# APPLICATION FOR A CERTIFICATE OF NEED

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

**APPLICANT TYPE:**

- ☐ 1. Hospice
- ☐ 2. Community Nursing Home
- ☐ 3. Sheltered Nursing Home
- ☐ 4. Community ICF/DD
- ☐ 5. State ICF/DD

**PREVIOUS CON NUMBERS:**

_____ _____ _____

**CON TRANSFERS:**

_____ _____ _____

**PROJECT TYPE:**

- ☐ 1. New Facility
- ☐ 2. Replacement Facility
- ☐ 3. Bed Addition
- ☐ 4. Bed Conversion
- ☐ 5. Freestanding Hospice Inpatient Facility

**PROJECT COSTS:**

Capital Expenditures _____

Operating Costs _____

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

_____ Community Nursing Home

_____ Sheltered Nursing Home

_____ Freestanding Inpatient Hospice

_____ ICF/DD

**ADDITIONAL PROJECT DETAILS/REMARKS:**

*AHCA Use Only:*

CON Number _____

Date Received _____

Fee Received _____

LOI Date _____

**SCHEDULE A** **All Applicants**

**FEE REMITTANCE**



**INSTRUCTIONS FOR THIS FORM**

1. This form is to be used by all applicants for a Certificate of Need except for those applying for a transfer of a CON.

2. Fee remittance in the correct amount should be submitted concurrently with the application. Applications submitted without a fee or with an insufficient fee will be processed in accordance with Rule 59C-1.008(3), Florida Administrative Code (F.A.C.).

   a. Applications filed in the batch review cycle have until close of business on the day a **complete** application is submitted to submit any additional fees required, or the application will be deemed incomplete and withdrawn from further review.

   b. Applications filed for expedited review with an insufficient fee will not be processed until the correct fee is received and will be returned in 30 days if the correct fee is not received by the Agency.

3. Fee remittance is to be submitted in the form of a check payable to the Agency for Health Care Administration.

4. Fees are to be computed as follows:

| Proposed Expenditures | Fee Schedule |
|---|---|
| No Expenditure | $10,000 |
| Any Expenditure | $10,000 plus .015 of each dollar of proposed expenditure |
| Maximum Fee | $50,000 |

LEGAL NAME OF APPLICANT: _____

MAILING ADDRESS: _____

_____

TELEPHONE NUMBER: _____

IDENTIFICATION OF PROJECT: _____

_____

TOTAL PROJECT COST (SCHEDULE 1, LINE 50) $ _____

PROJECT COST SUBJECT TO FEE (SCHEDULE 1, LINE 51) $ _____

APPLICATION FEE (SCHEDULE 1, LINE 26) $ _____

**Submit to:** **Agency for Health Care Administration**
**Certificate of Need Office**
**2727 Mahan Drive, MS 28**
**Tallahassee, Florida 32308**

**SCHEDULE B**

**All Applicants**
***Except* Transfer of CON**

**PROJECT DESCRIPTION**
**and**
**CONFORMANCE WITH REVIEW CRITERIA**



## 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), Florida Statutes (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.

Please indicate in this original submission if a partial award is being requested. **Partial award** requests should include any narrative or tabular information (schedules) which differs from that for the main proposal (59C-1.008(5), F.A.C.).

**D. REVIEW PROCEDURE** To be completed by agency staff.

## E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA

The following indicates the level of conformity of the proposed project(s) with the criteria and application content requirements found in sections 408.035 and 408.037, F.S.; and applicable rules of the State of Florida; Chapters 59C-1 and 59C-2, F.A.C.

Agency rules may require the applicant to provide information or documentation for the specific type of project proposed. Please refer to the facility-specific rules found in Rules 59C-1.034 - 1.037 of the F.A.C., and be sure that your responses include any supplemental information required for the type of project being proposed.

### 1. FIXED NEED POOL

Does the project proposed respond to need as published by a fixed need pool? Or does the project proposed seek beds or facilities in excess of the fixed need pool? (If so, provide any needs analysis or other justification supporting the number of beds or facility sought. The facility-specific agency rules describe the documentation necessary when the need pool shows no numeric need).
(Rule 59C-1.008(2), F.A.C.)

### 2. AGENCY RULE PREFERENCES AND CRITERIA

Does the project respond to preferences and criteria stated in agency rules? (Hospice Rule 59C-1.0355, F.A.C., Nursing Homes Rule 59C-1.036, F.A.C. and Immediate Care Facility for the Developmentally Disabled Rule 59C-1.034, F.A.C.)

## 3. STATUTORY REVIEW CRITERIA

a. 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.)

b. Does the applicant have a history of providing quality of care? Has the applicant demonstrated the ability to provide quality care? An applicant proposing to establish Medicare-certified nursing facility beds must provide a detailed description of the services to be provided, patient characteristics, ancillary services, patient assessment tools, admission policies, and discharge policies. 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. and Rule 59C-1.036 F.A.C.)

c. What resources, including health personnel, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? Please include the following in your response:
   - a detailed listing of the needed capital expenditures (Schedule 1);
   - a complete listing of all capital projects (Schedule 2);
   - source of funds (Schedule 3);
   - 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
   - an audited financial statement of the applicant.

   (s.408.035(4) and 408.037(1)(b) and (c), F. S.)

d. What is the immediate and long term financial feasibility of the proposal? (s.408.035(6), F.S.)

e. 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;
   - current patient care costs and charges (if an existing facility);
   - reduction in charges to patients; and
   - extent to which proposed services will enhance access to health care for the residents of the service district.

   (s.408.035(7), F.S.)

f. 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-4, 59A-26, or 59A-38 F.A.C.)

g. Does the applicant have a history of and /or propose to provide health care services to Medicaid patients and the medically indigent? (s.408.035(9), F.S.)

**SCHEDULE C**

**All Applicants**

**CERTIFICATE OF NEED**
**PREDICATED ON**
**CONDITIONS**

**A.** I understand that s. 408.040(1), F.S., provides for a certificate of need to be awarded predicated upon statements made in the application. These statements can be expressed as conditions placed on an awarded certificate of need. I also understand that the requirements for compliance with such conditions appear in Rules 59C-1.013 and 59C-1.021, F.A.C.

**B.** Among the representations I have made in this application, there are items which present special features or address unique circumstances. I have checked one or more specific items below. In so doing, I seek to have one or more conditions placed upon a certificate of need that may be awarded to me. I understand that any conditions become factors upon which an award may be made. I also understand that representatives of the certificate of need office will consider such conditions and commitments in the review of my application. Furthermore, I understand that such commitments may be used to distinguish one applicant from another in making an award.

**C.** I have checked and described the items below which represent special features or addressed unique circumstances that shall appear as conditions on a certificate of need should one be awarded.

_____1. Specific site within the subdistrict. The parcel or address is as follows:

_____2. Percent of a particular population subgroup to be served. The population subgroup, along with the percent to be served, is as follows:

_____3. Special programs, listed as:

_____4. Other, specified as:

**D.** For each special feature or unique circumstance identified in C, I have described in one (1) page (attached) how conformance to the conditions will be measured. (**Indicate how many pages follow this page_____**).

**E.** _____I do not wish to accept any conditions.

**F.** Notwithstanding my response to either item C or E above, I understand that the identification of public policy can necessitate that a certificate of need bear one or more conditions. I fully understand that the Certificate of Need Office may identify one or more conditions as a requirement for awarding a certificate of need.

_____ _____
Signature of Authorized Representative Date

_____
Please type or print the above name

_____
Title

**SCHEDULE D**

## Nursing Homes

## CERTIFICATION BY THE APPLICANT

**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), F.S., 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 cost of the project. In addition, I will complete written monitoring reports as required in Rule 59C-1.013, F.A.C. 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

**SCHEDULE D-1**

**Hospice and ICF/DDs**

**CERTIFICATION BY THE APPLICANT**



**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, F.A.C. 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

**SCHEDULE 1**

**ESTIMATED PROJECT COSTS**

## ALL APPLICANTS

## EXCEPT TRANSFER OF CON

**Land Costs (Number of acres _____)**

1. Purchased price of land _____
2. If donated land, fair market value _____
3. If converted from use other than 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 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**

**SCHEDULE 1**

**ESTIMATED PROJECT COSTS**

## ALL APPLICANTS

## EXCEPT TRANSFER OF CON

**Project Development Cost**

26. Certificate of Need application fee _____
27. Feasibility studies, market surveys _____
28. Legal and accounting fees _____
29. Healthcare consultant 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 discounts _____
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**

All Applicants

# LISTING OF ALL CAPITAL PROJECTS

**CAPITAL PROJECTS AND EXPENDITURES APPROVED, UNDER DEVELOPMENT, OR PLANNED (APPLICANT)**
**(Total Capital Commitment, Both Health Care and Other)**

**INSTRUCTIONS FOR THIS SCHEDULE**

Capital projects include all planned expenditures whose useful life are more than one fiscal year and which under generally accepted accounting principles (GAAP) are not properly chargeable as an expense of operations and are therefore required to be capitalized as an asset. An itemized list or grouping of capital projects is not required; however this schedule is arranged to suggest the detail that could be used. "A" and "B" totals for all columns are needed under either circumstance.

The individual projects that have Florida CON numbers, exemption numbers, or non-reviewable numbers should be listed separately. The other categories for other states' projects and other capital budget items can be totaled as shown on the schedule.

Section "A" items are the projects and expenditures that have received all approvals necessary prior to construction or purchase. Section "A" projects that are in progress should include only the unexpended amount. In the assumptions, give details that include the original project cost and the amount already spent to clearly show the unexpended amount on Schedule 2.

Section "B" items have received internal approval but are awaiting outside approval. Section "B" includes the project for this application and any certificate of need applications and exemption or non-reviewable requests which are before the agency for determination, and involve a capital project at the time of submission of the proposed project.

Be sure all columns are completed as applicable to show the sources of funds. Attach detail for these funds according to the following guidelines:

*Amount in Hand* should be supported by the most recent audited financial statement or other documented evidence.

*Amount from Operations* should be supported by the most recent statement of cash flows (cash flow from operations) or other detailed explanation to show adequacy of cash flows.

*Assured But Not in Hand* should be supported by detail of these arrangements, including the name of the source and nature of the agreement.

*Currently Being Sought* should have attached detail and supporting documentation explaining the efforts and potential source of the funds.

Attach a narrative assessing the financial impact of categories A and B separately and taken together upon the project proposed in this application.

Complete the following information on all capital projects, acquisitions, and expenditures whether or not the state in which the activity occurs has a certificate of need or capital expenditure review program pursuant to Section 1122 of the Social Security Act.

Include maturities of long-term debt payable through the latest capital project's funding period along with the source of funds. This should include not only payments on debt currently in existence but also anticipated payments on debt to be incurred during the total Schedule 2 period.

**SCHEDULE 2**

## All Applicants

# LISTING OF ALL CAPITAL PROJECTS



### A. PROJECTS OR EXPENDITURES APPROVED OR UNDERWAY:

| DESCRIPTION OF PROJECT OR EXPENDITURE (1) | NUMBER OF BEDS | CERTIFICATE OF NEED NUMBER (OR EXEMPT #) | EXPENDITURE OR PROJECT AMOUNT | SOURCE OF FUNDS: AMOUNT IN HAND | SOURCE OF FUNDS: AMOUNT FROM OPERATIONS | SOURCE OF FUNDS: ASSURED BUT NOT IN HAND (2) | SOURCE OF FUNDS: CURRENTLY BEING SOUGHT (2) |
|---|---|---|---|---|---|---|---|
| CON Reviewable: | | | | | | | |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| Exempt/Non-Review: | | | | | | | |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| Other States' Projects | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| Other Capitalization | | | $ | $ | $ | $ | $ |
| Equipment | | | $ | $ | $ | $ | $ |
| Furnishings | | | $ | $ | $ | $ | $ |
| Renovations | | | $ | $ | $ | $ | $ |
| Maturities of Long-Term Debt | | | $ | $ | $ | $ | $ |
| | | **TOTAL** | A. $ | $ | $ | $ | $ |

(1) Attach a narrative of not more than two pages assessing the financial and administrative impact of categories A and B above separately and taken together upon the project proposed in this application. The availability of financial resources should be addressed.
(2) Attach details of funds assured but not in hand and funds currently being sought including source commitment documentation and proof of ability to fund if affiliate provider.



AHCA Form 3150-0001 August 2024

Rule 59C-1.008, Florida Administrative Code
Form available at: https://ahca.myflorida.com/con-application

**SCHEDULE 2**

## All Applicants

# LISTING OF ALL CAPITAL PROJECTS



### B. PROJECTS OR EXPENDITURES APPLIED FOR, PENDING APPROVAL, OR PLANNED:

| DESCRIPTION OF PROJECT OR EXPENDITURE (1) | NUMBER OF BEDS | CERTIFICATE OF NEED NUMBER (OR EXEMPT #) | EXPENDITURE OR PROJECT AMOUNT | SOURCE OF FUNDS: AMOUNT IN HAND | SOURCE OF FUNDS: AMOUNT FROM OPERATIONS | SOURCE OF FUNDS: ASSURED BUT NOT IN HAND (2) | SOURCE OF FUNDS: CURRENTLY BEING SOUGHT (2) |
|---|---|---|---|---|---|---|---|
| CON Reviewable: | | | | | | | |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| Exempt/Non-Review: | | | | | | | |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| Other States' Projects | | | $ | $ | $ | $ | $ |
| Other Capitalization | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| | | | $ | $ | $ | $ | $ |
| Maturities of Long-Term Debt | | | $ | $ | $ | $ | $ |
| | | TOTAL | B. $ | $ | $ | $ | $ |
| | | GRAND TOTAL | C. $ | $ | $ | $ | $ |

(1) Attach a narrative of not more than two pages assessing the financial and administrative impact of categories A and B above separately and taken together upon the project proposed in this application. The availability of financial resources should be addressed.

(2) Attach details of funds assured but not in hand and funds currently being sought including source commitment documentation and proof of ability to fund if affiliate provider.

NOTE: THIS SCHEDULE INCLUDES THE PROJECT FOR THIS APPLICATION.

**SCHEDULE 3**

## All Applicants

## SOURCE OF FUNDS

1. **CASH ON HAND** $_____

   If sufficient amount is not shown on most recent audited balance sheet, attach proof of current availability.

2. **OPERATING CASH FLOWS** _____

   If availability is not assured by most recent audited statement of cash flows, attach information to support the assumption.

3. **RELATED COMPANY FINANCING** _____

   a) Attach copy of binding, enforceable document which authorizes funding; and
   b) Attach proof of financial position to lend, i.e. audited financial statements of lender.

4. **NON-RELATED COMPANY FINANCING** _____

   Attach letter of commitment or letter of interest.

5. **OTHER:** _____

   Identify and attach supporting detail.

**TOTAL FUNDS** _____

Assets converted from other use
(if converted assets are used in total project cost - Schedule 1) _____

**TOTAL** (must agree with Schedule 1, Line 50) $_____

NOTES: 1) Sources of funds for this project will be analyzed in conjunction with Schedule 2 sources of funds.
2) Supporting documentation for sources of funds should be attached immediately following this schedule, except for the audited financial statements of the applicant, this should be attached following the last schedule (Schedule 11).

**SCHEDULE 4**

Page 1 of 1

**All Applicants with Current Licensed Beds**

**UTILIZATION OF EXISTING BEDS**

| | DATES | LICENSED BEDS | | PATIENT DAYS | | PERCENT UTILIZATION | |
|---|---|---|---|---|---|---|---|
| | | NURSING HOME | OTHER | NURSING HOME | OTHER | NURSING HOME | OTHER |
| **3RD PRIOR YEAR** | | | | | | | |
| (12-month period) | | | | | | | |
| **2ND PRIOR YEAR** | | | | | | | |
| 1st Quarter | | | | | | | |
| 2nd Quarter | | | | | | | |
| 3rd Quarter | | | | | | | |
| 4th Quarter | | | | | | | |
| | **TOTAL** | | | | | | |
| **MOST RECENT YEAR** | | | | | | | |
| 1st Quarter | | | | | | | |
| 2nd Quarter | | | | | | | |
| 3rd Quarter | | | | | | | |
| 4th Quarter | | | | | | | |
| | **TOTAL** | | | | | | |

Indicate the type of licensed beds shown in the "Other" category above: _____

PLEASE SHOW UTILIZATION FOR THE TOTAL OF LICENSED BEDS AT YOUR FACILITY

And

IF THE PROJECT WILL INCREASE A BED TYPE THAT ALREADY EXISTS AT YOUR FACILITY (for example, an increase in the number of nursing home beds) INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS UTILIZATION ONLY FOR THE SERVICE THAT WILL BE EXPANDED

**SCHEDULE 5**

**All Applicants**

**PROJECTED UTILIZATION**
**AFTER PROJECT COMPLETION**

| | DATES | LICENSED BEDS | | PATIENT DAYS (1) | | PERCENT UTILIZATION | |
|---|---|---|---|---|---|---|---|
| | | NURSING HOME | OTHER | NURSING HOME | OTHER (1) | NURSING HOME | OTHER |
| **FIRST YEAR OF OPERATION** | | | | | | | |
| 1st Quarter | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 2nd Quarter | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 3rd Quarter | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 4th Quarter | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| | **TOTAL** | _____ | _____ | _____ | _____ | _____ | _____ |
| **SECOND YEAR OF OPERATION** | | | | | | | |
| 1st Quarter | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 2nd Quarter | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 3rd Quarter | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 4th Quarter | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| | **TOTAL** | _____ | _____ | _____ | _____ | _____ | _____ |

PROJECTS MEASURING UTILIZATION BY COUNTING ADMISSIONS (rather than patient days): Use only this column, and indicate the measurement used.

Attach an explanation of assumptions and the specific methodology used to project utilization.

FOR PROJECTS THAT MODIFY THE NUMBER OR TYPE OF LICENSED BEDS:

Indicate the type of licensed beds shown in the "Other" category above: _____

PLEASE SHOW PROJECTED UTILIZATION FOR THE TOTAL OF LICENSED BEDS AT YOUR FACILITY

And

IF THE PROJECT WILL INCREASE A BED TYPE THAT ALREADY EXISTS AT YOUR FACILITY (for example, an increase in the number of nursing home beds), INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS PROJECTED UTILIZATION ONLY FOR THE BEDS THAT WILL BE EXPANDED OR INITIATED

*SCHEDULE 6*

# New Inpatient Health Care Facilities

**STAFFING PATTERN**
**Year One Ending _____**

| | FTE MORNING | FTE EVENING | FTE NIGHT | FTE TOTAL | AVERAGE ANNUAL SALARY per FTE |
|---|---|---|---|---|---|
| **ADMINISTRATION** | | | | | |
| Administrator | | | | | |
| Director of Nursing | | | | | |
| Admissions Director | | | | | |
| Bookkeeper | | | | | |
| Secretary | | | | | |
| Medical Records Clerk | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **PHYSICIANS** | | | | | |
| Medical Director | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **NURSING** | | | | | |
| R.N.s | | | | | |
| L.P.N.s | | | | | |
| Nurses' Aides | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **ANCILLARY** | | | | | |
| Physical Therapist | | | | | |
| Speech Therapist | | | | | |
| Occupational Therapist | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **DIETARY** | | | | | |
| Dietary Supervisor | | | | | |
| Cooks | | | | | |
| Dietary Aides | | | | | |
| **TOTAL** | | | | | |
| **SOCIAL SERVICES** | | | | | |
| Social Service Director | | | | | |
| Activity Director | | | | | |
| Activities Assistant | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **HOUSEKEEPING** | | | | | |
| Housekeeping Supervision | | | | | |
| Housekeepers | | | | | |
| **TOTAL** | | | | | |
| **LAUNDRY** | | | | | |
| Laundry Supervisor | | | | | |
| Laundry Aides | | | | | |
| **TOTAL** | | | | | |
| **PLANT MAINTENANCE** | | | | | |
| Maintenance Supervisor | | | | | |
| Maintenance Assistance | | | | | |
| Security | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **GRAND TOTAL** | | | | | |

NEW INPATIENT HEALTH CARE FACILITIES: A new nursing home, hospice, intermediate care facility for the developmentally disabled, or freestanding inpatient hospice facility that will be licensed when the project is complete.

*SCHEDULE 6*

# New Inpatient Health Care Facilities

**STAFFING PATTERN**
**Year Two Ending _____**

| | FTE MORNING | FTE EVENING | FTE NIGHT | FTE TOTAL | AVERAGE ANNUAL SALARY per FTE |
|---|---|---|---|---|---|
| **ADMINISTRATION** | | | | | |
| Administrator | | | | | |
| Director of Nursing | | | | | |
| Admissions Director | | | | | |
| Bookkeeper | | | | | |
| Secretary | | | | | |
| Medical Records Clerk | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **PHYSICIANS** | | | | | |
| Medical Director | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **NURSING** | | | | | |
| R.N.s | | | | | |
| L.P.N.s | | | | | |
| Nurses' Aides | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **ANCILLARY** | | | | | |
| Physical Therapist | | | | | |
| Speech Therapist | | | | | |
| Occupational Therapist | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **DIETARY** | | | | | |
| Dietary Supervisor | | | | | |
| Cooks | | | | | |
| Dietary Aides | | | | | |
| **TOTAL** | | | | | |
| **SOCIAL SERVICES** | | | | | |
| Social Service Director | | | | | |
| Activity Director | | | | | |
| Activities Assistant | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **HOUSEKEEPING** | | | | | |
| Housekeeping Supervision | | | | | |
| Housekeepers | | | | | |
| **TOTAL** | | | | | |
| **LAUNDRY** | | | | | |
| Laundry Supervisor | | | | | |
| Laundry Aides | | | | | |
| **TOTAL** | | | | | |
| **PLANT MAINTENANCE** | | | | | |
| Maintenance Supervisor | | | | | |
| Maintenance Assistance | | | | | |
| Security | | | | | |
| Other: _____ | | | | | |
| **TOTAL** | | | | | |
| **GRAND TOTAL** | | | | | |

NEW INPATIENT HEALTH CARE FACILITIES: A new nursing home, hospice, intermediate care facility for the developmentally disabled, or freestanding inpatient hospice facility that will be licensed when the project is complete.

**SCHEDULE 6A** **All Currently Licensed Facilities or Programs**

**STAFFING PATTERN**
**Year One Ending _____**



| | CURRENT TOTAL NUMBER OF FTE STAFF(1) | FTE STAFF ADDED BY THIS PROJECT | | NEW TOTAL NUMBER OF FTE STAFF |
|---|---|---|---|---|
| | | NUMBER | AVERAGE ANNUAL SALARY FOR FTE ADDED | |
| **ADMINISTRATION** | | | | |
| Administrator | | | | |
| Director of Nursing | | | | |
| Admissions Director | | | | |
| Bookkeeper | | | | |
| Secretary | | | | |
| Medical Records Clerk | | | | |
| Other: _____ | | | | |
| **PHYSICIANS** | | | | |
| Unit/Program Director | | | | |
| Other: _____ | | | | |
| **NURSING** | | | | |
| R.N.s | | | | |
| L.P.N.s | | | | |
| Nurses' Aides | | | | |
| Other: _____ | | | | |
| **ANCILLARY** | | | | |
| Physical Therapist | | | | |
| Speech Therapist | | | | |
| Occupational Therapist | | | | |
| Other: _____ | | | | |
| **DIETARY** | | | | |
| Dietary Supervisor | | | | |
| Cooks | | | | |
| Dietary Aides | | | | |
| **SOCIAL SERVICES** | | | | |
| Social Service Director | | | | |
| Activity Director | | | | |
| Activities Assistant | | | | |
| Other: _____ | | | | |
| **HOUSEKEEPING** | | | | |
| Housekeeping Supervision | | | | |
| Housekeepers | | | | |
| **LAUNDRY** | | | | |
| Laundry Supervisor | | | | |
| Laundry Aides | | | | |
| **PLANT MAINTENANCE** | | | | |
| Maintenance Supervisor | | | | |
| Maintenance Assistance | | | | |
| Security | | | | |
| Other: _____ | | | | |
| **GRAND TOTAL** | | | //////////////////////////////// | |

FTE STAFF TOTAL FOR THE ENTIRE FACILITY.

**SCHEDULE 6A** **All Currently Licensed Facilities or Programs**



**STAFFING PATTERN**
**Year Two Ending _____**

| | CURRENT TOTAL NUMBER OF FTE STAFF(1) | FTE STAFF ADDED BY THIS PROJECT | | NEW TOTAL NUMBER OF FTE STAFF |
|---|---|---|---|---|
| | | NUMBER | AVERAGE ANNUAL SALARY FOR FTE ADDED | |
| **ADMINISTRATION** | | | | |
| Administrator | | | | |
| Director of Nursing | | | | |
| Admissions Director | | | | |
| Bookkeeper | | | | |
| Secretary | | | | |
| Medical Records Clerk | | | | |
| Other: _____ | | | | |
| **PHYSICIANS** | | | | |
| Unit/Program Director | | | | |
| Other: _____ | | | | |
| **NURSING** | | | | |
| R.N.s | | | | |
| L.P.N.s | | | | |
| Nurses' Aides | | | | |
| Other: _____ | | | | |
| **ANCILLARY** | | | | |
| Physical Therapist | | | | |
| Speech Therapist | | | | |
| Occupational Therapist | | | | |
| Other: _____ | | | | |
| **DIETARY** | | | | |
| Dietary Supervisor | | | | |
| Cooks | | | | |
| Dietary Aides | | | | |
| **SOCIAL SERVICES** | | | | |
| Social Service Director | | | | |
| Activity Director | | | | |
| Activities Assistant | | | | |
| Other: _____ | | | | |
| **HOUSEKEEPING** | | | | |
| Housekeeping Supervision | | | | |
| Housekeepers | | | | |
| **LAUNDRY** | | | | |
| Laundry Supervisor | | | | |
| Laundry Aides | | | | |
| **PLANT MAINTENANCE** | | | | |
| Maintenance Supervisor | | | | |
| Maintenance Assistance | | | | |
| Security | | | | |
| Other: _____ | | | | |
| **GRAND TOTAL** | | | //////////////////////////////// | |

FTE STAFF TOTAL FOR THE ENTIRE FACILITY.

**SCHEDULE 7** **Nursing Homes**

**PROJECTED REVENUES**



**PROJECTED OPERATING YEAR 1 (ENDING _____):**

| | | SELF PAY Col. 1 | MEDICAID Col. 2 | MEDICAID HMO Col. 3 | MEDICARE Col. 4 | MEDICARE HMO Col. 5 | COMMERCIAL INSURANCE Col. 6 | OTHER MANAGED CARE Col. 7 | OTHER PAYERS Col. 8 | OTHER REVENUE Col. 9 | TOTAL Col. 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Routine Services | | | | | | | | | | |
| 2 | Physical Therapy | | | | | | | | | | |
| 3 | Speech Therapy | | | | | | | | | | |
| 4 | Occupational Therapy | | | | | | | | | | |
| 5 | Audiological Therapy | | | | | | | | | | |
| 6 | Medical Supplies | | | | | | | | | | |
| 7 | Pharmacy | | | | | | | | | | |
| 8 | Laboratory | | | | | | | | | | |
| 9 | Radiology | | | | | | | | | | |
| 10 | Other Ancillary | | | | | | | | | | |
| 11 | Unrestricted Grants/Donations | | | | | | | | | | |
| 12 | Outpatient Clinic | | | | | | | | | | |
| 13 | Other Nursing Home Revenue | | | | | | | | | | |
| 14 | Charity Allowance | | | | | | | | | | |
| 15 | Contractual Adjustments | | | | | | | | | | |
| 16 | Prior Year Cost Settlements | | | | | | | | | | |
| 17 | **TOTAL NURSING HOME REVENUE** | | | | | | | | | | |
| 18 | Restricted Grants/Donations | | | | | | | | | | |
| 19 | **NON NURSING HOME REVENUES** | | | | | | | | | | |
| 20 | **TOTAL REVENUE** | | | | | | | | | | |
| 21 | % of Nursing Home Revenue | | | | | | | | | | 100% |
| 22 | **TOTAL ADMISSIONS** | | | | | | | | | | |
| 23 | **TOTAL PATIENT DAYS** | | | | | | | | | | |
| 24 | % of Total Patient Days | | | | | | | | | | 100% |
| 25 | **REVENUE PER PATIENT DAY** | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |

Attach notes describing assumptions used in projecting revenues.

PLEASE SHOW PROJECTED REVENUES FOR THE TOTAL OF LICENSED BEDS AT YOUR FACILITY. IF YOUR PROJECT EXPANDS EXISTING CAPACITY, INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS PROJECTED REVENUES **ONLY** FOR THE ADDED BEDS.

26 Total Number of Nursing Home Beds _____

27 Total Number of Other Beds _____

28 Average Occupancy for Nursing Home Beds _____%

29 Average Occupancy for Other Beds _____%

**SCHEDULE 7** **Nursing Homes**

**PROJECTED REVENUES**



**PROJECTED OPERATING YEAR 2 (ENDING _____):**

| | | SELF PAY Col. 1 | MEDICAID Col. 2 | MEDICAID HMO Col. 3 | MEDICARE Col. 4 | MEDICARE HMO Col. 5 | COMMERCIAL INSURANCE Col. 6 | OTHER MANAGED CARE Col. 7 | OTHER PAYERS Col. 8 | OTHER REVENUE Col. 9 | TOTAL Col. 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Routine Services | | | | | | | | | | |
| 2 | Physical Therapy | | | | | | | | | | |
| 3 | Speech Therapy | | | | | | | | | | |
| 4 | Occupational Therapy | | | | | | | | | | |
| 5 | Audiological Therapy | | | | | | | | | | |
| 6 | Medical Supplies | | | | | | | | | | |
| 7 | Pharmacy | | | | | | | | | | |
| 8 | Laboratory | | | | | | | | | | |
| 9 | Radiology | | | | | | | | | | |
| 10 | Other Ancillary | | | | | | | | | | |
| 11 | Unrestricted Grants/Donations | | | | | | | | | | |
| 12 | Outpatient Clinic | | | | | | | | | | |
| 13 | Other Nursing Home Revenue | | | | | | | | | | |
| 14 | Charity Allowance | | | | | | | | | | |
| 15 | Contractual Adjustments | | | | | | | | | | |
| 16 | Prior Year Cost Settlements | | | | | | | | | | |
| 17 | **TOTAL NURSING HOME REVENUE** | | | | | | | | | | |
| 18 | Restricted Grants/Donations | | | | | | | | | | |
| 19 | **NON NURSING HOME REVENUES** | | | | | | | | | | |
| 20 | **TOTAL REVENUE** | | | | | | | | | | |
| 21 | % of Nursing Home Revenue | | | | | | | | | | 100% |
| 22 | **TOTAL ADMISSIONS** | | | | | | | | | | |
| 23 | **TOTAL PATIENT DAYS** | | | | | | | | | | |
| 24 | % of Total Patient Days | | | | | | | | | | 100% |
| 25 | **REVENUE PER PATIENT DAY** | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |

Attach notes describing assumptions used in projecting revenues.

PLEASE SHOW PROJECTED REVENUES FOR THE TOTAL OF LICENSED BEDS AT YOUR FACILITY. IF YOUR PROJECT EXPANDS EXISTING CAPACITY, INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS PROJECTED REVENUES **ONLY** FOR THE ADDED BEDS.

26 Total Number of Nursing Home Beds _____

27 Total Number of Other Beds _____

28 Average Occupancy for Nursing Home Beds _____%

29 Average Occupancy for Other Beds _____%



**AHCA Form 3150-0001 August 2024**

Rule 59C-1.008, Florida Administrative Code

Form available at: https://ahca.myflorida.com/con-application

**SCHEDULE 7A**

# Hospice

## PROJECTED REVENUES



**PROJECTED OPERATING YEAR 1 (ENDING _____):**

| | | SELF PAY Col. 1 | MEDICAID Col. 2 | MEDICAID HMO Col. 3 | MEDICARE Col. 4 | MEDICARE HMO Col. 5 | COMMERCIAL INSURANCE Col. 6 | OTHER MANAGED CARE Col. 7 | OTHER PAYERS Col. 8 | OTHER REVENUE Col. 9 | TOTAL Col. 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **PATIENT SERVICE REVENUES** | | | | | | | | | | |
| 1 | Routine Care 0-60 Days | | | | | | | | | | |
| 2 | Routine Care 61+ Days | | | | | | | | | | |
| 3 | Respite Care | | | | | | | | | | |
| 4 | Other Inpatient Ancillary | | | | | | | | | | |
| 5 | General Inpatient Care | | | | | | | | | | |
| 6 | Other | | | | | | | | | | |
| 7 | **TOTAL PATIENT SERVICE REVENUES** | | | | | | | | | | |
| | **DEDUCTIONS FROM REVENUE** | | | | | | | | | | |
| 8 | Contractual Adjustments | | | | | | | | | | |
| 9 | Charity Care | | | | | | | | | | |
| 10 | Other | | | | | | | | | | |
| 11 | **TOTAL DEDUCTIONS FROM REVENUE** | | | | | | | | | | |
| 12 | **NET PATIENT SERVICE REVENUE** | | | | | | | | | | |
| 13 | **OTHER OPERATING REVENUE** | | | | | | | | | | |
| 14 | **NET OPERATING REVENUE** | | | | | | | | | | |
| 15 | Admissions | | | | | | | | | | |
| 16 | Patient Days | | | | | | | | | | |
| 17 | % of Patient Days | | | | | | | | | | |
| 18 | Revenue per Patient Days | | | | | | | | | | |

**SCHEDULE 7A**

# Hospice

## PROJECTED REVENUES



**PROJECTED OPERATING YEAR 2 (ENDING _____):**

| | | SELF PAY Col. 11 | MEDICAID Col. 12 | MEDICAID HMO Col. 13 | MEDICARE Col. 14 | MEDICARE HMO Col. 15 | COMMERCIAL INSURANCE Col. 16 | OTHER MANAGED CARE Col. 17 | OTHER PAYERS Col. 18 | OTHER REVENUE Col. 19 | TOTAL Col. 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **PATIENT SERVICE REVENUES** | | | | | | | | | | |
| 1 | Routine Care 0-60 Days | | | | | | | | | | |
| 2 | Routine Care 61+ Days | | | | | | | | | | |
| 3 | Respite Care | | | | | | | | | | |
| 4 | Other Inpatient Ancillary | | | | | | | | | | |
| 5 | General Inpatient Care | | | | | | | | | | |
| 6 | Other | | | | | | | | | | |
| 7 | **TOTAL PATIENT SERVICE REVENUES** | | | | | | | | | | |
| | **DEDUCTIONS FROM REVENUE** | | | | | | | | | | |
| 8 | Contractual Adjustments | | | | | | | | | | |
| 9 | Charity Care | | | | | | | | | | |
| 10 | Other | | | | | | | | | | |
| 11 | **TOTAL DEDUCTIONS FROM REVENU** | | | | | | | | | | |
| 12 | **NET PATIENT SERVICE REVENUE** | | | | | | | | | | |
| 13 | **OTHER OPERATING REVENUE** | | | | | | | | | | |
| 14 | **NET OPERATING REVENUE** | | | | | | | | | | |
| 15 | Admissions | | | | | | | | | | |
| 16 | Patient Days | | | | | | | | | | |
| 17 | % of Patient Days | | | | | | | | | | |
| 18 | Revenue per Patient Day | | | | | | | | | | |

**SCHEDULE 7B** **ICF/DDs** **PROJECTED REVENUES**



**PROJECTED OPERATING YEAR 1 (ENDING _____):**

| | | SELF PAY Col. 1 | MEDICAID Col. 2 | MEDICAID HMO Col. 3 | MEDICARE Col. 4 | MEDICARE HMO Col. 5 | COMMERCIAL INSURANCE Col. 6 | OTHER MANAGED CARE Col. 7 | OTHER PAYERS Col. 8 | OTHER REVENUE Col. 9 | TOTAL Col. 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Routine Services | | | | | | | | | | |
| 2 | Physical Therapy | | | | | | | | | | |
| 3 | Speech Therapy | | | | | | | | | | |
| 4 | Occupational Therapy | | | | | | | | | | |
| 5 | Audiological Therapy | | | | | | | | | | |
| 6 | Medical Supplies | | | | | | | | | | |
| 7 | Pharmacy | | | | | | | | | | |
| 8 | Laboratory | | | | | | | | | | |
| 9 | Radiology | | | | | | | | | | |
| 10 | Other Ancillary | | | | | | | | | | |
| 11 | Unrestricted Grants/Donations | | | | | | | | | | |
| 12 | Outpatient Clinic | | | | | | | | | | |
| 13 | Other Revenue | | | | | | | | | | |
| 14 | Charity Allowance | | | | | | | | | | |
| 15 | Contractual Adjustments | | | | | | | | | | |
| 16 | Prior Year Cost Settlements | | | | | | | | | | |
| 17 | **TOTAL ICF/DD REVENUE** | | | | | | | | | | |
| 18 | Restricted Grants/Donations | | | | | | | | | | |
| 19 | **NON ICF/DD REVENUES** | | | | | | | | | | |
| 20 | **TOTAL REVENUE** | | | | | | | | | | |
| 21 | % of ICF/DD Revenue | | | | | | | | | | 100% |
| 22 | **TOTAL ADMISSIONS** | | | | | | | | | | |
| 23 | **TOTAL PATIENT DAYS** | | | | | | | | | | |
| 24 | % of Total Patient Days | | | | | | | | | | 100% |
| 25 | **REVENUE PER PATIENT DAY** | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |

Attach notes describing assumptions used in projecting revenues.

PLEASE SHOW PROJECTED REVENUES FOR THE TOTAL OF LICENSED BEDS AT YOUR FACILITY. IF YOUR PROJECT EXPANDS EXISTING CAPACITY, INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS PROJECTED REVENUES **ONLY** FOR THE ADDED BEDS.

26 Total Number of ICF/DD Beds _____

27 Total Number of Other Beds _____

28 Average Occupancy for ICF/DD Beds _____%

29 Average Occupancy for Other Beds _____%

**SCHEDULE 7B** **ICF/DDs**

**PROJECTED REVENUES**



**PROJECTED OPERATING YEAR 2 (ENDING _____):**

| | | SELF PAY Col. 11 | MEDICAID Col. 12 | MEDICAID HMO Col. 13 | MEDICARE Col. 14 | MEDICARE HMO Col. 15 | COMMERCIAL INSURANCE Col. 16 | OTHER MANAGED CARE Col. 17 | OTHER PAYERS Col. 18 | OTHER REVENUE Col. 19 | TOTAL Col. 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Routine Services | | | | | | | | | | |
| 2 | Physical Therapy | | | | | | | | | | |
| 3 | Speech Therapy | | | | | | | | | | |
| 4 | Occupational Therapy | | | | | | | | | | |
| 5 | Audiological Therapy | | | | | | | | | | |
| 6 | Medical Supplies | | | | | | | | | | |
| 7 | Pharmacy | | | | | | | | | | |
| 8 | Laboratory | | | | | | | | | | |
| 9 | Radiology | | | | | | | | | | |
| 10 | Other Ancillary | | | | | | | | | | |
| 11 | Unrestricted Grants/Donations | | | | | | | | | | |
| 12 | Outpatient Clinic | | | | | | | | | | |
| 13 | Other Nursing Home Revenue | | | | | | | | | | |
| 14 | Charity Allowance | | | | | | | | | | |
| 15 | Contractual Adjustments | | | | | | | | | | |
| 16 | Prior Year Cost Settlements | | | | | | | | | | |
| 17 | **TOTAL ICF/DD REVENUE** | | | | | | | | | | |
| 18 | Restricted Grants/Donations | | | | | | | | | | |
| 19 | **NON ICF/DD REVENUES** | | | | | | | | | | |
| 20 | **TOTAL REVENUE** | | | | | | | | | | |
| 21 | % of ICF/DD Revenue | | | | | | | | | | 100% |
| 22 | **TOTAL ADMISSIONS** | | | | | | | | | | |
| 23 | **TOTAL PATIENT DAYS** | | | | | | | | | | |
| 24 | % of Total Patient Days | | | | | | | | | | 100% |
| 25 | **REVENUE PER PATIENT DAY** | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |

Attach notes describing assumptions used in projecting revenues.

PLEASE SHOW PROJECTED REVENUES FOR THE TOTAL OF LICENSED BEDS AT YOUR FACILITY. IF YOUR PROJECT EXPANDS EXISTING CAPACITY, INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS PROJECTED REVENUES **ONLY** FOR THE ADDED BEDS.

26 Total Number of ICF/DD Beds _____

27 Total Number of Other Beds _____

28 Average Occupancy for ICF/DD Beds _____%

29 Average Occupancy for Other Beds _____%

**SCHEDULE 8**

# Nursing Homes

**PROJECTED INCOME AND EXPENSES**



**PROJECTED YEAR 1 (ENDING _____)**

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | THIS PROJECT ONLY FULLY ALLOCATED ACTIVITY | |
|---|---|---|---|---|---|---|---|
| | | Amount Col. 1 | Per Patient Day Col. 2 | Amount Col. 3 | Per Patient Day Col. 4 | Amount Col. 5 | Per Patient Day Col. 6 |
| | **NURSING HOME REVENUE** | | | | | | |
| 1 | SCHEDULE 7, LINE 17, COLUMN 10 | $ | $ | $ | $ | $ | $ |
| | **EXPENSES** | | | | | | |
| | **ADMINISTRATION AND OVERHEAD** | | | | | | |
| 2 | Plant Operation | | | | | | |
| 3 | Housekeeping | | | | | | |
| 4 | Administration | | | | | | |
| 5 | Owners (Shareholders) Administrative Compensation | | | | | | |
| 6 | **TOTAL ADMIN. AND OVERHEAD** | $ | $ | $ | $ | $ | $ |
| | **ANCILLARY COST CENTERS** | | | | | | |
| 7 | Physical Therapy | | | | | | |
| 8 | Speech Therapy | | | | | | |
| 9 | Occupational Therapy | | | | | | |
| 10 | Medical Supplies Charged to Patients | | | | | | |
| 11 | Radiology | | | | | | |
| 12 | Laboratory | | | | | | |
| 13 | Pharmacy | | | | | | |
| 14 | Other _____ | | | | | | |
| 15 | **TOTAL ANCILLARY COST CENTERS** | $ | $ | $ | $ | $ | $ |
| | **PATIENT CARE COSTS** | | | | | | |
| 16 | Nursing | | | | | | |
| 17 | Dietary | | | | | | |
| 18 | Other _____ | | | | | | |
| 19 | **TOTAL PATIENT CARE COSTS** | $ | $ | $ | $ | $ | $ |

Note: For applicants whose operations extend beyond a single facility, a narrative must be attached to detail the impact of the proposed project on the cost of other services provided by the applicant.

# Nursing Homes

## PROJECTED INCOME AND EXPENSES

**PROJECTED YEAR 1 (ENDING _____)**

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | THIS PROJECT ONLY FULLY ALLOCATED ACTIVITY | |
|---|---|---|---|---|---|---|---|
| | | Amount Col. 1 | Per Patient Day Col. 2 | Amount Col. 3 | Per Patient Day Col. 4 | Amount Col. 5 | Per Patient Day Col. 6 |
| | **PROPERTY COST** | | | | | | |
| | **DEPRECIATION AND AMORTIZATION** | | | | | | |
| 20 | This project | | | | | | |
| 21 | Other than this project | | | | | | |
| | **GROSS INTEREST ON PROPERTY** | | | | | | |
| 22 | This project | | | | | | |
| 23 | Other than this project | | | | | | |
| 24 | **RENT ON PROPERTY** | | | | | | |
| 25 | **INSURANCE ON PROPERTY** | | | | | | |
| 26 | **TAXES ON PROPERTY** | | | | | | |
| 27 | **TOTAL PROPERTY COST** | $ | $ | $ | $ | $ | $ |
| | **OTHER COST CENTERS - NURSING FACILITY** | | | | | | |
| 28 | Laundry and Linen | | | | | | |
| 29 | Outpatient Clinic | | | | | | |
| | Other (beauty, barber, gift shop, etc) | | | | | | |
| 30 | _____ | | | | | | |
| 31 | _____ | | | | | | |
| 32 | **TOTAL OTHER COST CENTERS** | $ | $ | $ | $ | $ | $ |
| 33 | **TOTAL NURSING HOME COSTS** | $ | $ | $ | $ | $ | $ |
| 34 | **NURSING HOME OPERATING INCOME OR (LOSS)** | $ | $ | $ | $ | $ | $ |
| | **RESTRICTED GRANT/DONATION REVENUE** | | | | | | |
| 35 | SCHEDULE 7, LINE 18, COLUMN 10 | $ | $ | $ | $ | $ | $ |
| 36 | **NURSING HOME INCOME OR LOSS** | $ | $ | $ | $ | $ | $ |

**SCHEDULE 8**

# Nursing Homes

## PROJECTED INCOME AND EXPENSES



**PROJECTED YEAR 1 (ENDING _____)**

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | THIS PROJECT ONLY FULLY ALLOCATED ACTIVITY | |
|---|---|---|---|---|---|---|---|
| | | Amount Col. 1 | Per Patient Day Col. 2 | Amount Col. 3 | Per Patient Day Col. 4 | Amount Col. 5 | Per Patient Day Col. 6 |
| **NON NURSING HOME REVENUE** | | | | | | | |
| 37 | SCHEDULE 7, LINE 19, COLUMN 10 | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ |
| | **NON NURSING HOME COSTS (e.g. ALF, etc.)** | | | | | | |
| 38 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 39 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 40 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 41 | **TOTAL NON NURSING HOME COSTS** | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ |
| 42 | **NON NURSING HOME INCOME (LOSS)** | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ |
| 43 | **NET INCOME OR (LOSS) BEFORE INCOME TAXES** | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ |
| 44 | Provisions for Income Taxes | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ |
| 45 | **NET INCOME OR (LOSS)** | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ | $ _____ |

Note: For applicants whose operations extend beyond a single facility, a narrative must be attached to detail the impact of the proposed project on the cost of other services provided by the applicant.

ATTACH NOTES DESCRIBING THE ASSUMPTIONS USED IN PROJECTING EXPENSES AND COSTS

**SCHEDULE 8**

# Nursing Homes

## PROJECTED INCOME AND EXPENSES



**PROJECTED YEAR 2 (ENDING _____)**

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | THIS PROJECT ONLY FULLY ALLOCATED ACTIVITY | |
|---|---|---|---|---|---|---|---|
| | | Amount Col. 7 | Per Patient Day Col. 8 | Amount Col. 9 | Per Patient Day Col. 10 | Amount Col. 11 | Per Patient Day Col. 12 |
| **NURSING HOME REVENUE** | | | | | | | |
| 1 | SCHEDULE 7, LINE 17, COLUMN 20 | $ | $ | $ | $ | $ | $ |
| **EXPENSES** | | | | | | | |
| | **ADMINISTRATION AND OVERHEAD** | | | | | | |
| 2 | Plant Operation | | | | | | |
| 3 | Housekeeping | | | | | | |
| 4 | Administration | | | | | | |
| 5 | Owners (Shareholders) Administrative Compensation | | | | | | |
| 6 | **TOTAL ADMIN. AND OVERHEAD** | $ | $ | $ | $ | $ | $ |
| | **ANCILLARY COST CENTERS** | | | | | | |
| 7 | Physical Therapy | | | | | | |
| 8 | Speech Therapy | | | | | | |
| 9 | Occupational Therapy | | | | | | |
| 10 | Medical Supplies Charged to Patients | | | | | | |
| 11 | Radiology | | | | | | |
| 12 | Laboratory | | | | | | |
| 13 | Pharmacy | | | | | | |
| 14 | Other _____ | | | | | | |
| 15 | **TOTAL ANCILLARY COST CENTERS** | $ | $ | $ | $ | $ | $ |
| | **PATIENT CARE COSTS** | | | | | | |
| 16 | Nursing | | | | | | |
| 17 | Dietary | | | | | | |
| 18 | Other _____ | | | | | | |
| 19 | **TOTAL PATIENT CARE COSTS** | $ | $ | $ | $ | $ | $ |

Note: For applicants whose operations extend beyond a single facility, a narrative must be attached to detail the impact of the proposed project on the cost of other services provided by the applicant.

# Nursing Homes

## PROJECTED INCOME AND EXPENSES

### PROJECTED YEAR 2 (ENDING _____)

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | THIS PROJECT ONLY FULLY ALLOCATED ACTIVITY | |
|---|---|---|---|---|---|---|---|
| | | Amount Col. 7 | Per Patient Day Col. 8 | Amount Col. 9 | Per Patient Day Col. 10 | Amount Col. 11 | Per Patient Day Col. 12 |
| | **PROPERTY COST** | | | | | | |
| | **DEPRECIATION AND AMORTIZATION** | | | | | | |
| 20 | This project | | | | | | |
| 21 | Other than this project | | | | | | |
| | **GROSS INTEREST ON PROPERTY** | | | | | | |
| 22 | This project | | | | | | |
| 23 | Other than this project | | | | | | |
| 24 | **RENT ON PROPERTY** | | | | | | |
| 25 | **INSURANCE ON PROPERTY** | | | | | | |
| 26 | **TAXES ON PROPERTY** | | | | | | |
| 27 | **TOTAL PROPERTY COST** | $ | $ | $ | $ | $ | $ |
| | **OTHER COST CENTERS - NURSING FACILITY** | | | | | | |
| 28 | Laundry and Linen | | | | | | |
| 29 | Outpatient Clinic | | | | | | |
| | Other (beauty, barber, gift shop, etc) | | | | | | |
| 30 | _____ | | | | | | |
| 31 | _____ | | | | | | |
| 32 | **TOTAL OTHER COST CENTERS** | $ | $ | $ | $ | $ | $ |
| 33 | **TOTAL NURSING HOME COSTS** | $ | $ | $ | $ | $ | $ |
| 34 | **NURSING HOME OPERATING INCOME OR (LOSS)** | $ | $ | $ | $ | $ | $ |
| | **RESTRICTED GRANT/DONATION REVENUE** | | | | | | |
| 35 | SCHEDULE 7, LINE 18, COLUMN 20 | $ | $ | $ | $ | $ | $ |
| 36 | **NURSING HOME INCOME OR LOSS** | $ | $ | $ | $ | $ | $ |

**SCHEDULE 8**

# Nursing Homes

## PROJECTED INCOME AND EXPENSES



**PROJECTED YEAR 2 (ENDING _____)**

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | THIS PROJECT ONLY FULLY ALLOCATED ACTIVITY | |
|---|---|---|---|---|---|---|---|
| | | Amount Col. 7 | Per Patient Day Col. 8 | Amount Col. 9 | Per Patient Day Col. 10 | Amount Col. 11 | Per Patient Day Col. 12 |
| **NON NURSING HOME REVENUE** | | | | | | | |
| 37 | SCHEDULE 7, LINE 19, COLUMN 20 | $ | $ | $ | $ | $ | $ |
| | **NON NURSING HOME COSTS (e.g. ALF, etc.)** | | | | | | |
| 38 | | | | | | | |
| 39 | | | | | | | |
| 40 | | | | | | | |
| 41 | **TOTAL NON NURSING HOME COSTS** | $ | $ | $ | $ | $ | $ |
| 42 | **NON NURSING HOME INCOME (LOSS)** | $ | $ | $ | $ | $ | $ |
| 43 | **NET INCOME OR (LOSS) BEFORE INCOME TAXES** | $ | $ | $ | $ | $ | $ |
| 44 | Provisions for Income Taxes | $ | $ | $ | $ | $ | $ |
| 45 | **NET INCOME OR (LOSS)** | $ | $ | $ | $ | $ | $ |

Note: For applicants whose operations extend beyond a single facility, a narrative must be attached to detail the impact of the proposed project on the cost of other services provided by the applicant.

ATTACH NOTES DESCRIBING THE ASSUMPTIONS USED IN PROJECTING EXPENSES AND COSTS

**SCHEDULE 8A** **Hospice and ICF/DDs**



**PROJECTED INCOME AND EXPENSES**

**PROJECTED YEAR 1 (ENDING _____)**

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | INCREMENTAL DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| | | Amount | Per Patient Day(1) | Amount | Per Patient Day(1) | Amount | Per Patient Day(1) |
| | | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 |
| **NET OPERATING REVENUE** | | | | | | | |
| 1 | SCHEDULE 7A , LINE 14, COLUMN 10 OR SCHEDULE 7B, LINE 17, COLUMN 10 | $_____ | $_____ | $_____ | $_____ | $_____ | $_____ |
| **EXPENSES** | | | | | | | |
| | **PATIENT SERVICE** | | | | | | |
| 2 | Nursing | _____ | _____ | _____ | _____ | _____ | _____ |
| 3 | Other | _____ | _____ | _____ | _____ | _____ | _____ |
| | **ANCILLARY** | | | | | | |
| 4 | Physical Therapy | _____ | _____ | _____ | _____ | _____ | _____ |
| 5 | Speech Therapy | _____ | _____ | _____ | _____ | _____ | _____ |
| 6 | Occupational Therapy | _____ | _____ | _____ | _____ | _____ | _____ |
| 7 | Medical Supplies | _____ | _____ | _____ | _____ | _____ | _____ |
| 8 | Radiology | _____ | _____ | _____ | _____ | _____ | _____ |
| 9 | Laboratory | _____ | _____ | _____ | _____ | _____ | _____ |
| 10 | Pharmacy | _____ | _____ | _____ | _____ | _____ | _____ |
| 11 | Other | _____ | _____ | _____ | _____ | _____ | _____ |
| 12 | **TOTAL ANCILLARY** | $_____ | $_____ | $_____ | $_____ | $_____ | $_____ |
| 13 | Ambulatory | _____ | _____ | _____ | _____ | _____ | _____ |
| | **ADMINISTRATION AND OVERHEAD** | | | | | | |
| 14 | Plant Operations | _____ | _____ | _____ | _____ | _____ | _____ |
| 15 | Housekeeping | _____ | _____ | _____ | _____ | _____ | _____ |
| 16 | Administration | _____ | _____ | _____ | _____ | _____ | _____ |
| 17 | Other | _____ | _____ | _____ | _____ | _____ | _____ |
| 18 | **TOTAL ADMINISTRATION AND OVERHEAD** | $_____ | $_____ | $_____ | $_____ | $_____ | $_____ |

For utilization other than "patient day," use the applicable measure consistent with Schedules 5 and 7A.

# Hospice and ICF/DDs

## PROJECTED INCOME AND EXPENSES

### PROJECTED YEAR 1 (ENDING )

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | INCREMENTAL DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| | | Amount | Per Patient Day(1) | Amount | Per Patient Day(1) | Amount | Per Patient Day(1) |
| | | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 |
| | **PROPERTY COSTS** | | | | | | |
| 19 | Depreciation and Amortization | | | | | | |
| 20 | Interest | | | | | | |
| 21 | Rent | | | | | | |
| 22 | Insurance | | | | | | |
| 23 | Taxes | | | | | | |
| 24 | **TOTAL PROPERTY COSTS** | $ | $ | $ | $ | $ | $ |
| 25 | **OTHER OPERATING COSTS** | $ | $ | $ | $ | $ | $ |
| 26 | **TOTAL OPERATING EXPENSES** | $ | $ | $ | $ | $ | $ |
| 27 | **NET PROFIT FROM OPERATIONS** | $ | $ | $ | $ | $ | $ |
| 28 | **NON-OPERATING REVENUES** | $ | $ | $ | $ | $ | $ |
| | **NON-OPERATING EXPENSES** | | | | | | |
| 29 | Income Taxes | | | | | | |
| 30 | Other | | | | | | |
| 31 | **TOTAL NON-OPERATING EXPENSES** | $ | | | | | |
| 32 | **NET PROFIT (OR LOSS)** | $ | $ | $ | $ | $ | $ |

**SCHEDULE 8A** **Hospice and ICF/DDs**



**PROJECTED INCOME AND EXPENSES**

**PROJECTED YEAR 2 (ENDING _____)**

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | INCREMENTAL DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| | | Amount | Per Patient Day(1) | Amount | Per Patient Day(1) | Amount | Per Patient Day(1) |
| | | Col. 7 | Col. 8 | Col. 9 | Col. 10 | Col. 11 | Col. 12 |
| **NET OPERATING REVENUE** | | | | | | | |
| 1 | SCHEDULE 7A, LINE 14, COLUMN 10 OR SCHEDULE 7B, LINE 17, COLUMN 20 | $ | $ | $ | $ | $ | $ |
| **EXPENSES** | | | | | | | |
| | **PATIENT SERVICE** | | | | | | |
| 2 | Nursing | | | | | | |
| 3 | Other | | | | | | |
| | **ANCILLARY** | | | | | | |
| 4 | Physical Therapy | | | | | | |
| 5 | Speech Therapy | | | | | | |
| 6 | Occupational Therapy | | | | | | |
| 7 | Medical Supplies | | | | | | |
| 8 | Radiology | | | | | | |
| 9 | Laboratory | | | | | | |
| 10 | Pharmacy | | | | | | |
| 11 | Other | | | | | | |
| 12 | **TOTAL ANCILLARY** | $ | $ | $ | $ | $ | $ |
| 13 | Ambulatory | | | | | | |
| | **ADMINISTRATION AND OVERHEAD** | | | | | | |
| 14 | Plant Operations | | | | | | |
| 15 | Housekeeping | | | | | | |
| 16 | Administration | | | | | | |
| 17 | Other | | | | | | |
| 18 | **TOTAL ADMINISTRATION AND OVERHEAD** | $ | $ | $ | $ | $ | $ |

For utilization other than "patient day," use the applicable measure consistent with Schedules 5 and 7A.

# Hospice and ICF/DDs



## PROJECTED INCOME AND EXPENSES

### PROJECTED YEAR 2 (ENDING _____)

| | | INCLUDING THIS PROJECT | | WITHOUT THIS PROJECT | | INCREMENTAL DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| | | Amount | Per Patient Day(1) | Amount | Per Patient Day(1) | Amount | Per Patient Day(1) |
| | | Col. 7 | Col. 8 | Col. 9 | Col. 10 | Col. 11 | Col. 12 |
| | **PROPERTY COSTS** | | | | | | |
| 19 | Depreciation and Amortization | | | | | | |
| 20 | Interest | | | | | | |
| 21 | Rent | | | | | | |
| 22 | Insurance | | | | | | |
| 23 | Taxes | | | | | | |
| 24 | **TOTAL PROPERTY COSTS** | $ | $ | $ | $ | $ | $ |
| 25 | **OTHER OPERATING COSTS** | $ | $ | $ | $ | $ | $ |
| 26 | **TOTAL OPERATING EXPENSES** | $ | $ | $ | $ | $ | $ |
| 27 | **NET PROFIT FROM OPERATIONS** | $ | $ | $ | $ | $ | $ |
| 28 | **NON-OPERATING REVENUES** | $ | $ | $ | $ | $ | $ |
| | **NON-OPERATING EXPENSES** | | | | | | |
| 29 | Income Taxes | | | | | | |
| 30 | Other | | | | | | |
| 31 | **TOTAL NON-OPERATING EXPENSES** | $ | $ | $ | $ | $ | $ |
| 32 | **NET PROFIT (OR LOSS)** | $ | $ | $ | $ | $ | $ |

**All Applicants Proposing Construction or Renovation**

**ARCHITECTURAL CRITERIA**

**1.** Please complete the table below. This summary information must be consistent with the financial schedules and the schematic plans you have completed for this project.

**TABLE A**

| | | Amounts | Source of Information |
|---|---|---|---|
| A. | Total GSF of New Construction | _____ | Schematic Plans |
| B. | Total GSF of Renovation | _____ | Schematic Plans |
| C. | Total GSF of Project | _____ | Schematic Plans |
| | NSF Per Bed in Patient Rooms | | |
| D. | 1-Bed Rooms | _____ | Schematic Plans |
| E. | 2-Bed Rooms | _____ | Schematic Plans |
| F. | 3-Bed Rooms | _____ | Schematic Plans |
| G. | 4-Bed Rooms | _____ | Schematic Plans |
| H. | New Construction Cost | $_____ | Schedule 1, Line 12a |
| I. | New Construction Cost per GSF | $_____ | H. divided by A. |
| J. | Renovation Cost | $_____ | Schedule 1, Line 12b |
| K. | Renovation Cost per GSF | $_____ | J. divided by B. |
| L. | Total Construction Cost | $_____ | H. plus J. |
| M. | Rate of Contingency | _____ | % of Line L |
| N. | Total Building Cost | $_____ | Schedule 1 (Line 21) |
| O. | Total Building Cost per GSF | $_____ | N. divided by C. |
| P. | Total Building Cost per Bed | $_____ | N. divided by # of beds |
| Q. | Movable Equipment Cost | $_____ | Schedule 1 (Line 23) |
| R. | Total Project Cost | $_____ | Schedule 1 (Line 50) |
| S. | Total Project Cost per Bed | $_____ | R. divided by # of beds |
| T. | Percent of Inflation | _____ | Included in N. |
| U. | Amount of Inflation | $_____ | Included in N. |

**NOTE: If the project involves a structure that is existing, or one that is under construction and not yet licensed as a health care facility, costs must be allocated since capitalization will occur.**

**2.** Describe the proposed project in detail. Discuss the major features of the design such as the number of stories, the number of bedrooms by category of private and semi-private, and the number of baths and other spaces for basic services. Include, if applicable, a description of the areas for specialized services and ancillary support spaces along with any special architectural features for special programs. If demolition is planned, provide information regarding the scope of demolition and show the existing configuration of the spaces if applicable. Address the features of the project which will enhance the quality of care and the quality of life of the residents. Discuss the costs and methods of the proposed construction, including costs and methods of energy provision and the availability of alternative, less costly, or more effective methods of construction. The applicant must include but is not limited to the following:

- Patient room size and configuration
- Resident choices of furnishings and decorations
- Resident/staff communications
- Nurse call system
- Wandering control
- Design for privacy and patient confidentiality
- Facility aspects fostering resident independence when appropriate
- Special features for dementia units where applicable

**3.** Describe the significant building materials involved in this project; address the anticipated types of structural, finish, and mechanical/electrical systems and methods. Explain how the materials and design apply to this specific project and how they will satisfy the code requirements for construction and life safety.

**Indicate how many pages follow this page _____**

**4.** Will your proposed project be affected by any statutes other than Chapter 400 and Section 408.031-408.045, F.S., or rules other than Rules 59A-4, 59A-35 and 59C-1, F.A.C?

YES _____ NO _____

If yes, please list all statutes and rules which will affect your project, whether due to licensure, funding or location. Include federal rules or statutes. Give the citation and the effect upon the proposed project.

Note that intermediate care facilities for the developmentally disabled are licensed under Chapters 59A-26 and 59A-35 F.A.C. Freestanding inpatient hospice facilities are licensed under Chapters 59A-38 and 59A-35 F.A.C.

**Indicate how many pages follow this page _____**

**5.** If the project includes renovation of an existing facility, will correction of life safety code deficiencies occur?

YES _____ NO _____

If yes, please list all the citations to be corrected whether or not the correction is due to existing citation or updating of the structure.

Citations by code to be corrected as part of this project:

1.

2.

3.

4.

5.

**6.** Provide a schematic drawing of the facility or project you propose. Large drawing sheets may be folded and inserted into an envelope. The drawings must be to scale, preferably no smaller than 1/16"=1', and must include a ¼" =1'-0" plan of specialty spaces such as typical patient rooms, private and semi-private, with the net room sizes indicated.* The drawings must be legible and consistent with standard architectural drafting practice for schematic phase drawings. All spaces on the drawings must be clearly and correctly labeled: give particular attention to any items pertaining to special programs, architectural features and other amenities. Smoke compartments must be clearly indicated and noted if applicable. Additional notes on the plans or in the narrative must include type and methods of construction, total number of beds, the applicable rules and building codes proposed to be used for design and construction of the project and the total gross square footage**. Include the applicable editions of each rule or code: for example, The Florida Building Code 7th Edition (2020), Chapter 59A-4, Florida Administrative Code, (latest edition), etc.

**7.** If the site has been secured, or if the project is attached to an existing building, or if the facility is on a site with existing buildings, a plot plan at a small, legible and standard scale must be included. Show property lines, existing structures and all data affecting the facility under consideration.

If the site is not secured, indicate the proposed number of acres in the parcel on which the project will be built and the criteria that will be used in selecting the site such as Disaster Preparedness issues.

**Plans and written material must agree.**

*Net Square Footage (NSF) - The measurement of the inside floor area, from inside finish to inside finish, excluding areas consumed by baths, door swing areas, lavatories and other fixed equipment.

**Gross Square Footage (GSF) - The area within the outside face of the exterior walls, exclusive of area open and unobstructed to the sky.

**Indicate how many pages follow this page _____**

**SCHEDULE 10**

**All Applicants**

**PROJECT COMPLETION FORECAST**



Enter **one** of the following dates:

*Comparative* reviews - Agency Initial Decision Deadline date *[Rule 59C-1.008(1), F.A.C.]* _____

OR

*Expedited* reviews - 90 days from the date the application will be submitted to the agency

_____

Assuming CON approval becomes the final agency action on that date, indicate the number of days ***from the above anticipated agency decision date*** to each phase of the completion forecast.

| **Phase** | **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-4, F.A.C] | _____ | _____ |
| 3. Construction contract signed | _____ | _____ |
| 4. Building permit secured [Rule 59C-1.018(2)(a), F.A.C.] | _____ | _____ |
| 5. Site preparation completed [Rule 59C-1.018(2)(a), F.A.C.] | _____ | _____ |
| 6. Building construction commenced [Rule 59C-1.018(2)(a), F.A.C.] | _____ | _____ |
| 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), F.A.C.] | _____ | _____ |
| 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.**

## All Applicants

## FINES, LIENS, OR OVERPAYMENTS

***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.*