



# 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

**APPLICANT TYPE:**

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

**PROJECT TYPE:**

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

**OWNERSHIP TYPE:**

- 1. For Profit
- 2. Not For Profit
- 3. Nursing Home Chain
- 4. Government

**PREVIOUS CON NUMBERS:**

\_\_\_\_\_

**CON TRANSFERS:**

\_\_\_\_\_

**PROJECT COSTS:**

Capital Expenditures \_\_\_\_\_

Operating Costs \_\_\_\_\_

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

\_\_\_\_\_ Community Nursing Home

\_\_\_\_\_ Freestanding Inpatient Hospice

\_\_\_\_\_ Sheltered Nursing Home

\_\_\_\_\_ ICF/DD

**ADDITIONAL PROJECT DETAILS/REMARKS:**

*AHCA Use Only:*

CON Number \_\_\_\_\_

Date Received \_\_\_\_\_

Fee Received \_\_\_\_\_

LOI Date \_\_\_\_\_

**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:

<u>Proposed Expenditures</u>	<u>Fee Schedule</u>
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**

**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:
- 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 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.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:
- o applicant facility;
  - o current patient care costs and charges (if an existing facility);
  - o reduction in charges to patients; and
  - o 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

- 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

**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**



**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**

**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.

**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			CURRENTLY BEING SOUGHT (2)
				AMOUNT IN HAND	AMOUNT FROM OPERATIONS	ASSURED BUT NOT IN HAND (2)	
CON Reviewable:			\$	\$	\$	\$	
			\$	\$	\$	\$	
			\$	\$	\$	\$	
			\$	\$	\$	\$	
			\$	\$	\$	\$	
			\$	\$	\$	\$	
Exempt/Non-Review:			\$	\$	\$	\$	
			\$	\$	\$	\$	
			\$	\$	\$	\$	
			\$	\$	\$	\$	
			\$	\$	\$	\$	
Other States' Projects			\$	\$	\$	\$	
			\$	\$	\$	\$	
Other Capitalization			\$	\$	\$	\$	
Equipment			\$	\$	\$	\$	
Furnishings			\$	\$	\$	\$	
Renovations			\$	\$	\$	\$	
Maturities of Long-Term Debt			\$	\$	\$	\$	
			\$	\$	\$	\$	
<b>TOTAL</b>			<b>A.</b>				
			\$	\$	\$	\$	

(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.

**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	AMOUNT IN HAND	SOURCE OF FUNDS			CURRENTLY BEING SOUGHT (2)
					AMOUNT FROM OPERATIONS	ASSURED BUT NOT IN HAND (2)		
CON Reviewable:			\$		\$			\$
			\$		\$			\$
			\$		\$			\$
			\$		\$			\$
			\$		\$			\$
			\$		\$			\$
Exempt/Non-Review:			\$		\$			\$
			\$		\$			\$
			\$		\$			\$
			\$		\$			\$
			\$		\$			\$
Other States' Projects			\$		\$			\$
			\$		\$			\$
Other Capitalization			\$		\$			\$
			\$		\$			\$
Maturities of Long-Term Debt			\$		\$			\$
			\$		\$			\$
<b>TOTAL</b>			<b>B.</b>		<b>\$</b>			<b>\$</b>
<b>GRAND TOTAL</b>			<b>C.</b>		<b>\$</b>			<b>\$</b>

(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.	<b>CASH ON HAND</b>	\$ _____
	If sufficient amount is not shown on most recent audited balance sheet, attach proof of current availability.	
2.	<b>OPERATING CASH FLOWS</b>	_____
	If availability is not assured by most recent audited statement of cash flows, attach information to support the assumption.	
3.	<b>RELATED COMPANY FINANCING</b>	_____
	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.	<b>NON-RELATED COMPANY FINANCING</b>	_____
	Attach letter of commitment or letter of interest.	
5.	<b>OTHER:</b> _____	
	Identify and attach supporting detail.	
	<b>TOTAL FUNDS</b>	_____
	Assets converted from other use (if converted assets are used in total project cost - Schedule 1)	_____
	<b>TOTAL</b> (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**

**All Applicants  
with Current  
Licensed Beds**

**UTILIZATION OF EXISTING BEDS**

Page 1 of 1

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

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
<b>FIRST YEAR OF OPERATION</b>							
	1st Quarter	_____	_____	_____	_____	_____	_____
	2nd Quarter	_____	_____	_____	_____	_____	_____
	3rd Quarter	_____	_____	_____	_____	_____	_____
	4th Quarter	_____	_____	_____	_____	_____	_____
	<b>TOTAL</b>	_____	_____	_____	_____	_____	_____
<b>SECOND YEAR OF OPERATION</b>							
	1st Quarter	_____	_____	_____	_____	_____	_____
	2nd Quarter	_____	_____	_____	_____	_____	_____
	3rd Quarter	_____	_____	_____	_____	_____	_____
	4th Quarter	_____	_____	_____	_____	_____	_____
	<b>TOTAL</b>	_____	_____	_____	_____	_____	_____

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
<b>ADMINISTRATION</b>					
Administrator	_____	_____	_____	_____	_____
Director of Nursing	_____	_____	_____	_____	_____
Admissions Director	_____	_____	_____	_____	_____
Bookkeeper	_____	_____	_____	_____	_____
Secretary	_____	_____	_____	_____	_____
Medical Records Clerk	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>PHYSICIANS</b>					
Medical Director	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>NURSING</b>					
R.N.s	_____	_____	_____	_____	_____
L.P.N.s	_____	_____	_____	_____	_____
Nurses' Aides	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>ANCILLARY</b>					
Physical Therapist	_____	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>DIETARY</b>					
Dietary Supervisor	_____	_____	_____	_____	_____
Cooks	_____	_____	_____	_____	_____
Dietary Aides	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>SOCIAL SERVICES</b>					
Social Service Director	_____	_____	_____	_____	_____
Activity Director	_____	_____	_____	_____	_____
Activities Assistant	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>HOUSEKEEPING</b>					
Housekeeping Supervision	_____	_____	_____	_____	_____
Housekeepers	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>LAUNDRY</b>					
Laundry Supervisor	_____	_____	_____	_____	_____
Laundry Aides	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>PLANT MAINTENANCE</b>					
Maintenance Supervisor	_____	_____	_____	_____	_____
Maintenance Assistance	_____	_____	_____	_____	_____
Security	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>GRAND TOTAL</b>	_____	_____	_____	_____	////////////////////

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
<b>ADMINISTRATION</b>					
Administrator	_____	_____	_____	_____	_____
Director of Nursing	_____	_____	_____	_____	_____
Admissions Director	_____	_____	_____	_____	_____
Bookkeeper	_____	_____	_____	_____	_____
Secretary	_____	_____	_____	_____	_____
Medical Records Clerk	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>PHYSICIANS</b>					
Medical Director	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>NURSING</b>					
R.N.s	_____	_____	_____	_____	_____
L.P.N.s	_____	_____	_____	_____	_____
Nurses' Aides	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>ANCILLARY</b>					
Physical Therapist	_____	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>DIETARY</b>					
Dietary Supervisor	_____	_____	_____	_____	_____
Cooks	_____	_____	_____	_____	_____
Dietary Aides	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>SOCIAL SERVICES</b>					
Social Service Director	_____	_____	_____	_____	_____
Activity Director	_____	_____	_____	_____	_____
Activities Assistant	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>HOUSEKEEPING</b>					
Housekeeping Supervision	_____	_____	_____	_____	_____
Housekeepers	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>LAUNDRY</b>					
Laundry Supervisor	_____	_____	_____	_____	_____
Laundry Aides	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>PLANT MAINTENANCE</b>					
Maintenance Supervisor	_____	_____	_____	_____	_____
Maintenance Assistance	_____	_____	_____	_____	_____
Security	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____
<b>TOTAL</b>	_____	_____	_____	_____	////////////////////
<b>GRAND TOTAL</b>	_____	_____	_____	_____	////////////////////

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 \_\_\_\_\_**

Page 1 of 1

	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	
<b>ADMINISTRATION</b>				
Administrator	_____	_____	_____	_____
Director of Nursing	_____	_____	_____	_____
Admissions Director	_____	_____	_____	_____
Bookkeeper	_____	_____	_____	_____
Secretary	_____	_____	_____	_____
Medical Records Clerk	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>PHYSICIANS</b>				
Unit/Program Director	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>NURSING</b>				
R.N.s	_____	_____	_____	_____
L.P.N.s	_____	_____	_____	_____
Nurses' Aides	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>ANCILLARY</b>				
Physical Therapist	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>DIETARY</b>				
Dietary Supervisor	_____	_____	_____	_____
Cooks	_____	_____	_____	_____
Dietary Aides	_____	_____	_____	_____
<b>SOCIAL SERVICES</b>				
Social Service Director	_____	_____	_____	_____
Activity Director	_____	_____	_____	_____
Activities Assistant	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>HOUSEKEEPING</b>				
Housekeeping Supervision	_____	_____	_____	_____
Housekeepers	_____	_____	_____	_____
<b>LAUNDRY</b>				
Laundry Supervisor	_____	_____	_____	_____
Laundry Aides	_____	_____	_____	_____
<b>PLANT MAINTENANCE</b>				
Maintenance Supervisor	_____	_____	_____	_____
Maintenance Assistance	_____	_____	_____	_____
Security	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>GRAND TOTAL</b>	_____	_____	////////////////////	_____

FTE STAFF TOTAL FOR THE ENTIRE FACILITY.

**SCHEDULE 6A**

**All Currently Licensed  
Facilities or Programs**

**STAFFING PATTERN  
Year Two Ending \_\_\_\_\_**

Page 1 of 1

	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	
<b>ADMINISTRATION</b>				
Administrator	_____	_____	_____	_____
Director of Nursing	_____	_____	_____	_____
Admissions Director	_____	_____	_____	_____
Bookkeeper	_____	_____	_____	_____
Secretary	_____	_____	_____	_____
Medical Records Clerk	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>PHYSICIANS</b>				
Unit/Program Director	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>NURSING</b>				
R.N.s	_____	_____	_____	_____
L.P.N.s	_____	_____	_____	_____
Nurses' Aides	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>ANCILLARY</b>				
Physical Therapist	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>DIETARY</b>				
Dietary Supervisor	_____	_____	_____	_____
Cooks	_____	_____	_____	_____
Dietary Aides	_____	_____	_____	_____
<b>SOCIAL SERVICES</b>				
Social Service Director	_____	_____	_____	_____
Activity Director	_____	_____	_____	_____
Activities Assistant	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>HOUSEKEEPING</b>				
Housekeeping Supervision	_____	_____	_____	_____
Housekeepers	_____	_____	_____	_____
<b>LAUNDRY</b>				
Laundry Supervisor	_____	_____	_____	_____
Laundry Aides	_____	_____	_____	_____
<b>PLANT MAINTENANCE</b>				
Maintenance Supervisor	_____	_____	_____	_____
Maintenance Assistance	_____	_____	_____	_____
Security	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
<b>GRAND TOTAL</b>	_____	_____	////////////////////	_____

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 <b>TOTAL NURSING HOME REVENUE</b>										
18 Restricted Grants/Donations										
19 <b>NON NURSING HOME REVENUES</b>										
20 <b>TOTAL REVENUE</b>										100%
21 % of Nursing Home Revenue										
22 <b>TOTAL ADMISSIONS</b>										
23 <b>TOTAL PATIENT DAYS</b>										
24 % of Total Patient Days										100%
25 <b>REVENUE PER PATIENT DAY</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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 Bed: \_\_\_\_\_ %  
 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 <b>TOTAL NURSING HOME REVENUE</b>										
18 Restricted Grants/Donations										
19 <b>NON NURSING HOME REVENUES</b>										
20 <b>TOTAL REVENUE</b>										100%
21 % of Nursing Home Revenue										
22 <b>TOTAL ADMISSIONS</b>										
23 <b>TOTAL PATIENT DAYS</b>										100%
24 % of Total Patient Days										
25 <b>REVENUE PER PATIENT DAY</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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 Bed: \_\_\_\_\_ %  
 29 Average Occupancy for Other Beds \_\_\_\_\_ %

**PROJECTED REVENUES**

**PROJECTED OPERATING YEAR 1 (ENDING \_\_\_\_\_):**

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



**PROJECTED REVENUES**

**PROJECTED OPERATING YEAR 2 (ENDING \_\_\_\_\_):**

	SELF PAY	MEDICAID	MEDICAID	MEDICARE	MEDICARE	COMMERCIAL	OTHER	OTHER	OTHER	TOTAL
	Col. 11	Col. 12	HMO Col. 13	HMO Col. 14	HMO Col. 15	INSURANCE Col. 16	MANAGED CARE Col. 17	PAYERS Col. 18	REVENUE Col. 19	Col. 20
<b>PATIENT SERVICE REVENUES</b>										
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	<b>TOTAL PATIENT SERVICE REVENUE:</b>									
<b>DEDUCTIONS FROM REVENUE</b>										
8	Contractual Adjustments									
9	Charity Care									
10	Other									
11	<b>TOTAL DEDUCTIONS FROM REVENUE:</b>									
12	<b>NET PATIENT SERVICE REVENUE</b>									
13	<b>OTHER OPERATING REVENUE</b>									
14	<b>NET OPERATING REVENUE</b>									
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 <b>TOTAL ICF/DD REVENUE</b>										
18 Restricted Grants/Donations										
19 <b>NON ICF/DD REVENUES</b>										
20 <b>TOTAL REVENUE</b>										100%
21 % of ICF/DD Revenue										
22 <b>TOTAL ADMISSIONS</b>										
23 <b>TOTAL PATIENT DAYS</b>										
24 % of Total Patient Days										100%
25 <b>REVENUE PER PATIENT DAY</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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**

Page 2 of 2

**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 <b>TOTAL ICF/DD REVENUE</b>										
18 Restricted Grants/Donations										
19 <b>NON ICF/DD REVENUES</b>										
20 <b>TOTAL REVENUE</b>										100%
21 % of ICF/DD Revenue										
22 <b>TOTAL ADMISSIONS</b>										
23 <b>TOTAL PATIENT DAYS</b>										
24 % of Total Patient Days										100%
25 <b>REVENUE PER PATIENT DAY</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$	

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

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.

**SCHEDULE 8**

**Nursing Homes**

**PROJECTED INCOME AND EXPENSES**

	PROJECTED YEAR 1 (ENDING _____)		Amount Col. 3	Per Patient Day Col. 4	Amount Col. 5	Per Patient Day Col. 6
	INCLUDING THIS PROJECT Amount Col. 1	WITHOUT THIS PROJECT Per Patient Day Col. 2				
<b>PROPERTY COST</b>						
<b>DEPRECIATION AND AMORTIZATION</b>						
This project						
Other than this project						
<b>GROSS INTEREST ON PROPERTY</b>						
This project						
Other than this project						
<b>RENT ON PROPERTY</b>						
<b>INSURANCE ON PROPERTY</b>						
<b>TAXES ON PROPERTY</b>						
<b>TOTAL PROPERTY COST</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>OTHER COST CENTERS - NURSING FACILITY</b>						
Laundry and Linen						
Outpatient Clinic						
Other (beauty, barber, gift shop, etc)						
<b>TOTAL OTHER COST CENTERS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>TOTAL NURSING HOME COSTS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>NURSING HOME OPERATING INCOME OR (LOSS)</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>RESTRICTED GRANT/DONATION REVENUE</b>						
SCHEDULE 7, LINE 18, COLUMN 10	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>NURSING HOME INCOME OR LOSS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**SCHEDULE 8**

**Nursing Homes**

**PROJECTED INCOME AND EXPENSES**

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

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

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.

**SCHEDULE 8**

**Nursing Homes**

**PROJECTED INCOME AND EXPENSES**

	PROJECTED YEAR 2 (ENDING _____)		WITHOUT THIS PROJECT		THIS PROJECT ONLY	
	Amount Col. 7	Per Patient Day Col. 8	Amount Col. 9	Per Patient Day Col. 10	FULLY ALLOCATED Amount Col. 11	Per Patient Day Col. 12
<b>PROPERTY COST</b>						
<b>DEPRECIATION AND AMORTIZATION</b>						
This project						
Other than this project						
<b>GROSS INTEREST ON PROPERTY</b>						
This project						
Other than this project						
<b>RENT ON PROPERTY</b>						
<b>INSURANCE ON PROPERTY</b>						
<b>TAXES ON PROPERTY</b>						
<b>TOTAL PROPERTY COST</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>OTHER COST CENTERS - NURSING FACILITY</b>						
Laundry and Linen						
Outpatient Clinic						
Other (beauty, barber, gift shop, etc)						
<b>TOTAL OTHER COST CENTERS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>TOTAL NURSING HOME COSTS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>NURSING HOME OPERATING INCOME OR (LOSS)</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>RESTRICTED GRANT/DONATION REVENUE</b>						
SCHEDULE 7, LINE 18, COLUMN 20	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>NURSING HOME INCOME OR LOSS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**Nursing Homes**

**PROJECTED INCOME AND EXPENSES**

**PROJECTED YEAR 2 (ENDING \_\_\_\_\_)**

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

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

**PROJECTED INCOME AND EXPENSES**

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

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



	PROJECTED YEAR 1 (ENDING _____)		WITHOUT THIS PROJECT		INCREMENTAL DIFFERENCE	
	INCLUDING THIS PROJECT	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
<b>PROPERTY COSTS</b>						
19 Depreciation and Amortization						
20 Interest						
21 Rent						
22 Insurance						
23 Taxes						
<b>24 TOTAL PROPERTY COSTS</b>	\$	\$	\$	\$	\$	\$
<b>25 OTHER OPERATING COSTS</b>	\$	\$	\$	\$	\$	\$
<b>26 TOTAL OPERATING EXPENSES</b>	\$	\$	\$	\$	\$	\$
<b>27 NET PROFIT FROM OPERATIONS</b>	\$	\$	\$	\$	\$	\$
<b>28 NON-OPERATING REVENUES</b>	\$	\$	\$	\$	\$	\$
<b>NON-OPERATING EXPENSES</b>						
29 Income Taxes						
30 Other						
<b>31 TOTAL NON-OPERATING EXPENSES</b>	\$	\$	\$	\$	\$	\$
<b>32 NET PROFIT (OR LOSS)</b>	\$	\$	\$	\$	\$	\$

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

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

PROJECTED YEAR 2 (ENDING _____)					
	INCLUDING THIS PROJECT		WITHOUT THIS PROJECT		INCREMENTAL DIFFERENCE Per Patient Day(1) Col. 12
	Amount Col. 7	Per Patient Day(1) Col. 8	Amount Col. 9	Per Patient Day(1) Col. 10	
<b>PROPERTY COSTS</b>					
19 Depreciation and Amortization					
20 Interest					
21 Rent					
22 Insurance					
23 Taxes					
<b>24 TOTAL PROPERTY COSTS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>25 OTHER OPERATING COSTS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>26 TOTAL OPERATING EXPENSES</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>27 NET PROFIT FROM OPERATIONS</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>28 NON-OPERATING REVENUES</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>NON-OPERATING EXPENSES</b>					
29 Income Taxes					
30 Other					
<b>31 TOTAL NON-OPERATING EXPENSES</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>32 NET PROFIT (OR LOSS)</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

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**

	<u>Amounts</u>	<u>Source of Information</u>
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:
- o Patient room size and configuration
  - o Resident choices of furnishings and decorations
  - o Resident/staff communications
  - o Nurse call system
  - o Wandering control
  - o Design for privacy and patient confidentiality
  - o Facility aspects fostering resident independence when appropriate
  - o 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 1/4"=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 7<sup>th</sup> 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 \_\_\_\_\_**

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.

<u>Phase</u>	<u>DAYS REQUIRED</u>	<u>Anticipated Date (MONTH/YEAR)</u>
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.**

**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.*