Nevada Certificate of Need Application

The Certificate of Need process is coordinated by the Nevada Health Authority under Nevada Revised Statutes (NRS) 439A.100. Please email questions to [Info@NVHA.nv.gov](mailto:Info@NVHA.nv.gov).

**Section I. APPLICANT IDENTIFICATION AND CERTIFICATION**

* 1. *Identification of Legal Applicant:* Identify the applicant as defined in NAC 439A.240: *a natural person, trust, estate, partnership, corporation (including an association, joint stock company and insurance company), state, political subdivision or instrumentality or a legal entity recognized by the State.*

Applicant Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

* 1. *Project Information*

Project Title: Click or tap here to enter text.

1.3 *Description of Legal Applicant*

a. Type of Organization

Private for Profit Corporation Limited Partnership

Public for Profit Corporation State Organization

Private Non-Profit Corporation County Organization

General Partnership Other (Specify):

b. If a corporation, indicate where and when incorporated:

Where:Click or tap here to enter text.

When:Click or tap here to enter text.

c. Identify principals having 25% or more ownership:

|  |  |
| --- | --- |
| Name of Individual | Percentage Owned |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter name. | Click or tap here to enter text. |
| Click or tap here to enter name. | Click or tap here to enter text. |
| Click or tap here to enter name. | Click or tap here to enter text. |

d. If a corporation, attach an appendix labeled Appendix A with a list of the chairman, directors and officers. If a partnership, attach an appendix labeled Appendix B with a list of general and limited partners, if any.

1.4 *Contact Person*: Identify the individual designated as the contact person who will receive all notices and communications pertaining to this application.

Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Organization: Click or tap here to enter text.

Address: Click or tap here to enter text.

Office Phone: Click or tap here to enter text.

Cell Phone: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

**Certification and Signature:** This section should be completed and signed by the person who is authorized to commit the applicant to the project and to the expenditure of funds.

In accordance with NRS 439A.100 and the accompanying regulations, I hereby certify that this application is complete and correct to the best of my knowledge and belief. I understand that the applicant for a letter of approval has the burden of proof to satisfy all applicable criteria for review. I also understand that this application and all information submitted is public information and will be made available for public review and inspection.

Printed Name: Click or tap here to enter text. Title: Click or tap here to enter text.

Signature: Date: Click or tap to enter a date.

**Submit the original and four (4) copies along with a check for $9,500 payable to the Nevada Health Authority for the application fee to:**

**Nevada Health Authority  
Attn: Certificate of Need Application  
4070 Silver Sage Drive  
Carson City, Nevada 89701**

Note: NAC 439A.595 states that the applicant for a letter of approval has the burden of proof to satisfy all applicable criteria for review contained in NAC 439A.637, inclusive.

**Section II. PROJECT DESCRIPTION**

2.1 *Project Summary:* Provide a one-page description of the proposed project.

Click or tap here to enter text.

2.2 *Project Capital Expenditure Estimates*:

|  |  |
| --- | --- |
| **Total dollar amount** | $Click or tap here to enter text. |
| **For new square footage only** | $Click or tap here to enter text. |

2.3 *Project Location*:

|  |  |
| --- | --- |
| **Project Location** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |

1. Attach an appendix labeled Appendix C with documentation of ownership, lease or option to purchase.

1. Attach an appendix labeled Appendix D with a location map which includes street names and a facility plot plan and/or schematic.

2.4 *Project Schedule*: Complete the following schedule for the proposed project.

|  |  |
| --- | --- |
| **Step** | **Target Date** |
| **Use permit** | Click or tap to enter a date. |
| **Building permit** | Click or tap to enter a date. |
| **Groundbreaking/construction begins** | Click or tap to enter a date. |
| **Construction ends** | Click or tap to enter a date. |
| **Entire project completed** | Click or tap to enter a date. |
| **Licensing & certification** | Click or tap to enter a date. |
| **Services begin** | Click or tap to enter a date. |

2.5 *Project Organization and Planning:*

a. Attach an appendix labeled Appendix E with an organization chart(s) showing lines of managerial and fiscal responsibility for all individuals and entities involved in this project. Show the proposed project’s place in its parent organization, if appropriate.

b. Describe the process by which this project was developed.

Click or tap here to enter text. Use as much space as needed.

**Section III. NEED FOR THE PROJECT TO BE UNDERTAKEN**

Pursuant to NAC 439A.605, the applicant must demonstrate that the population to be served has a need for the project to be undertaken based upon:

3.1 *Project Service Area and Population*

a. Identify the proposed service area.

Click or tap here to enter text. Use as much space as needed.

b. Identify the total population for the proposed service area and estimate the number of persons who will have a need for the proposed project. Use a population projection for the year which is five years from the year that the application is filed. Population projections are available from the State Demographer. If other estimates are used, cite the source of such information and show the method used to derive the estimates.

Click or tap here to enter text. Use as much space as needed.

3.2 *Existing Providers of Similar Services*:

Provide information regarding existing providers of services similar to those proposed in this application. Explain the assumption that existing providers will not be able to meet the projected needs of the target population.

Click or tap here to enter text. Use as much space as needed.

**Section IV. FINANCIAL FEASIBILITY**

4.1 *Capital Expenditures*:

|  |  |  |
| --- | --- | --- |
| **Cost** | **Total Project** | **Portion @ New Square Footage** |
| Land acquisition | $Enter dollar amount. | $Enter dollar amount. |
| Architectural & engineering cost | $Enter dollar amount. | $Enter dollar amount. |
| Site development | $Enter dollar amount. | $Enter dollar amount. |
| Construction expenditure | $Enter dollar amount. | $Enter dollar amount. |
| Fixed equipment (not construction expense) | $Enter dollar amount. | $Enter dollar amount. |
| Major medical equipment | $Enter dollar amount. | $Enter dollar amount. |
| Other equipment and furnishings | $Enter dollar amount. | $Enter dollar amount. |
| Other (specify) Click here to enter text | $Enter dollar amount. | $Enter dollar amount. |
| 10% Contingency | $Enter dollar amount. | $Enter dollar amount. |
| **TOTAL PROJECT COST** | $Enter dollar amount. | $Enter dollar amount. |

4.2 *Proposed Funding of Project:*

Funds available as of application filing date: $Click or tap here to enter text.

**Attach in an appendix labeled Appendix F with evidence that funds are available**

4.3 *Long-Term Financing*:

|  |  |
| --- | --- |
| Loan principal | $Click or tap here to enter text. |
| Interest rate | Click or tap here to enter text. |
| Term (years) | Click or tap here to enter text. |

1. Identify the anticipated source(s) of long-term financing.

Click or tap here to enter text.

1. Check anticipated debt instrument.

Mortgage Bonds Other (Specify): Click here to enter text.

1. Will the proposed long-term loan refinance the construction loan?

Yes  No

4.4 *Project Financing*

a. Provide information regarding the construction financing. Note that “financing” includes all project capital expenditures regardless of funding source.

**Construction Financing:**

|  |  |  |
| --- | --- | --- |
| **Funding** | **Amount** | **Percent of Total** |
| From applicant’s funds | $Click or tap here to enter text. | Click or tap here to enter text. |
| Amount to be financed | $Click or tap here to enter text. | Click or tap here to enter text. |
| Total capital expenditures | $Click or tap here to enter text. | Click or tap here to enter text. |

b. Construction loan information

Source of construction loan: Click or tap here to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| **Loan principal** | **Interest rate** | **Total dollars** | **Term(years)** |
| Click or tap here to enter text. | Enter rate here. | $Enter Dollar Amount. | Enter Years here. |
| Click or tap here to enter text. | Enter rate here. | $Enter Dollar Amount. | Enter Years here. |
| Click or tap here to enter text. | Enter rate here. | $Enter Dollar Amount. | Enter Years here. |

1. Provide information about existing short and long-term loans not related to the proposed project that are held by the applicant.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Lender** | **Interest Rate** | **Term** | **Annual Payment** | **Remaining Principal** |
| Enter text here. | Interest Rate. | Term. | Annual Payment. | Remaining Principal |
| Enter text here. | Interest Rate. | Term. | Annual Payment. | Remaining Principal |
| Enter text here. | Interest Rate. | Term. | Annual Payment. | Remaining Principal |
| Enter text here. | Interest Rate. | Term. | Annual Payment. | Remaining Principal |

4.5 *Financial Sustainability*: NAC 439A.625 requires the applicant demonstrate that it will be able to operate in a manner which is financially feasible as a result of the proposed project without unnecessarily increasing the cost to the user or payer for health service provided by the applicant.

Explain how the proposed facility is expected to become financially self-supporting within 3 years after completion or, if the new construction is an addition to an existing facility, that the financial viability of the existing facility will not be adversely affected by the proposed project.

Click or tap here to enter text.

4.6 *Financial Feasibility*: Provide a response to each of the following criteria related to financial feasibility.

a. The ability of the applicant to obtain any required financing for the proposed project;

Click or tap here to enter text.

b. The extent to which the proposed financing may adversely affect the financial viability of the applicant’s facility because of its effect on the long-term and short-term debt of the applicant;

Click or tap here to enter text.

c. The availability and degree of commitment to the applicant of the financial resources required to operate the proposed project until the project or the applicant’s facility becomes financially self-supporting;

Click or tap here to enter text.

d. The relationship between the applicant’s estimated costs of operation, proposed charges and estimated revenues;

Click or tap here to enter text.

e. The level at which the affected health services of the applicant must be used for the applicant to break even financially and the likelihood that those levels will be achieved;

Click or tap here to enter text.

f. Whether the applicant’s projected costs of operation and charges are reasonable in relationship to each other and to the health services provided by the applicant.

Click or tap here to enter text.

g. Whether the projected revenues to be received by the applicant are likely to be from governmental programs if the applicant will be eligible for reimbursement from those programs.

|  |  |
| --- | --- |
| **Source** | **Percentage** |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |

4.7 *Ability to Support Operations*:

a. Identify the source and amount of funds committed to the applicant which may be required to operate the proposed project or the applicant’s facility until such time as the project becomes financially self-supporting.

|  |  |
| --- | --- |
| **Source** | **Amount** |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |
| Click or tap here to enter text. | Enter percentage here. |

b. If an existing facility, attach an appendix labeled Appendix G with copies of financial statements for the three preceding fiscal years including statements of revenues/expenses and balance sheets.

c. For a new facility, attach an appendix labeled Appendix H with a pro-forma revenue/expense statement for each of the first three full years of operation of the proposed project.

* 1. *Bed Information*:

|  |  |
| --- | --- |
| Existing number of licensed beds | Beds (specify by type). |
| Number added by new construction | Beds (specify by type). |
| Conversion from other use | Beds (specify by type). |
| Number to be removed | Beds (specify by type). |
| Projected number of licensed beds | Beds (specify by type). |

4.9 *Line Drawings*: Attach an appendix labeled Appendix I with scale drawings of all new construction and/or remodeling.

**Section V. EFFECT ON COSTS TO CONSUMER OR PAYOR**

5.1 *Effect on Cost of Healthcare*: NAC 439A.635 requires the applicant demonstrate that the proposed project will not have an unnecessarily adverse effect on the cost of health services to users or payers.

Explain how the proposed project will result in a significant savings in costs to users or payers without an adverse effect on the quality of care or, if the proposed project will not result in a significant savings in costs to the user or payer for health services, the extent to which costs of the service are justified by:

a. A clinical or operational need.

Click or tap here to enter text.

b. A corresponding increase in the quality of care.

Click or tap here to enter text.

c. A significant reduction in risks to the health of the patients to be served by the applicant.

Click or tap here to enter text.

5.2 *Effect on cost*: Provide a response to the following criteria related to the effect on costs.

a. The added costs to the applicant resulting from any proposed financing for the project.

Click or tap here to enter text.

b. The relationship between project costs of construction, remodeling or renovation and the prevailing cost for similar activity in the area.

Click or tap here to enter text.

c. The health or other benefits to be received by users compared to the cost to users or payers resulting from the proposed project.

Click or tap here to enter text.

d. Whether alternative methods of providing the proposed service are available

which provide a greater benefit for the cost without adversely affecting quality of care.

Click or tap here to enter text.

5.3 Demonstrate that the proposed project will not have an unnecessary adverse effect on the costs of health services to the user or payer.

Click or tap here to enter text.

**Section VI. APPROPRIATENESS**

*6.1 Location:*

a. Describe the location of the proposed project including the time for travel and distance to other facilities for required transfers of patients or transfers in the event of an emergency.

Click or tap here to enter text.

b. Describe the distance and the time for travel required for the population to be served to reach the applicant’s facility and other facilities providing similar services.

Click or tap here to enter text.

c. Describe the nature of and requirements for zoning for the area surrounding the proposed location of the project.

Click or tap here to enter text.

*6.2 Effect on existing costs and quality of care: Explain the extent to which:*

a. The proposed project is likely to stimulate competition which will result in a reduction in costs for the user or payer.

Click or tap here to enter text.

b. The proposed project is likely to increase costs to the user or payer through reductions in market shares for services if those reductions would increase costs per unit of service.

Click or tap here to enter text.

c. The proposed project contains innovations or improvements in the delivery or financing of health services which will significantly reduce the cost of health care to the user or payer or enhance the quality of care.

Click or tap here to enter text.

6.3 *Reduction, Elimination or Relocation of Health Services or Facility:*

If the proposed project involves the reduction, elimination or relocation of an existing health facility or service, how will the needs of the population currently being served continue to be met?

Click or tap here to enter text.

6.4 *Consistency with Existing System*: Explain whether the proposed project is consistent with the existing system of health care, based upon:

a. The effect of the proposed project on the availability and the cost of existing health services in the area of required personnel.

Click or tap here to enter text.

b. The extent to which the applicant will have adequate arrangements for referrals to and from other health facilities in the area which provide for avoidance of unnecessary duplication of effort, comprehensive and continuous care of patients, and communication and cooperation between related facilities or services.

Click or tap here to enter text.

6.5 *Applicant History:* Describe the quality of care provided by the applicant for any existing health facility or service owned or operated by the applicant based upon:

a. Whether the applicant has had any adverse action taken against it with regard to a license or certificate held by the applicant and the results of that action.

Click or tap here to enter text.

b. The extent to which the applicant has previously provided similar health services.

Click or tap here to enter text.

c. Any additional evidence in the record regarding the applicant’s quality of care.

Click or tap here to enter text.

6.6 *Accessibility:* Explain the extent to which equal access by all persons in the area to the applicant’s facility or service will be provided, based upon:

a. Whether any segment of the population in the area will be denied access to health services similar to those proposed by the applicant as a result of the proposed project.

Click or tap here to enter text.

b. The extent to which the applicant will provide uncompensated care, exclusive to bad debt, and the effect of the proposed project on the cost to local and state governments and other facilities for providing care to indigents.

Click or tap here to enter text.

c. The extent to which financial barriers to access by persons of low income, including any financial preconditions to providing service, will prevent those persons from obtaining needed health services.

Click or tap here to enter text.

6.7 *Referrals:* Provide the following information for each health facility/program with which the applicant will have an arrangement for referrals.

Facility: Click or tap here to enter text.

Agreement for: Click or tap here to enter text.

Facility: Click or tap here to enter text.

Agreement for: Click or tap here to enter text.

Facility: Click or tap here to enter text.

Agreement for: Click or tap here to enter text.

Facility: Click or tap here to enter text.

Agreement for: Click or tap here to enter text.

**Section VII. HEALTH CARE ACCESS**

7.0 *Healthcare Distribution, Access and Outcomes:*

Describe the extent to which the project is consistent with the purposes set forth in NRS 439A.020 and the priorities set forth in NRS 439A.081. Including without limitation:

a. The impact of the project on other health care facilities;

Click or tap here to enter text.

b. The need for any equipment that the project proposes to add, the manner in which such equipment will improve the quality of health care and any protocols provided in the project for avoiding repetitive testing;

Click or tap here to enter text.

c. The impact of the project on disparate health outcomes for different populations in the area that will be served by the project;

Click or tap here to enter text.

d. The manner in which the project will expand, promote or enhance the capacity to provide primary health care in the area that will be served by the project;

Click or tap here to enter text.

e. Any plan by the applicant to collect and analyze data concerning the effect of the project on health care quality and patient outcomes in the area served by the project;

Click or tap here to enter text.

f. Any plan by the applicant for controlling the spread of infectious diseases;

Click or tap here to enter text.

g. The manner in which the applicant will coordinate with and support existing health facilities and practitioners, including, without limitation, mental health facilities, programs for the treatment and prevention of substance abuse and providers of nursing services.

Click or tap here to enter text.