Oklahoma State Department of Health
Health Facilities Systems
P.O Box 268823
Oklahoma City, OK 73126-8823
Tel. (405) 426-8175

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 capitol 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

B. Contact Person: _____

Fax Number E-mail Address

_____

Street Address City State Zip Telephone Fax Number

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.

_____ New Facility	_____ Remodeling, Renovation or Alteration of Existing Facility
_____ Full or Partial Replacement	_____ Licensure Conversion or Existing Facility
_____ Expansion of Facility	_____ Other (Specify): _____
_____ Modernization of Existing Facility	_____ 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:

Work Unit	Existing	Proposed	Added* (Deleted)
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.

Specific Activity	Number of Months After Approval
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/Mentally Retarded Beds

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) Depreciation			(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 _____