

**CERTIFICATE OF NEED APPLICATION
FOR FACILITY ACQUISITION**

INSTRUCTIONS

1. This form is used to request Certificate of Need approval of an acquisition of a long-term care facility or a mental health facility.
2. The original notarized application must be submitted to the Oklahoma State Department of Health, at the address above. Additional copies are not required.
3. **A filing fee must accompany this application.** The capital cost used to calculate the fee is defined in 63 O.S. 2001, Section 1-852.1(C)(2) and OAC 310:4-1-5.

Psychiatric or chemical dependency facilities: The fee is three quarters of one percent (.75%) of the project's capital cost. The minimum fee is \$1,500; the maximum is \$10,000 for psychiatric and chemical dependency facilities.

Long-term care facilities: The fee for nursing facilities, specialized facilities and skilled nursing units is one percent (1%) of the project's capital cost with a minimum fee of \$1,000, and a maximum of \$3,000.

4. Within fifteen (15) days after receipt of the application and fee, the OSDH will send written notice to the contact person stating whether or not the application is complete.

I. FACILITY AND CONTACT PERSON IDENTIFICATION

A. Name of Facility: _____

Street Address City State Zip Code Telephone

B. Contact Person: _____

Mailing Address City State Zip Code Area Code/Telephone Area Code/Fax Number

II. TRANSACTION METHOD

- A. How will the facility be acquired? (for example, lease, purchase, stock transfer, merger, or a combination of these)

III. PERSON OR ENTITY FROM WHOM THE FACILITY IS BEING ACQUIRED

A. Name: _____

Mailing Address City State Zip Code Telephone

1. When do you expect to sign a contract or agreement? [_____] (Attach a copy of the contract or agreement.

2. When do you expect to operate the facility? [_____]

B. 1. Is the entity listed in Item III.A, the current lessor (landlord)? Yes[] No[]

2. Is the entity listed in Item III.A, the current lessee (tenant)? Yes[] No[]

3. If no to either III.B.1 or III.B.2, complete the following for the current owner or leaseholder.

Name: _____

Mailing Address City State Zip Code Telephone

IV. APPLICANT'S QUALIFICATIONS

A. Disclosure Statement. Complete and attach the Disclosure Statement, ODH Form #614.

B. If the applicant lists less than sixty (60) months experience as an operator, submit a plan for operating the facility. The plan must include:

1. Organizational papers, bylaws, articles or incorporation, partnership agreements, business plans, or other documents which confirm the applicant's claims about the policies, rights, duties, and responsibilities of the applicant and its principals;
2. Written statements from the person or persons who will fill management or administrative staffing and leadership positions, including but not limited to the director of nursing, the medical director, the administrator, and the applicant's policy body. The statements must specify the minimum amount of time they shall spend working in the facility.
3. Attach a statement from the applicant agreeing to advise the Department prior to any change in the staffing and leadership during the first six months of operation after the acquisition is finalized.
4. Attach a statement from the applicant agreeing that any person added to or replacing another person in the staffing or leadership plan during the first six months of operation shall comply with 63 O.S. Section 1-853.D and OAC 310-4-1-7.

C. Council Minutes. Attach copies of residents' council minutes and family council minutes, if any, and the facility's written response to the councils' requests or grievances, for the three (3) months prior to the date of application, for each of the applicant's current holdings in Oklahoma. Patient names or other identifying information regarding patients must be clacked out or removed from all minutes. Are all attached documents free of patient names and other identifying information for patients?

___Yes ___ No

V. STAFFING

A. Name of administrator after acquisition: _____

License Number

Address

- B. 1. Attach a list of proposed staffing after the facility is acquired. List staffing in number of Full Time Equivalent (FTE) employees, and itemize by personnel categories. ODH Form 953-E (Staffing Projection and Professional Certification).
2. If the facility currently operates under a staffing waiver, provide a plan of action to comply with staffing requirements. Include a timetable for full staffing.
3. The documentation of staffing shall include written statements from the administrator, the director of nursing, the pharmacist, and the medical director, indicating their intentions to contract or accept employment with the applicant.

VI. PROJECT COST

- A. Purchase costs for this project \$_____
- B. Annual Lease \$_____ and length of lease (in years)_____
- C. If project involves donation, stock transfer, lease, or any transaction below fair market value, provide the following.
 1. Current Book Value of Building _____
 2. Current Book Value of Equipment _____
 3. Current Book Value of other capital assets being transferred _____
- D. If the total capital cost does not equal the contract price for the facility, explain the difference.

VII. FINANCIAL

- A. **Funds to complete the acquisition.** Itemize the sources to fund the total project cost. (The total of these funding sources should equal the total capital cost of the project. Attach an explanation if the funding sources listed in this item do not equal the total capital cost of the project.)

Repayment Source Principal Period (Yrs.)	Discount Amount	Net Or Pts.	Proceeds
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- B. **Financial documentation.** Provide supporting information for the financial sources listed in Item VII.A.
 1. **Conventional, bank, seller-carried, third party, or bond financing.** State the proposed principle amount, interest rate and repayment terms. A representative of the lending institution, seller, third party or trust authority must attest this information.

2. **Equity financing.** Provide 1) a balance sheet for the acquiring party(s) that is dated within the past twelve (12) months and that reflects cash or cash equivalents sufficient to fund the project; or 2) a certificate of deposit or other proof that funds are available and not pledged for other purposes.
 3. **Third party funding or guarantee.** Provide a balance sheet, certificate of deposit or other attested proof for the third party unless it is an agency of state or federal government, a licensed insurer or surplus lines insurer. Provide copies of documents and contracts to substantiate the relationship between the applicant and the third party.
 4. **Book value.** If book value is used to establish the capital cost of this project, provide a copy of the financial statement showing the book value. The financial statement must be audited or based on generally accepted accounting principles.
- C. **Budget.** Complete a proforma operating budget of revenues and expenses for the first one (1) month, and the first twelve (12) months after the facility is acquired. Psychiatric and Chemical Dependency facilities complete **Schedule A**. Nursing facilities, specialized facilities, and skilled nursing units complete **Schedule B**.
- D. **Funds for services and staffing.** In addition to the funds needed to acquire the facility, document the availability of financial resources equivalent to the first one (1) month of projected expenses, as shown on Schedule A or B. Follow the documentation guidelines in Item VII-B, above, to demonstrate the availability of funds for services and staffing.

NOTE: All balance sheets provided for Section VII of this form shall include information sufficient to assess the net value of each asset. Also, the balance sheets shall identify any claims that would affect an asset's use as collateral. Confirm and provide financial documentation that the funds are not pledged or otherwise encumbered.

VIII. THIS AFFIRMS THAT THE INFORMATION IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF OUR KNOWLEDGE AND BELIEF.

I certify that the foregoing is true and complete to the best of my knowledge and belief.

 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: _____

SCHEDULE A

PSYCHIATRIC AND CHEMICAL DEPENDENCY FACILITIES PROJECTED BUDGET OF REVENUES AND EXPENSES (Dollars in Thousands)

	First Year Ending Month _____ Year _____		First Year Ending Month _____ Year _____
Patient Service Revenues:		Admissions	\$ _____
Inpatient	\$ _____	Patient Days:	\$ _____
Outpatient	\$ _____	Medicare	\$ _____
Total Pt. Service Revenues	\$ _____	Medicaid	\$ _____
Less Deduction:		Private Pay	\$ _____
Contractual Adjustments	\$ _____	Other _____	\$ _____
Charity Care	\$ _____	Total Patient Days	\$ _____
Bad Debts	\$ _____	ALOS (Days)	\$ _____
Other	\$ _____	Outpatient Visits:	\$ _____
Total Deductions	\$ _____	Emergency Room Visits	\$ _____
Net Patient Revenue:		Out Patients Visits	\$ _____
Other Operating Revenue:	\$ _____	Total	\$ _____
Total Operating Revenue:	\$ _____	Inpatient Charge Per Patient Day:	
Operating Expenses:		Medicare	\$ _____
Salaries	\$ _____	Medicaid	\$ _____
Other Operating Expenses	\$ _____	Private	\$ _____
Interest Expense	\$ _____	Other _____	\$ _____
Depreciation	\$ _____	Average All Payors (A)	\$ _____
Lease Expense	\$ _____	Charge Per Outpatient Visit (B)	\$ _____
Total Operating Expenses	\$ _____	Inpatient Cost/Patient Day (C)	\$ _____
Gain (Loss) from Operations:		Cost Per Outpatient Visit (D)	\$ _____
Nonoperating Revenues:	\$ _____		
Interest Income	\$ _____		
Other (specify) _____	\$ _____		
Total Nonoperating Revenue	\$ _____		
Excess Revenues over Expenses (Expenses over Revenues):	\$ _____		

- (A) Compute using total inpatient revenue divided by total patient days (excluding newborn).
- (B) Compute using total outpatient revenue divided by total outpatient visits (including ER).
- (C) Compute using total cost of providing inpatient services divided by total patient days (excluding newborn).
- (D) Compute using total cost of providing outpatient services divided by outpatient visits (including ER).

SCHEDULE B

**LONG TERM CARE FACILITIES
PROJECTED BUDGET OF REVENUES AND EXPENSES**

Item	First Year Ending Month _____ Year _____
Revenues:	
Private Pay	\$ _____
Medicaid	\$ _____
Medicare	\$ _____
Other (specify) _____	\$ _____
Total Revenues	\$ _____
Expenses:	
Payroll Expense	\$ _____
Other Operating Expenses	\$ _____
Lease Expense	\$ _____
Depreciation	\$ _____
Interest:	
Assumed Debt	\$ _____
New Debt	\$ _____
Other (specify) _____	\$ _____
Total Expenses	\$ _____
Net Income (Loss)	\$ _____
Projected Patient Days:	
Private Pay	\$ _____
Medicaid	\$ _____
Medicare	\$ _____
Other	\$ _____
Total Projected Patient Days	\$ _____
Occupancy Rate (%)	_____ %
Projected Charge Per Patient Day:	
Private Pay	\$ _____
Medicaid	\$ _____
Medicare	\$ _____
Other	\$ _____
Projected Cost Per Patient Day	\$ _____