

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 ODH Form #614, *Certificate of Need Disclosure Statement*. **(Psychiatric facilities need only complete and submit Table 1.)**

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 [OAC 310:620-3-3]:

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 (6) 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 the requirements at 63 O.S. Section 1-853(D) and OAC 310-4-1-7.1. **(This requirement is not applicable to psychiatric hospitals.)**

B. **Financial documentation [OAC 310:620-3-1(1)].** 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 [OAC 310:620-3-1(2)].** Complete a projected 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 [OAC 310:620-3-1(4)].** In addition to the funds needed to acquire the facility, document the availability of financial resources equivalent to the average monthly projected expenses, as shown on Schedule A or B. The amount of the average monthly expenses shall be calculated based on a per-month average of the projected twelve-month budget of revenues and expenses submitted with the application. 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. NOTICE TO RESIDENTS AND FAMILIES [310:620-3-4.1].

Pursuant to 63 O.S. § 1-852(I), applicants seeking to acquire a long term care facility shall post notice in a public area in each facility operated by the applicant in Oklahoma, to inform residents and families of the applicant's proposed action. The notice shall include:

- (1) The name of the applicant;
- (2) The name and location of the facility to be acquired;
- (3) A brief explanation of the public's opportunity to participate in the review of the certificate of need application;
- (4) The location where and the times when the certificate of need application shall be available for public inspection; and
- (5) The address and deadline for submitting written comments to the Department.

IX. 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:

Inpatient	\$ _____	Admissions	\$ _____
Outpatient	\$ _____	Patient Days:	\$ _____
Total Pt. Service Revenues	\$ _____	Medicare	\$ _____

Less Deduction:

Contractual Adjustments	\$ _____	Medicaid	\$ _____
Charity Care	\$ _____	Private Pay	\$ _____
Bad Debts	\$ _____	Other _____	\$ _____
Other	\$ _____	Total Patient Days	\$ _____
Total Deductions	\$ _____	ALOS (Days)	\$ _____

Net Patient Revenue:

Net Patient Revenue:	\$ _____	Emergency Room Visits	\$ _____
Other Operating Revenue:	\$ _____	Out Patients Visits	\$ _____
Total Operating Revenue:	\$ _____	Total	\$ _____

Operating Expenses:

Salaries	\$ _____	Inpatient Charge Per Patient Day:	
Other Operating Expenses	\$ _____	Medicare	\$ _____
Interest Expense	\$ _____	Medicaid	\$ _____
Depreciation	\$ _____	Private	\$ _____
Lease Expense	\$ _____	Other _____	\$ _____
Total Operating Expenses	\$ _____	Average All Payors (A)	\$ _____

Gain (Loss) from Operations:

Gain (Loss) from Operations:	\$ _____	Charge Per Outpatient Visit (B)	\$ _____
Nonoperating Revenues:	\$ _____	Inpatient Cost/Patient Day (C)	\$ _____

Interest Income	\$ _____	Cost Per Outpatient Visit (D)	\$ _____
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

	First Year Ending	
Item	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	\$ _____	_____

Confidential

TABLE 1

PROJECTED STAFFING PATTERN

1. Name of Facility: _____
2. Projected Staffing Pattern - Show number of full-time FTE'S per shift. Blank columns may be used for staff not already designated.

Shift Times	RN	LPN	Nurse Aide/ CMA	House Keeping	Laundry	Activity	Social Service	Food Service	Maintenance		