Department of Inspections, Appeals, & Licensing

Application For Certificate of Need

HOSPITAL

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

PLEASE NOTE: The Department of Inspections, Appeals, & Licensing ("DIAL"), Health and Safety Division reviews and approves all hospital bed increases prior to issuing a new or amended license. Notification to this division at the time of, or prior to, CON application is highly recommended. Contact Hema Lindstrom at hema.lindstrom@dia.iowa.gov for more information.

Type of Hospital (check one)

_______ Acute Care
_______ Critical Access
_______ Psychiatric
_______ Rehabilitation
_______ Other (specify) ________________________

OVERVIEW

1. Applicant Name ____

2. Name of Hospital ____

3. Address

____
Street City County Zip

4. Person responsible for project ____

Telephone ____________________________ FAX _____________________
___

E-mail: ____________________________
___

5. Type of ownership: Proprietary____________ Nonproprietary ___________

6. Provide a list of names and addresses of all persons holding ten (10) percent or more interest in the facility.

7. Provide an overview of the ownership structure of the facility, including the parent company/owner if applicable.

8. Will the hospital be leased? Yes _____ No _____

   If yes, to/from whom ___________________________
   Monthly Cost ___________
   Term _________
   Total cost of a one year lease_________
   Attach a schedule of leases, if any, associated with the proposed project. Indicate the term of the lease, yearly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.

DESCRIPTION OF PROJECT

9. Provide a narrative description of the proposed project, including background information about the applicant and/or facility.

10. Indicate anticipated date for:

    Completion of Construction ________________

    Offering of Services ________________

11. Do you have a long-range development plan? Yes _____ No _____

    If yes, attach a copy and provide a statement describing the relationship of the proposed project to the long-range plan.

12. Identify any agencies, organization, groups, or individuals who provided consultation or other input into this project. Identify the impact of the input where appropriate.

13. Attach a forecasted capital budget for three years that includes the proposed project.

14. If the proposed project includes new construction, renovation or expansion, fill out Exhibit 1 indicating square footage of the functional areas.

    14a. Explain your rationale for the space allocated and why you believe it is adequate.
    14b. Provide a schematic of the facility.

15. 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.

16. Describe in detail your contact with regulatory entities such as the State Fire Marshal – Building Code Bureau; Department of Inspections and Appeals – Health Facilities Division; and city zoning commission for approval of your project. With whom at these entities did you correspond? Provide copies of any and all correspondence with these entities.

17. Describe how you will adhere to current Life Safety Codes and FGI guidelines.

NEED DETERMINATION

18. Describe in detail the need for the proposed project. Specify the methodology, assumptions, and data used in your determination.

19. Identify and discuss the factors which support the need for the proposed project.

20. Describe what you consider to be the geographic service area for this project.

21. Describe what you identify to be the existing or target patient population for this project in the area described.

22. Describe the current local conditions that favor the occupancy or sustainability of the proposed facility.

23. If the proposed project involves the 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.

24. 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.

25. If the proposed project involves replacement of facilities and/or equipment, provide a statement describing the age, condition, life expectancy and intended disposition of the use of facilities and/or equipment being replaced.

26. 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 geographic area and patient population(s) identified in Q. #20 and Q. #21.

27. Describe 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.

28. As part of the public notice requirement, send a letter to each hospital in the county offering the services for which you are applying 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

29. Describe 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.
30. If new or additional personnel will be needed as a result of the proposed project, describe either what evidence there is that these personnel will be available, or the plans your facility has for recruiting them.

31. Attach a table listing 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 either list, provide the following information for each medical staff member:

    A. License type (e.g., MD, DO, ARNP, PA, etc.)
    B. Specialty (Indicate whether Board certified, Board eligible or self-declared)
    C. Staff Status
    D. Total admissions and total patient days for each of the most recent two years.

FINANCIAL FEASIBILITY

32. 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.

33. Does your facility plan to fund a depreciation account for this project?
    Yes ________ No _______

    If Yes, describe the source of depreciation funds.
    If No, provide a statement of explanation.

34. Attach a table listing new equipment (if any) for the proposed project and the manner of acquisition (purchase, lease, etc.).

35. Will any of the equipment be leased? Yes _____ No ______

    If yes, what equipment (list) __________________
    Monthly Cost ____________
    Term _________

    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.

36. If applicable, attach audited financial statements and notes to the financial statements for each of the most recent three years.

37. Attach a copy of your anticipated balance sheet for the year the proposed project will be completed.

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

SOURCE OF FUNDS

		Estimated Amount
Cash on Hand	$	________
Borrowing *		________
Federal Funds *		________
State Funds *		________
Gift and Contributions		________
Lease		________
Other *		________
Total Source of Funds	$	________

39. 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, describe:

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:

	Year	Principal	Interest	Annual Debt Service
1st payment to final payment				

40. Provide 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.

41. Indicate the percentage breakdown by source of total patient revenue:

	PRESENTLY	AFTER OFFERING OF SERVICE
Private Pay	________	________
Medicare	________	________
Medicaid	________	________
BC/BS	________	________
Other Private Insurance	________	________
HMO's	________	________
Other	________	________

TOTAL ______________ ______________

42. Provide 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.

43. If applicable, attach audited financial statements and notes to the financial statements for the most recent three years.

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

Yes _____ No _____ If Yes, First Year $__________
Second Year $__________
Third Year $__________

Breakeven point in time, if any
(If later than three (3) years) ___________

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

46. 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.

47. Describe any studies that were done to support the need for and financial feasibility of the proposed project.

OTHER CRITERIA

48. Describe 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.

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

50. Describe 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.

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

52. Describe how patients will experience serious problems obtaining care of the type proposed in the absence of the proposed service.

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 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, etc.)

EXHIBIT 2

BED UTILIZATION STATISTICS

Provide the number of licensed and staff beds.

Exclude services provided by a 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		
	20__	20__	20__	20__	20__	20__
SERVICE						
Medical / Surgical						
Licensed Beds	_______	_______	_______	_______	_______	_______
Staffed Beds	_______	_______	_______	_______	_______	_______
Admissions	_______	_______	_______	_______	_______	_______
Patient Days	_______	_______	_______	_______	_______	_______
Avg. Length of Stay	_______	_______	_______	_______	_______	_______
Percent of Occupancy	_______	_______	_______	_______	_______	_______
Intensive Care Unit						
Licensed Beds	_______	_______	_______	_______	_______	_______
Staffed Beds	_______	_______	_______	_______	_______	_______
Admissions	_______	_______	_______	_______	_______	_______
Patient Days	_______	_______	_______	_______	_______	_______
Avg. Length of Stay	_______	_______	_______	_______	_______	_______
Percent of Occupancy	_______	_______	_______	_______	_______	_______
Coronary Care Unit *						
Licensed Beds	_______	_______	_______	_______	_______	_______
Staffed Beds	_______	_______	_______	_______	_______	_______
Admissions	_______	_______	_______	_______	_______	_______
Patient Days	_______	_______	_______	_______	_______	_______
Avg. Length of Stay	_______	_______	_______	_______	_______	_______
Percent of Occupancy	_______	_______	_______	_______	_______	_______

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

	Historical			Forecasted		
	20__	20__	20__	20__	20__	20__
SERVICE						
Pediatric						
Licensed Beds	_______	_______	_______	_______	_______	_______
Staffed Beds	_______	_______	_______	_______	_______	_______
Admissions						

Patient Days						
Avg. Length of Stay						
Percent of Occupancy						
Obstetric						
Licensed Beds						
Staffed Beds						
Admissions						
Patient Days						
Avg. Length of Stay						
Percent of Occupancy						
Neonatal Intensive Care						
Licensed Beds						
Staffed Beds						
Admissions						
Patient Days						
Avg. Length of Stay						
Percent of Occupancy						
Psychiatric						
Licensed Beds						
Staffed Beds						
Admissions						
Patient Days						
Avg. Length of Stay						
Percent of Occupancy						
Rehabilitation						
Licensed Beds						
Staffed Beds						
Admissions						
Patient Days						
Avg. Length of Stay						
Percent of Occupancy						
Substance Abuse						
Licensed Beds						
Staffed Beds						
Admissions						
Patient Days						
Avg. Length of Stay						
Percent of Occupancy						

	Historical			Forecasted		
	20__	20__	20__	20__	20__	20__
SERVICE						
Other (e.g. Long-Term Care)						
Licensed Beds	_______	_______	_______	_______	_______	_______
Staffed Beds	_______	_______	_______	_______	_______	_______
Admissions	_______	_______	_______	_______	_______	_______
Patient Days	_______	_______	_______	_______	_______	_______
Avg. Length of Stay	_______	_______	_______	_______	_______	_______
Percent of Occupancy	_______	_______	_______	_______	_______	_______
Total						
Licensed Beds	_______	_______	_______	_______	_______	_______
Staffed Beds	_______	_______	_______	_______	_______	_______
Admissions	_______	_______	_______	_______	_______	_______
Patient Days	_______	_______	_______	_______	_______	_______
Avg. Length of Stay	_______	_______	_______	_______	_______	_______
Percent of Occupancy	_______	_______	_______	_______	_______	_______

EXHIBIT 3
Estimated Application of Funds and Estimated Depreciation

	Estimated Amount	First Year Estimated Average Useful Life	(12 Months) Estimated First Year Depreciation
Application of Funds			
1. Site Costs:			
Site Acquisition	$___________		
Demolition of Existing Structures	$___________		
Site Preparation	$___________		
Other (Specify)	$___________		
Subtotal	$___________		
2. Land Improvements (Specify)	$___________		

____
____
____

	Estimated Amount	First Year Estimated Average Useful Life	(12 Months) 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 it lease cost)

Total value of the lease including sales tax, delivery and installation

Cost $___________

6. Land Lease

Annual Cost $___________

7. Building 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	$___________