COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED

Instructions for Certificate of Need Application
CON - FORM 2A

FORMAL AND ADMINISTRATIVE OR
NON-SUBSTANTIVE REVIEW

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, other than for ground ambulance service, 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.

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

(2) 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.

(3) 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.

(4) 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.**

(5) 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.

(6) Please print name, sign, and date the application.

DETACH THIS SHEET BEFORE SUBMITTING THE APPLICATION

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

COMMONWEALTH OF KENTUCKY
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CERTIFICATE OF NEED APPLICATION

FORMAL AND ADMINISTRATIVE OR NON-SUBSTANTIVE REVIEW

SECTION A: GENERAL INFORMATION

1. FACILITY, PROGRAM, OR SERVICE:
   NAME _____
   PHYSICAL STREET ADDRESS _____
   CITY/STATE/ZIP _____
   COUNTY _____

2. OWNER OF THE FACILITY or SERVICE (business entity to be licensed):
   NAME _____
   ADDRESS _____
   CITY/STATE/ZIP _____

3. CONTACT PERSON:
   NAME _____ (Title) _____
   ADDRESS _____
   COMPANY _____
   CITY/STATE/ZIP _____
   TELEPHONE NUMBER _____
   EMAIL ADDRESS _____

Complete all pertinent questions. If not applicable, indicate NA.

4. ATTORNEY'S NAME (If applicable) _____
   ADDRESS _____
   CITY/STATE/ZIP _____
   TELEPHONE NUMBER _____

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

   _____ Sole Proprietorship
   _____ Partnership limited _____ general _____
   _____ 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)

6. List the name and business address of any owner, investor, or stockholder whose ownership interest is greater than 10%.

7. If the owner is a corporation, attach evidence of incorporation.
   (See Appendix # _____)

8. If the owner is a partnership, submit a copy of the partnership agreement.
   (See Appendix # _____)

9. If the owner is an out of state corporation, attach evidence of Kentucky registration and identify the process agent.
   (See Appendix # _____)

10. If the existing facility or service or the proposed facility or service will be managed by someone other than the owner, identify and explain the relationship.

Complete all pertinent questions. If not applicable, indicate NA.

SECTION B - PROJECT DESCRIPTION

1. Clearly define and describe the proposed project. This description shall include all components of the proposed project, i.e., services to be provided, details of construction or renovation projects with square footages before and after construction or renovation, the size proposed for each area after completion, present and proposed location of each affected department for renovation projects, the use planned for any vacated areas for relocated departments, etc.

2. If you are an existing facility or your proposal involves beds or the services listed below, please complete the following table. (Identify deletions or conversions of beds by placing a negative sign (-) before the number proposed to be deleted or converted from and a positive sign (+) before the number proposed to be added or converted to.)

ACUTE CARE	CURRENT LICENSED BEDS	CON APPROVAL	PROPOSED ADDITIONS OR DELETIONS	PROPOSED CONVERSIONS	TOTAL AFTER COMPLETION OF PROJECT
Total Acute Care (excluding neonatal)					
Neonatal Level II					
Neonatal Level III					
Neonatal Level IV					
TOTAL					

OTHER	CURRENT LICENSED BEDS	CON APPROVAL	PROPOSED ADDITIONS OR DELETIONS	PROPOSED CONVERSIONS	TOTAL AFTER COMPLETION OF PROJECT
Chemical Dependency Treatment					
Physical Rehabilitation					
Psychiatric					
TOTAL					

LONG TERM CARE	CURRENT LICENSED BEDS	CON APPROVAL	PROPOSED ADDITIONS OR DELETIONS	PROPOSED CONVERSIONS	TOTAL AFTER COMPLETION OF PROJECT
ICF-IID					
Nursing Facility					
Nursing Home					
Personal Care					
Other					
TOTAL					

OTHER SERVICES	CURRENT LICENSED BEDS	CON APPROVAL	PROPOSED ADDITIONS OR DELETIONS	PROPOSED CONVERSIONS	TOTAL AFTER COMPLETION OF PROJECT
Cardiac Catheterization Labs					
Linear Accelerator					
MRI					
PET					
Other (Identify)					
TOTAL					

3. If the proposal involves a new or relocated facility or service, attach a map that identifies the proposed location unless the new service is to be located in an existing licensed facility.
(See Appendix # _____)

Complete all pertinent questions. If not applicable, indicate NA.

SECTION C – NONSUBSTANTIVE REVIEW

If there are no review criteria in the State Health Plan for the health facility or service described in your application or your application meets the nonsubstantive review requirements of 900 KAR 6:075, you may request that your application be granted nonsubstantive review status. Please indicate if you are requesting nonsubstantive review.

YES _____ I am requesting nonsubstantive review.*

NO _____ I am not requesting nonsubstantive review.

*If you are requesting nonsubstantive review, please complete only the following questions in the remainder of the application:

- Section D – Certificate of Need Review Criteria:
  - 1 (if applicable),
  - 2 A (1-5),
  - 4 A,
  - 4 B,
  - 4 D,
  - 4 F,
  - 4 M,
  - 4 N,
  - 4 O,
  - 4 P(1) and
  - 4 P(2)
- Section E

SECTION D - CERTIFICATE OF NEED REVIEW CONSIDERATIONS

1. Consistency with Plans

Explain in detail whether the proposal is consistent with 900 KAR 5:020, the State Health Plan. Be sure to address each review criteria contained in the State Health Plan for the type of health facility or health service that is being proposed.

2. Need and Accessibility

A. Need

(1) Identify the geographic area that this proposal seeks to serve and document how it was determined that there is a need for this proposal in the defined geographic area.

(2) Document the applicant's ability to meet the need identified above.

(3) If the proposal involves an existing facility or service, provide the percentage of occupancy based on licensed bed capacity, the number of procedures performed, and the number of patients served during the last 12 months.

(4) Estimate, by type of bed or clinical service, the utilization of the proposed facility or services (percentage of occupancy, number of procedures to be performed, and number of patient days and patients to be served) for the first and second year of operation following completion of the project. State whether your projections are on a cumulative or noncumulative basis. Document the method used to determine these projections.

(5) Estimate the number of patients and the county of origin of patients to be served in the first and second years of operation.

Year One		
County of Origin	**Number of Patients**	**Percentage of Patients Served**

*Add rows if needed

Year Two		
County of Origin	**Number of Patients**	**Percentage of Patients Served**

*Add rows if needed

Complete all pertinent questions. If not applicable, indicate NA.

B. Accessibility

Explain to what extent the proposed facility or service will be available to all residents of the geographic area that will be served.

3. Interrelationships and Linkages

A. Explain in detail how this proposal will serve to accomplish appropriate and effective linkages with other services, facilities, and elements of the health care system in the region and state, and provide documentation of efforts to secure linkages.

B. Explain in detail the applicant's efforts to achieve comprehensive care, proper utilization of services, and efficient functioning of the health care system.

4. Costs, Economic Feasibility, and Resources Availability

A. Does this proposal require a capital expenditure?
YES _____ NO _____

If yes, complete the following "Estimated Capital Cost". Do not include debt service reserve fund, as this is not a capitalized expenditure.

ESTIMATED CAPITAL COST

(1) Predevelopment Costs:

a. Preliminary and programming costs $ _____
b. Site acquisition $ _____
c. Architectural and engineering costs $ _____

(2) Physical Plant Costs:

a. Construction or renovation costs (including fixed equipment) $ _____
b. Building (purchase price or fair market value, if leased*) $ _____
c. Site improvement costs $ _____

(3) Other:

a. Financing costs (e.g. underwriters discount fees, etc.) $ _____
b. Interest during construction $ _____
c. Contingency (e.g., change orders, etc.) $ _____
d. Other (specify) $ _____

(4) Equipment (include fair market value, if leased*):

a. New $ _____
b. Replacement $ _____
TOTAL $ _____

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

Complete all pertinent questions. If not applicable, indicate NA.

B. Does this proposal involve any lease arrangement (building, equipment, service, etc.)?

YES _____ NO _____

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

C. Submit documentation of the fair market value of any equipment to be acquired by purchase, lease, donation, transfer or other comparable arrangement.
(See Appendix # _____)

D. If this proposal involves a lease arrangement, complete the following:

		Annual Lease Payment	Years of Lease
(1)	Equipment (Specify)	$ _____	_____
		$ _____	_____
		$ _____	_____
		$ _____	_____
(2)	Other (Building, etc.)	$ _____	_____

E. List major equipment proposed to be acquired (purchased, leased, or donated) with a value that is equal to or greater than the major medical equipment expenditure minimum found at 900 KAR 6:030. Include costs of shipping and installation. For leased or donated equipment, list the appraised fair market value.

Equipment Item	Cost/Fair Market Value

Complete all pertinent questions. If not applicable, indicate NA.

F. Provide the following square footage and cost information for all construction and renovation projects reflecting total construction or renovation costs as reported in question 4.A.(2)a.

NEW CONSTRUCTION

	New Construction Gross Square Footage	New Construction Costs	Construction Cost Per Gross Square Foot
Nursing Unit Areas			
Ancillary Services Areas			
Administration Areas			
Circulation Spaces			
Maintenance or Support Areas			
TOTAL			

RENOVATION

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

G. 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 4. A. (2) a.

Complete all pertinent questions. If not applicable, indicate NA.

H. Explain any unusual factors that tend to increase project costs (i.e., site preparation, type of construction, etc.).

I. Indicate the proposed sources of capital funds for the expenditure reported in question 4. A.

Cash or Negotiable Securities	$	_____
Gifts of Bequests	$	_____
Grant	$	_____
(Specify type and timetable for application and commitment)		_____
Mortgage or 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 from question 4.A., excluding fair market value of space and equipment)

J. 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 # _____)

K. Estimated terms of the debt

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	$ _____	

L. What is the projected operational break-even level of this project? How is this determined? When is break-even expected to occur?

Complete all pertinent questions. If not applicable, indicate NA.

M. If this proposal involves an existing facility or service, provide the following patient-payment classification for the previous two fiscal years including ancillaries. The total gross revenue shall equal the gross patient revenue from 4.P.(1). Contractual allowances shall not be deducted from Medicare and Medicaid. (If less than twelve months, please indicate.)

	Number of Patient Days or Encounters		Gross Revenue	
	20 ____	20 ____	20 ____	20 ____
Medicare				
Medicaid				
SSI/State Supplemental Assistance				
Third Party Payors				
Self Pay				
Charity				
TOTAL				

N. If this proposal involves an existing facility or service, estimate the following patient-payment classification for the first two fiscal years of operation of the total facility or service including ancillaries after implementation of this proposal, if approved. The total gross revenue shall equal the gross patient revenue from 4.P.(1). Contractual allowances shall not be deducted from Medicare and Medicaid. (If less than twelve months, please indicate.)

	Number of Patient Days/Encounters		Gross Revenue	
	20 ____	20 ____	20 ____	20 ____
Medicare				
Medicaid				
SSI/State Supplemental Assistance				
Third Party Payors				
Self Pay				
Charity				
TOTAL				

Complete all pertinent questions. If not applicable, indicate NA.

O. Estimate the following patient-payment classification for the first and second years of operation for this proposal including ancillaries. The total gross revenue shall equal the gross patient revenue from 4.P.(2). Contractual allowances shall not be deducted from Medicare and Medicaid. (If less than twelve months, please indicate.)

	Number of Patient Days or Encounters		Gross Revenue	
	20 _____	20 _____	20 _____	20 _____
Medicare				
Medicaid				
SSI/State Supplemental Assistance				
Third Party Payors				
Self Pay				
Charity				
TOTAL				

Complete all pertinent questions. If not applicable, indicate NA.

P.(1) Complete the following income statement for the past two fiscal years of operation of the total facility and for the first two fiscal years of operation of the total facility after the proposal has been implemented, including the revenues and expenses of this proposal. Services such as home health, ambulance service, etc. shall provide the following information for the total operation of the service. Also, indicate the number of patient days or units of service for the corresponding fiscal year. (If less than twelve months, please indicate.)

	Expenses and Revenue			
	Previous Two Fiscal Years		Projected Two Fiscal Years	
	20 ____	20 ____	20 ____	20 ____
Gross Patient Revenue*				
Non-Patient Revenue**				
Income Adjustments:				
Charity				
Bad Debt				
Contractual Allowances				
Adjusted Gross Revenue				
Operating Expenses:				
Payroll (include all payroll taxes)				
Interest				
Depreciation				
Other Direct Expenses*** (include all non-payroll and non-income taxes)				
Indirect Expenses				
Total Operating Expenses				
Revenue Before Income Taxes				
Federal and State Taxes**** (if applicable)				
Net Revenue (Loss)				
Units of Service				
Patient Days				

*Include revenue from sales of ancillary items.

**Include donations, investment or interest revenue, bequests, etc.

***Include expenses associated with ancillary items included in gross revenue.

****Include benefits of net operating loss carrybacks and carryforwards.

Complete all pertinent questions. If not applicable, indicate NA.

P. (2) Complete the following income statement for the specific proposed services for the first two fiscal years of operation. If the proposal pertains to an expansion, provide the previous two fiscal years of expenses and revenues. Also, indicate the number of patient days or units of service for the corresponding fiscal year.

	Expenses and Revenue			
	Previous Two Fiscal Years		Projected Two Fiscal Years	
	20 ____	20 ____	20 ____	20 ____
Gross Patient Revenue*				
Non-Patient Revenue**				
Income Adjustments:				
Charity				
Bad Debt				
Contractual Allowances				
Adjusted Gross Revenue				
Operating Expenses				
Payroll (include all payroll taxes)				
Interest				
Depreciation				
Other Direct Expenses*** (include all non-payroll and non-income taxes)				
Indirect Expenses				
Total Operating Expenses				
Revenue Before Income Taxes				
Federal and State Taxes**** (if applicable)				
Net Revenue (Loss)				
Units of Service				
Patient Days				

*Include revenue from sales of ancillary items.

**Include donations, investment or interest revenue, bequests, etc.

***Include expenses associated with ancillary items included in gross revenue.

****Include benefits of net operating loss carrybacks and carryforwards.

Complete all pertinent questions. If not applicable, indicate NA.

Q.

(1) What types and number of personnel will be required to implement this proposal, if approved (RNs, LPNs, physicians, technicians, aides, etc.)? Indicate in Full Time Equivalents (FTE). Add rows as necessary.

Personnel by Credentials (RN, LPN, tech, etc.)	Number of Personnel	FTE

(2) Describe the availability of the skilled and supportive personnel required to staff components of this proposal and in-service training programs for staff.

R. Indicate present and projected patient costs per adjusted patient day or unit of service and present and projected patient charges per adjusted patient day or unit of service. Identify units of service (i.e. 15 minutes, 30 minutes, etc.). Attach a present and projected fee schedule including break down by type of procedure, if applicable. (See Appendix #_____).

5. Quality of Services

A. Provide information on previous health care experience, education, etc. for principals responsible for assuring that quality care will be provided.

B. Identify each type of license, certification, and accreditation currently held by the facility or service or those required to implement the project.

C. If the applicant is accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting body, attach evidence of the current accreditation status. (Attach and identify as Appendix #_____).

D. If the applicant is an existing health service provider, attach the most recent licensure inspection report from the Office of Inspector General, Division of Health Care. If deficiencies were noted in the report, attach the plan of correction. (Attach and identify as Appendix #_____)

Complete all pertinent questions. If not applicable, indicate NA.

SECTION E - PROJECT SCHEDULE

1. Complete the following project schedule by filling in all dates that are applicable to the project.

A. Land (site) acquisition _____

B. Plans and specifications completed _____

C. Plans and specifications submitted to the:

(1) Fire Marshal _____

(2) Office of Inspector General _____

D. Funding or financing secured _____

E. Contracts secured and signed:

(1) Construction _____

(2) Equipment _____

F. Construction time frames

(1) Commencement of construction _____

(2) Completion of shelled-in structure _____

(3) Completion of construction _____

G. 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

Complete all pertinent questions. If not applicable, indicate NA.