

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 Ground Ambulance Service
CON FORM - 2B**

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.

This original form, one copy and the filing fee must be received in this office by 4:30 p.m. on the deadline in 900 KAR 6:060. The forms and fee should 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.

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, 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: _____
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COMMONWEALTH OF KENTUCKY
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APPLICATION FOR GROUND AMBULANCE SERVICE

SECTION A: GENERAL INFORMATION

1. SERVICE NAME _____
PHYSICAL STREET ADDRESS _____
CITY/STATE/ZIP _____
COUNTY _____

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

3. CONTACT PERSON _____ (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. If you are requesting nonsubstantive review status under KRS 216B.095 (3) (e) for the establishment of an industrial ambulance, please indicate.
Yes _____ No _____

6. 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)

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 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. Please indicate the class ambulance service proposed pursuant to 202 KAR 7:545 License Classifications. Clearly define and describe the proposed project. Indicate the number of vehicles you intend to operate, and the area to be served. Also, indicate whether the proposed services will be a basic life support or advanced life support service.
2. Pursuant to 202 KAR 7:501, clearly define the proposed geographic service area. Clearly describe the area in terms of specific geographic and governmental boundaries and attach a map identifying the proposed service area. Fire protection district is not an acceptable description.
3. If you are an existing service, describe your existing service including the type of service, number of vehicles operated, the geographic service area and if basic or advanced life support services are provided.

SECTION C - CONFORMANCE WITH CRITERIA

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 ambulance services.

2. Need and Accessibility

The proposal shall meet an identified need in a defined geographic area and be accessible to all residents of the area. A defined geographic area shall be defined as the area the proposal seeks to serve, including its demographics, and shall not be limited to the geographical boundaries.

- A. Describe the need for the service in this proposed service area. **Document how this need was determined.** Demonstrate if patients currently have access to the proposed services in the proposed service area and specific ways in which accessibility of the service will be increased by this project.
- B. Estimate the number of emergency runs expected to be made in the first year of operation and **document how this need was determined.**
- C. Estimate the number of non-emergency health transportation runs expected to be made in the first year of operation and **document how this need was determined.**
- D. If you are an existing service, how many emergency and/or non-emergency runs were made in the last twelve (12) months?

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

- E. Estimate the expected patient origin for the first and second years of operation in terms of number of patients and percentages of the total number of patients by county.
- F. What will the response time be from the base location to the farthest point within the defined serviced area?

3. Interrelationships and Linkages

The proposal shall serve to accomplish appropriate and effective linkages with other services, facilities, and elements of the health care system in the region and state, accompanied by assurance of effort to achieve comprehensive care, proper utilization of services and efficient functioning of the health care system.

- A. Provide evidence of community/provider support and endorsement for the proposed project. Attach **original** letters of support from organizations or individuals in the proposed service area such as:

_____ the local medical society or other provider organizations;
_____ other health service providers;
_____ consumer/civic organizations;
_____ community service providers.

(See Appendix # _____)

Form letters and petitions are not recommended to be submitted as letters of support.

- B. List and describe below the nature of all working relationships (formal and informal) and arrangements which have been made with other health service providers to assure appropriate back-up and support services or which provide for sharing of services or equipment.
- C. Identify existing services (ground ambulance or non-emergency transportation) currently providing services in the proposed area which address the current needs identified in this application.

4. Costs, Economic Feasibility and Resources Availability

The proposal, when measured against the cost of alternatives for meeting needs, shall be judged to be an effective and economical use of resources, not only of capital investment, but also ongoing requirements for health manpower and operational financing.

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

YES _____ NO _____

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

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

		<u>LEASE COST</u>	
		Annual Lease Payment	Years of Lease
(1)	Vehicle(s)	\$ _____	_____
(2)	Building	\$ _____	_____
(3)	Land	\$ _____	_____
(4)	Equipment (Specify)	\$ _____	_____
	_____	\$ _____	_____
	_____	\$ _____	_____
	_____	\$ _____	_____
(5)	Other _____	\$ _____	_____

F. 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.

G. Are capital funds to be generated externally or internally? If externally, attach a letter from the funding source indicating that they have been contacted in regard to the possible financing of the project. If internally, attach letter from the institution's president or chairman of the board indicating that the funds are available for possible commitment to this project.

_____ Internally
 _____ Externally
 (See Appendix # _____)

H. 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/Loan (Specify type and timetable for application and commitment)	\$ _____
Bonds (Specify type and timetable for application and commitment)	\$ _____
Total Funds Available	\$ _____

I. What are the 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.

J. Personnel

What types of personnel and how many will be required if this proposal is approved (EMTs, 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

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

L. If you are an existing provider, list charges for each patient run and projected charges after implementation of this proposal.

	CURRENT		PROJECTED	
	BLS	ALS	BLS	ALS
(1) Base rate (\$# of miles included)				
(2) Additional mileage				
(3) Additional charges (oxygen, IVs, etc.)				

(Attach fee schedule)

M. If you are proposing a new service, what will be the charges for each patient run?

	PROJECTED	
	BLS	ALS
(1) Base rate (\$# of miles included)		
(2) Additional mileage		
(3) Additional charges (oxygen, IVs, etc.)		

(Attach fee schedule)

N. If this proposal involves an existing service, provide the following patient payment information for the previous two fiscal years. Contractual allowances should not be deducted from Medicare and Medicaid. (If less than twelve months please indicate)

<u>Number of Runs</u>		<u>Revenue</u>	
20 _____	20 _____	20 _____	20 _____

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

Medicare	_____	_____	_____	_____
Medicaid	_____	_____	_____	_____
Third Party Payors	_____	_____	_____	_____
Self Pay	_____	_____	_____	_____
Charity	_____	_____	_____	_____
Uncollectibles	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

O. If you are proposing a new or expanded service, estimate for the first and second year of operation. Contractual allowances should not be deducted from Medicare and Medicaid. (If less than twelve months please indicate.)

	<u>Number of Runs</u>		<u>Revenue</u>	
	20 _____	20 _____	20 _____	20 _____
Medicare	_____	_____	_____	_____
Medicaid	_____	_____	_____	_____
Third Party Payors	_____	_____	_____	_____
Self Pay	_____	_____	_____	_____
Charity	_____	_____	_____	_____
Uncollectibles	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

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

P. Complete the following income statement for the past two fiscal years of operation of the **total service** and for the first two fiscal years of operation of the **total service** after the proposal has been implemented, including the revenues and expenses of this proposal. (If less than twelve months, please indicate.)

	<u>Expenses and Revenue</u>			
	<u>Previous Two</u>		<u>Projected Two</u>	
	<u>Fiscal Years</u>		<u>Fiscal Years</u>	
	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)	_____	_____	_____	_____
a. Number of Runs	_____	_____	_____	_____

*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. If the proposal pertains to an expansion, complete the following statement for the first two fiscal years of operation of the expansion only. (If less than twelve months, please indicate.)

	<u>Expenses and Revenue</u>			
	<u>Previous Two</u>		<u>Projected Two</u>	
	<u>Fiscal Years</u>		<u>Fiscal Years</u>	
	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)	_____	_____	_____	_____
a. Number of Runs	_____	_____	_____	_____

*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.

5. Quality of Services

The applicant shall be prepared to and capable of undertaking and carrying out the responsibilities involved in the proposal in a manner consistent with appropriate standards and requirements assuring the provision of quality health care and services.

- A. Identify the type(s) of license(s) currently held by the service and/or those required to implement the project.

- B. If the applicant is an existing provider, attach the most recent licensure inspection report. If deficiencies were noted in the report, attach the plan of correction.
(See Appendix # _____)

- C. Provide information on previous health care experience, education, etc. for principals responsible for assuming that quality care will be provided.

SECTION D – PROJECT SCHEDULE

1. Please complete the following project schedule by filling in all dates that are applicable to the project. Indicate the projected dates of:

- A. Funding/financing secured _____
- B. Building constructed, bought or leased _____
- C. Equipment purchased or leased _____
- D. Personnel trained and employed _____
- E. 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.