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

CON PROPOSED TO BE TRANSFERRED:

CON Number Date Issued

CURRENT HOLDER OF THE CON:

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

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 _____

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

TRANSFER OF A CERTIFICATE OF NEED

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), 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 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 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? 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. 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.)

3. 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-Trn)
   - a complete listing of all capital projects (Schedule 2)
   - source of funds (Schedule 3)
   - staffing patterns (Schedule 6 or 6A)
   - 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.)

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

5. 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.
   - improvement in quality of services provided.

   (s.408.035(7), 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-4, 59A-26, or 59A-38 F.A.C.)

7. 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.)

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 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.

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

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-Trn

TRANSFER OF A CERTIFICATE OF NEED

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

SCHEDULE 1-Trn

TRANSFER OF A CERTIFICATE OF NEED

PROJECT COSTS

		ESTIMATED PROJECT COSTS	For TRANSFERS that EXCEED ORIGINAL TOTAL PROJECT COST	
	Project Development Cost		**ACTUAL COST**	**DIFFERENCE**
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

TRANSFER OF A CERTIFICATE OF NEED

PROJECT COMPLETION FORECAST

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.

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.

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, F.S., 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

_____

Notary Signature