COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED

Instructions for Certificate of Need Application
OHP – 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, all applications for Certificate of Need are required to complete this application form.

The original application form and one (1) copy must be submitted to the Office of Health Policy no less than thirty (30) days after filing a letter of intent.

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. ANSWER ALL QUESTIONS. IFTHE 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, should 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 _____

   ADDRESS
   (Exact location – not PO Box #) _____

   CITY/STATE/ZIP _____

   COUNTY _____

2. OWNER OF THE FACILITY, PROGRAM, OR SERVICE:
   (Legally responsible person, corporation or other entity who is or will be the license holder)

   NAME _____

   ADDRESS _____

   CITY/STATE/ZIP _____

3. CONTACT PERSON:

   NAME _____
   (TITLE)

   ADDRESS _____

   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/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 instrumentality's 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 must include all components of the proposed project, i.e., services to be provided, details of construction/renovation projects with square footages before and after construction or renovation, the size proposed for the area(s) 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 the proposal includes a request for long-term care beds, please complete the following:

   A. Total number of beds requested:

   Nursing Facility Beds _____
   Intermediate Care Beds _____
   Skilled Nursing Beds _____
   Total number of Beds _____

   B. Total Number of beds to be certified for Medicaid participation

   Nursing Facility Beds _____
   Intermediate Care Beds _____
   Skilled Nursing Beds _____
   Total number of Beds _____

   C. Expected date that Medicaid Certification will be sought

   Date

   Nursing Facility Beds _____
   Intermediate Care Beds _____
   Skilled Nursing Beds _____

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

3. 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 ADDTIONS OR DELETIONS	PROPOSED CONVERSIONS	TOTAL AFTER COMPLETION OF PROJECT
Medical/Surgical					
Obstetrics					
Pediatric					
Neonatal Level II					
Neonatal Level III					
I C U					
C C U					
Other (Identify)					
TOTAL					

OTHER	CURRENT LICENSED BEDS	CON APPROVAL	PROPOSED ADDTIONS OR DELETIONS	PROPOSED CONVERSIONS	TOTAL AFTER COMPLETION OF PROJECT
Chem. Dependency Treatment					
Physical Rehab.					
Psychiatric					
Personal Care					
TOTAL					

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

OTHER SERVICES	CURRENT LICENSED BEDS	CON APPROVAL	PROPOSED ADDITIONS OR DELETIONS	PROPOSED CONVERSIONS	TOTAL AFTER COMPLETION OF PROJECT
Operating Rooms (including cysto rooms)					
Cardiac Catheterization Labs					
Open Heart Surgery Operating Rooms					
Linear Accelerator/Cobalt					
MRI					
Lithotripter					
Other (Identify)					
TOTAL					

4. If the proposal involves a new or relocated facility/service, attach a map which identifies the proposed location unless the new service is to be located in an existing 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 you may request that your application be granted nonsubstantive review status pursuant to 900 KAR 6:075. 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, only Subsection 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) of Section D (Certificate of Need Review Criteria) and Section E of the remainder of this application must be completed.

SECTION D - CERTIFICATE OF NEED REVIEW CONSIDERATIONS

1. Consistency with Plans.

Explain in detail whether the proposal is consistent with 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 % 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/services (% 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 expected patient origin for the first and second years of operation in terms of patient and percentages of the total number of patients by county.

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/engineering costs $ _____

(2) Physical Plant Costs:

a. Construction and/or renovation costs (Including fixed equipment) $ _____
b. Building (purchase price or FMV, 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 FMV, if leased):

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

* Fair market value should be calculated by multiplying the annual lease payment by 7.

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

B. Does this proposal involve any lease arrangement (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:

		LEASE COST	
		Annual Lease Payment	Years of Lease
(1)	Equipment (Specify)	$ _____	_____
		$ _____	_____
		$ _____	_____
		$ _____	_____
(2)	Other	$ _____	_____

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 and/or renovation costs as reported in question 4 A (2) a.

NEW CONSTRUCTION

	Existing Gross Square Footage	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/Support Areas				
TOTAL				

RENOVATION

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

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

Construction/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 & commitment)		_____
Mortgage/Loan	$	_____
(Specify type and timetable for application & commitment)		_____
Bonds	$	_____
(Specify type and timetable for application & 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/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 pertinent questions. If not applicable, indicate NA.

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

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

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

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

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 and/or service including ancillaries after implementation of this proposal, if approved. (If less than twelve months please indicate) The total gross revenue should equal the gross patient revenue from 4 P.(1). Contractual allowances should not be deducted from Medicare and Medicaid.

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

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

	Number of Patient Days/Encounters		Gross Revenue	
	20 _____	20 _____	20 _____	20 _____
Medicare				
Medicaid				
SSI/State Supplemental Assistance				
Third Party Payors				
Self Pay				
Charity				
Uncollectibles				
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. (If less than twelve months please indicate.) Services such as home health, ambulance service, etc. must 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				
Uncollectibles				
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/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				
Uncollectibles				
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/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 (RN's, LPN's, physicians, technicians, aides, etc.)? Indicate in Full Time Equivalents (FTE). If you are an existing health service provider, indicate the number and types of additional personnel that will be need to be hired.

(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/unit of service and present and projected patient charges per adjusted patient day/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 #_____).

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

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 the type(s) of license(s), certification(s) and accreditation(s) currently held by the facility/service and/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. If deficiencies were noted in the report, attach the plan of correction. (Attach and identify as Appendix #_____)

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 Marshall _____
      (2) Office of Inspector General _____

   D. Funding/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. Completion and Operation of Project _____

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 - Print)

   _____
   (Title)

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