

11. If the proposed project involves replacement equipment, attach a statement describing the age, condition, life expectancy and intended use or disposition of the equipment being replaced.
12. On an attachment, list the names and addresses of other affected or potentially affected providers of the service similar to the one for which you are seeking a certificate of need and serving the patient population(s) identified in Question #7. For each of these providers, specify the following data and describe your efforts to obtain it.
 - 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 (3) years following offering of the service.
13. 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.

AVAILABILITY OF PERSONNEL

14. Attach a statement describing in detail any changes in staffing produced by this project. 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 you have for recruiting them.
15. Attach a statement describing the training and experience of the personnel who will make professional use of the proposed piece of equipment.

FINANCIAL FEASIBILITY

16. Attach a statement indicating the manner of acquisition, the estimated purchase price of the equipment or fair market value if leased, and the estimated useful life.
17. Attach a schedule of leases, if any, associated with the proposed project. Indicate the term of lease, yearly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.
18. Indicate the amounts for project financing by the following breakdown. Attach a description of asterisked items.

<u>Source of Funds</u>	<u>Estimated Amount</u>
Cash on Hand	_____
Borrowing **	_____
Gifts and Contributions	_____
Lease	_____
Other **	_____
Total Source of Funds	_____

To support the debt portion, attach a letter from the lender indicating the probable terms of the borrowing.

19. Fill out Exhibit 1, 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.
20. Attach a narrative statement indicating what the patient charges for the proposed project will be. Describe in detail what increases will be necessary, how charge determinations were made, and how the proposed project will be cost effective. If no patient charge increases are contemplated, specify how all relevant costs will be covered.
21. Will there be an operating deficit as a result of the project?
 Yes ____ No ____ If Yes,

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

Break even point in time, if any (if later than 3 years) _____

22. Attach a copy of your most recent balance sheet.

OTHER CRITERIA

23. 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.
24. 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 therefore.
25. Attach a statement describing what impact the proposed project will have on the distance, convenience cost of transportation and accessibility to health services for people who live outside metropolitan areas.

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: _____

Agency: _____

Address: _____

Phone: _____

Email: _____

Exhibit 1
Estimate Application of Funds and Estimated Depreciation

	<u>Estimated Amount</u>	<u>First Year Estimated Average Useful Life</u>	<u>(12 Months) Estimated First Year Depreciation</u>
<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	\$ _____		