



**CERTIFICATE OF NEED APPLICATION FOR
STANDARD REVIEW**

INSTRUCTIONS

1. This form is for Certification of Need projects to be reviewed under the Standard Review process described in Section 310:4-1-5 of the rules for Certification of Need Hearings. Other application forms are available for limited scope projects such as acquisitions, replacement facilities, or 10-bed expansion or long-term care facilities.
2. When ready for filing, the original notarized application form shall be submitted to the Oklahoma State Department of Health at the address above.
3. A filing fee must accompany this application. For psychiatric and chemical dependence facilities the fee is three quarters of one percent (.75%) of the capital cost of the project. (The capital cost is that amount listed in Item I.D.) The minimum fee is \$1,500; the maximum is \$10,000 for psychiatric and chemical dependency facilities. For long-term care facilities the fee is one percent (1%) OF THE CAPITAL COST OF THE PROJECT. (The capital cost is that amount listed in Item I.D.) The minimum fee is \$1,000 and no maximum is set for long-term care projects.
4. Within fifteen (15) days after receipt of the application the Department will send written notice to the contact person, if additional information is needed.

I. INTRODUCTION

A. Name of facility: _____

Street Address	City	State	Zip	Telephone	Fax Number
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B. Contact Person: _____

Fax Number E-mail Address

Street Address	City	State	Zip	Telephone	Fax Number
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C. Briefly describe the project proposed:

D. What is the total estimated capital cost? \$ _____

E. What is the lease cost? \$ _____ Annual lease cost for _____ years.

F. What is the book value of buildings? \$ _____ Equipment \$ _____

G. How many months after Department approvals will the project commence? _____

H. How many months after Department approvals will the project be completed? _____

I. Is this project required to remedy an emergency situation? _____ Yes _____ No

J. If "yes," describe:

Note: "Emergency Situation" refers only to a project undertaken to correct a deficiency in Terms of the facility or services offered, as identified under the Life Safety Code, Medicare/Medicaid Requirements, or Licensure Requirements, etc.

K. This project was approved by our Policy Body on _____, 20____ (NOTE: Attach an attested copy of the minutes of the applicant's Policy Body in which the proposed program was submitted and approved immediately following this page.)

II. CLASSIFICATION OF APPLICANT(S)

Long Term Care Facility Information

- A. Complete and attach the Disclosure statement, ODH Form #614 Certificate of Need Disclosure Statement.
- 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 of incorporation, partnership agreements, business plans, or other documents which confirm the applicants 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 (6) months of operation shall comply with 63 O.S. Section 1 853.F and OAC 310-4-1-7.
- C. Name of administrator after acquisition: _____
License Number: _____ Address: _____
- D. 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) may be completed for this item.
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.
- E. 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 applicants' current holdings in Oklahoma. Patient names or other identifying information regarding patients must be blacked out or removed from all minutes. Are all attached documents free of patient names and other identifying information for patients? ____ Yes ____ No

Psychiatric or Chemical Dependency Facility Information

- A. Name of licensed operating organization: _____
Location: _____
Address City State/Zip Telephone Number
- B. Check the following items that best describe the operating organization of the facility or service (if different from the owner):
____ Voluntary, Non-Profit ____ Governmental (specify type, e.g., state, county, city, trust authority.)
____ Proprietary or Investor Owned
- C. Identify the principals involved in the operation of the facility. (If the operating organization is a non-profit corporation or a public entity give names and addresses of all officers. If the operating organization is a proprietary corporation include names and addresses of persons owning stock in the corporation and indicate percentage of ownership. If the operating organization is partnership or sole proprietorship give names and addresses of all the owners and percent owned by each.)

NAME	ADDRESS	% OWNED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If more space is needed, attach a separate sheet.)

III. GENERAL INFORMATION

- A. Long-term care facility applicants must 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.
- B. Attach audited Financial Reports (income and expense statement, balance sheet, and auditors' notes) for each of the three (3) most recently completed fiscal years. _____
- C. What is the current long-term indebtedness of the facility? \$ _____

To Whom Owed	Original Amount	Remaining Balance	Date Final Payment	Annual Debt Service
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Provide the following information about patient revenue sources in your institution for the last three years.

Revenue Sources	FY Yr. Ended Mo. _____ Yr. _____	FY Yr. Ended Mo. _____ Yr. _____	FY Yr. Ended Mo. _____ Yr. _____
Gross Patient Revenues:			
a. Medicare	_____	_____	_____
b. Medicaid	_____	_____	_____
b. Commercial Insurance	_____	_____	_____
c. HMO's	_____	_____	_____
d. Self-Pay Patients	_____	_____	_____
e. Other _____	_____	_____	_____
Total Gross Patient Revenues:	_____	_____	_____
Deductions from Revenue:			
a. Medicare	_____	_____	_____
b. Medicaid	_____	_____	_____
c. Commercial Insurance	_____	_____	_____
d. HMO's	_____	_____	_____
e. Bad Debts	_____	_____	_____
f. Charity	_____	_____	_____
g. Other _____	_____	_____	_____
Total Deduction from Revenues:	_____	_____	_____
Net Patient Care Revenues	_____	_____	_____
Average Charges/Inpatient Day	_____	_____	_____

IV. DESCRIPTION OF PROPOSED PROJECT

A. Describe fully and in detail the activities you propose to undertake through this project. This should be a general description of those activities that you wish to undertake and for which approval is sought with this application. In addition, if the project includes the establishment of any new services not currently provided, describe each new service. (Attach a separate sheet if more space is needed.)

B. Does the project involve a new license or a change in licensure, or new or additional licensed beds?

____ Yes ____ No If "yes," complete the following.

1. Does this project involve a new or changed facility license? ____ Yes ____ No. If "yes," what type of facility license will be sought?

2. For projects involving new or additional beds, complete these tables.

a) Service/Department	# Current Beds Allocated	Proposed Allocation
Psychiatric	_____	_____
Licensed Nursing	_____	_____
Alcohol/Chemical Dependency	_____	_____
Total Licensed Beds	_____	_____
b) Types of Bed Accommodations		
Private Beds	_____	_____
Semi-Private Beds	_____	_____
Ward Beds	_____	_____
Swing Beds	_____	_____

3. Does this project involve the replacement of any beds for which the facility is currently licensed? ____ Yes ____ No If "yes," how many beds will be replaced, and to which departments are these beds allocated?

V. PERSONNEL REQUIREMENTS

A. Does the project involve the addition of staffing? ____ Yes ____ No If "yes," specify by personnel classification and department the number of full time equivalents needed.

Personnel Classification	Department	Specialty	# of New FTEs
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If "yes," describe plans for the recruitment of additional personnel needed in support of the proposed project. If this project requires recruitment of physicians, provide any available written documentation showing recruitment efforts, such as letters from or contracts with physicians, along with physician's name, specialty and board status.

B. Provide a complete listing of all persons holding professional appointments on the staff at your facility who will be making use of the new facility.

Personnel Classification	Department	Specialty	# of New FTEs
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. If the project is for a new long-term care service or is being proposed by an existing long-term care facility, provide the administrator's name and license number.

Name: _____ License No. _____

D. Will this project require any additional consultative personnel or other specialized services provided under contract? ____ Yes ____ No If "yes," identify and explain the contractual arrangements (including annualized fees) and the need for such services.

VI. CONSTRUCTION ASPECTS

- A. Check the appropriate terms which best describe the construction or remodeling activities involved in this project.

<input type="checkbox"/> New Facility	<input type="checkbox"/> Remodeling, Renovation or Alteration of Existing Facility
<input type="checkbox"/> Full or Partial Replacement	<input type="checkbox"/> Licensure Conversion or Existing Facility
<input type="checkbox"/> Expansion of Facility	<input type="checkbox"/> Other (Specify): _____
<input type="checkbox"/> Modernization of Existing Facility	<input type="checkbox"/> None (If none, go to Section VII.)

- B. If a new replacement facility or an expansion of a facility, how many total square feet will be constructed:

1. Detail, by department or work unit, the total square footage of each functional area involved in this project in terms of what presently exists and what will be available upon completion of the project.

Example:

<u>Work Unit</u>	<u>Existing</u>	<u>Proposed</u>	<u>Added* (Deleted)</u>
Emergency Room	1,500 Sq. Ft.	1,850 Sq. Ft.	380 Sq. Ft.

Totals

(*) Note the total square feet added should agree with the number of feet to be constructed, as listed in "B" above. If they do not agree, attach an explanation of the difference.

- C. State the precise location upon which the facility is proposed for construction or; if more than one site is contemplated, the precise location of each site. (The location(s) must be described either in terms of an appropriate street address, if available, or through provision of a complete legal description.)
- D. Attach evidence in the form of a deed that demonstrates the applicant holds fee simple title to the property(s) upon which the facility is proposed for construction, or in the case of an option to acquire the property(s), evidence in the form of an option agreement to acquire fee simple title to the property. If a lease is involved, evidence in the form of a lease agreement that demonstrates the lease agreement has been made, or in the case of an option to lease the property, a copy of the option agreement to lease.

Is evidence attached as requested? ☐ Yes ☐ No If "no," describe why evidence is not attached.

- E. Describe the method or methods by which this construction project and components will be undertaken (i.e., General Construction, Contract, Force Account, Fast Track Method, etc.):
- F. Provide below an estimated time schedule for construction, including the date you expect this proposed project to be fully operational.

<u>Specific Activity</u>	<u>Number of Months After Approval</u>
Solicitation of Bids:	_____
Award of Construction Contract(s):	_____
Construction Commences:	_____
Completion of Contracts:	_____
Occupancy of New Facility of Space:	_____
Other: _____	_____

(If phasing is planned indicate sequence and timing and expected dates of start and completion of various phases.)

- NOTE: This date should agree with the completion date listed in Item I, Page 1.

- G. Does this project include the construction of any unfinished or "shelled in" space that is to be finished off at some point in the future? ☐ Yes ☐ No If "yes," answer the following.

VII. JUSTIFICATION OF NEED FOR THE PROJECT

Explain the reason **why** this proposed project is needed both in terms of **your facility** and in terms of the broader need of **your service area**.

- A. Summarize the reason or reasons why this project is needed. (This summary should be clear and concise; more detailed explanations should be provided in the following items.)

In an attachment, address any applicable goals, criteria or standards adopted by the Department for review purposes. (Check those that you have addressed in the attachment.)

- ☐ Certificate of Need Standards for Licensed Nursing Facility Beds
☐ Certificate of Need Standards for Psychiatric and Chemical Dependency Service Beds
☐ Certificate of Need Standards for Intermediate Care Facility/Individuals Intellectual Disabilities

- B. If none of the standards in "B" above apply to this project, respond to Items C-1 through C-4 below.

1. Discuss the population's need for this project **and** provide relevant statistical data and other information that demonstrates that need. (If this project involves expansion of an existing facility or service, provide utilization data for the facility or service for the past three years.
2. Discuss how this project will meet the needs of the population to be served.
3. Does the facility's service area have any special demographic characteristics that need to be considered in the review of this application? ☐ Yes ☐ No If "yes," describe the demographic characteristics of the population to be served.
4. Discuss any alternatives considered for meeting identified health service needs before you decided on this proposed project, and state why such alternatives were discarded:

VIII. FINANCIAL AND ECONOMIC FEASIBILITY

- A. Detail the capital cost of the project in the following:

1. Land Acquisition	\$ _____
Site Development	\$ _____
Soil Survey & Investigation	\$ _____
Construction	\$ _____
Equipment (Fair Market Value)	\$ _____
Fixed	\$ _____
Movable	\$ _____
Architect Fees	\$ _____
Engineering Fees	\$ _____
Supervision (Owners Cost Allowance)	\$ _____
Performance & Payment Bonds	\$ _____
Contingency (For Change Orders)	\$ _____
Inflation Factor (To Midpoint of Construction)	\$ _____
SUBTOTAL	\$ _____

2. Feasibility Study & Report \$ _____
- Underwriting Discount \$ _____
- Interest During Construction \$ _____
- Principal Repayment Reserve Fund (do not include in Subtotal or Total) \$ _____
- Consultant Fee:
- List _____ \$ _____
- _____ \$ _____
- _____ \$ _____
- _____ \$ _____
- SUBTOTAL** \$ _____
3. Bond Issue Costs (or other debt incurrence costs):
- Discounts or Points (other debt only) \$ _____
- Legal Fee \$ _____
- Printing Expenses \$ _____
- Registration \$ _____
- Title and Recording \$ _____
- Rating Fee \$ _____
- SUBTOTAL** \$ _____
4. **The total estimates capital cost of the project** (Enter here & on page 1, Item D) \$ _____

B. Detail the least cost of the project in the following:

Rental _____ Lease _____ Lease/Purchase _____

Fair Market Value On Equipment \$ _____

Annual Payment \$ _____

Total Payment Over The Lease Period \$ _____

Lease Period (years or months) \$ _____

Identify the Leased Items

C. How is this project going to be financed?

1. Amount \$ _____ from fund balances on hand or equity contribution. Identify:

Fund Name	\$ BALANCE IN FUND(S)	
	Last Completed FY	\$ Amount to be Used for This Project
Operating Fund	_____	_____
Plant Fund	_____	_____
Construction Fund	_____	_____
Endowment Fund	_____	_____
Equity Fund	_____	_____
Matching Funds	_____	_____
Other: _____	_____	_____

Explain:

2. Amount \$_____ from gifts and donations, general obligation bonds, grants, appropriations or allocations which **will not be repaid** from operating revenues. Identify and show dollar amount from each source and explain whether these funds are presently committed, or if not committed, evidence that they will be:
3. Amount to be financed through incurring an indebtedness that is to be repaid from future Operating Revenues:

Source	Principal Amount	Discount or Points	Net Proceeds	Rate of Interest	Repayment Period Yrs
Bank Loan	_____	_____	_____	_____	_____
Revenue Bonds	_____	_____	_____	_____	_____
G.O. Bonds	_____	_____	_____	_____	_____
Farm Home Loans	_____	_____	_____	_____	_____
HUD Loans	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Explain "other" and/or "features" which will clarify any of the above.

4. Provide the following information, as appropriate:
 - a. If the project is to be financed through the issuance of revenue bond, provide a copy of the inducement resolution adopted by the issuing trust authority.
 - b. If the project is to be financed utilizing conventional financing (banks, saving and loan associations or other types of commercial lending institutions), provide evidence in the form of a commitment letter or a letter of credit from the lending institution that funds have been approved to finance the project.
 - c. If the project is to be financed entirely or in part through an equity contribution, provide financial statements for the applicant that are dated within the last twelve (12) months, and that are certified by the applicant as to the accuracy of the statements. In the case of a newly formed corporation, partnership, joint venture or other type of business venture that has no historical operating experience or very limited operating experience, or has been in existence less than one (1) year, provide financial statements dated within the last twelve (12) months and certified as to the accuracy of the statements for each principal involved in the business organization.
 - d. If the project is to be financed utilizing taxable bonds, G.O. Bonds, or a HUD loan, provide written documentation that demonstrates the financing has been properly authorized and approved by all applicable governmental agencies and governing bodies.

D. What is the annual debt service requirement for this project? \$ _____

What is the total debt service requirement for this project? \$ _____

1. Debt Service Cash Flow Schedule

	(1) <u>Depreciation</u>			(2)	(3)		(4)	(5)	
Yr	Yrs* Life Bldg	Yrs* Life Fixed Equipment	Yrs* Life Movable Equipment	Finance & Legal Fees	Pre-Opening Expense	(1)+(2)+(3) Total	Principal	Interest Total	(4)+(5)
1	_____	_____	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____	_____	_____	_____	_____
8	_____	_____	_____	_____	_____	_____	_____	_____	_____
9	_____	_____	_____	_____	_____	_____	_____	_____	_____
10	_____	_____	_____	_____	_____	_____	_____	_____	_____
11	_____	_____	_____	_____	_____	_____	_____	_____	_____
12	_____	_____	_____	_____	_____	_____	_____	_____	_____
13	_____	_____	_____	_____	_____	_____	_____	_____	_____
14	_____	_____	_____	_____	_____	_____	_____	_____	_____
15	_____	_____	_____	_____	_____	_____	_____	_____	_____
16	_____	_____	_____	_____	_____	_____	_____	_____	_____
17	_____	_____	_____	_____	_____	_____	_____	_____	_____
18	_____	_____	_____	_____	_____	_____	_____	_____	_____
19	_____	_____	_____	_____	_____	_____	_____	_____	_____
20	_____	_____	_____	_____	_____	_____	_____	_____	_____

*Identify the estimated useful life of the assets used to calculate the annual depreciation.

2. Are there any restrictions or incurrent additional debt? _____ Yes ____ No If "yes," explain:

- E. Is any part of the cost of your project to be financed by **Revenue Bonds**? _____ Yes _____ No
If "no," go to Item "F" below.

These questions address Revenue Bonds, the Trust Indenture, and control and disposition of earnings from short-term investments (Certificates of Deposit, Treasury Notes, etc.) from the time the proceeds of the bonds are deposited with the Trustee until the Trustee disburses them.

1. Provide the name and address of the Authority that will issue Revenue Bonds and the names of its Chairman and Secretary.

a. Legal Name and Address of Authority _____

Street _____ City _____ State _____ Zip _____

b. Name of general-purpose government, if any, which has taken a beneficial interest in the authority:

Address _____

City _____ County _____ State _____ Zip _____

2. Name and address of the Trustee Bank:

Name _____

Address _____

City _____ County _____ State _____ Zip _____

Name of Trust Officer _____

- F. Do you intend to repay the debt strictly from revenues for services to patients or clients? _____ Yes _____ No
If "no," explain.

- G. Provide the following information using the appropriate budget form (attached and identified below) about prospective or budgeted income and expenses for our institution for each of the first three (3) years following completion of proposed project.

Schedule A Hospitals and Related Facilities

Schedule B Long-Term Care Facilities

- H. The applicant must have sufficient reserves to cover any losses that might occur, in spite of Positive Projections. Describe and document the reserves that will be available to provide operating funds and cover unexpected losses or expenses during the first three (3) years following completion of the proposed project.
- I. 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.

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.

Signature of Notary Public

Seal or Stamp

My Commission Expires _____

My Commission Number is _____