



TRANSFER OF A CERTIFICATE OF NEED

LEGAL NAME OF APPLICANT _____

FACILITY/PROJECT NAME _____

AUTHORIZED REPRESENTATIVE/CONTACT PERSON _____

CHIEF EXECUTIVE OFFICER _____

MAILING ADDRESS _____

STREET ADDRESS/SITE LOCATION _____

CITY, STATE, AND ZIP CODE _____

CITY _____

TELEPHONE (AREA CODE AND NUMBER) _____

DISTRICT/SUBDISTRICT (IF APPLICABLE) _____

EMAIL ADDRESS _____

COUNTY:

- | | |
|------------------|-----------------|
| 1. Alachua | 31. Jackson |
| 2. Baker | 32. Jefferson |
| 3. Bay | 33. Lafayette |
| 4. Bradford | 34. Lake |
| 5. Brevard | 35. Lee |
| 6. Broward | 36. Leon |
| 7. Calhoun | 37. Levy |
| 8. Charlotte | 38. Liberty |
| 9. Citrus | 39. Madison |
| 10. Clay | 40. Manatee |
| 11. Collier | 41. Marion |
| 12. Columbia | 42. Martin |
| 13. DeSoto | 43. Miami/Dade |
| 14. Dixie | 44. Monroe |
| 15. Duval | 45. Nassau |
| 16. Escambia | 46. Okaloosa |
| 17. Flagler | 47. Okeechobee |
| 18. Franklin | 48. Orange |
| 19. Gadsden | 49. Osceola |
| 20. Gilchrist | 50. Palm Beach |
| 21. Glades | 51. Pasco |
| 22. Gulf | 52. Pinellas |
| 23. Hamilton | 53. Polk |
| 24. Hardee | 54. Putnam |
| 26. Hernando | 55. Saint Johns |
| 27. Highlands | 57. Santa Rosa |
| 28. Hillsborough | 58. Sarasota |
| 29. Holmes | 59. Seminole |
| 30. Indian River | 60. Sumter |
| | 61. Suwannee |

- | |
|----------------|
| 62. Taylor |
| 63. Union |
| 64. Volusia |
| 65. Wakulla |
| 66. Walton |
| 67. Washington |

OWNERSHIP TYPE:

1. For Profit
2. Not For Profit
3. Hospital System
4. Nursing Home Chain
5. Local Government
6. State Hospital

CON PROPOSED TO BE TRANSFERRED:

CON Number _____	Date Issued _____
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CURRENT HOLDER OF THE CON:

APPLICANT TYPE:

1. Hospice
2. Community Nursing Home
3. Sheltered Nursing Home
4. Community ICF/DD
5. State ICF/DD
6. Children's Hospital
7. Psychiatric Hospital
8. Rehabilitation Hospital

PROJECT COSTS:

Capital Expenditures _____

Operating Costs _____

NUMBER OF NEW/AFFECTED BEDS (+/-):

- | | |
|--------------------------------------|--|
| _____ Community Nursing Home | _____ Psychiatric - Child/Adolescent |
| _____ Sheltered Nursing Home | _____ Substance Abuse - Adult |
| _____ Freestanding Inpatient Hospice | _____ Substance Abuse - Child/Adolescent |
| _____ Psychiatric - Adult | _____ Comprehensive Medical Rehabilitation |

ADDITIONAL PROJECT DETAILS/REMARKS:

AHCA Use Only:

CON Number _____

Date Received _____

Fee Received _____

A. PROJECT IDENTIFICATION

1. Applicant /CON Action No.
Applicant Address
Authorized Representative
2. Service District/Subdistrict/County

B. PUBLIC HEARING To be completed by agency staff.

C. PROJECT SUMMARY (s. 408.037(1), F. S.)

If the project is an addition to an existing health care facility, also provide the facility's existing bed complement and services offered.

D. REVIEW PROCEDURE To be completed by agency staff.

E. CONFORMITY OF PROJECT WITH STATUTORY REVIEW CRITERIA

1. Is need for the project evidenced by the availability, quality of care, accessibility and extent of utilization of existing health care facilities and health services in the applicant's service area?
[s. 408.035(1), (2) and (5) F. S.]
2. Does the applicant have a history of providing quality of care? Has the applicant demonstrated the ability to provide quality care? Is the applicant a Gold Seal Program nursing facility that is proposing to add beds to an existing nursing home? Please discuss your licensure history within and outside of Florida, and discuss any accreditation(s) held. [s. 408.035(3) and (10) F. S.]
3. What resources, including health manpower, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? Please include the following in your response:
 - o a detailed listing of the needed capital expenditures (Schedule 1);
 - o a complete listing of all capital projects (Schedule 2);
 - o source of funds (Schedule 3);
 - o staffing patterns (Schedule 6 or 6A)
 - o a detailed financial projection, including a statement of the projected revenue and expenses for the first two years of operation, and a statement of the assumptions made (Schedules 7, 7A, or 7B; and 8 or 8A); and
 - o an audited financial statement of the applicant.
[s. s. 408.035(4) and 408.037(1)(b) and (c), F. S.]

4. Will the proposed project foster competition to promote quality and cost-effectiveness? Please discuss the effect of the proposed project on any of the following:
 - applicant facility (if a hospital);
 - current patient care costs and charges (if an existing facility);
 - reduction in charges to patients; and
 - improvement in quality of services provided.[s. 408.035(5) and (7), F. S.]
5. What is the immediate and long term financial feasibility of the proposal? [s. 408.035(6), F.S.]
6. Are the proposed costs and methods of construction reasonable? Do they comply with statutory and rule requirements? Please address those items found in "Architectural Criteria" (Schedule 9). [s. 408.035(8), F. S.; Ch. 59A-3 or 59A-4, F. A. C.]
7. Does the applicant have a history of providing health services to Medicaid patients and the medically indigent? Does the applicant propose to provide health services to Medicaid patients and the medically indigent? [s. 408.035(9), F. S.]

- A.** I, _____, certify that this application for a certificate of need presents information that I relied upon and to the best of my knowledge was complete, correct, and accurate. I understand that a representative of the certificate of need office may make a request for additional information in order to deem my application complete.
- B.** I understand section 408.810(8), *Florida Statutes*, requires every applicant to furnish, before being granted a license to operate a nursing home, satisfactory proof of financial ability to operate the home. The financial information presented in this application is *not* intended to satisfy this requirement. In order to satisfy this requirement, I understand and I agree that as a part of the application for License for a Nursing Home I will receive and complete "Attachment A - Proof of Financial Ability to Operate." This information will be reviewed by the Certificate of Need Financial Analysis Unit and returned to Long Term Care prior to completion of the licensure application process.
- C.** I hereby provide assurances that I will provide services to Medicaid recipients and Medicare beneficiaries at least equal to the levels of services projected in this application.
- D.** I understand that if I am issued a certificate of need, a representative of the certificate of need office may request information about the project. The requested information will be used to document the progress, scope, and costs of the project. In addition, I will complete written monitoring reports as required in Rule 59C-1.013, *Florida Administrative Code*. This rule specifies the frequency and the content of the progress reports. Failure to comply with reporting requirements may result in penalties, as described in the enabling statutes and rules.
- E.** I certify that I am either the applicant or a representative of the applicant, and possess the authority to submit this application.
- F.** I understand that, if issued a certificate of need as a result of this application, the applicant is bound by the representations in it.
- G.** I will accept a condition or conditions on the award of a certificate of need based upon any representation of intent contained in this application.
- H.** I certify that the applicant for this project will provide utilization reports to the agency, the Local Health Council or the Agency's designee.
- I.** I certify that the applicant will license and operate the nursing home or nursing home beds described in this application.
- J.** I certify that the person identified below has authority to bind the applicant to the proposal.

Legal Name of the Applicant

Signature of Authorized Representative

Please type or print the above name

Date

Title

- A.** I, _____, certify that this application for a certificate of need presents information that I relied upon and to the best of my knowledge was complete, correct, and accurate. I understand that a representative of the certificate of need office may make a request for additional information in order to deem my application complete.
- B.** I hereby provide assurances that I will provide services to Medicaid recipients and Medicare beneficiaries at least equal to the levels of services projected in this application.
- C.** I understand that if I am issued a certificate of need, a representative of the certificate of need office may request information about the project. The requested information will be used to document the progress, scope, and costs of the project. In addition, I will complete written monitoring reports as required in Rule 59C-1.013, *Florida Administrative Code*. This rule specifies the frequency and the content of the progress reports. Failure to comply with reporting requirements may result in penalties, as described in the enabling statutes and rules.
- D.** I certify that I am either the applicant or a representative of the applicant, and possess the authority to submit this application.
- E.** I understand that, if issued a certificate of need as a result of this application, the applicant is bound by the representations in it.
- F.** I will accept a condition or conditions on the award of a certificate of need based upon any representation of intent contained in this application.
- G.** I certify that the applicant for this project will license and operate the health services, programs, or beds described in this application.
- H.** I certify that the applicant for this project will provide utilization reports to the agency, the Local Health Council or its designee.
- I.** I certify that the person identified below has authority to bind the applicant to the proposal.

Legal Name of the Applicant

Signature of Authorized Representative

Please type or print the above name

Date

Title

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PROJECT COSTS

	ESTIMATED PROJECT COSTS	For TRANSFERS that EXCEED ORIGINAL TOTAL PROJECT COST	
		ACTUAL COST	DIFFERENCE
Land Costs (Number of acres _____)			
1. Purchase price of land	_____	_____	_____
2. If donated land, fair market value	_____	_____	_____
3. If converted from use other than hospital or nursing home, include original cost plus improvements less depreciation	_____	_____	_____
4. Environmental impact and other land use or traffic studies	_____	_____	_____
5. Site survey, soil investigation report	_____	_____	_____
6. Site preparation cost	_____	_____	_____
7. Water, sewer and other utility systems	_____	_____	_____
8. Landscaping	_____	_____	_____
9. Roads and walks (site walks other than immediate building and landscape hard surfaces	_____	_____	_____
10. Other (must specify): _____	_____	_____	_____
11. TOTAL LAND COST	_____	_____	_____
Building Costs			
12a. New construction (labor, materials, overhead, and profit)	_____	_____	_____
12b. Renovation (labor, materials, overhead, and profit)	_____	_____	_____
13. If donated building, fair market value	_____	_____	_____
14. If converted from use other than hospital or nursing home, include original cost plus improvements less depreciation	_____	_____	_____
15. Architectural/engineering fees (fee _____ %)	_____	_____	_____
16. Construction supervision	_____	_____	_____
17. Plans and Construction fees	_____	_____	_____
18. Other building consultant fees: _____ (fee _____ %)	_____	_____	_____
19. Permits and inspection fees	_____	_____	_____
20. Other (must specify): _____	_____	_____	_____
21. TOTAL BUILDING COST	_____	_____	_____
Equipment Cost			
22. Fixed equipment cost not in building contract	_____	_____	_____
23. Movable equipment	_____	_____	_____
24. Major technical equipment	_____	_____	_____
25. TOTAL EQUIPMENT COST	_____	_____	_____

ATTACH A BRIEF NARRATIVE EXPLAINING ASSUMPTIONS USED FOR EACH LINE ITEM PROVIDED IN THIS SCHEDULE

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PROJECT COSTS

		ESTIMATED PROJECT COSTS	For TRANSFERS that EXCEED ORIGINAL TOTAL PROJECT COST	
			ACTUAL COST	DIFFERENCE
Project Development Cost				
26.	Certificate of Need application fee	_____	_____	_____
27.	Feasibility studies, market surveys	_____	_____	_____
28.	Legal and accounting fees	_____	_____	_____
29.	Healthcare consultants fees	_____	_____	_____
30.	Other (must specify): _____	_____	_____	_____
31.	TOTAL PROJECT DEVELOPMENT COSTS	_____	_____	_____
Financing Cost				
32.	Financial consultant fees	_____	_____	_____
33.	Legal and underwriters' fees	_____	_____	_____
34.	Loan of bond issue discount	_____	_____	_____
35.	Local application or origination fee	_____	_____	_____
36.	Title insurance (not included in land)	_____	_____	_____
37.	Loan closing costs	_____	_____	_____
38.	Bond and prospectus printing fees	_____	_____	_____
39.	Prospectus consulting fees	_____	_____	_____
40.	Construction period interest	_____	_____	_____
41.	Other (must specify): _____	_____	_____	_____
42.	TOTAL FINANCING COSTS	_____	_____	_____
Start-Up Cost (must specify):				
43.	_____	_____	_____	_____
44.	_____	_____	_____	_____
45.	_____	_____	_____	_____
46.	TOTAL START-UP COST	_____	_____	_____
Other Intangible Assets and Deferred Costs (must specify):				
47.	_____	_____	_____	_____
48.	_____	_____	_____	_____
49.	TOTAL INTANGIBLE ASSETS AND DEFERRED COSTS	_____	_____	_____
50.	TOTAL PROJECT COST (lines 11+21+25+31+42+46+49)	_____	_____	_____
51.	PROJECT COST SUBJECT TO FEE (line 50 less line 26)	_____	_____	_____

ATTACH A BRIEF NARRATIVE EXPLAINING ASSUMPTIONS USED FOR EACH LINE ITEM PROVIDED IN THIS SCHEDULE

A. Original termination date of the Certificate of Need proposed to be transferred: _____

B. **Extended** termination date:

Original termination date plus 60 days

Date established by an exemption for combination of nursing home CONs: _____

Date established by an exemption for division of a nursing home CON: _____

Assuming CON approval of the transfer becomes the final agency action on the latest of the dates indicated above; indicate the number of days **from that date** to each phase of the completion forecast.

<u>Phase</u>	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	_____	_____
2. Construction documents approved by the Agency for Health Care Administration, Plans and Construction (60 days) [Rule 59A-3 or 59A-4]	_____ _____	_____ _____
3. Construction contract signed	_____	_____
4. Building permit secured [Rule 59C-1.018(2)(a)]	_____	_____
5. Site preparation completed [Rule 59C-1.018(2)(a)]	_____	_____
6. Building construction commenced [Rule 59C-1.018(2)(a)]	_____	_____
7. Construction 40% complete	_____	_____
8. Construction 80% complete	_____	_____
9. Construction 100% complete (approved for occupancy)	_____	_____
10. *Issuance of license [Rule 59C-1.013(2)(a)]	_____	_____
11. *Initiation of service	_____	_____

***For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Section 408.831, F.S. states:

(1) In addition to any other remedies provided by law, the agency may deny each application or suspend or revoke each license, registration, or certificate of entities regulated or licensed by it:

(a) If the applicant, licensee, or a licensee subject to this part which shares a common controlling interest with the applicant has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless a repayment plan is approved by the agency; or (b) For failure to comply with any repayment plan.

Please complete the following:

_____ No. There are no outstanding fines, liens, or overpayments.

_____ Yes. There are outstanding fines, liens, or overpayments, as described below.

If you checked "yes" above, provide the following information on each outstanding obligation (use additional sheets as necessary):

Name of Agency/Department Owed: _____

Total Owed: \$ _____ Date Original Debt Incurred: _____

Current Balance Owed: \$ _____ Date Last Payment Made: _____

Your signature on this application will serve as your attestation that the information contained above is true and accurate. A license, certificate or registration can be suspended or revoked, and an application denied, for failure to pay outstanding fines, liens, and overpayments per section 408.831, F.S.

If you have any questions, please call the Certificate of Need Office at (850)412-4401.

- A. I, _____, certify that I am authorized to represent the holder of certificate of need number _____, issued to _____.
- B. I propose to transfer the certificate of need to another entity, who will be an applicant for approval of that transfer.
- C. I understand that section 408.042, *Florida Statutes*, mandates that the holder of a certificate of need shall not charge a price for the transfer of the certificate of need to another person that exceeds the total amount of the actual costs incurred by the holder in obtaining the certificate of need.
- D. I hereby attest that:
 - 1. The costs incurred in obtaining the certificate of need were \$ _____; and
 - 2. I have not charged the intended recipient of the transferred certificate of need a price in excess of the costs incurred.

Signature of Authorized Representative

Date

Please type or print the above name

Title

Sworn to and subscribed before me this _____ day of _____ 20____

By _____

Commission Expires _____

Personally Known _____

Produced Identification _____ Type _____