COMMONWEALTH OF KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

OFFICE OF INSPECTOR GENERAL DIVISION OF CERTIFICATE OF NEED

# Instructions for Certificate of Need Application for Change of Location, Replacement, Cost Escalation, or Acquisition

**CON - FORM 2C**

In accordance with KRS Chapter 216B, Licensure and Regulation of Health Facilities and Services and the general procedures and criteria adopted there under, each applicant for a Certificate of Need for a change of location, replacement, cost escalation, or acquisition shall complete this application form.

This completed form and the filing fee shall be received in this office by 4:30 p.m. on the deadline established in 900 KAR 6:060. The forms and fee shall be sent to the Cabinet for Health and Family Services, Office of Inspector General, Division of Certificate of Need, 275 East Main Street 5E-A, Frankfort, KY 40621, or emailed to [CON@ky.gov.](mailto:CON@ky.gov)

### General Instructions – All Applicants

1. Submit a check for the appropriate application fee made payable to the Kentucky State Treasurer based upon the following fee schedule

|  |  |
| --- | --- |
| PROPOSED CAPITAL EXPENDITURE | CON APPLICATION FEE |
| $0 TO $200,000 | $1,000 |
| $200,001 TO $5,000,000 | Five-tenths (.5) percent of the capital expenditure computed to the nearest dollar |
| Over $5,000,000 | $25,000 |

1. Submit your answers on this official application form. Do not retype the form. Answer all questions. If the question is not applicable; indicate so by putting “NA” in the space.
2. If additional space is required to answer questions, please use a separate piece of paper, number answers to correspond to appropriate questions, and attach in consecutive order in proximity to related questions.
3. Please place all supporting documents in an appendix at the back of the completed application. Please make reference to any appendix in the blanks provided (See Appendix # ). **Insert a cover sheet for each appendix and place a number on each cover sheet.**
4. Do not include reference tabs on the application form or the appendices. It is preferable that the application form

**not** be bound. However, if you bind the application form, please bind with a two (2) hole fastener, top center.

1. Please print name, sign, and date the application.

**DETACH THIS SHEET BEFORE SUBMITTING THE APPLICATION**

**FOR AGENCY USE ONLY. CON NUMBER:**

COMMONWEALTH OF KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

OFFICE OF INSPECTOR GENERAL DIVISION OF CERTIFICATE OF NEED

# CERTIFICATE OF NEED APPLICATION FOR CHANGE OF LOCATION, REPLACEMENT, COST ESCALATION, OR ACQUISITION

## SECTION A: GENERAL INFORMATION

1. **FACILITY, PROGRAM, OR SERVICE:**

NAME ORIGINAL PHYSICAL STREET

ADDRESS CITY/STATE/ZIP

COUNTY

(CHANGE OF LOCATION APPLICATIONS ONLY) PROPOSED PHYSICAL

STREET ADDRESS CITY/STATE/ZIP COUNTY

### OWNER OF THE FACILITY OR SERVICE (business entity to be licensed):

NAME

ADDRESS CITY/STATE/ZIP

## CONTACT PERSON:

NAME COMPANY (Title)

ADDRESS

CITY/STATE/ZIP TELEPHONE NUMBER EMAIL ADDRESS

## ATTORNEY’S NAME

### (if applicable):

ADDRESS

CITY/STATE/ZIP TELEPHONE NUMBER

1. If you are requesting nonsubstantive review status under KRS 216.095(3)(a), (b), (c), or (d), please indicate and provide the date the original certificate of need was issued.

Date CON issued

A. To change the location of a proposed health facility;

* 1. To replace or relocate a licensed health services facility if there is no substantial change in health services, service area, or bed capacity;
  2. To replace or repair worn equipment if the worn equipment has been used by the applicant in a health facility for five (5) years or more; or
  3. For cost escalations.

1. Identify type of ownership for the existing or proposed health facility or service.

Sole Proprietorship Partnership

Limited Liability Partnership Limited Liability Company Professional Service Corporation Private (for profit) Corporation Non-Profit Corporation

Governmental (The Commonwealth and its instrumentalities and political subdivisions)

1. List the name and business address of any owner, investor, or stockholder whose ownership interest is greater than 10%.
2. If the owner is a corporation, attach evidence of incorporation. (See Appendix # )
3. If the owner is a partnership, submit a copy of the partnership agreement. (See Appendix # )
4. If the owner is an out of state corporation, attach evidence of Kentucky registration and identify the process agent. (See Appendix #
5. If the applicant’s existing facility or service or the proposed facility or service will be managed by someone other than the owner, identify and explain the relationship.

## SECTION B: PROJECT DESCRIPTION

1. Delineate the factors that contributed to the cost escalation, replacement of facility or equipment, or change of location. If construction or renovation is involved, clearly describe, providing details with square footages before and after construction or renovation, the size proposed for each area after completion, and present and proposed location of each affected department.
2. If the proposal involves a new or relocated facility or service, attach a map that identifies the proposed location. (See Appendix # )

## SECTION C: CONFORMANCE WITH CRITERIA

1. Need and Accessibility
   1. Describe and document the need to relocate, escalate the capital expenditure, or replace the facility or equipment.
2. Costs, Economic Feasibility, and Resources Availability
   1. Does this proposal require a capital expenditure? YES NO
   2. For a cost escalation, indicate the amount of the original approved capital expenditure that has been obligated.
   3. Complete the following “Cost Breakdown” for all proposals requiring a capital expenditure. If the application is for a change of location of a proposed health facility or a cost escalation, use Table D. Do not include debt service reserve fund, as this is not a capitalized expenditure.

## ESTIMATED CAPITAL COST

* + 1. Predevelopment Costs:
       1. Preliminary and programming costs $
       2. Site acquisition $
       3. Architectural and engineering costs $
    2. Physical Plant Costs:
       1. Construction or renovation costs (including fixed equipment) $
       2. Building (purchase price or fair market value if leased\*) $
       3. Site improvement costs $
    3. Other:
       1. Financing costs (e.g., underwriters discount fees, etc.) $
       2. Interest during construction $
       3. Contingency (e.g., change orders, etc.) $
       4. Other (specify) $
    4. Equipment (purchase price or fair market value, if leased\*):
       1. New $
       2. Replacement $

**TOTAL** $

\* Fair market value shall be calculated by multiplying the annual lease payment by seven.

* 1. Complete the following “Cost Breakdown” for all changes of location of a proposed health facility or cost escalations. Do not include debt service reserve fund, as this is not a capitalized expenditure.

## ESTIMATED CAPITAL COST

Increase/

* + 1. .Predevelopment Costs: Original Current Decrease
       1. Preliminary and programming costs $ $ $
       2. Site acquisition $ $ $ c Architectural and engineering costs $ $ $
    2. Physical Plant Costs:
       1. Construction or renovation costs

(Including fixed equipment) $ $ $

* + - 1. Building (purchase price or fair market $

value, if leased\*) $ $

* + - 1. Site improvement costs $ $ $
    1. Other:
       1. Financing costs $ $ $ (e.g., underwriters discount fees, etc.)
       2. Interest during construction. $ $ $
       3. Contingency (e.g., change orders, etc.) $ $ $
       4. Other (specify) $ $ $
    2. Equipment (include fair market value, if leased\*):
       1. New $ $ $
       2. Replacement $ $ $

**TOTAL** $ $ $

\*Fair market value of space shall be calculated by multiplying the annual lease payment by seven.

* 1. Submit documentation of the fair market value of any land, building, (or part thereof), or equipment to be acquired by purchase, lease, donation, transfer, or other comparable arrangement.

(See Appendix # )

* 1. Does this proposal involve a lease arrangement (facility, building, land, equipment, service, etc.)?

Yes No

Capital Lease Operating Lease

If yes, please explain the arrangements and identify all parties for each lease.

* 1. If this proposal involves a lease arrangement, please complete the following:

Annual Lease Years of

Payment Lease

* + 1. Facility $
    2. Building $
    3. Land $
    4. Equipment (specify) $

$

$

$

* + 1. Other $
  1. List major equipment proposed to be acquired (purchased, leased, or donated) with a value greater than the major medical equipment expenditure minimum set forth at https://chfs.ky.gov/agencies/os/oig/dcn. Include costs of shipping and installation. For leased or donated equipment, list the appraised fair market value.

### Equipment Item Cost or Fair Market Value

* 1. Provide the following square footage and cost information for all construction and renovation projects reflecting total construction and renovation costs as reported in subsection C(2)a. or D(2)a.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | NEW CONSTRUCTION |  |
| New Construction Gross Square Footage | New Construction Costs | Construction Costs Per  Gross Square Foot |
| Nursing Unit Areas |  |  |  |
| Ancillary Services Areas |  |  |  |
| Administration Areas |  |  |  |
| Circulation Spaces |  |  |  |
| Maintenance and Support Areas |  |  |  |

TOTAL

RENOVATION

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Nursing Unit Areas | Existing Gross Square Footage |  | Renovated Gross Square Footage |  | Renovation Costs |  | Renovation Cost Per Gross Square Foot |
| Ancillary Services Areas |  |  |  |  |  |  |  |
| Administration Areas |  |  |  |  |  |  |  |
| Circulation Spaces |  |  |  |  |  |  |  |
| Maintenance and Support Areas |  |  |  |  |  |  |  |
| TOTAL |  |  |  |  |  |  |  |

* 1. If this proposal involves the addition of new beds, complete the following:

Construction or Renovation cost per bed\* $ Gross square feet per bed

\*Use amount as stated in question C.(2)a.

* 1. Explain any unusual factors that tend to increase project costs (i.e., site preparation, type construction, etc.).
  2. Indicate the proposed sources of capital funds for the expenditure reported in question C.

|  |  |
| --- | --- |
| Cash or Negotiable Securities | $ |
| Gifts of Bequests | $ |
| Grant | $ |
| (Specify type and timetable for application and commitment) |  |
| Mortgage/Loan | $ |
| (Specify type and timetable for application and commitment) |  |
| Bonds | $ |
| (Specify type and timetable for application and commitment) |  |
| Total Funds Available | $ |

(Total MUST correspond to total questions C. and D. unless a lease or existing ownership is involved)

* 1. If funds are to be generated externally, attach a letter from the funding source indicating that it has been contacted in regard to the possible financing of the project. If internally, attach a letter from the institution’s chief executive or chief operating officer indicating that the funds are available for possible commitment to this project.

(See Appendix # )

* 1. Estimated terms of the ~~d~~ebt.

Mortgage or Loans $ Bonds $ Interest Rate % Interest Rate % Payment Period yrs. Payment Period yrs. Annual Debt Service $ Annual Debt Service $

Tax Exempt ( ) yes ( ) no

Debt Service Reserve

Fund $

## SECTION D - PROJECT SCHEDULE

1. Complete the following project schedule by filling in all dates that are applicable to the project. Indicate the projected dates of:
   1. Land (site) acquisition
   2. Plans and specifications completed
   3. Plans and specifications submitted to the Fire Marshal and the Office of Inspector General, Division of Health Care
   4. Funding or financing secured
   5. Contracts secured and signed
      1. construction
      2. equipment
   6. Construction time frames
      1. commencement of construction
      2. completion of shelled-in structure
      3. completion of construction
   7. Date of licensure
2. Please sign and date the application.

I hereby declare that, to the best of my knowledge, the information provided in this application is true and accurate.

Authorized Signature Date

Name (printed)

Title