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.

Psychiatric or chemical dependency facilities: Pursuant to OAC 310:4-1-5(3)(B) 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 purposes of determining filing fees, capital cost is defined at OAC 310:4-1-5(1).

Capital Cost. For purposes of determining filing fees, capital cost means one or more of the following depending on the underlying nature of the transaction.

(A) For construction, the total cost of the project shall include the following components as applicable: land acquisition and site development, soil survey and investigation, construction, equipment, architect fees, engineering fees, supervision, performance and payment bonds, contingency, and inflation factor.

(B) For acquisition by purchase, the total cost of the project shall be the greater of current book value of building and/or equipment, or total contract price including any exchanges or other consideration.

(C) For acquisition by lease, the total cost of the project shall be the current book value of the facility to be leased plus any additional capital expenditures, such as equipment purchases.

(D) For a sale and leaseback, or a combination lease and purchase, the total cost of the project shall be the greater of the purchase cost or current book value of the facility.

(E) For a non-monetary transfer of stock, the total capital cost of the project shall be zero dollars ($0).

(F) For a transfer of stock in which one party pays or exchanges other consideration to acquire the stock of another party, the total cost of the project shall be the greater of the value of the consideration given for the stock or the book value of the facility on the seller's books.

(G) For a management contract that includes no purchase, lease, donation, transfer of stock, corporate merger, assignment or foreclosure of building, equipment or other assets, the capital cost shall be zero dollars ($0).

(H) For any other type of project, including but not limited to an addition of beds through conversion of a previously constructed physical plant, the project cost shall be based on the greater of the book value or fair market value of the assets required to accomplish the project.

(I) For any type of project in which book value is used to establish the capital cost, the book value shall be based on audited financial statements or upon generally accepted accounting principles.

Long-term care facilities: Pursuant to 63 O.S. 2009, Section 1-852.1(A), the fee for nursing facilities, specialized facilities and skilled nursing units is $3,000. [63:1-852.1(A): Each application for a new certificate of need applied for pursuant to the provisions of Section 1-852 of this title, except for those applications filed by state agencies, shall be accompanied by an application fee of Three Thousand Dollars ($3,000.00).]

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: ________________________________

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone</th>
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</thead>
</table>

Health Facility Systems
1000 NE 10th Street
Oklahoma City, OK 73117-1299
405.271.6868
Fax 405.271.7360
E-mail HealthResources@health.ok.gov
Web http://hfs.health.ok.gov

Oklahoma State Department of Health
Protective Health Services
ODH Form 618
Page 1 of 8
Revised 08/09/2011
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: ________________________________

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.)
C. Council Minutes [OAC 310:4-1-13(d)(7)]. 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? (This requirement is not applicable to psychiatric hospitals.)

_____ Yes  _____ No

V. STAFFING [OAC 310:620-3-2]

A. Name of administrator after acquisition: __________________________________________

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<th>License Number</th>
<th>Address</th>
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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. The attached Table 1 may be used as a guideline for the purposes of providing this information.

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. (This portion does not apply to psychiatric facilities.)

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 [63 O.S. § 1-880.6(c)(6) and OAC 310:4-1-13(d)(5)]

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.)

<table>
<thead>
<tr>
<th>Repayment Source</th>
<th>Principal Amount</th>
<th>Discount Or Pts.</th>
<th>Net Proceeds</th>
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<tbody>
<tr>
<td>Period (Yrs.)</td>
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_________________________
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.

<table>
<thead>
<tr>
<th>Typed or Printed Name of Person Signing for Applicant</th>
<th>Signature of Applicant</th>
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<tr>
<th>Name of Corporation, Partnership or Association</th>
<th>Official Title or Position</th>
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State of ___________________ County of ___________________

Signed and sworn to (or affirmed) before me on this ______ day of ________ 20__.

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

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<th>Signature of Notary Public</th>
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Seal or Stamp

My Commission Expires: ______ / ______ / ______

My Commission Number is: _____________________
## SCHEDULE A

### PSYCHIATRIC AND CHEMICAL DEPENDENCY FACILITIES

#### PROJECTED BUDGET OF REVENUES AND EXPENSES

(Dollars in Thousands)

<table>
<thead>
<tr>
<th></th>
<th>First Year Ending</th>
<th>Month</th>
<th>Year</th>
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<tr>
<th>Patient Service Revenues:</th>
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<tbody>
<tr>
<td>Inpatient</td>
<td>$ _______</td>
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<tr>
<td>Outpatient</td>
<td>$ _______</td>
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<tr>
<td>Total Pt. Service Revenues</td>
<td>$ _______</td>
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</tbody>
</table>

| Less Deduction:          |                       |       |      |
| Contractual Adjustments  | $ _______            |       |      |
| Charity Care             | $ _______            |       |      |
| Bad Debts                | $ _______            |       |      |
| Other                    | $ _______            |       |      |
| Total Deductions         | $ _______            |       |      |

| Net Patient Revenue:     |                       |       |      |
|                         | $ _______            |       |      |

| Other Operating Revenue: |                       |       |      |
|                         | $ _______            |       |      |

| Total Operating Revenue: |                       |       |      |
|                         | $ _______            |       |      |

| Operating Expenses:      |                       |       |      |
|                         | $ _______            | Medicare |      |
|                         | Other Operating Expenses | $ _______ | Medicare |
| Interest Expense        | $ _______            | Private |      |
| Depreciation            | $ _______            | Other |      |
| Lease Expense           | $ _______            | Average All Payors (A) | $ _______ |
| Total Operating Expenses | $ _______         | Charge Per Outpatient Visit (B) | $ _______ |

| Gain (Loss) from Operations: |                       |       |      |
|                             | $ _______            | Inpatient Cost/Patient Day (C) | $ _______ |

| Nonoperating Revenues:   |                       |       |      |
|                         | $ _______            | Cost Per Outpatient Visit (D) | $ _______ |

| 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**

<table>
<thead>
<tr>
<th>Item</th>
<th>First Year Ending</th>
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<tbody>
<tr>
<td></td>
<td>Month</td>
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</table>

### 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

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*Oklahoma State Department of Health
Protective Health Services*
### 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.

<table>
<thead>
<tr>
<th>Shift Times</th>
<th>RN</th>
<th>LPN</th>
<th>Nurse Aide/ CMA</th>
<th>House Keeping</th>
<th>Laundry</th>
<th>Activity</th>
<th>Social Service</th>
<th>Food Service</th>
<th>Maintenance</th>
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