Department of Inspections, Appeals, & Licensing

Application For Certificate of Need

AMBULATORY SURGERY CENTER

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

1. Applicant Name ____

2. Name of Facility ____

3. Address ____
   Street City County Zip

4. Person responsible for this project ______________________________

   Telephone ____________________ FAX ________________________

   E-mail: ____________________

5. Type of ownership: Proprietary ___ Nonproprietary ____

6. Will the sponsor/owner be the operator? Yes _____ No ____

   If no, provide the name of the operator or management firm:
   ____

7. Will the facility be leased? Yes _____ No _____

   If yes, to/from whom ____________________________
   Monthly Cost ____________
   Term _________
   Total cost of a one-year lease ___________

   Attach a schedule of leases associated with the proposed project. Indicate the term of lease, monthly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.

8. Will any of the equipment be leased? Yes ____ No _____

If yes, what equipment (list) _______________
Monthly Cost ___________
Term ________
Total value of the lease, including sales tax, delivery and installation __________

Attach a schedule of leases associated with each piece of equipment. Indicate the term of lease, monthly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.

9. Attach a list of the names and addresses of all persons holding ten (10) percent or more equity in the facility.

10. If the facility is incorporated, attach a list giving the name, address and position of each corporate officer.

11. Name of Administrator, Director or CEO: ____________________________________

DESCRIPTION OF PROJECT

12. Provide a detailed narrative description of the proposed project (e.g., Does this involve constructing, remodeling, purchasing or leasing of a building? What equipment will be needed? How many operating and recovery rooms will there be? Etc.) Add an attachment if needed.

    12a. Provide information about the procedures that will be offered.

13. Fill out Exhibit 1 to indicate the total square footage of space planned and divide this into clinical patient treatment exam and surgical areas, office, administration, and indirect service areas such as corridors and mechanical space. Also:

    13a. Explain your rationale for the space allocated and why you believe it is adequate.
    13b. Provide schematic drawings for the proposed project.

14. Describe in detail your contact with regulatory entities such as the state fire marshal, Department of Inspections and Appeals, and city zoning commission for approval of your project. With whom at these entities did you correspond? Provide copies of any correspondence with these entities.

15. Describe how you will adhere to current Life Safety Codes.

16. Will you seek accreditation (i.e., from AAAASF or other accreditation body) for your facility? What are the associated costs?

17. Will you seek Medicare certification as an ASC? Yes _____ No _____

18. For applicable items, indicate anticipated date for:

Completion of Construction/Modernization: _______________________

Offering of Service ______________________

NEED DETERMINATION

19. In detail, describe the need for the proposed project.

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

    20a. Historical utilization statistics for each of the most recent three years, if applicable.

    20b. Expected utilization statistics for each of the first three (3) years after the proposal is operational (list assumptions used).

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

22. Where are the area residents now receiving services similar to those proposed? Provide the names and addresses of providers offering similar or the same services, including hospitals, located in the geographic area noted in Q. #21. What volume of service are others providing?

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

24. State any other indicators of community need for this proposal.

25. As part of the public notice requirement, send a letter to each outpatient surgical service provider (including hospital-based) and ambulatory surgery center in the county stating that you are applying for a certificate of need and briefly describing your project. Attach a copy of the letter to this application.

PERSONNEL

26. 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?

27. 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.

28. Specify your existing and forecasted full-time equivalents (FTEs):

Department		Current	Forecasted
Administrative		________	________
Physician(s)		________	________
Nursing:	RN	________	________
	LPN	________	________
	Aides/Orderlies	________	________
Therapists (specify type)		________	________
Other (specify)		________	________
TOTAL FTE'S		________	________

29. If new/additional personnel will be needed as a result of the proposed project, attach a statement describing what evidence there is that these personnel will be available and the plans your facility has for recruiting and employing them.

30. Describe plans for providing training and experience to new and existing personnel. Address legal limitations of professional practice.

FINANCIAL FEASIBILIITY

31. What do you propose to charge for each service provided? What are the charges for similar services from other providers in your area? Please elaborate regarding comparability of service

and any cost savings involved (i.e., if the physician fee is included in your charge it should be included in area wide charge comparisons).

32. 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.

33. By source, indicate the percentage breakdown of total patient revenues for your facility.

Private Pay	______________
Medicare	______________
Medicaid	______________
BC/BS	______________
Other private insurance	______________
Other (specify)	______________
TOTAL	______________

34. 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.

35. 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 or other insurer, please explain briefly how this cost will be recovered (e.g., through patient charges, owner's income taxes, etc.)

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

	<u>Estimated Amount</u>
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 <u>attach an amortization schedule</u> 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 the proposed lease.

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

OTHER CRITERIA

38. 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, persons with disabilities, and the elderly.

39. Describe what potentially less costly or more appropriate alternatives to the proposed project including but not limited to staffing, scheduling, design service sharing, etc., were considered and rejected. Specify the reasons therefor.

40. Describe what impact the proposed project will have on-the distance, convenience, cost of transportation, and accessibility to health services for persons who live outside metropolitan areas.

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

42. Describe how patients will experience serious problems obtaining care of the type proposed in the absence of that 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 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/or to speak for you before the Health Facilities Council, specify below:

Name ____
Agency ____
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, operating rooms, 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)	$___________		

____
____
____

Application of Funds	Estimated Amount	Estimated Average Useful Life	Estimated First Year Depreciation
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	$___________