contributions	\$ _____
Lease	\$ _____
Other*	\$ _____
Total	\$ _____

To support the debt portion, attach a letter either from the lender indicating the probable terms of the borrowing or from the underwriters of the bond financial consultants indicating the probable terms of the bond indenture. Fill out Exhibit 3.

28. Attach a statement listing new equipment (if any) for the proposed project and the manner of acquisition (purchase, lease etc).
29. 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.
30. 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 the following:
  - A. Terms of Debt
    1. Face Amount
    2. Interest
    3. Payment period
    4. Restrictions on additional debt
    5. Prepayment
    6. Other restrictions or requirements
  - 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>	<u>Principal</u>	<u>Interest</u>	<u>Annual Debt Service</u>
1st payment to final payment			

31. Attach audited financial statements and notes to the financial statements, or Department of Social Services cost reports for each of the three (3) most recent years.

32. Will there be an operating deficit as a result of the project? Y or N

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

Break even point in time, if any  
(if later than three (3) years)\_\_\_\_\_

33. Describe how your facility has allowed for start-up funds.

34. On an attachment, provide forecasts of revenue and expense for each of the three (3) years after the service is offered. Include a list of assumptions used in the forecasts and support for the assumptions. Use revenue and expense categories itemized in the Department of Human Service report as a basis for any projections. Include only the revenue and expenses for this project. Indicate total per day maintenance (room and board) expense and service expense categories, and what your total per day cost/charge will be.

35. What will be the sources of this operating revenue and why do you feel assured of receiving it?

Since county funds are so central to this care, attach a letter of support from each county Board of Supervisors you can expect to deal with. This letter must include the estimate of the per patient daily cost which will be the county's share (service component of your costs), and should contain the strongest possible statement of support and intent to use your facility.

36. Describe the daytime programming your clients will use, and state what the cost per day is for those services. Attach a letter from these organizations stating they can absorb your additional clients.

**OTHER CRITERIA**

37. Attach a statement describing what potentially less costly or more appropriate alternatives to the project were considered.

**CERTIFICATION**

I, 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.

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Signature of Owner or

Printed Name

Chairperson, Board of Directors

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Position or Title

Date

If you wish to designate an official representative to act on your behalf, as addressee for written notification and to speak for you before the Health Facilities Council, specify below:

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_



**Exhibit 2-A**  
**Facility Utilization - Historical**

	Year 20__			Year 20__			Year 20__		
ICF/ID	Pri.	St.	Total	Pri.	St.	Total	Pri.	St.	Total
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___
RCF/ID	Pri.	St.	Total	Pri.	St.	Total	Pri.	St.	Total
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___

**Exhibit 2-B**

**Facility Utilization - Forecasted**

ICF/ID	Pri.	St.	Total	Pri.	St.	Total	Pri.	St.	Total
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___
RCF/ID	Pri.	St.	Total	Pri.	St.	Total	Pri.	St.	Total
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___

Pri. = Private Pay Residents

St. = State Assisted Residents

**Exhibit 3**  
**Estimate Application of Funds and Estimated Depreciation**

	Estimated Amount	First Year Estimated Average Useful Life	(12 Months) Estimated First Year Deprec.
<u>Application of Funds</u>			
Site Costs:			
Site Acquisition	\$ _____		
Demolition of Existing Structures	\$ _____		
Site Preparation	\$ _____		
Other (Specify)	\$ _____		
Subtotal \$	\$ _____		
Land Improvements (Specify) \$	\$ _____		
Facility Costs:			
General (Construction Shell)	\$ _____	_____	_____
Heating, Ventilating, A/C	\$ _____	_____	_____
Plumbing	\$ _____	_____	_____
Electrical	\$ _____	_____	_____
Elevator	\$ _____	_____	_____
Other Fixed Equipment	\$ _____	_____	_____
Architectural	\$ _____	_____	_____
Construction Management, Supervision, Engineering, Testing, Inspection	\$ _____	_____	_____
Other (Specify)	\$ _____	_____	_____
Subtotal	\$ _____	_____	_____
Movable Equipment	\$ _____	_____	_____
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	\$ _____		