

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, each applicant for a Certificate of Need 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: _____ |
|-----------------------------|--------------------------|

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CERTIFICATE OF NEED 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 _____

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

- _____ 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)

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.

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. Clearly define the proposed geographic service area pursuant to 202 KAR 7:501. 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 provider, 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.

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

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 non-emergency runs were made in the last twelve (12) months?
- 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 service 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.

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

- A. Provide evidence of community and 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 or 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 that have been made with other health service providers to assure appropriate back-up and support services or that provide for sharing of services or equipment.
- C. Identify existing services (ground ambulance or non-emergency transportation) currently providing services in the proposed area that 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.

- A. Does this proposal require a capital expenditure? (Note that this includes leases of property, office space and equipment, donations, transfers or comparable arrangements.)

_____ YES _____ NO

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

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

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

| | | <u>Annual Lease Payment</u> | <u>Years of Lease</u> |
|-----|---------------------|---------------------------------|---------------------------|
| (1) | Vehicles | \$ _____ | _____ |
| (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 established by 900 KAR 6:030. Include costs of shipping and installation. For leased or donated equipment, list the appraised fair market value.

| <u>Equipment Item</u> | <u>Cost or Fair Market Value</u> |
|-----------------------|----------------------------------|
|-----------------------|----------------------------------|

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.

(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 or Loan | \$ | _____ |

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

(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 and 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 | \$ _____ |

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)

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

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 shall 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.

- O. If you are proposing a new or expanded service, estimate for the first and second year of operation. Contractual allowances shall 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) | _____ | _____ | _____ | _____ |
| Number of Runs | _____ | _____ | _____ | _____ |

*Include revenue from sales of ancillary items.

**Include donations, investment and 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) | _____ | _____ | _____ | _____ |
| Number of Runs | _____ | _____ | _____ | _____ |

*Include revenue from sales of ancillary items.

**Include donations, investment and 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.

