

**OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES/HEALTH RESOURCES DEVELOPMENT
SERVICE**

P.O. Box 268823

Oklahoma City, OK 73126-8823

Tel. (405) 271-6868 Fax. (405) 271-7360

**CERTIFICATE OF NEED
DISCLOSURE STATEMENT**

Instructions

1. Submit this disclosure statement if the project involves a nursing facility, specialized facility, the nursing care component of a continuum of care facility or skilled nursing unit requesting approval under the Long Term Care Certificate of Need Act. However, if *the applicant is a publicly held company required to file periodic reports under the Securities and Exchange Act of 1934, or a wholly owned subsidiary of a publicly held company, . . . the applicant shall not be required to submit a disclosure statement, but shall submit the most recent annual and quarterly reports required by the Securities and Exchange Commission, which provide information regarding legal proceedings in which the applicant has been involved.*
2. File the disclosure statement with the following Certificate of Need Applications: Standard (#615); Expansion by Ten (10) Beds or Ten Percent (10%) of Capacity (#616); Facility Replacement (#617); Facility Acquisition (#618).
3. The applicant for a long-term care facility shall include:
 - a. The person or entity that is or will be the owner, as that term is defined in 63 O.S. Section 1-1902;
 - b. The person or entity that is or will be the licensee, as that term is defined in 63 O.S. Section 1-1902;
 - c. The person or entity that is or will be, for longer than six (6) months, the manager as that term is defined in OAC 310: 675-1-2; and
 - d. Any person with a controlling interest, as that term is defined in 63 O.S. Section 1-851.1
4. For the purposes of the disclosure statement use the following statutory definitions:

“Person” means any individual, corporation, industry, firm, partnership, association, venture, trust, institution, federal, state or local governmental instrumentality, agency or body or any other legal entity however organized.

“Person with a controlling interest” means a person who meets any one or more of the following requirements:

 - a. Controls fifty percent (50%) or more of the common stock of the corporate entity involved or controls fifty percent (50%) or more of the interest in the partnership involved,
 - b. Controls a percentage of stock greater than any other stockholder or equal to the other single largest stockholder or controls a percentage of partnership interest greater than any other partner or equal to the other single largest partnership interest, or
 - c. A managing member of a Limited Liability Company (LLC).

Disclosure Information

I. Complete Table I for the applicant and **any person with a controlling interest**. The table supplied with this form may be reproduced if more than one (1) page is needed to list the applicant and all appropriate persons. Under the column headed "Authority" on Table I indicate whether or not each person with controlling interest has authority to adopt or substantially influence governing policies that affect the financial performance or quality of care of the facility for which a Certificate of Need has been applied.

II. Complete Table II for *any legal entity in which the applicant holds a debt or equity interest of at least five percent (5%), or which is a parent company or subsidiary of the applicant*. If this item does not apply, confirm by marking an "X" in the following box:

No Table II is attached because the applicant holds no debt or equity interest of at least five percent (5%) in another legal entity and the applicant has no parent or subsidiary company.

III. Attach a description of the experience and credentials of the applicant, including any past or present permits, licenses, certifications, or operational authorizations relating to long-term care facility regulation. If the individual or entity that is or will be the facility's licensee has not established a record of performance in long-term care facility operations in the state of Oklahoma of at least sixty (60) months immediately preceding the filing of the application, then fully describe the credentials and experience of each person with a controlling interest. For each facility listed as proof of experience for a person with controlling interest indicate whether or not that person had authority to adopt or substantially influence governing policies that affected the financial performance or quality of care of the prior holding or operation. Title the attachment as Disclosure Item III. If this item does not apply confirm by marking an "X" in the following box:

No Disclosure Item III is attached because the applicant has no experience or credentials relating to long-term care facility regulation

IV. Attach a listing and explanation of any administrative, civil or criminal legal actions against the applicant or any person with a controlling interest which resulted in a final agency order or final judgment by a court of record including, but not limited to, final orders or judgments on appeal related to long term care in five (5) years immediately preceding the filing of the application. Such actions shall include, without limitation, any permit denial or any sanction imposed by a state regulatory authority or Centers for Medicare and Medicaid Services. Title the attachment as Disclosure Item IV. If this item does not apply confirm by marking an "X" in the following box:

No Disclosure Item IV is attached because no final agency order or final judgment by a court of record has been issued against the applicant or any person with a controlling interest.

V. What percentage of the long-term care facility holdings listed in Disclosure Item III during the preceding sixty (60) months had a facility license or certification revoked, rescinded, canceled, terminated, involuntarily suspended, or refused renewal; or license or certification relinquished voluntarily in lieu of penalty? _____%

If the percentage is 10% or more the Certificate of Need must be refused. If the applicant has experienced some such sanctions but the percentage is less than 10%, submit clear and convincing evidence that the sanctions were not due to the action or inaction of the applicant or any person with a controlling interest. Label the submission as Disclosure Item V.

No Disclosure Item V is attached because the applicant had no facility license or certification revoked, rescinded, canceled, terminated, involuntarily suspended, or refused renewal; or license or certification relinquished voluntarily in lieu of penalty.

VI. Has any nursing facility or specialized facility for persons with Alzheimer's disease or related disorders listed in Disclosure Item III been cited with findings of substandard quality of care or actual harm on the last three (3) consecutive standard or complaint surveys?

Yes No

If "yes," the applicant must submit clear and convincing evidence that the findings were not due to the action or inaction of the applicant or any person with a controlling interest. Label the submission as Disclosure Item VI.

VII. Has any specialized facility for mentally retarded persons or any intermediate care facility for mentally retarded persons listed in Disclosure Item III had three or more routine or complaint surveys that resulted in determinations that the facility was out of compliance with two or more Conditions of Participation in the Medicaid program in the preceding thirty-six (36) months where compliance was not achieved within sixty (60) days?

Yes No

If "yes," the applicant must submit clear and convincing evidence that the non-compliance was not due to the action or inaction of the applicant or any person with a controlling interest. Label the submission as Disclosure Item VII.

VIII. Has the applicant, in all current and prior ownership, operation and management of long-term care facilities complied with all lawful orders of suspension, receivership, temporary management, or administrative penalty issued by the State Health Department or by other authorities with similar responsibilities in other states or by the Center For Medicare and Medicaid Services.

Yes No

If "no," submit clear and convincing evidence that the failure to comply was not due to the action or inaction of the applicant or any person with a controlling interest. Label the submission as Disclosure Item VIII.

IX. Has the applicant had, in the last thirty-six (36) months, *findings of substandard quality of care or noncompliance with two or more conditions of participation on twenty percent (20%) or more of the surveys conducted in the applicant's long-term care facility holdings or against any long-term care facility operated by a person with a controlling interest during the preceding thirty-six months?*

Yes No

Has the applicant had, in the preceding thirty-six (36) months, *a temporary manager, monitor, or receiver appointed?*

Yes No

Has the applicant had, in the preceding thirty-six (36) months, *a civil money penalty imposed of Thirty-five Thousand Dollars or more?*

Yes No

If "yes," submit the name and location of each facility involved, applicable dates, and amounts of any penalties assessed. Label the statement as Disclosure Item IX.

X. If the response to any question in item IX was “yes,” respond to the following:

Were civil money penalties, denials of payment, or other administrative penalties assessed based on findings of substandard quality of care, actual harm, or potential for more than minimal harm, at any of the applicant’s facilities within the preceding 36 months?

Yes

No

Have civil money penalties, denials of payment or other administrative penalties been assessed based on findings of substandard quality of care, actual harm or the potential for more than minimal harm, in 20% or more of the facilities operated by the applicant during the 36 month period?

Yes

No

Submit clear and convincing evidence that the administrative penalty was not due to the applicant’s action or inaction. Label the submission as Disclosure Item X.

XI. Attach a *listing of any federal long-term care agency and any state long-term care agency outside Oklahoma that has or has had regulatory responsibility over the applicant.* Title the attachment as Disclosure Item XI. If this item does not apply, confirm by marking an “X” in the following box:

No Disclosure Item XI is attached, because no federal or state long-term care agency has or has had jurisdiction over the applicant.

Note: *Italic* wording is from 63 O.S. 2001, Sections 1-851 et seq.

Instruction: Attach affirmation for the applicant and for each person with controlling interest.

AFFIRMATION ATTACHMENT

To the Disclosure Statement

By my signature below, I certify that the foregoing is true and correct to the best of my knowledge and belief and also certify that I am not less than twenty-one (21) years of age; of reputable and responsible character; in sound physical and mental health; have not been convicted of a felony in connection with the management or operation of a home, or facility as defined in Section 1-1902 of Title 63 or in the care and treatment of the residents of a home, or facility as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes. If the applicant is a firm, partnership or corporation, the applicant shall not be eligible to be licensed if any member of the firm or partnership or any officer or major stockholder has been convicted of a felony as cited in the above-mentioned law.

Typed or Printed Name of Person Signing for Applicant

Signature of Applicant

Name of Corporation, Partnership or Association

Official Title or Position

State of _____

County of _____

Signed and sworn to (or affirmed) before me on this _____ day of _____, 20____

Name(s) of person(s) making statement.

Seal or Stamp:

Signature of Notary Public

My Commission Expires: _____ / _____ / _____

My Commission Number is: _____

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