

CERTIFICATE OF NEED APPLICATION FOR EXEMPTION  
FOR A LICENSED NURSING OR SPECIALIZED FACILITY  
TEN BED OR TEN PERCENT EXPANSION OF LICENSED CAPACITY

I. Name and address of facility affected: \_\_\_\_\_

\_\_\_\_\_  
(Area Code) Telephone Number

\_\_\_\_\_  
(Area Code) Fax Number

II. Name and address of contact person: \_\_\_\_\_

\_\_\_\_\_  
(Area Code) Telephone Number

\_\_\_\_\_  
(Area Code) Fax Number

III. Number of beds to be added: \_\_\_\_\_  by construction  by conversion

Note: The number of beds must be no more than ten percent of current beds, or no more than 10 beds, whichever is greater.

IV. Total capital cost: \_\_\_\_\_

Note: Total capital cost must be less than \$1,000,000 including, but not limited to: site acquisition, construction, fixed and movable equipment, architectural designs and arrangements for financing.

V. Provide average occupancy rate for this facility: \_\_\_\_\_%

Note: The occupancy rate must be 93% or more during the twelve-month period preceding the filing of the application. Attach documentation of computation method for occupancy rate. Attach copies of QOC-3 reports as submitted to the Oklahoma Health Care Authority for the twelve (12) months preceding the filing of this application.

VI. Submit ODH Forms 953-B Disclosure Statement, 953-C Detail Attachment and 953-D Affirmation Attachment to provide complete disclosure of all persons and entities involved in and affected by the transfer.

VII. This form must be accompanied by a \$100.00 filing fee. Make checks payable to the Oklahoma State Department of Health.

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: \_\_\_\_\_