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.

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 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 _____

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

NAME _____
ADDRESS _____
CITY/STATE/ZIP _____

3. CONTACT PERSON:

NAME _____
COMPANY _____ (Title)
ADDRESS _____
CITY/STATE/ZIP _____
TELEPHONE NUMBER _____
EMAIL ADDRESS _____

4. ATTORNEY'S NAME (if applicable): _____
ADDRESS _____

Complete all questions, if not applicable indicate NA.

CITY/STATE/ZIP _____
TELEPHONE NUMBER _____

5. 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;
   _____ B. To replace or relocate a licensed health services facility if there is no substantial change in health services, service area, or bed capacity;
   _____ C. 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
   _____ D. For cost escalations.

6. 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)

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

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

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

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

11. 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.

Complete all questions, if not applicable indicate NA.

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

   A. Describe and document the need to relocate, escalate the capital expenditure, or replace the facility or equipment.

2. Costs, Economic Feasibility, and Resources Availability

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

   B. For a cost escalation, indicate the amount of the original approved capital expenditure that has been obligated.

Complete all questions, if not applicable indicate NA.

C. 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:

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 (purchase price or 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 questions, if not applicable indicate NA.

D. 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

		Original	Current	Increase/ Decrease
(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 of space shall be calculated by multiplying the annual lease payment by seven.

Complete all questions, if not applicable indicate NA.

E. 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 # _____)

F. 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.

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

			Annual Lease Payment	Years of Lease
(1)	Facility	$		
(2)	Building	$		
(3)	Land	$		
(4)	Equipment (specify)	$		
		$		
		$		
		$		
(5)	Other	$		

H. 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**

Complete all questions, if not applicable indicate NA.

I. 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

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

Complete all questions, if not applicable indicate NA.

J. 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.

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

L. 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)

M. 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 # _____)

N. 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	$ _____	

Complete all questions, if not applicable indicate NA.

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:

A. Land (site) acquisition _____

B. Plans and specifications completed _____

C. Plans and specifications submitted to the Fire Marshal and the Office of Inspector General, Division of Health Care _____

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 questions, if not applicable indicate NA.