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

COST ESCALATION FORM

1. APPLICANT: _____

2. FACILITY or SERVICE NAME (if different):
_____

3. CERTIFICATE OF NEED NUMBER: _____

4. DATE CERTIFICATE OF NEED ISSUED: _____

5. SCOPE OF PROJECT AS STATED ON CERTIFICATE OF NEED: _____

_____

6. Please complete the following:

A. Total capital expenditure required for the project $ _____

B. Capital expenditure authorized by certificate of need or previously approved cost escalation $ _____

C. Total cost escalation (A – B) $ _____

7. Please delineate the factors that have caused the cost escalation.

8. Has the scope of the project changed since the original approval in terms of proposed beds or services, square footage for construction projects, or other factors?
YES____ NO_____

If yes, please describe the change and explain why the change is necessary.

9. Has the CON holder obligated a capital expenditure in excess of the amount authorized by an existing certificate of need or a previously approved administrative escalation? KRS 216B.015(35) states: "'To obligate' means to enter any enforceable contract for the construction, acquisition, lease, or financing of a capital asset. A contract shall be considered enforceable when all contingencies and conditions in the contract have been met."

   NO ____ YES _____ If yes, please indicate the amount of the obligation and date and type of obligation incurred.

10. I hereby declare to the best of my knowledge that the information provided on this form is true and accurate.

_____
(SIGNATURE OF APPLICANT) (DATE)

_____
(NAME – PRINT)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP CODE)

_____
(TELEPHONE NUMBER – INCLUDING AREA CODE)

_____
(EMAIL ADDRESS)

COMPLETE AND RETURN TO:

OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED
275 EAST MAIN STREET 5EA
FRANKFORT, KY 40621
Phone: (502) 564-9592
Email: CON@ky.gov
Fax: (502) 564-6546