LTC Facility Expansion

CERTIFICATION by the Division of Regulation and Licensure (DRL)

Part I: Facility Information

Name of Facility: _____

Address (no PO Box): _____

City, State, Zip, County: _____

Number and Type of Beds: _____ ☐ RCF/ALF ☐ ICF/SNF *(check RCF/ALF for residential care and assisted living facility or ICF/SNF for intermediate care and skilled nursing facility)*

Owner(s): _____

Operator(s): _____

Project Number: _____

Part II: Quarterly RCF/ALF/ICF/SNF Bed Occupancy Rate

Occupancy statistics for this facility for the most recent six consecutive calendar quarters prior to the LOI date shown above:

(circle appropriate quarter, insert the Calendar Year (CY), and complete information below)

Qtr 1 2 3 4 CY____: ____% **Qtr 1 2 3 4 CY____: ____%** **Qtr 1 2 3 4 CY____: ____%**

Qtr 1 2 3 4 CY____: ____% **Qtr 1 2 3 4 CY____: ____%** **Qtr 1 2 3 4 CY____: ____%**

Six-quarter average: _____%

☐ Yes ☐ No For expansion through the **purchase** of beds, based on the DRL Quarterly Survey Data, the 90% bed occupancy requirement has been met.

☐ Yes ☐ No For expansion through the **addition** of beds, based on the DRL's Quarterly Survey Data, the 92% bed occupancy requirement has been met for under 40 LTC beds, or 93% for 40 bed or more LTC beds (see above).

Part III: Deficiencies

☐ Yes ☐ No For expansion through the **purchase** or **addition** of beds, based on the DRL's annual facility survey, the above-named facility has not had any final Class I patient care deficiencies during the past 18 months.

Part IV: Certification of Information

Statement: The above information is an accurate representation of the findings by the DRL in accordance with appropriate CON rules.

Signature: _____

Title/Date: _____ _____