



Florida Rules and Laws

FLORIDA HOSPICE

& PALLIATIVE CARE ASSOCIATION

Table of Contents and Explanation of References

Florida Law - Hospice Licensure Law

Chapter 400, Part VI, Florida Statutes (2011)

Certificate of Need Law

Chapter 408, Sections 408.031 – 408.0455, Florida Statutes (2011)

Florida Administrative Rules

Hospice Licensure Rules, Chapter 58A-2, Florida Administrative Code

Florida Administrative Rules

Certificate of Need Rules, Chapter 59C-1 – CON, Florida Administrative Code

Procedures for the Administration of Sections 408.031 – 408.045

Florida Statutes, Health Facility and Services Development Act

Explanation and Guidelines:

Florida Law is superior to Florida Administrative rule. If there is a conflict between what is stated in law and rule, what is stated in law controls.

Florida law is referenced in three ways:

- Laws of Florida (LOF or L.O.F.) = official laws of Florida as passed by the legislature, approved by the governor, and filed with the secretary of state. They are created during any regular or special session of the legislature.
- Florida Statutes (FS, F.S., or Fla. Stat.) = codified version of official laws of Florida as done by Division of Statutory Revision, Office of Legislative Services, joint office of Florida House of Representatives and Senate. These are created and updated each year as a result of one or more legislative sessions.
- Florida Administrative Code (FAC or F.A.C.) = administrative rule promulgated by a state agency with jurisdiction and authority. These are created, modified, or repealed at any time with proper notice and opportunity for hearing by Florida's state agencies.

Chapter 400, Part IV

Hospices

400.6005	Legislative findings and intent.
400.601	Definitions.
400.602	Licensure required; prohibited acts; exemptions; display, transferability of license.
400.6045	Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.
400.605	Administration; forms; fees; rules; inspections; fines.
400.60501	Outcome measures; adoption of national initiatives; annual report.
400.6051	Construction and renovation; requirements.
400.606	License; application; renewal; conditional license or permit; certificate of need.
400.6065	Background screening.
400.607	Denial, suspension, revocation of license; emergency actions; imposition of administrative fine; grounds.
400.6085	Contractual services.
400.609	Hospice services.
400.6095	Patient admission; assessment; plan of care; discharge; death.
400.610	Administration and management of a hospice.
400.6105	Staffing and personnel.
400.611	Interdisciplinary records of care; confidentiality.

400.6005 Legislative findings and intent.—The Legislature finds that terminally ill individuals and their families, who are no longer pursuing curative medical treatment, should have the opportunity to select a support system that permits the patient to exercise maximum independence and dignity during the final days of life. The Legislature finds that hospice care provides a cost-effective and less intrusive form of medical care while meeting the social, psychological, and spiritual needs of terminally ill patients and their families. The intent of this part is to provide for the development, establishment, and enforcement of basic standards to ensure the safe and adequate care of persons receiving hospice services.

History.—s. 1, ch. 93-179.

400.601 Definitions.—As used in this part, the term:

- (1) “Agency” means the Agency for Health Care Administration.
- (2) “Department” means the Department of Elderly Affairs.
- (3) “Hospice” means a centrally administered corporation or a limited liability company that provides a continuum of palliative and supportive care for the terminally ill patient and his or her family.
- (4) “Hospice care team” means an interdisciplinary team of qualified professionals and volunteers who, in consultation with the patient, the patient’s family, and the patient’s primary or attending physician, collectively assess, coordinate, and provide the appropriate palliative and supportive care to hospice patients and their families.
- (5) “Hospice residential unit” means a homelike living facility, other than a facility licensed under other parts of this chapter, under chapter 395, or under chapter 429, that is operated by a hospice for the benefit of its patients and is considered by a patient who lives there to be his or her primary residence.
- (6) “Hospice services” means items and services furnished to a patient and family by a hospice, or by others under arrangements with such a program, in a place of temporary or permanent residence used as the patient’s home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institutions or in the hospice inpatient facility.
- (7) “Palliative care” means services or interventions which are not curative but are provided for the reduction or abatement of pain and human suffering.
- (8) “Patient” means the terminally ill individual receiving hospice services.
- (9) “Plan of care” means a written assessment by the hospice of each patient’s and family’s needs and preferences, and the services to be provided by the hospice to meet those needs.

- (10) “Terminally ill” means that the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.

History.—s. 1, ch. 79-186; s. 1, ch. 80-64; s. 256, ch. 81-259; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 2, 14, ch. 93-179; s. 788, ch. 95-148; s. 57, ch. 95-418; s. 1, ch. 2006-155; s. 65, ch. 2006-197; s. 14, ch. 2012-160.

400.602 Licensure required; prohibited acts; exemptions; display, transferability of license.—

- (1)
- (a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and to entities licensed by or applying for such licensure from the agency pursuant to this part. A license issued by the agency is required in order to operate a hospice in this state. Any person or legal entity that is not licensed as a hospice under this part may not use the word “hospice” in its name, or offer or advertise hospice services or hospice-like services in such a way as to mislead a person to believe that the offeror is a hospice licensed under this part.
 - (b) It is unlawful for any person or legal entity offering, describing, or advertising hospice services or hospice-like services or otherwise holding itself out as a hospice to do so without stating the year of initial licensure as a hospice in the state or the year of initial licensure of the hospice entity or affiliate based in the state that owns the hospice. At a minimum, the year of initial licensure must be stated directly beneath the name of the licensed entity in a type no less than 25 percent of the size of the type used for the name or other indication of hospice services or hospice-like services and must be prominently stated at least one time on any document, item, or other medium offering, describing, or advertising hospice services or hospice-like services. This requirement excludes any materials relating to the care and treatment of an existing hospice patient.
- (2) Services provided by a hospital, nursing home, or other health care facility, health care provider, or caregiver, or under the Community Care for the Elderly Act, do not constitute a hospice unless the facility, provider, or caregiver establishes a separate and distinct administrative program to provide home, residential, and homelike inpatient hospice services.
- (3)
- (a) A separately licensed hospice may not use a name which is substantially the same as the name of another hospice licensed under this part.
 - (b) A licensed hospice which intends to change its name or address must notify the agency at least 60 days before making the change.

History.—s. 3, ch. 79-186; s. 2, ch. 80-64; s. 2, ch. 81-271; s. 2, ch. 81-318; ss. 66, 79, 83, ch. 83-181; s. 10, ch. 89-527; ss. 3, 14, ch. 93-179; s. 58, ch. 95-418; s. 11, ch. 97-270; s. 2, ch. 2006-155; s. 84, ch. 2007-230.

400.6045 Patients with Alzheimer’s disease or other related disorders; staff training requirements; certain disclosures.—

- (1) A hospice licensed under this part must provide the following staff training:
- (a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with persons who have Alzheimer’s disease or dementia-related disorders.
 - (b) In addition to the information provided under paragraph (a), employees who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer’s disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.
 - (c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer’s disease or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the patient’s independence in activities of daily living, and instruction in skills for working with families and caregivers.
 - (d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.

- (e) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 4 hours.
 - (f) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.
 - (g) The Department of Elderly Affairs or its designee must approve the required 1-hour and 3-hour training provided to employees or direct caregivers under this section. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 1-hour and 3-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.
 - (h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different hospice or to a home health agency, assisted living facility, nursing home, or adult day care center.
 - (i) An employee who is hired on or after July 1, 2003, must complete the required training by July 1, 2004, or by the deadline specified in this section, whichever is later.
- (2) A hospice licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The hospice must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the hospice and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the hospice's records as part of the license renewal procedure.

History.—s. 5, ch. 93-105; s. 4, ch. 2003-271.

400.605 Administration; forms; fees; rules; inspections; fines.—

- (1) The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. The department, in consultation with the agency, shall by rule establish minimum standards and procedures for a hospice pursuant to this part. The rules must include:
 - (a) The qualifications of professional and ancillary personnel to ensure the provision of appropriate and adequate hospice care.
 - (b) Standards and procedures for the administrative management of a hospice.
 - (c) Standards for hospice services that ensure the provision of quality patient care.
 - (d) Components of a patient plan of care.
 - (e) Procedures relating to the implementation of advanced directives and do-not-resuscitate orders.
 - (f) Procedures for maintaining and ensuring confidentiality of patient records.
 - (g) Standards for hospice care provided in freestanding inpatient facilities that are not otherwise licensed medical facilities and in residential care facilities such as nursing homes, assisted living facilities, adult family-care homes, and hospice residential units and facilities.
 - (h) Components of a comprehensive emergency management plan, developed in consultation with the Department of Health, the Department of Elderly Affairs, and the Division of Emergency Management.
 - (i) Standards and procedures relating to the establishment and activities of a quality assurance and utilization review committee.
 - (j) Components and procedures relating to the collection of patient demographic data and other information on the provision of hospice care in this state.
- (2) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this part, part II of chapter 408, and applicable rules. The amount of the fee shall be established by rule and may not exceed \$1,200 per biennium.
- (3) In accordance with s. 408.811, the agency shall conduct annual inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance. The

agency shall conduct such inspections and investigations as are necessary in order to determine the state of compliance with the provisions of this part, part II of chapter 408, and applicable rules.

- (4) In accordance with part II of chapter 408, the agency may impose an administrative fine for any violation of the provisions of this part, part II of chapter 408, or applicable rules.

History.—s. 2, ch. 79-186; s. 2, ch. 81-318; ss. 69, 79, 83, ch. 83-181; s. 13, ch. 91-282; ss. 4, 14, ch. 93-179; s. 59, ch. 95-418; s. 1, ch. 99-139; s. 15, ch. 2000-140; s. 2, ch. 2005-191; s. 85, ch. 2007-230; s. 278, ch. 2011-142.

400.60501 Outcome measures; adoption of national initiatives; annual report.—

- (1) No later than December 31, 2007, the Department of Elderly Affairs, in conjunction with the Agency for Health Care Administration, shall develop outcome measures to determine the quality and effectiveness of hospice care for hospices licensed in the state. At a minimum, these outcome measures shall include a requirement that 50 percent of patients who report severe pain on a 0-to-10 scale must report a reduction to 5 or less by the end of the 4th day of care on the hospice program.
- (2) For hospices licensed in the state, the Department of Elderly Affairs, in conjunction with the Agency for Health Care Administration, shall:
 - (a) Consider and adopt national initiatives, such as those developed by the National Hospice and Palliative Care Organization, to set benchmarks for measuring the quality of hospice care provided in the state.
 - (b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.

History.—s. 7, ch. 2006-155.

400.6051 Construction and renovation; requirements.—

- (1) The requirements for the construction and the renovation of a hospice residential or inpatient facility or unit must comply with the provisions of chapter 553 which pertain to building construction standards, including plumbing, electrical code, glass, manufactured buildings, accessibility for persons with disabilities, and the state minimum building codes. The Agency for Health Care Administration shall provide technical assistance to the Florida Building Commission in updating the construction standards of the Florida Building Code which govern hospice facilities.
- (2) Upon request by the prospective licensee of an inpatient hospice facility, the agency may provide an informal review of a facility prior to construction in order to assist the facility in complying with agency rules and this part.
- (3) The agency may charge a fee that is commensurate with the cost of providing consultation under this section and that is not refundable.

History.—s. 3, ch. 2005-191; s. 1, ch. 2007-238.

400.606 License; application; renewal; conditional license or permit; certificate of need.—

- (1) In addition to the requirements of part II of chapter 408, the initial application and change of ownership application must be accompanied by a plan for the delivery of home, residential, and homelike inpatient hospice services to terminally ill persons and their families. Such plan must contain, but need not be limited to:
 - (a) The estimated average number of terminally ill persons to be served monthly.
 - (b) The geographic area in which hospice services will be available.
 - (c) A listing of services which are or will be provided, either directly by the applicant or through contractual arrangements with existing providers.
 - (d) Provisions for the implementation of hospice home care within 3 months after licensure.
 - (e) Provisions for the implementation of hospice homelike inpatient care within 12 months after licensure.
 - (f) The number and disciplines of professional staff to be employed.
 - (g) The name and qualifications of any existing or potential contractee.
 - (h) A plan for attracting and training volunteers.If the applicant is an existing licensed health care provider, the application must be accompanied by a copy of the most recent profit-loss statement and, if applicable, the most recent licensure inspection report.

- (2) In addition to the requirements of part II of chapter 408, the application for license renewal shall be accompanied by an update of the plan for delivery of hospice care only if information contained in the plan submitted pursuant to subsection (1) is no longer applicable.
- (3) The agency shall not issue a license to a hospice that fails to receive a certificate of need under the provisions of part I of chapter 408. A licensed hospice is a health care facility as that term is used in s. 408.039(5) and is entitled to initiate or intervene in an administrative hearing.
- (4) A freestanding hospice facility that is engaged in providing inpatient and related services and that is not otherwise licensed as a health care facility shall obtain a certificate of need. However, a freestanding hospice facility that has six or fewer beds is not required to comply with institutional standards such as, but not limited to, standards requiring sprinkler systems, emergency electrical systems, or special lavatory devices.
- (5) The agency may deny a license to an applicant that fails to meet any condition for the provision of hospice care or services imposed by the agency on a certificate of need by final agency action, unless the applicant can demonstrate that good cause exists for the applicant's failure to meet such condition.

History.—s. 6, ch. 79-186; s. 5, ch. 81-271; s. 2, ch. 81-318; ss. 70, 79, 83, ch. 83-181; s. 47, ch. 87-92; ss. 5, 14, ch. 93-179; s. 60, ch. 95-418; s. 54, ch. 98-171; s. 3, ch. 2006-155; s. 86, ch. 2007-230; s. 15, ch. 2012-160.

400.6065 Background screening.—The agency shall require level 2 background screening for personnel as required in s. 408.809(1)(e) pursuant to chapter 435 and s. 408.809.

History.—ss. 55, 71, ch. 98-171; s. 22, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 17, ch. 2004-267; s. 87, ch. 2007-230; s. 9, ch. 2010-114.

400.607 Denial, suspension, revocation of license; emergency actions; imposition of administrative fine; grounds.—

- (1) The agency may deny, revoke, and suspend a license, impose an action under s. 408.814, and impose an administrative fine, which may not exceed \$5,000 per violation, for the violation of any provision of this part, part II of chapter 408, or applicable rules.
- (2) Any of the following actions by a licensed hospice or any of its employees shall be grounds for action by the agency against a hospice:
 - (a) A violation of the provisions of this part, part II of chapter 408, or applicable rules.
 - (b) An intentional or negligent act materially affecting the health or safety of a patient.
- (3) If, 3 months after the date of obtaining a license, or at any time thereafter, a hospice does not have in operation the home-care component of hospice care, the agency shall immediately revoke the license of such hospice.
- (4) If, 12 months after the date of obtaining a license pursuant to s. 400.606, or at any time thereafter, a hospice does not have in operation the inpatient components of hospice care, the agency shall immediately revoke the license of such hospice.
- (5) The remedies set forth in this section are independent of and cumulative to other remedies provided by law.

History.—s. 7, ch. 79-186; s. 2, ch. 81-318; ss. 71, 79, 83, ch. 83-181; ss. 6, 14, ch. 93-179; s. 56, ch. 98-171; s. 50, ch. 2004-267; s. 88, ch. 2007-230.

400.6085 Contractual services.—A hospice may contract out for some elements of its services. However, the core services, as set forth in s. 400.609(1), with the exception of physician services, shall be provided directly by the hospice. Any contract entered into between a hospice and a health care facility or service provider must specify that the hospice retains the responsibility for planning, coordinating, and prescribing hospice care and services for the hospice patient and family. A hospice that contracts for any hospice service is prohibited from charging fees for services provided directly by the hospice care team that duplicate contractual services provided to the patient and family.

- (1) A contract for hospice services, including inpatient services, must:
 - (a) Identify the nature and scope of services to be provided.
 - (b) Require that direct patient care shall be maintained, supervised, and coordinated by the hospice care team.
 - (c) Limit the services to be provided to only those expressly authorized by the hospice in writing.
 - (d) Delineate the roles of hospice staff and contract staff in the admission process and patient assessment.
 - (e) Identify methods for ensuring continuity of hospice care.
 - (f) Plan for joint quality assurance.

- (g) Specify the written documentation, including patient records, required of contract staff.
 - (h) Specify qualifications of persons providing the contract services.
 - (i) Specify the effective dates for the contract.
- (2) With respect to contractual arrangements for inpatient hospice care:
- (a) Licensed beds designated for inpatient hospice care through contract between an existing health care facility and a hospice shall not be required to be delicensed from one type of health care in order to enter into a contract with a hospice, nor shall the physical plant of any facility licensed pursuant to chapter 395 or part II of this chapter be required to be altered, except that a homelike atmosphere may be required.
 - (b) Hospices contracting for inpatient care beds shall not be required to obtain an additional certificate of need for the number of such designated beds. Such beds shall remain licensed to the health care facility and be subject to the appropriate inspections.
 - (c) Staffing standards for inpatient hospice care provided through a contract may not exceed the staffing standards required under the license held by the contractee.
 - (d) Under no circumstances may a hospice place a patient requiring inpatient care in a health care facility that is under a moratorium, has had its license revoked, or has a conditional license, accreditation, or rating. However, a hospice may continue to provide care or initiate care for a terminally ill person already residing in such a facility.

History.—s. 7, ch. 93-179; s. 219, ch. 99-13; s. 2, ch. 99-139.

400.609 Hospice services.—Each hospice shall provide a continuum of hospice services which afford the patient and the family of the patient a range of service delivery which can be tailored to specific needs and preferences of the patient and family at any point in time throughout the length of care for the terminally ill patient and during the bereavement period. These services must be available 24 hours a day, 7 days a week, and must include:

- (1) SERVICES.—
 - (a) The hospice care team shall directly provide the following core services: nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services. Physician services may be provided by the hospice directly or through contract. A hospice may also use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances.
 - (b) Each hospice must also provide or arrange for such additional services as are needed to meet the palliative and support needs of the patient and family. These services may include, but are not limited to, physical therapy, occupational therapy, speech therapy, massage therapy, home health aide services, infusion therapy, provision of medical supplies and durable medical equipment, day care, homemaker and chore services, and funeral services.
- (2) HOSPICE HOME CARE.—Hospice care and services provided in a private home shall be the primary form of care. The goal of hospice home care shall be to provide adequate training and support to encourage self-sufficiency and allow patients and families to maintain the patient comfortably at home for as long as possible. The services of the hospice home care program shall be of the highest quality and shall be provided by the hospice care team.
- (3) HOSPICE RESIDENTIAL CARE.—Hospice care and services, to the extent practicable and compatible with the needs and preferences of the patient, may be provided by the hospice care team to a patient living in an assisted living facility, adult family-care home, nursing home, hospice residential unit or facility, or other nondomestic place of permanent or temporary residence. A resident or patient living in an assisted living facility, adult family-care home, nursing home, or other facility subject to state licensing who has been admitted to a hospice program shall be considered a hospice patient, and the hospice program shall be responsible for coordinating and ensuring the delivery of hospice care and services to such person pursuant to the standards and requirements of this part and rules adopted under this part.
- (4) HOSPICE INPATIENT CARE.—The inpatient component of care is a short-term adjunct to hospice home care and hospice residential care and shall be used only for pain control, symptom management, or respite care. The total number of inpatient days for all hospice patients in any 12-month period may not exceed 20 percent of the total number of hospice days for all the hospice patients of the licensed hospice. Hospice inpatient care shall be under the direct administration of the hospice, whether the inpatient facility is a freestanding hospice facility or part of a facility licensed pursuant to chapter 395 or part II of this chapter. The facility or rooms within a facility

used for the hospice inpatient component of care shall be arranged, administered, and managed in such a manner as to provide privacy, dignity, comfort, warmth, and safety for the terminally ill patient and the family. Every possible accommodation must be made to create as homelike an atmosphere as practicable. To facilitate overnight family visitation within the facility, rooms must be limited to no more than double occupancy; and, whenever possible, both occupants must be hospice patients. There must be a continuum of care and a continuity of caregivers between the hospice home program and the inpatient aspect of care to the extent practicable and compatible with the preferences of the patient and his or her family. Fees charged for hospice inpatient care, whether provided directly by the hospice or through contract, must be made available upon request to the Agency for Health Care Administration. The hours for daily operation and the location of the place where the services are provided must be determined, to the extent practicable, by the accessibility of such services to the patients and families served by the hospice.

- (5) **BEREAVEMENT COUNSELING.**—The hospice bereavement program must be a comprehensive program, under professional supervision, that provides a continuum of formal and informal supportive services to the family for a minimum of 1 year after the patient’s death. This subsection does not constitute an additional exemption from chapter 490 or chapter 491.

History.—s. 9, ch. 79-186; s. 7, ch. 81-271; s. 2, ch. 81-318; ss. 73, 79, 83, ch. 83-181; s. 5, ch. 91-48; s. 67, ch. 91-221; s. 97, ch. 92-33; ss. 8, 14, ch. 93-179; s. 789, ch. 95-148; s. 21, ch. 95-210; s. 3, ch. 99-139.

400.6095 Patient admission; assessment; plan of care; discharge; death.—

- (1) Each hospice shall make its services available to all terminally ill persons and their families without regard to age, gender, national origin, sexual orientation, disability, diagnosis, cost of therapy, ability to pay, or life circumstances. A hospice shall not impose any value or belief system on its patients or their families and shall respect the values and belief systems of its patients and their families.
- (2) Admission to a hospice program shall be made upon a diagnosis and prognosis of terminal illness by a physician licensed pursuant to chapter 458 or chapter 459 and shall be dependent on the expressed request and informed consent of the patient.
- (3) At the time of admission, the hospice shall inquire whether advance directives have been executed pursuant to chapter 765, and if not, provide information to the patient concerning the provisions of that chapter. The hospice shall also provide the patient with information concerning patient rights and responsibilities pursuant to s. 381.026.
- (4) The admission process shall include a professional assessment of the physical, social, psychological, spiritual, and financial needs of the patient. This assessment shall serve as the basis for the development of a plan of care.
- (5) Each hospice, in collaboration with the patient and the patient’s primary or attending physician, shall prepare and maintain a plan of care for each patient, and the care provided to a patient must be in accordance with the plan of care. The plan of care shall be made a part of the patient’s medical record and shall include, at a minimum:
 - (a) Identification of the primary caregiver, or an alternative plan of care in the absence of a primary caregiver, to ensure that the patient’s needs will be met.
 - (b) The patient’s diagnosis, prognosis, and preferences for care.
 - (c) Assessment of patient and family needs, identification of the services required to meet those needs, and plans for providing those services through the hospice care team, volunteers, contractual providers, and community resources.
 - (d) Plans for instructing the patient and family in patient care.
 - (e) Identification of the nurse designated to coordinate the overall plan of care for each patient and family.
 - (f) A description of how needed care and services will be provided in the event of an emergency.
- (6) The hospice shall provide an ongoing assessment of the patient and family needs, update the plan of care to meet changing needs, coordinate the care provided with the patient’s primary or attending physician, and document the services provided.
- (7) In the event a hospice patient chooses to be discharged or transferred to another hospice, the hospice shall arrange for continuing care and services and complete a comprehensive discharge summary for the receiving provider.
- (8) The hospice care team may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. The department shall adopt rules providing for the implementation of such orders. Hospice staff shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation

pursuant to such an order and applicable rules. The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

- (9) The death of a person enrolled as a hospice patient shall be considered an attended death for the purposes of s. 406.11(1)(a)5. However, a hospice shall report the death to the medical examiner if any unusual or unexpected circumstances are present.

History.—s. 9, ch. 93-179; s. 6, ch. 99-331; s. 16, ch. 2000-140; s. 4, ch. 2000-295; s. 89, ch. 2007-230.

400.610 Administration and management of a hospice.—

- (1) A hospice shall have a clearly defined organized governing body, consisting of a minimum of seven persons who are representative of the general population of the community served. The governing body shall have autonomous authority and responsibility for the operation of the hospice and shall meet at least quarterly. The governing body shall:
- (a) Adopt an annual plan for the operation of the hospice, which shall include a plan for providing for uncompensated care and philanthropic community activities.
 - (b) 1. Prepare and maintain a comprehensive emergency management plan that provides for continuing hospice services in the event of an emergency that is consistent with local special needs plans. The plan shall include provisions for ensuring continuing care to hospice patients who go to special needs shelters. The plan shall include the means by which the hospice provider will continue to provide staff to provide the same type and quantity of services to their patients who evacuate to special needs shelters which were being provided to those patients prior to evacuation. The plan is subject to review and approval by the county health department, except as provided in subparagraph 2. During its review, the county health department shall contact state and local health and medical stakeholders when necessary. The county health department shall complete its review to ensure that the plan complies with criteria in rules of the Department of Elderly Affairs within 90 days after receipt of the plan and shall either approve the plan or advise the hospice of necessary revisions. Hospice providers may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the provider to reach its clients. A hospice shall demonstrate a good faith effort to comply with the requirements of this paragraph by documenting attempts of staff to follow procedures as outlined in the hospice's comprehensive emergency management plan and to provide continuing care for those hospice clients who have been identified as needing alternative caregiver services in the event of an emergency.
 - 2. For any hospice that operates in more than one county, the Department of Health during its review shall contact state and local health and medical stakeholders when necessary. The Department of Health shall complete its review to ensure that the plan complies with criteria in rules of the Department of Elderly Affairs within 90 days after receipt of the plan and shall approve the plan or advise the hospice of necessary revisions. The Department of Health shall make every effort to avoid imposing differing requirements on a hospice that operates in more than one county as a result of differing or conflicting comprehensive plan requirements of the counties in which the hospice operates.
 - (c) Adopt an annual budget.
 - (d) Appoint a director who shall be responsible for the day-to-day management and operation of the hospice and who shall serve as the liaison between the governing body and the hospice staff.
 - (e) Undertake such additional activities as necessary to ensure that the hospice is complying with the requirements for hospice services as set forth in this part.
- (2) Each hospice shall develop and implement a comprehensive quality assurance and utilization review plan to be used for ongoing internal evaluation of the appropriateness and effectiveness of the hospice services provided. Each hospice shall take the corrective actions identified by the review and report a summary of these actions to the governing body at least annually.
- (3) Each hospice shall ensure that adequate policies, procedures, and systems are developed and implemented to provide effective delivery of services.

History.—s. 10, ch. 79-186; s. 2, ch. 81-318; ss. 74, 79, 83, ch. 83-181; ss. 10, 14, ch. 93-179; s. 17, ch. 2000-140; s. 24, ch. 2006-71.

400.6105 Staffing and personnel.—

- (1) Each hospice shall have a medical director licensed pursuant to chapter 458 or chapter 459 who shall have responsibility for directing the medical care and treatment of hospice patients.
- (2) Each hospice shall employ a full-time registered nurse licensed pursuant to part I of chapter 464 who shall coordinate the implementation of the plan of care for each patient.
- (3) A hospice shall employ a hospice care team or teams who shall participate in the establishment and ongoing review of the patient's plan of care, and be responsible for and supervise the delivery of hospice care and services to the patient. The team shall, at a minimum, consist of a physician licensed pursuant to chapter 458 or chapter 459, a nurse licensed pursuant to part I of chapter 464, a social worker, and a pastoral or other counselor. The composition of the team may vary for each patient and, over time, for the same patient to ensure that all the patient's needs and preferences are met.
- (4) A hospice must maintain a trained volunteer staff for the purpose of providing both administrative support and direct patient care. A hospice must use trained volunteers who work in defined roles and under the supervision of a designated hospice employee for an amount of time that equals at least 5 percent of the total patient care or administrative hours provided by all paid hospice employees and contract staff in the aggregate. The hospice shall document and report the use of volunteers, including maintaining a record of the number of volunteers, the number of hours worked by each volunteer, and the tasks performed by each volunteer.
- (5) A hospice may contract with other persons or legal entities to provide additional services beyond those provided by the hospice care team or, to supplement the number of persons on the hospice care team, to ensure that the needs of patients and their families are met. Persons hired on contract shall have the same qualifications as are required of hospice personnel.
- (6) Each hospice shall provide ongoing training and support programs for hospice staff and volunteers.

History.—s. 11, ch. 93-179; s. 106, ch. 2000-318; s. 4, ch. 2006-155.

400.611 Interdisciplinary records of care; confidentiality.—

- (1) An up-to-date, interdisciplinary record of care being given and patient and family status shall be kept. Records shall contain pertinent past and current medical, nursing, social, and other therapeutic information and such other information that is necessary for the safe and adequate care of the patient. Notations regarding all aspects of care for the patient and family shall be made in the record. When services are terminated, the record shall show the date and reason for termination.
- (2) Patient records shall be retained for a period of 5 years after termination of hospice services, unless otherwise provided by law. In the case of a patient who is a minor, the 5-year period shall begin on the date the patient reaches or would have reached the age of majority.
- (3) Patient records of care are confidential. A hospice may not release a record or any portion thereof, unless:
 - (a) A patient or legal guardian has given express written informed consent;
 - (b) A court of competent jurisdiction has so ordered; or
 - (c) A state or federal agency, acting under its statutory authority, requires submission of aggregate statistical data. Any information obtained from patient records by a state agency pursuant to its statutory authority is confidential and exempt from the provisions of s. 119.07(1).

History.—s. 11, ch. 79-186; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 12, 14, ch. 93-179; s. 232, ch. 96-406.

Certificate of Need Law

Chapter 408, Sections 408.031 – 408.0455

Florida Statutes (2011)

PART I

HEALTH FACILITY AND SERVICES PLANNING

(ss. 408.031-408.7071)

- 408.031 Short title.
- 408.032 Definitions relating to Health Facility and Services Development Act.
- 408.033 Local and state health planning.
- 408.034 Duties and responsibilities of agency; rules.
- 408.035 Review criteria.
- 408.036 Projects subject to review; exemptions.
- 408.0361 Cardiovascular services and burn unit licensure.
- 408.037 Application content.
- 408.038 Fees.
- 408.039 Review process.
- 408.040 Conditions and monitoring.
- 408.041 Certificate of need required; penalties.
- 408.042 Limitation on transfer.
- 408.043 Special provisions.
- 408.0435 Moratorium on nursing home certificates of need.
- 408.044 Injunction.
- 408.045 Certificate of need; competitive sealed proposals.
- 408.0455 Rules; pending proceedings.

408.031 Short title.—Sections 408.031-408.045 shall be known and may be cited as the “Health Facility and Services Development Act.”

History.—s. 18, ch. 87-92; s. 15, ch. 92-33; s. 7, ch. 95-144. *Note.*—Former s. 381.701.

408.032 Definitions relating to Health Facility and Services Development Act.—As used in ss. 408.031-408.045, the term:

- (1) “Agency” means the Agency for Health Care Administration.
- (2) “Capital expenditure” means an expenditure, including an expenditure for a construction project undertaken by a health care facility as its own contractor, which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance, which is made to change the bed capacity of the facility, or substantially change the services or service area of the health care facility, health service provider, or hospice, and which includes the cost of the studies, surveys, designs, plans, working drawings, specifications, initial financing costs, and other activities essential to acquisition, improvement, expansion, or replacement of the plant and equipment.
- (3) “Certificate of need” means a written statement issued by the agency evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.
- (4) “Commenced construction” means initiation of and continuous activities beyond site preparation associated with erecting or modifying a health care facility, including procurement of a building permit applying the use of agency-approved construction documents, proof of an executed owner/contractor agreement or an irrevocable or binding forced account, and actual undertaking of foundation forming with steel installation and concrete placing.
- (5) “District” means a health service planning district composed of the following counties:
 - District 1.—Escambia, Santa Rosa, Okaloosa, and Walton Counties.
 - District 2.—Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties.
 - District 3.—Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties.

District 4.—Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties.

District 5.—Pasco and Pinellas Counties.

District 6.—Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.

District 7.—Seminole, Orange, Osceola, and Brevard Counties.

District 8.—Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.

District 9.—Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.

District 10.—Broward County.

District 11.—Miami-Dade and Monroe Counties.

- (6) “Exemption” means the process by which a proposal that would otherwise require a certificate of need may proceed without a certificate of need.
- (7) “Expedited review” means the process by which certain types of applications are not subject to the review cycle requirements contained in s. 408.039(1), and the letter of intent requirements contained in s. 408.039(2).
- (8) “Health care facility” means a hospital, long-term care hospital, skilled nursing facility, hospice, or intermediate care facility for the developmentally disabled. A facility relying solely on spiritual means through prayer for healing is not included as a health care facility.
- (9) “Health services” means inpatient diagnostic, curative, or comprehensive medical rehabilitative services and includes mental health services. Obstetric services are not health services for purposes of ss. 408.031-408.045.
- (10) “Hospice” or “hospice program” means a hospice as defined in part IV of chapter 400.
- (11) “Hospital” means a health care facility licensed under chapter 395.
- (12) “Intermediate care facility for the developmentally disabled” means a residential facility licensed under chapter 393 and certified by the Federal Government pursuant to the Social Security Act as a provider of Medicaid services to persons who are mentally retarded or who have a related condition.
- (13) “Long-term care hospital” means a hospital licensed under chapter 395 which meets the requirements of 42 C.F.R. s. 412.23(e) and seeks exclusion from the acute care Medicare prospective payment system for inpatient hospital services.
- (14) “Mental health services” means inpatient services provided in a hospital licensed under chapter 395 and listed on the hospital license as psychiatric beds for adults; psychiatric beds for children and adolescents; intensive residential treatment beds for children and adolescents; substance abuse beds for adults; or substance abuse beds for children and adolescents.
- (15) “Nursing home geographically underserved area” means:
 - (a) A county in which there is no existing or approved nursing home;
 - (b) An area with a radius of at least 20 miles in which there is no existing or approved nursing home; or
 - (c) An area with a radius of at least 20 miles in which all existing nursing homes have maintained at least a 95 percent occupancy rate for the most recent 6 months or a 90 percent occupancy rate for the most recent 12 months.
- (16) “Skilled nursing facility” means an institution, or a distinct part of an institution, which is primarily engaged in providing, to inpatients, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- (17) “Tertiary health service” means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The agency shall establish by rule a list of all tertiary health services.

History.—s. 19, ch. 87-92; s. 19, ch. 88-294; s. 2, ch. 89-308; s. 7, ch. 89-354; s. 21, ch. 91-158; s. 54, ch. 91-221; s. 1, ch. 91-282; ss. 15, 16, ch. 92-33; s. 10, ch. 92-58; s. 22, ch. 93-214; s. 8, ch. 95-144; s. 28, ch. 95-210; s. 2, ch. 95-394; s. 1, ch. 97-270; s. 3, ch. 2000-256; s. 4, ch. 2000-318; s. 2, ch. 2004-383; s. 74, ch. 2006-197; s. 111, ch. 2008-4.

Note.—Former s. 381.702.

408.033 Local and state health planning.—

(1) LOCAL HEALTH COUNCILS.—

- (a) Local health councils are hereby established as public or private nonprofit agencies serving the counties of a district. The members of each council shall be appointed in an equitable manner by the county commissions having jurisdiction in the respective district. Each council shall be composed of a number of

persons equal to 1 1/2 times the number of counties which compose the district or 12 members, whichever is greater. Each county in a district shall be entitled to at least one member on the council. The balance of the membership of the council shall be allocated among the counties of the district on the basis of population rounded to the nearest whole number; except that in a district composed of only two counties, no county shall have fewer than four members. The appointees shall be representatives of health care providers, health care purchasers, and nongovernmental health care consumers, but not excluding elected government officials. The members of the consumer group shall include a representative number of persons over 60 years of age. A majority of council members shall consist of health care purchasers and health care consumers. The local health council shall provide each county commission a schedule for appointing council members to ensure that council membership complies with the requirements of this paragraph. The members of the local health council shall elect a chair. Members shall serve for terms of 2 years and may be eligible for reappointment.

- (b) Each local health council may:
1. Develop a district area health plan that permits each local health council to develop strategies and set priorities for implementation based on its unique local health needs.
 2. Advise the agency on health care issues and resource allocations.
 3. Promote public awareness of community health needs, emphasizing health promotion and cost-effective health service selection.
 4. Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and assist the agency and other state agencies in carrying out data collection activities that relate to the functions in this subsection.
 5. Monitor the onsite construction progress, if any, of certificate-of-need approved projects and report council findings to the agency on forms provided by the agency.
 6. Advise and assist any regional planning councils within each district that have elected to address health issues in their strategic regional policy plans with the development of the health element of the plans to address the health goals and policies in the State Comprehensive Plan.
 7. Advise and assist local governments within each district on the development of an optional health plan element of the comprehensive plan provided in chapter 163, to assure compatibility with the health goals and policies in the State Comprehensive Plan and district health plan. To facilitate the implementation of this section, the local health council shall annually provide the local governments in its service area, upon request, with:
 - a. A copy and appropriate updates of the district health plan;
 - b. A report of hospital and nursing home utilization statistics for facilities within the local government jurisdiction; and
 - c. Applicable agency rules and calculated need methodologies for health facilities and services regulated under s. 408.034 for the district served by the local health council.
 8. Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of local, state, federal, and private funds distributed to meet the needs of the medically indigent and other underserved population groups.
 9. In conjunction with the Department of Health, plan for services at the local level for persons infected with the human immunodeficiency virus.
 10. Provide technical assistance to encourage and support activities by providers, purchasers, consumers, and local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.
 11. Provide the agency with data required by rule for the review of certificate-of-need applications and the projection of need for health services and facilities in the district.
- (c) Local health councils may conduct public hearings pursuant to s. 408.039(3)(b).
- (d) Each local health council shall enter into a memorandum of agreement with each regional planning council in its district that elects to address health issues in its strategic regional policy plan. In addition, each local health council shall enter into a memorandum of agreement with each local government that includes an optional health element in its comprehensive plan. Each memorandum of agreement must specify the manner in which each local government, regional planning council, and local health council will coordinate its activities to ensure a unified approach to health planning and implementation efforts.
- (e) Local health councils may employ personnel or contract for staffing services with persons who possess appropriate qualifications to carry out the councils' purposes. However, such personnel are not state employees.

- (f) Personnel of the local health councils shall provide an annual orientation to council members about council member responsibilities.
- (g) Each local health council may accept and receive, in furtherance of its health planning functions, funds, grants, and services from governmental agencies and from private or civic sources and to perform studies related to local health planning in exchange for such funds, grants, or services. Each council shall, no later than January 30 of each year, render an accounting of the receipt and disbursement of such funds received by it to the Department of Health.

(2) FUNDING.—

- (a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birthing centers, clinical laboratories except community nonprofit blood banks and clinical laboratories operated by practitioners for exclusive use regulated under s. 483.035, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, health care clinics, and multiphasic testing centers and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics.
- (b) 1. A hospital licensed under chapter 395, a nursing home licensed under chapter 400, and an assisted living facility licensed under chapter 429 shall be assessed an annual fee based on number of beds.
2. All other facilities and organizations listed in paragraph (a) shall each be assessed an annual fee of \$150.
3. Facilities operated by the Department of Children and Family Services, the Department of Health, or the Department of Corrections and any hospital which meets the definition of rural hospital pursuant to s. 395.602 are exempt from the assessment required in this subsection.
- (c) 1. The agency shall, by rule, establish fees for hospitals and nursing homes based on an assessment of \$2 per bed. However, no such facility shall be assessed more than a total of \$500 under this subsection.
2. The agency shall, by rule, establish fees for assisted living facilities based on an assessment of \$1 per bed. However, no such facility shall be assessed more than a total of \$150 under this subsection.
3. The agency shall, by rule, establish an annual fee of \$150 for all other facilities and organizations listed in paragraph (a).
- (d) The agency shall, by rule, establish a facility billing and collection process for the billing and collection of the health facility fees authorized by this subsection.
- (e) A health facility which is assessed a fee under this subsection is subject to a fine of \$100 per day for each day in which the facility is late in submitting its annual fee up to the maximum of the annual fee owed by the facility. A facility which refuses to pay the fee or fine is subject to the forfeiture of its license.
- (f) The agency shall deposit in the Health Care Trust Fund all health care facility assessments that are assessed under this subsection and shall transfer such funds to the Department of Health for funding of the local health councils. The remaining certificate-of-need application fees shall be used only for the purpose of administering the certificate-of-need program.

(3) DUTIES AND RESPONSIBILITIES OF THE AGENCY.—

- (a) The agency is responsible for the coordinated planning of health care services in the state.
- (b) The agency shall develop and maintain a comprehensive health care database for the purpose of health planning and for certificate-of-need determinations. The agency or its contractor is authorized to require the submission of information from health facilities, health service providers, and licensed health professionals which is determined by the agency, through rule, to be necessary for meeting the agency's responsibilities as established in this section.
- (c) The Department of Health shall contract with the local health councils for the services specified in subsection (1). All contract funds shall be distributed according to an allocation plan developed by the department. The department may withhold funds from a local health council or cancel its contract with a local health council which does not meet performance standards agreed upon by the department and local health councils.

History.—s. 20, ch. 87-92; s. 40, ch. 88-380; s. 35, ch. 88-394; s. 1, ch. 89-104; s. 24, ch. 89-294; s. 2, ch. 89-296; s. 15, ch. 89-527; s. 2, ch. 91-48; s. 22, ch. 91-158; ss. 2, 104, ch. 91-282; s. 5, ch. 91-429; ss. 15, 17, ch. 92-33; s. 2, ch. 92-174; s. 66, ch. 92-289; s. 22, ch. 93-120; s. 11, ch. 93-129; s. 33, ch. 93-206; s. 8, ch. 93-267; s. 9, ch. 95-144; s. 29, ch. 95-210; s. 3, ch. 95-394; s. 11, ch. 97-79; s. 1, ch. 97-91; s. 35, ch. 97-103; s. 62, ch. 97-237; s. 175, ch. 99-8; s. 4, ch. 2000-256; s. 5, ch. 2000-318; s. 3, ch. 2004-383; s. 75, ch. 2006-197; s. 114, ch. 2010-102.

Note.—Former s. 381.703.

408.034 Duties and responsibilities of agency; rules.—

- (1) The agency is designated as the single state agency to issue, revoke, or deny certificates of need and to issue, revoke, or deny exemptions from certificate-of-need review in accordance with present and future federal and state statutes. The agency is designated as the state health planning agency for purposes of federal law.
- (2) In the exercise of its authority to issue licenses to health care facilities and health service providers, as provided under chapters 393 and 395 and parts II and IV of chapter 400, the agency may not issue a license to any health care facility or health service provider that fails to receive a certificate of need or an exemption for the licensed facility or service.
- (3) The agency shall establish, by rule, uniform need methodologies for health services and health facilities. In developing uniform need methodologies, the agency shall, at a minimum, consider the demographic characteristics of the population, the health status of the population, service use patterns, standards and trends, geographic accessibility, and market economics.
- (4) Prior to determining that there is a need for additional community nursing facility beds in any area of the state, the agency shall determine that the need cannot be met through the provision, enhancement, or expansion of home and community-based services. In determining such need, the agency shall examine nursing home placement patterns and demographic patterns of persons entering nursing homes and the availability of and effectiveness of existing home-based and community-based service delivery systems at meeting the long-term care needs of the population. The agency shall recommend to the Legislature changes that could be made to existing home-based and community-based delivery systems to lessen the need for additional nursing facility beds.
- (5) The agency shall establish by rule a nursing-home-bed-need methodology that has a goal of maintaining a subdistrict average occupancy rate of 94 percent and that reduces the community nursing home bed need for the areas of the state where the agency establishes pilot community diversion programs through the Title XIX aging waiver program.
- (6) The agency may adopt rules necessary to implement ss. 408.031-408.045.

History.—s. 21, ch. 87-92; s. 8, ch. 89-354; s. 1, ch. 91-263; s. 15, ch. 92-33; s. 18, ch. 93-214; s. 10, ch. 95-144; s. 2, ch. 98-85; s. 5, ch. 2000-256; s. 6, ch. 2000-318; s. 13, ch. 2002-223; s. 9, ch. 2004-298; s. 4, ch. 2004-383; s. 3, ch. 2005-60; s. 76, ch. 2006-197.
Note.—Former s. 381.704.

408.035 Review criteria.—

- (1) The agency shall determine the reviewability of applications and shall review applications for certificate-of-need determinations for health care facilities and health services in context with the following criteria, except for general hospitals as defined in s. 395.002:
 - (a) The need for the health care facilities and health services being proposed.
 - (b) The availability, quality of care, accessibility, and extent of utilization of existing health care facilities and health services in the service district of the applicant.
 - (c) The ability of the applicant to provide quality of care and the applicant's record of providing quality of care.
 - (d) The availability of resources, including health personnel, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation.
 - (e) The extent to which the proposed services will enhance access to health care for residents of the service district.
 - (f) The immediate and long-term financial feasibility of the proposal.
 - (g) The extent to which the proposal will foster competition that promotes quality and cost-effectiveness.
 - (h) The costs and methods of the proposed construction, including the costs and methods of energy provision and the availability of alternative, less costly, or more effective methods of construction.
 - (i) The applicant's past and proposed provision of health care services to Medicaid patients and the medically indigent.
 - (j) The applicant's designation as a Gold Seal Program nursing facility pursuant to s. 400.235, when the applicant is requesting additional nursing home beds at that facility.
- (2) For a general hospital, the agency shall consider only the criteria specified in paragraph (1)(a), paragraph (1)(b), except for quality of care in paragraph (1)(b), and paragraphs (1)(e), (g), and (i).

History.—s. 22, ch. 87-92; s. 20, ch. 88-294; s. 15, ch. 92-33; ss. 37, 50, ch. 93-217; s. 30, ch. 95-210; s. 36, ch. 97-103; s. 39, ch. 97-264; s. 2, ch. 97-270; s. 20, ch. 99-394; s. 6, ch. 2000-256; s. 7, ch. 2000-318; s. 5, ch. 2004-383; s. 1, ch. 2008-29.
Note.—Former s. 381.705.

408.036 Projects subject to review; exemptions.—

- (1) **APPLICABILITY.**—Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(g), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.
 - (a) The addition of beds in community nursing homes or intermediate care facilities for the developmentally disabled by new construction or alteration.
 - (b) The new construction or establishment of additional health care facilities, including a replacement health care facility when the proposed project site is not located on the same site as or within 1 mile of the existing health care facility, if the number of beds in each licensed bed category will not increase.
 - (c) The conversion from one type of health care facility to another, including the conversion from a general hospital, a specialty hospital, or a long-term care hospital.
 - (d) The establishment of a hospice or hospice inpatient facility, except as provided in s. 408.043.
 - (e) An increase in the number of beds for comprehensive rehabilitation.
 - (f) The establishment of tertiary health services, including inpatient comprehensive rehabilitation services.
- (2) **PROJECTS SUBJECT TO EXPEDITED REVIEW.**—Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:
 - (a) A transfer of a certificate of need, except that when an existing hospital is acquired by a purchaser, all certificates of need issued to the hospital which are not yet operational shall be acquired by the purchaser, without need for a transfer.
 - (b) Replacement of a nursing home within the same district, if the proposed project site is located within a geographic area that contains at least 65 percent of the facility's current residents and is within a 30-mile radius of the replaced nursing home.
 - (c) Relocation of a portion of a nursing home's licensed beds to a facility within the same district, if the relocation is within a 30-mile radius of the existing facility and the total number of nursing home beds in the district does not increase.

The agency shall develop rules to implement the provisions for expedited review, including time schedule, application content which may be reduced from the full requirements of s. 408.037(1), and application processing.
- (3) **EXEMPTIONS.**—Upon request, the following projects are subject to exemption from the provisions of subsection (1):
 - (a) For hospice services or for swing beds in a rural hospital, as defined in s. 395.602, in a number that does not exceed one-half of its licensed beds.
 - (b) For the conversion of licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, so long as the conversion of the beds does not involve the construction of new facilities. The total number of skilled nursing beds, including swing beds, may not exceed one-half of the total number of licensed beds in the rural hospital as of July 1, 1993. Certified skilled nursing beds designated under this paragraph, excluding swing beds, shall be included in the community nursing home bed inventory. A rural hospital that subsequently decertifies any acute care beds exempted under this paragraph shall notify the agency of the decertification, and the agency shall adjust the community nursing home bed inventory accordingly.
 - (c) For the addition of nursing home beds at a skilled nursing facility that is part of a retirement community that provides a variety of residential settings and supportive services and that has been incorporated and operated in this state for at least 65 years on or before July 1, 1994. All nursing home beds must not be available to the public but must be for the exclusive use of the community residents.
 - (d) For an inmate health care facility built by or for the exclusive use of the Department of Corrections as provided in chapter 945. This exemption expires when such facility is converted to other uses.
 - (e) For mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957.
 - (f) For the creation of a single nursing home within a district by combining licensed beds from two or more licensed nursing homes within such district, regardless of subdistrict boundaries, if 50 percent of the beds in the created nursing home are transferred from the only nursing home in a county and its utilization data demonstrate that it had an occupancy rate of less than 75 percent for the 12-month period ending 90 days before the request for the exemption. This paragraph is repealed upon the expiration of the moratorium established in s. 408.0435(1).

- (g) For state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs in accordance with part II of chapter 296 for which at least 50 percent of the construction cost is federally funded and for which the Federal Government pays a per diem rate not to exceed one-half of the cost of the veterans' care in such state nursing homes. These beds shall not be included in the nursing home bed inventory.
- (h) For combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificates of need to be consolidated by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption. The longest validity period among the certificates shall be applicable to each of the combined certificates.
- (i) For division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificate of need to be divided by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption.
- (j) For the addition of hospital beds licensed under chapter 395 for comprehensive rehabilitation in a number that may not exceed 10 total beds or 10 percent of the licensed capacity, whichever is greater.
 - 1. In addition to any other documentation otherwise required by the agency, a request for exemption submitted under this paragraph must:
 - a. Certify that the prior 12-month average occupancy rate for the licensed beds being expanded meets or exceeds 80 percent.
 - b. Certify that the beds have been licensed and operational for at least 12 months.
 - 2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.
 - 3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of hospital beds until the beds are licensed.
- (k) For the addition of nursing home beds licensed under chapter 400 in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater; or, for the addition of nursing home beds licensed under chapter 400 at a facility that has been designated as a Gold Seal nursing home under s. 400.235 in a number not exceeding 20 total beds or 10 percent of the number of licensed beds in the facility being expanded, whichever is greater.
 - 1. In addition to any other documentation required by the agency, a request for exemption submitted under this paragraph must:
 - a. Certify that the facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition.
 - b. Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 96 percent.
 - c. Certify that any beds authorized for the facility under this paragraph before the date of the current request for an exemption have been licensed and operational for at least 12 months.
 - 2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.
 - 3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of nursing home beds until the beds are licensed.
- (l) For the establishment of:
 - 1. A Level II neonatal intensive care unit with at least 10 beds, upon documentation to the agency that the applicant hospital had a minimum of 1,500 births during the previous 12 months;
 - 2. A Level III neonatal intensive care unit with at least 15 beds, upon documentation to the agency that the applicant hospital has a Level II neonatal intensive care unit of at least 10 beds and had a minimum of 3,500 births during the previous 12 months; or
 - 3. A Level III neonatal intensive care unit with at least 5 beds, upon documentation to the agency that the applicant hospital is a verified trauma center pursuant to s. 395.4001(14), and has a Level II neonatal intensive care unit, if the applicant demonstrates that it meets the requirements for quality of care, nurse staffing, physician staffing, physical plant, equipment, emergency transportation, and data reporting found in agency certificate-of-need rules for Level II and Level III neonatal intensive care units and if the applicant commits to the provision of services to

Medicaid and charity patients at a level equal to or greater than the district average. Such a commitment is subject to s. 408.040.

- (m) 1. For the provision of adult open-heart services in a hospital located within the boundaries of a health service planning district, as defined in s. 408.032(5), which has experienced an annual net out-migration of at least 600 open-heart-surgery cases for 3 consecutive years according to the most recent data reported to the agency, and the district's population per licensed and operational open-heart programs exceeds the state average of population per licensed and operational open-heart programs by at least 25 percent. All hospitals within a health service planning district which meet the criteria reference in sub-subparagraphs 2.a.-h. shall be eligible for this exemption on July 1, 2004, and shall receive the exemption upon filing for it and subject to the following:
 1. A hospital that has received a notice of intent to grant a certificate of need or a final order of the agency granting a certificate of need for the establishment of an open-heart-surgery program is entitled to receive a letter of exemption for the establishment of an adult open-heart-surgery program upon filing a request for exemption and complying with the criteria enumerated in sub-subparagraphs 2.a.-h., and is entitled to immediately commence operation of the program.
 2. An otherwise eligible hospital that has not received a notice of intent to grant a certificate of need or a final order of the agency granting a certificate of need for the establishment of an open-heart-surgery program is entitled to immediately receive a letter of exemption for the establishment of an adult open-heart-surgery program upon filing a request for exemption and complying with the criteria enumerated in sub-subparagraphs 2.a.-h., but is not entitled to commence operation of its program until December 31, 2006.
 2. A hospital shall be exempt from the certificate-of-need review for the establishment of an open-heart-surgery program when the application for exemption submitted under this paragraph complies with the following criteria:
 - a. The applicant must certify that it will meet and continuously maintain the minimum licensure requirements adopted by the agency governing adult open-heart programs, including the most current guidelines of the American College of Cardiology and American Heart Association Guidelines for Adult Open Heart Programs.
 - b. The applicant must certify that it will maintain sufficient appropriate equipment and health personnel to ensure quality and safety.
 - c. The applicant must certify that it will maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.
 - d. The applicant can demonstrate that it has discharged at least 300 inpatients with a principal diagnosis of ischemic heart disease for the most recent 12-month period as reported to the agency.
 - e. The applicant is a general acute care hospital that is in operation for 3 years or more.
 - f. The applicant is performing more than 300 diagnostic cardiac catheterization procedures per year, combined inpatient and outpatient.
 - g. The applicant's payor mix at a minimum reflects the community average for Medicaid, charity care, and self-pay patients or the applicant must certify that it will provide a minimum of 5 percent of Medicaid, charity care, and self-pay to open-heart-surgery patients.
 - h. If the applicant fails to meet the established criteria for open-heart programs or fails to reach 300 surgeries per year by the end of its third year of operation, it must show cause why its exemption should not be revoked.
 3. By December 31, 2004, and annually thereafter, the agency shall submit a report to the Legislature providing information concerning the number of requests for exemption it has received under this paragraph during the calendar year and the number of exemptions it has granted or denied during the calendar year.
- (n) For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital without an approved adult open-heart-surgery program. In addition to any other documentation required by the agency, a request for an exemption submitted under this paragraph must comply with the following:
 1. The applicant must certify that it will meet and continuously maintain the requirements adopted by the agency for the provision of these services. These licensure requirements shall be adopted by rule pursuant to ss. 120.536(1) and 120.54 and must be consistent with the guidelines published by the American College of Cardiology and the American Heart Association for the

provision of percutaneous coronary interventions in hospitals without adult open-heart services. At a minimum, the rules shall require the following:

- a. Cardiologists must be experienced interventionalists who have performed a minimum of 75 interventions within the previous 12 months.
 - b. The hospital must provide a minimum of 36 emergency interventions annually in order to continue to provide the service.
 - c. The hospital must offer sufficient physician, nursing, and laboratory staff to provide the services 24 hours a day, 7 days a week.
 - d. Nursing and technical staff must have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers.
 - e. Cardiac care nursing staff must be adept in hemodynamic monitoring and Intra-aortic Balloon Pump (IABP) management.
 - f. Formalized written transfer agreements must be developed with a hospital with an adult open-heart-surgery program, and written transport protocols must be in place to ensure safe and efficient transfer of a patient within 60 minutes. Transfer and transport agreements must be reviewed and tested, with appropriate documentation maintained at least every 3 months.
 - g. Hospitals implementing the service must first undertake a training program of 3 to 6 months' duration, which includes establishing standards and testing logistics, creating quality assessment and error management practices, and formalizing patient-selection criteria.
2. The applicant must certify that it will use at all times the patient-selection criteria for the performance of primary angioplasty at hospitals without adult open-heart-surgery programs issued by the American College of Cardiology and the American Heart Association. At a minimum, these criteria would provide for the following:
- a. Avoidance of interventions in hemodynamically stable patients who have identified symptoms or medical histories.
 - b. Transfer of patients who have a history of coronary disease and clinical presentation of hemodynamic instability.
3. The applicant must agree to submit a quarterly report to the agency detailing patient characteristics, treatment, and outcomes for all patients receiving emergency percutaneous coronary interventions pursuant to this paragraph. This report must be submitted within 15 days after the close of each calendar quarter.
4. The exemption provided by this paragraph does not apply unless the agency determines that the hospital has taken all necessary steps to be in compliance with all requirements of this paragraph, including the training program required under sub-subparagraph 1.g.
5. Failure of the hospital to continuously comply with the requirements of sub-subparagraphs 1.c.-f. and subparagraphs 2. and 3. will result in the immediate expiration of this exemption.
6. Failure of the hospital to meet the volume requirements of sub-subparagraphs 1.a. and b. within 18 months after the program begins offering the service will result in the immediate expiration of the exemption.

If the exemption for this service expires under subparagraph 5. or subparagraph 6., the agency may not grant another exemption for this service to the same hospital for 2 years and then only upon a showing that the hospital will remain in compliance with the requirements of this paragraph through a demonstration of corrections to the deficiencies that caused expiration of the exemption. Compliance with the requirements of this paragraph includes compliance with the rules adopted pursuant to this paragraph.

- (o) For the addition of mental health services or beds if the applicant commits to providing services to Medicaid or charity care patients at a level equal to or greater than the district average. Such a commitment is subject to s. 408.040.
- (p) For replacement of a licensed nursing home on the same site, or within 3 miles of the same site, if the number of licensed beds does not increase.
- (q) For consolidation or combination of licensed nursing homes or transfer of beds between licensed nursing homes within the same planning subdistrict, by providers that operate multiple nursing homes within that

planning subdistrict, if there is no increase in the planning subdistrict total number of nursing home beds and the site of the relocation is not more than 30 miles from the original location.

(r) For beds in state mental health treatment facilities defined in s. 394.455 and state mental health forensic facilities operated under chapter 916.

(s) For beds in state developmental disabilities centers as defined in s. 393.063.

(4) REQUESTS FOR EXEMPTION.—A request for exemption under subsection (3) may be made at any time and is not subject to the batching requirements of this section. The request shall be supported by such documentation as the agency requires by rule. The agency shall assess a fee of \$250 for each request for exemption submitted under subsection (3).

(5) NOTIFICATION.—Health care facilities and providers must provide to the agency notification of:

(a) Replacement of a health care facility when the proposed project site is located in the same district and on the existing site or within a 1-mile radius of the replaced health care facility, if the number and type of beds do not increase.

(b) The termination of a health care service, upon 30 days' written notice to the agency.

(c) The addition or delicensure of beds.

Notification under this subsection may be made by electronic, facsimile, or written means at any time before the described action has been taken.

History.—s. 23, ch. 87-92; s. 21, ch. 88-294; s. 2, ch. 89-527; ss. 3, 16, ch. 91-282; s. 15, ch. 92-33; s. 67, ch. 92-289; s. 30, ch. 93-129; s. 19, ch. 93-214; s. 38, ch. 93-217; ss. 3, 4, ch. 94-206; s. 58, ch. 95-144; s. 143, ch. 95-418; s. 3, ch. 97-270; s. 4, ch. 97-290; s. 3, ch. 98-14; s. 22, ch. 98-80; s. 3, ch. 98-85; s. 8, ch. 98-303; s. 7, ch. 2000-256; s. 15, ch. 2000-305; s. 8, ch. 2000-318; s. 15, ch. 2001-104; s. 13, ch. 2003-2; s. 1, ch. 2003-274; s. 1, ch. 2003-289; s. 10, ch. 2004-298; s. 1, ch. 2004-382; s. 6, ch. 2004-383; s. 2, ch. 2006-161; s. 8, ch. 2006-192; s. 26, ch. 2006-195; s. 51, ch. 2006-227; s. 88, ch. 2007-5; s. 15, ch. 2008-244; s. 11, ch. 2009-20; s. 19, ch. 2010-4; s. 1, ch. 2011-195.

INote.—As amended by s. 1, ch. 2004-382. The amendment by s. 6, ch. 2004-383, used “received” instead of “reviewed.”

Note.—Former s. 381.706.

408.0361 Cardiovascular services and burn unit licensure.—

(1) Each provider of diagnostic cardiac catheterization services shall comply with rules adopted by the agency that establish licensure standards governing the operation of adult inpatient diagnostic cardiac catheterization programs. The rules shall ensure that such programs:

(a) Comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories.

(b) Perform only adult inpatient diagnostic cardiac catheterization services and will not provide therapeutic cardiac catheterization or any other cardiology services.

(c) Maintain sufficient appropriate equipment and health care personnel to ensure quality and safety.

(d) Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

(e) Demonstrate a plan to provide services to Medicaid and charity care patients.

(2) Each provider of adult cardiovascular services or operator of a burn unit shall comply with rules adopted by the agency that establish licensure standards that govern the provision of adult cardiovascular services or the operation of a burn unit. Such rules shall consider, at a minimum, staffing, equipment, physical plant, operating protocols, the provision of services to Medicaid and charity care patients, accreditation, licensure period and fees, and enforcement of minimum standards. The certificate-of-need rules for adult cardiovascular services and burn units in effect on June 30, 2004, are authorized pursuant to this subsection and shall remain in effect and shall be enforceable by the agency until the licensure rules are adopted. Existing providers and any provider with a notice of intent to grant a certificate of need or a final order of the agency granting a certificate of need for adult cardiovascular services or burn units shall be considered grandfathered and receive a license for their programs effective on the effective date of this act. The grandfathered licensure shall be for at least 3 years or until July 1, 2008, whichever is longer, but shall be required to meet licensure standards applicable to existing programs for every subsequent licensure period.

(3) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(a) Establishment of two hospital program licensure levels: a Level I program authorizing the performance of adult percutaneous cardiac intervention without onsite cardiac surgery and a Level II program authorizing the performance of percutaneous cardiac intervention with onsite cardiac surgery.

- (b) For a hospital seeking a Level I program, demonstration that, for the most recent 12-month period as reported to the agency, it has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has discharged or transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease and that it has a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes.
 - (c) For a hospital seeking a Level II program, demonstration that, for the most recent 12-month period as reported to the agency, it has performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease.
 - (d) Compliance with the most recent guidelines of the American College of Cardiology and American Heart Association guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety.
 - (e) Establishment of appropriate hours of operation and protocols to ensure availability and timely referral in the event of emergencies.
 - (f) Demonstration of a plan to provide services to Medicaid and charity care patients.
- (4) In order to ensure continuity of available services, the holder of a certificate of need for a newly licensed hospital that meets the requirements of this subsection may apply for and shall be granted Level I program status regardless of whether rules relating to Level I programs have been adopted. To qualify for a Level I program under this subsection, a hospital seeking a Level I program must be a newly licensed hospital established pursuant to a certificate of need in a physical location previously licensed and operated as a hospital, the former hospital must have provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations for the most recent 12-month period as reported to the agency, and the newly licensed hospital must have a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes. A hospital meeting the requirements of this subsection may apply for certification of Level I program status before taking possession of the physical location of the former hospital, and the effective date of Level I program status shall be concurrent with the effective date of the newly issued hospital license.
- (5)
- (a) The agency shall establish a technical advisory panel to develop procedures and standards for measuring outcomes of adult cardiovascular services. Members of the panel shall include representatives of the Florida Hospital Association, the Florida Society of Thoracic and Cardiovascular Surgeons, the Florida Chapter of the American College of Cardiology, and the Florida Chapter of the American Heart Association and others with experience in statistics and outcome measurement. Based on recommendations from the panel, the agency shall develop and adopt rules for the adult cardiovascular services that include at least the following:
 1. A risk adjustment procedure that accounts for the variations in severity and case mix found in hospitals in this state.
 2. Outcome standards specifying expected levels of performance in Level I and Level II adult cardiovascular services. Such standards may include, but shall not be limited to, in-hospital mortality, infection rates, nonfatal myocardial infarctions, length of stay, postoperative bleeds, and returns to surgery.
 3. Specific steps to be taken by the agency and licensed hospitals that do not meet the outcome standards within specified time periods, including time periods for detailed case reviews and development and implementation of corrective action plans.
 - (b) Hospitals licensed for Level I or Level II adult cardiovascular services shall participate in clinical outcome reporting systems operated by the American College of Cardiology and the Society for Thoracic Surgeons.

History.—s. 5, ch. 99-356; s. 48, ch. 2001-62; s. 2, ch. 2004-382; s. 7, ch. 2004-383; s. 1, ch. 2007-214; s. 2, ch. 2007-248; s. 88, ch. 2010-5.

408.037 Application content.—

- (1) Except as provided in subsection (2) for a general hospital, an application for a certificate of need must contain:
 - (a) A detailed description of the proposed project and statement of its purpose and need in relation to the district health plan.

- (b) A statement of the financial resources needed by and available to the applicant to accomplish the proposed project. This statement must include:
1. A complete listing of all capital projects, including new health facility development projects and health facility acquisitions applied for, pending, approved, or underway in any state at the time of application, regardless of whether or not that state has a certificate-of-need program or a capital expenditure review program pursuant to s. 1122 of the Social Security Act. The agency may, by rule, require less-detailed information from major health care providers. This listing must include the applicant's actual or proposed financial commitment to those projects and an assessment of their impact on the applicant's ability to provide the proposed project.
 2. A detailed listing of the needed capital expenditures, including sources of funds.
 3. A detailed financial projection, including a statement of the projected revenue and expenses for the first 2 years of operation after completion of the proposed project. This statement must include a detailed evaluation of the impact of the proposed project on the cost of other services provided by the applicant.
- (c) An audited financial statement of the applicant. In an application submitted by an existing health care facility, health maintenance organization, or hospice, financial condition documentation must include, but need not be limited to, a balance sheet and a profit-and-loss statement of the 2 previous fiscal years' operation.
- (2) An application for a certificate of need for a general hospital must contain a detailed description of the proposed general hospital project and a statement of its purpose and the needs it will meet. The proposed project's location, as well as its primary and secondary service areas, must be identified by zip code. Primary service area is defined as the zip codes from which the applicant projects that it will draw 75 percent of its discharges. Secondary service area is defined as the zip codes from which the applicant projects that it will draw its remaining discharges. If, subsequent to issuance of a final order approving the certificate of need, the proposed location of the general hospital changes or the primary service area materially changes, the agency shall revoke the certificate of need. However, if the agency determines that such changes are deemed to enhance access to hospital services in the service district, the agency may permit such changes to occur. A party participating in the administrative hearing regarding the issuance of the certificate of need for a general hospital has standing to participate in any subsequent proceeding regarding the revocation of the certificate of need for a hospital for which the location has changed or for which the primary service area has materially changed. In addition, the application for the certificate of need for a general hospital must include a statement of intent that, if approved by final order of the agency, the applicant shall within 120 days after issuance of the final order or, if there is an appeal of the final order, within 120 days after the issuance of the court's mandate on appeal, furnish satisfactory proof of the applicant's financial ability to operate. The agency shall establish documentation requirements, to be completed by each applicant, which show anticipated provider revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the provider, and an applicant's access to contingency financing. A party participating in the administrative hearing regarding the issuance of the certificate of need for a general hospital may provide written comments concerning the adequacy of the financial information provided, but such party does not have standing to participate in an administrative proceeding regarding proof of the applicant's financial ability to operate. The agency may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the provider.
- (3) The applicant must certify that it will license and operate the health care facility. For an existing health care facility, the applicant must be the licenseholder of the facility.

History.—s. 24, ch. 87-92; s. 15, ch. 92-33; s. 4, ch. 97-270; s. 8, ch. 2000-256; s. 9, ch. 2000-318; s. 2, ch. 2008-29.

Note.—Former s. 381.707.

408.038 Fees.—The agency shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the activities of the agency and shall be allocated as provided in s. 408.033. The fee shall be determined as follows:

- (1) A minimum base fee of \$10,000.
- (2) In addition to the base fee of \$10,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed \$50,000.

History.—s. 25, ch. 87-92; s. 2, ch. 89-104; s. 16, ch. 89-527; s. 4, ch. 91-282; s. 15, ch. 92-33; s. 11, ch. 95-144; s. 17, ch. 97-79; s. 9, ch. 2000-256; s. 10, ch. 2000-318; s. 8, ch. 2004-383.

408.039 Review process.—The review process for certificates of need shall be as follows:

- (1) **REVIEW CYCLES.**—The agency by rule shall provide for applications to be submitted on a timetable or cycle basis; provide for review on a timely basis; and provide for all completed applications pertaining to similar types of services or facilities affecting the same service district to be considered in relation to each other no less often than annually.
- (2) **LETTERS OF INTENT.**—
 - (a) At least 30 days prior to filing an application, a letter of intent shall be filed by the applicant with the agency, respecting the development of a proposal subject to review. No letter of intent is required for expedited projects as defined by rule by the agency.
 - (b) The agency shall provide a mechanism by which applications may be filed to compete with proposals described in filed letters of intent.
 - (c) Letters of intent must describe the proposal; specify the number of beds sought, if any; identify the services to be provided and the specific subdistrict location; and identify the applicant.
 - (d) Within 21 days after filing a letter of intent, the agency shall publish notice of the filing of letters of intent in the Florida Administrative Weekly and notice that, if requested, a public hearing shall be held at the local level within 21 days after the application is deemed complete. Notices under this paragraph must contain due dates applicable to the cycle for filing applications and for requesting a hearing.
- (3) **APPLICATION PROCESSING.**—
 - (a) An applicant shall file an application with the agency and shall furnish a copy of the application to the agency. Within 15 days after the applicable application filing deadline established by agency rule, the staff of the agency shall determine if the application is complete. If the application is incomplete, the staff shall request specific information from the applicant necessary for the application to be complete; however, the staff may make only one such request. If the requested information is not filed with the agency within 21 days after the receipt of the staff's request, the application shall be deemed incomplete and deemed withdrawn from consideration.
 - (b) Upon the request of any applicant or substantially affected person within 14 days after notice that an application has been filed, a public hearing may be held at the agency's discretion if the agency determines that a proposed project involves issues of great local public interest. In such cases, the agency shall attend the public hearing. The public hearing shall allow applicants and other interested parties reasonable time to present their positions and to present rebuttal information. A recorded verbatim record of the hearing shall be maintained. The public hearing shall be held at the local level within 21 days after the application is deemed complete.
 - (c) Except for competing applicants, in order to be eligible to challenge the agency decision on a general hospital application under review pursuant to paragraph (5)(c), existing hospitals must submit a detailed written statement of opposition to the agency and to the applicant. The detailed written statement must be received by the agency and the applicant within 21 days after the general hospital application is deemed complete and made available to the public.
 - (d) In those cases where a written statement of opposition has been timely filed regarding a certificate of need application for a general hospital, the applicant for the general hospital may submit a written response to the agency. Such response must be received by the agency within 10 days of the written statement due date.
- (4) **STAFF RECOMMENDATIONS.**—
 - (a) The agency's review of and final agency action on applications shall be in accordance with statutory criteria and the implementing administrative rules. In the application review process, the agency shall give a preference, as defined by rule of the agency, to an applicant which proposes to develop a nursing home in a nursing home geographically underserved area.
 - (b) Within 60 days after all the applications in a review cycle are determined to be complete, the agency shall issue its State Agency Action Report and Notice of Intent to grant a certificate of need for the project in its entirety, to grant a certificate of need for identifiable portions of the project, or to deny a certificate of need. The State Agency Action Report shall set forth in writing its findings of fact and determinations upon which its decision is based. If the agency intends to grant a certificate of need, the State Agency Action Report or the Notice of Intent shall also include any conditions which the agency intends to attach to the certificate of need. The agency shall designate by rule a senior staff person, other than the person who issues the final order, to issue State Agency Action Reports and Notices of Intent.

- (c) The agency shall publish its proposed decision set forth in the Notice of Intent in the Florida Administrative Weekly within 14 days after the Notice of Intent is issued.
- (d) If no administrative hearing is requested pursuant to subsection (5), the State Agency Action Report and the Notice of Intent shall become the final order of the agency. The agency shall provide a copy of the final order to the appropriate local health council.

(5) ADMINISTRATIVE HEARINGS.—

- (a) Within 21 days after publication of notice of the State Agency Action Report and Notice of Intent, any person authorized under paragraph (c) to participate in a hearing may file a request for an administrative hearing; failure to file a request for hearing within 21 days of publication of notice shall constitute a waiver of any right to a hearing and a waiver of the right to contest the final decision of the agency. A copy of the request for hearing shall be served on the applicant.
- (b) Hearings shall be held in Tallahassee unless the administrative law judge determines that changing the location will facilitate the proceedings. The agency shall assign proceedings requiring hearings to the Division of Administrative Hearings of the Department of Management Services within 10 days after the time has expired for requesting a hearing. Except upon unanimous consent of the parties or upon the granting by the administrative law judge of a motion of continuance, hearings shall commence within 60 days after the administrative law judge has been assigned. For an application for a general hospital, administrative hearings shall commence within 6 months after the administrative law judge has been assigned, and a continuance may not be granted absent a finding of extraordinary circumstances by the administrative law judge. All parties, except the agency, shall bear their own expense of preparing a transcript. In any application for a certificate of need which is referred to the Division of Administrative Hearings for hearing, the administrative law judge shall complete and submit to the parties a recommended order as provided in ss. 120.569 and 120.57. The recommended order shall be issued within 30 days after the receipt of the proposed recommended orders or the deadline for submission of such proposed recommended orders, whichever is earlier. The division shall adopt procedures for administrative hearings which shall maximize the use of stipulated facts and shall provide for the admission of prepared testimony.
- (c) In administrative proceedings challenging the issuance or denial of a certificate of need, only applicants considered by the agency in the same batching cycle are entitled to a comparative hearing on their applications. Existing health care facilities may initiate or intervene in an administrative hearing upon a showing that an established program will be substantially affected by the issuance of any certificate of need, whether reviewed under s. 408.036(1) or (2), to a competing proposed facility or program within the same district. With respect to an application for a general hospital, competing applicants and only those existing hospitals that submitted a detailed written statement of opposition to an application as provided in this paragraph may initiate or intervene in an administrative hearing. Such challenges to a general hospital application shall be limited in scope to the issues raised in the detailed written statement of opposition that was provided to the agency. The administrative law judge may, upon a motion showing good cause, expand the scope of the issues to be heard at the hearing. Such motion shall include substantial and detailed facts and reasons for failure to include such issues in the original written statement of opposition.
- (d) The applicant's failure to strictly comply with the requirements of s. 408.037(1) or paragraph (2)(c) is not cause for dismissal of the application, unless the failure to comply impairs the fairness of the proceeding or affects the correctness of the action taken by the agency.
- (e) The agency shall issue its final order within 45 days after receipt of the recommended order. If the agency fails to take action within such time, or as otherwise agreed to by the applicant and the agency, the applicant may take appropriate legal action to compel the agency to act. When making a determination on an application for a certificate of need, the agency is specifically exempt from the time limitations provided in s. 120.60(1).

(6) JUDICIAL REVIEW.—

- (a) A party to an administrative hearing for an application for a certificate of need has the right, within not more than 30 days after the date of the final order, to seek judicial review in the District Court of Appeal pursuant to s. 120.68. The agency shall be a party in any such proceeding.
- (b) In such judicial review, the court shall affirm the final order of the agency, unless the decision is arbitrary, capricious, or not in compliance with ss. 408.031-408.045.

- (c) The court, in its discretion, may award reasonable attorney's fees and costs to the prevailing party if the court finds that there was a complete absence of a justiciable issue of law or fact raised by the losing party.
- (d) The party appealing a final order that grants a general hospital certificate of need shall pay the appellee's attorney's fees and costs, in an amount up to \$1 million, from the beginning of the original administrative action if the appealing party loses the appeal, subject to the following limitations and requirements:
 - 1. The party appealing a final order must post a bond in the amount of \$1 million in order to maintain the appeal.
 - 2. Except as provided under s. 120.595(5), in no event shall the agency be held liable for any other party's attorney's fees or costs.

History.—s. 26, ch. 87-92; s. 9, ch. 89-354; s. 15, ch. 92-33; s. 125, ch. 92-279; s. 55, ch. 92-326; s. 12, ch. 95-144; s. 190, ch. 96-410; s. 18, ch. 97-79; s. 5, ch. 97-270; s. 10, ch. 2000-256; s. 11, ch. 2000-318; s. 9, ch. 2004-383; s. 3, ch. 2008-29.

Note.—Former s. 381.709.

408.040 Conditions and monitoring.—

(1)

- (a) The agency may issue a certificate of need, or an exemption, predicated upon statements of intent expressed by an applicant in the application for a certificate of need or an exemption. Any conditions imposed on a certificate of need or an exemption based on such statements of intent shall be stated on the face of the certificate of need or in the exemption approval.
- (b) The agency may consider, in addition to the other criteria specified in s. 408.035, a statement of intent by the applicant that a specified percentage of the annual patient days at the facility will be utilized by patients eligible for care under Title XIX of the Social Security Act. Any certificate of need issued to a nursing home in reliance upon an applicant's statements that a specified percentage of annual patient days will be utilized by residents eligible for care under Title XIX of the Social Security Act must include a statement that such certification is a condition of issuance of the certificate of need. The certificate-of-need program shall notify the Medicaid program office and the Department of Elderly Affairs when it imposes conditions as authorized in this paragraph in an area in which a community diversion pilot project is implemented. Effective July 1, 2012, the agency may not impose sanctions related to patient day utilization by patients eligible for care under Title XIX of the Social Security Act for nursing homes.
- (c) A certificateholder or an exemption holder may apply to the agency for a modification of conditions imposed under paragraph (a) or paragraph (b). If the holder of a certificate of need or an exemption demonstrates good cause why the certificate or exemption should be modified, the agency shall reissue the certificate of need or exemption with such modifications as may be appropriate. The agency shall by rule define the factors constituting good cause for modification.
- (d) If the holder of a certificate of need or an exemption fails to comply with a condition upon which the issuance of the certificate or exemption was predicated, the agency may assess an administrative fine against the certificateholder or exemption holder in an amount not to exceed \$1,000 per failure per day. Failure to annually report compliance with any condition upon which the issuance of the certificate or exemption was predicated constitutes noncompliance. In assessing the penalty, the agency shall take into account as mitigation the degree of noncompliance. Proceeds of such penalties shall be deposited in the Public Medical Assistance Trust Fund.

(2) 1

- (a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 18 months after the date of issuance, except a certificate of need of an entity which was issued on or before April 1, 2009, shall terminate 36 months after the date of issuance. The agency shall monitor the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application, and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good-faith effort, as defined by rule, to meet it.
- (b) A certificate of need issued to an applicant holding a provisional certificate of authority under chapter 651 shall terminate 1 year after the applicant receives a valid certificate of authority from the Office of Insurance Regulation of the Financial Services Commission.
- (c) The certificate-of-need validity period for a project shall be extended by the agency, to the extent that the applicant demonstrates to the satisfaction of the agency that good-faith commencement of the project is

being delayed by litigation or by governmental action or inaction with respect to regulations or permitting precluding commencement of the project.

History.—s. 27, ch. 87-92; s. 22, ch. 88-294; s. 15, ch. 92-33; s. 13, ch. 95-144; s. 6, ch. 97-270; s. 4, ch. 98-85; s. 11, ch. 2000-256; s. 12, ch. 2000-318; s. 434, ch. 2003-261; s. 10, ch. 2004-383; s. 3, ch. 2006-161; s. 2, ch. 2007-82; s. 4, ch. 2008-29; s. 1, ch. 2009-45; s. 14, ch. 2009-223; s. 3, ch. 2011-135.

In Note.—As amended by s. 14, ch. 2009-223. For a description of multiple acts in the same session affecting a statutory provision, see preface to the Florida Statutes, “Statutory Construction.” Paragraph (2)(a) was also amended by s. 1, ch. 2009-45, and that version reads:

(2)(a) *Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 3 years after the date of issuance. The agency shall monitor the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application, and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good-faith effort, as defined by rule, to meet it.*

Note.—Former s. 381.710.

408.041 Certificate of need required; penalties.—It is unlawful for any person to undertake a project subject to review under ss. 408.031-408.045 without a valid certificate of need. Any person violating the provisions of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation shall be considered a separate offense.

History.—s. 28, ch. 87-92; s. 62, ch. 91-224; s. 15, ch. 92-33; s. 14, ch. 95-144.

Note.—Former s. 381.711.

408.042 Limitation on transfer.—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. Such actual costs must be documented by an affidavit executed by the transferor under oath. A holder who violates this section is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082, or by a fine not exceeding \$10,000, or both.

History.—s. 29, ch. 87-92; s. 15, ch. 92-33; s. 7, ch. 97-270.

Note.—Former s. 381.712.

408.043 Special provisions.—

- (1) **OSTEOPATHIC ACUTE CARE HOSPITALS.**—When an application is made for a certificate of need to construct or to expand an osteopathic acute care hospital, the need for such hospital shall be determined on the basis of the need for and availability of osteopathic services and osteopathic acute care hospitals in the district. When a prior certificate of need to establish an osteopathic acute care hospital has been issued in a district, and the facility is no longer used for that purpose, the agency may continue to count such facility and beds as an existing osteopathic facility in any subsequent application for construction of an osteopathic acute care hospital.
- (2) **HOSPICES.**—When an application is made for a certificate of need to establish or to expand a hospice, the need for such hospice shall be determined on the basis of the need for and availability of hospice services in the community. The formula on which the certificate of need is based shall discourage regional monopolies and promote competition. The inpatient hospice care component of a hospice which is a freestanding facility, or a part of a facility, which is primarily engaged in providing inpatient care and related services and is not licensed as a health care facility shall also be required to obtain a certificate of need. Provision of hospice care by any current provider of health care is a significant change in service and therefore requires a certificate of need for such services.
- (3) **RURAL HEALTH NETWORKS.**—Preference shall be given in the award of a certificate of need to members of certified rural health networks, as provided for in s. 381.0406, subject to the following conditions:
 - (a) Need must be shown pursuant to s. 408.035.
 - (b) The proposed project must:
 1. Strengthen health care services in rural areas through partnerships between rural care providers;

or

2. Increase access to inpatient health care services for Medicaid recipients or other low-income persons who live in rural areas.

(c) No preference shall be given under this section for the establishment of skilled nursing facility services by a hospital.

(4) **PRIVATE ACCREDITATION NOT REQUIRED.**—Accreditation by any private organization may not be a requirement for the issuance or maintenance of a certificate of need under ss. 408.031-408.045.

History.—s. 30, ch. 87-92; s. 15, ch. 91-282; s. 15, ch. 92-33; s. 31, ch. 93-129; s. 8, ch. 97-270; s. 1, ch. 2003-161; s. 11, ch. 2004-383.

Note.—Former s. 381.713.

408.0435 Moratorium on nursing home certificates of need.—

- (1) Notwithstanding the establishment of need as provided for in this chapter, a certificate of need for additional community nursing home beds may not be approved by the agency until Medicaid managed care is implemented statewide pursuant to ss. 409.961-409.985 or October 1, 2016, whichever is earlier.
- (2) The Legislature finds that the continued growth in the Medicaid budget for nursing home care has constrained the ability of the state to meet the needs of its elderly residents through the use of less restrictive and less institutional methods of long-term care. It is therefore the intent of the Legislature to limit the increase in Medicaid nursing home expenditures in order to provide funds to invest in long-term care that is community-based and provides supportive services in a manner that is both more cost-effective and more in keeping with the wishes of the elderly residents of this state.
- (3) This moratorium on certificates of need shall not apply to sheltered nursing home beds in a continuing care retirement community certified by the former Department of Insurance or by the Office of Insurance Regulation pursuant to chapter 651.
- (4)
 - (a) The moratorium on certificates of need does not apply and a certificate of need for additional community nursing home beds may be approved for a county that meets the following circumstances:
 1. The county has no community nursing home beds; and
 2. The lack of community nursing home beds occurs because all nursing home beds in the county that were licensed on July 1, 2001, have subsequently closed.
 - (b) The certificate-of-need review for such circumstances shall be subject to the comparative review process consistent with the provisions of s. 408.039, and the number of beds may not exceed the number of beds lost by the county after July 1, 2001.

This subsection shall be repealed upon the expiration of the moratorium established in subsection (1).

- (5) The moratorium on certificates of need does not apply for the addition of nursing home beds licensed under chapter 400 to a nursing home located in a county having up to 50,000 residents, in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater. In addition to any other documentation required by the agency, a request submitted under this subsection must:
 - (a) Certify that the facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition.
 - (b) Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 94 percent and the facility had not had any class I or class II deficiencies since its initial licensure.
 - (c) For a facility that has been licensed for less than 24 months, certify that the prior 6-month average occupancy rate for the nursing home beds at the facility meets or exceeds 94 percent and that the facility has not had any class I or class II deficiencies since its initial licensure.

This subsection shall be repealed upon the expiration of the moratorium established in subsection (1).

- (6) The moratorium on certificates of need does not apply for the addition of nursing home beds licensed under chapter 400 in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater, if the facility meets the requirements of paragraph (a).
 - (a) In addition to any other documentation required by the agency, a request for the addition of beds under this subsection must certify that:

1. The facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition;
 2. The prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 96 percent;
 3. The occupancy rate for nursing home beds in the subdistrict is 94 percent or greater; and
 4. Any beds authorized for the facility under this subsection before the date of the current request for additional beds have been licensed and operational for at least 12 months.
- (b) A nursing home may request additional beds under this subsection as an exemption from the provisions of s. 408.036(1). The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this subsection.
- (c) The agency shall count beds authorized under this subsection as approved beds in the published inventory of nursing home beds until the beds are licensed.

This subsection shall be repealed upon the expiration of the moratorium established in subsection (1).

History.—s. 52, ch. 2001-45; s. 1693, ch. 2003-261; s. 12, ch. 2004-298; s. 14, ch. 2004-383; s. 1, ch. 2006-161; s. 4, ch. 2011-135.
Note.—Former s. 651.1185.

408.044 Injunction.—Notwithstanding the existence or pursuit of any other remedy, the agency may maintain an action in the name of the state for injunction or other process against any person to restrain or prevent the pursuit of a project subject to review under ss. 408.031-408.045, in the absence of a valid certificate of need.

History.—s. 31, ch. 87-92; s. 15, ch. 92-33; s. 15, ch. 95-144; s. 12, ch. 2000-256; s. 13, ch. 2000-318.
Note.—Former s. 381.714.

408.045 Certificate of need; competitive sealed proposals.—

- (1) The application, review, and issuance procedures for a certificate of need for an intermediate care facility for the developmentally disabled may be made by the agency by competitive sealed proposals.
- (2) The agency shall make a decision regarding the issuance of the certificate of need in accordance with the provisions of s. 287.057(16), rules adopted by the agency relating to intermediate care facilities for the developmentally disabled, and the criteria in s. 408.035, as further defined by rule.
- (3) Notification of the decision shall be issued to all applicants not later than 28 calendar days after the date responses to a request for proposal are due.
- (4) The procedures provided for under this section are exempt from the batching cycle requirements and the public hearing requirement of s. 408.039.
- (5) The agency may use the competitive sealed proposal procedure for determining a certificate of need for other types of health care facilities and services if the agency identifies an unmet health care need and when funding in whole or in part for such health care facilities or services is authorized by the Legislature.

History.—s. 3, ch. 83-244; s. 42, ch. 85-81; s. 32, ch. 87-92; s. 3, ch. 89-308; s. 30, ch. 90-268; ss. 15, 18, ch. 92-33; s. 16, ch. 95-144; s. 13, ch. 2000-256; s. 14, ch. 2000-318; s. 67, ch. 2002-1; s. 37, ch. 2002-207; s. 33, ch. 2010-151.
Note.—Former s. 381.4961; s. 381.715.

408.0455 Rules; pending proceedings.—The rules of the agency in effect on June 30, 2004, shall remain in effect and shall be enforceable by the agency with respect to ss. 408.031-408.045 until such rules are repealed or amended by the agency.

History.—s. 38, ch. 87-92; s. 19, ch. 92-33; s. 74, ch. 92-289; s. 19, ch. 97-79; s. 4, ch. 97-98; s. 9, ch. 97-270; s. 12, ch. 2004-383.
Note.—Former s. 381.7155.

Florida Administrative Rules

Hospice Licensure Rules, Chapter 58A-2

58A-2.005 Administration of the Hospice.

- (1) **Governing Body.** The hospice must established written bylaws for a governing body with autonomous authority for the conduct of the hospice program. The governing body must satisfy the following requirements:
 - (a) Members must reside or work in the hospice's service area as defined in paragraph 59C-1.0355(2)(k), F.A.C.
 - (b) No person shall be denied membership on the governing body by reason of race, creed, color, age or sex.
 - (c) Duties of the governing body must include:
 1. Adoption in writing of the following documents which must be in compliance with provisions of Chapter 400, Part IV, F.S., and these rules, with updates as necessary:
 - a. Criteria defining eligibility for hospice services;
 - b. A program for building and coordinating relationships with other community organizations in order to provide hospice patients assistance with meals, utility payments, legal services, home repair and equipment, and other needs as identified on an individual basis;
 - c. Standards of hospice care which will ensure compliance with these rules and Chapter 400, Part IV, F.S., and which will promote and maintain a quality of life for each patient and family that reflects the patient's needs and values;
 - d. A comprehensive emergency management plan for all administrative, residential, free-standing inpatient facilities, and hospice services designed to protect the safety of patients and their families and hospice staff; and
 - e. An annual operating and strategic plan and budget.
 2. Promulgation of rules and bylaws which include at least the following:
 - a. The purpose of the hospice;
 - b. Annual review of the rules and bylaws which shall be dated and signed by the chairman of the governing body;
 - c. The powers and duties of the officers and committees of the governing body;
 - d. The qualifications, method of selection and terms of office of members and chairpersons of the governing body and committees; and
 - e. A mechanism for the administrator's appointment of the medical director and other professional and ancillary personnel.
- (2) **Administrative Officer.** The hospice must employ an administrator whose duties must be outlined in a written job description, including job qualifications. The administrator must be approved by the governing body. The job description must be kept in an administrative file.
 - (a) The administrator shall be responsible for day-to-day operations and the quality of services delivered by the hospice.
 - (b) The administrator must be responsible for maintaining an administrative office for the purpose of the operations of the hospice.
- (3) **Administrative Policies and Practices.**
 - (a) The administrator must be responsible for developing, documenting and implementing administrative policies and practices which are consistent with these rules, the bylaws, and the plans and decisions adopted by the governing body. These policies and practices must ensure the most efficient operation of the hospice program and the safe and adequate care of the patient and family units. These policies and practices must include:
 1. Policies governing admission to the hospice program and discontinuation of care.
 2. Personnel policies applicable to all full-time and part-time paid employees and volunteers, including job descriptions, job qualifications and duties, which shall be kept in an administrative file.
 3. A plan for orientation and training of all staff, including volunteers, which must ensure that staff receive training prior to the delivery of services. This plan must describe the method of assessing

training needs and designing training to meet those needs, and must include a curriculum outline with specific objectives.

4. Financial policies and practices that include:

- a. An annual budget for approval by the governing body;
- b. An annual audited financial statement for approval by the governing body;
- c. An ongoing bookkeeping and financial management system that is developed and implemented according to sound business practice;
- d. An ongoing payroll system that is developed and implemented according to sound business practice;
- e. Procedures for accepting and accounting for gifts and donations; and
- f. A fee schedule for hospice care.

5. Policies for administering drugs and biologicals in the home which must include:

- a. All orders for medications shall be dated and signed by a physician licensed in the State of Florida pursuant to Chapter 458 or 459, F.S.
- b. All orders for medications shall contain the name of the drug, dosage, frequency and route.
- c. All verbal orders for medication or treatments, or changes in medication or treatment must be taken by a licensed health professional and recorded in the patient's record. Verbal orders must be signed by the physician within thirty (30) calendar days from the date of the order.
- d. Experimental drugs shall not be administered without the written consent of the patient or the patient's legal representative, surrogate or proxy. The program administering such drugs must fully inform the patient or the patient's legal representative, surrogate or proxy of any risks, and be prepared to invoke remedial action should an adverse reaction occur. A copy of the signed consent must be kept in the patient's record.

6. Policies and procedures for the administration and provision of pharmaceutical services in inpatient and residential settings that are consistent with the drug therapy needs of the patient as determined by the medical director or the patient's attending physician(s). The pharmaceutical services shall be directed by a pharmacist registered in the State of Florida.

7. Policies and procedures approved by the medical director and governing body pertaining to the drug control system in the hospice including specific policies and procedures for disposal of Class II drugs upon the death of a patient.

8. Procedures which ensure the hospice can provide patients with medications on a twenty-four (24) hours a day, seven (7) days a week basis.

9. Policies and procedures for maintenance, confidentiality, and retention of clinical records for a minimum five-year period following the patient's death.

10. Procedures for inpatient visitation by family and friends.

11. Procedures for maintaining a record of requests for services. The record shall indicate the action taken regarding each request for hospice services and whether or not the patient has the ability to pay for the services. In no case shall a hospice refuse or discontinue hospice services based on the inability of the patient to pay for such services.

12. Notice to the public that the hospice provides services regardless of ability to pay.

13. Notice to the public of all services provided by the hospice program, the geographic area in which the services are available, and admission criteria.

14. Policies for educating the community to enhance public awareness of hospice services.

15. Policies and procedures for completion, retention, and submission of reports and records as required by the department, agency, and other authorized agencies.

16. Policies and procedures for implementing universal precautions as established by the Centers for Disease Control and Prevention.

- (b) Equipment and personnel, under medical supervision, must be provided for diagnostic procedures to meet the needs of the hospice inpatient, residential and home-care programs. This must include the services of a clinical laboratory and radiological services, which must meet all standards of the State of Florida. There must be written agreements or contracts for such services unless provided on the premises of the hospice. The hospice program must ensure that services are available twenty-four (24) hours a day, seven (7) days a week, either through contractual agreement, written agreement, or direct service provision by

the hospice.

- (c) Each hospice shall develop an infection control program which specifies procedures and responsibilities for inpatient, residential care and home-care programs. Procedures regulating the structure and function of this program shall be approved by the medical director and the governing body, and shall comply with federal and state laws regarding blood-borne pathogens, infection control and biohazardous waste.

(4) Outcome Measures.

- (a) Effective with the report due by March 31, 2009, hospices must annually report the outcome measures outlined in this subsection on DOE Form H-002, State of Florida Department of Elder Affairs Hospice Demographic and Outcome Measures Report, August 11, 2008.
 - 1. The form is hereby incorporated by reference and may be obtained from the following address: Department of Elder Affairs, Planning and Evaluation Unit, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. The form may also be obtained from the department's Web site at: <http://elderaffairs.state.fl.us/english/hospice/DOEAformH002.xls>.
 - 2. The reporting time frame is January 1 through December 31, with the exception of the 2008 report, which only needs to include outcome measure data from the rule effective date through December 31, 2008.
 - 3. The report must be submitted to the following e-mail address no later than March 31 of the following year: hospicereport@elderaffairs.org. The report may alternately be submitted to the following address: Department of Elder Affairs, Planning and Evaluation Unit, 4040 Esplanade Way, Tallahassee, FL 32399-7000.
- (b) In addition to the outcome measure regarding pain management pursuant to Section 400.60501, F.S., each hospice must conduct the National Hospice and Palliative Care Organization (NHPCO) Patient/Family Satisfaction Survey, or a similar survey, with its patients and families.
 - 1. Each hospice must report results from survey questions that inquire about the following areas of concern:
 - a. Did the patient receive the right amount of medicine for his or her pain?
 - b. Based on the care the patient received, would the patient and/or family member/caregiver/legal representative/surrogate/ proxy recommend hospice services to others?
 - 2. The acceptable standard for this measure must be an affirmative response on at least fifty (50) percent of the survey responses received by the hospice.

(5) National Initiatives.

- (a) In accordance with Section 400.60501, F.S., and as referenced in subsection (4) of this rule, the department adopts the national initiative of utilizing patient/family surveys as a tool to set benchmarks for measuring quality of hospice care in the State of Florida.
- (b) The department has also considered the national initiatives that are under evaluation and development by the Centers for Medicare and Medicaid Services (CMS) located at 70 Fed. Reg., 30840-30893, dated May 27, 2005. Hospices are encouraged to utilize these guidelines, along with the initiatives developed by the National Hospice and Palliative Care Organization available at <http://www.nhpco.org>, in developing their own comprehensive data collection and performance measurement process for these initiatives.
- (c) Hospices must maintain documentary evidence of their compliance with these national initiatives and demonstrate their operations to the department or the agency during the survey process.

Specific Authority 400.605, 400.60501 FS. Law Implemented 400.605(1)(c), 400.60501 FS. History—New 5-6-82, Formerly 10A-12.05, 10A-12.005, Amended 4-27-94, Formerly 59A-2.005, Amended 6-5-97, 8-6-02, 8-10-03, 8-11-08.

Florida Administrative Rules

Certificate of Need Rules, Chapter 59C-1

59C-1.008 Certificate of Need Application Procedures.

(1) Letters of Intent and applications subject to comparative review shall be accepted in two batching cycles annually each for hospital beds and facilities and for other beds and programs, as specified in paragraph (g) of this subsection. The category “hospital beds and facilities” includes proposals for new hospital facilities, replacement hospital facilities if being replaced more than a mile away, the establishment of new neonatal level II and level III programs unless otherwise exempt pursuant to Section 408.036(3)(l), F.S., and comprehensive medical rehabilitation beds unless otherwise exempt pursuant to Section 408.036(3)(j), F.S., and except as provided in Section 408.037(2), F.S., for a general hospital. Unless otherwise directed by Section 408.037(2), F.S., general hospital applications shall conform to the schedules in this rule and will use all the applications and schedules described in paragraph (1)(f). The category “other beds and programs” includes proposals for pediatric open heart surgery, pediatric cardiac catheterization, organ transplantation, community nursing home projects, hospice programs, hospice inpatient facilities, and intermediate care facilities for the developmentally disabled.

(a) Letter of Intent. A letter of intent shall state with specificity the type of project proposed with sufficient clarity to notify the public of the intention to file a Certificate of Need application. A separate letter of intent is required for each type of project and for each type of bed or service having a separate need methodology, proposed to be located in a different planning area as defined for each program under this chapter, or licensing category, even if the projects are within the same facility. At least 30 days prior to the applicable batching cycle application due date, an applicant shall file a letter of intent respecting the development of a proposal in the following manner:

1. The letter of intent must be actually received by the agency by 5:00 p.m. local time. The original of the letter of intent must be submitted to the agency.
2. A letter of intent is for a specific project within a specific geographic planning area as defined by rule or statute for an established planning horizon. When no planning area is defined, the district should be specified.
3. A prospective applicant submitting a letter of intent is solely responsible for its conformity with any and all statutory and rule criteria.
4. If an application is not filed on or before the earliest subsequent due date for filing applications of the same type as that specified in the letter of intent, the letter of intent will be considered invalid and a new letter of intent must be timely filed in a subsequent batching cycle before an application may be filed.

(b) The contents of the letter of intent shall be consistent with Section 408.039(2)(c), F.S., and must be a written communication with an original signature. The applicant is solely responsible for the content and clarity of the letter of intent. The agency shall not assume any facts not clearly stated. Applications should be submitted with one bound copy and one unbound print copy.

(c) As to content, the letter of intent shall describe the proposal with specificity by indicating clearly and unequivocally the following information:

1. Identification of the applicant means the legal name, mailing address, and telephone number of the applicant.
 - a. If an existing health care facility or hospice seeks to undertake a project subject to a comparative review, then the legal name of the license holder must be stated and the license holder must be the applicant except when the applicant has a pending application to become the new licensee of the existing health care facility or hospice filed with the applicable licensure unit within the agency’s Bureau of Health Facility Regulation. In addition, the license number and date of expiration must be stated. It is the responsibility of the person issued a license to keep licensure information current. If agency records indicate information different from that presented in the letter of intent with respect to the identification of the holder of the license and the licensure status, then the agency records

create a rebuttable presumption as to the correctness of those records and therefore the letter of intent is not valid.

- b. If the proposal is for a project which will result in licensure of a new health care facility or hospice, the applicant seeking the certificate of need must be in existence at the time the letter of intent is submitted. If the applicant is a corporation, Limited Partnership, or otherwise organized, it must have filed an application with the Florida Department of State authorizing the applicant to conduct business in Florida.
 2. The letter of intent must identify the type of project proposed and shall contain only one project type as described in Section 408.036(1), F.S.
 3. The number of beds sought is indicated by the numerical representation of how many beds of a specific type will compose the proposed project.
 4. Services is the type of health care service sought and shall be indicated by describing the specific service requested.
 5. Location refers to the health planning subdistricts adopted in Chapter 59C-2, F.A.C., in each program rule under this chapter, or the service districts. The applicant must indicate the subdistrict by name or number. Applicants must also give the name of the county where the proposed project will be located, as provided in Chapter 59C-2, F.A.C.
- (d) Letter of Intent Deadline Extension. In order to provide for a mechanism by which applications may be filed to compete with the proposals described in filed letters of intent the following provisions apply:
1. In cases where a letter of intent for a specific type of project has been received by the agency 30 calendar days or more prior to the appropriate application filing due date as set forth in paragraph 59C-1.008(1)(g), F.A.C., and been initially accepted by the agency, a grace period shall be established.
 2. The grace period provides an opportunity for applicants applying for beds, services, or programs having the same Certificate of Need methodology or health service licensing category proposed in the initially accepted letter of intent in the same applicable subdistrict, district or region to file a proposed competing letter of intent. Under this grace period, a competing letter of intent must be filed not later than 16 days after the letter of intent deadline promulgated under paragraph 59C-1.008(1)(g), F.A.C.
 3. It shall be the sole responsibility of the agency to determine if a letter of intent is competing with any other letter of intent.
 4. The application filing due date shall not be extended for any applicant filing a letter of intent under the requirements of this paragraph.
 5. The agency shall publish notices of filing of letters of intent in the Florida Administrative Weekly in accordance with Section 408.039(2)(d), F.S.
- (e) Failure to comply with the applicable provisions of subsection (1) of this rule will result in the agency's rejecting the submitted document as a letter of intent. If rejected by the agency, the submitted document may not be amended or corrected but a new proposed letter of intent may be submitted if time allows. An application will not be accepted for review in a batching cycle for which a letter of intent has not been accepted by the agency.
- (f) Certificate of Need Application Submission.
- An application for a certificate of need shall be submitted on AHCA Forms 3150-0001, March 2009 Application For A Certificate Of Need, which includes a Cover Page, Schedules A, B, C, D, D-1, 1, 2, 3, 4, 5, 6, 6A, 7, 7A, 7B, 8, 8A, 9, 10, and 11, which are incorporated by reference herein. An application for a transfer of a certificate of need shall be submitted on AHCA Form 3150-0003, March 2009 Transfer Of A Certificate of Need which includes Schedules 1(TRN), 10(TRN), 12(TRN), B(TRN), D-1, in addition to a Cover (TRN) Page, which are incorporated by reference herein. An application for a general hospital shall be submitted on AHCA Form 3150-0002, March 2009 Application for a General Hospital Certificate of Need which includes Schedules 11, A(H), B(H), C, D(H) in addition to a Cover (H) Page, which are incorporated by reference herein. Paper copies or copies on electronic media of AHCA Form 3150-0001, March 2009 Application For A Certificate of Need, AHCA Form 3150-0002, March 2009 Application For A General Hospital Certificate of Need or AHCA Form 3150-0003, March 2009 Transfer of A Certificate of Need, and the Schedules may be obtained from:

Agency for Health Care Administration
Certificate of Need

2727 Mahan Drive, Mail Stop 28
Tallahassee, FL 32308

Electronic versions of AHCA Forms 3150-0001, 3150-0002 and 3150-0003 and the Schedules are also available at http://ahca.myflorida.com/MCHO/CON_FA/Application/index.shtml.

1. The application must be actually received by the agency by 5:00 p.m. local time on or before the application due date.
 2. Applications for projects which exceed the proposed number of beds contained in the letter of intent shall not be deemed complete for review by the agency and shall be withdrawn from further review.
 3. Applications may propose a lesser number of beds than that contained in the letter of intent.
- (g) Applications Subject to Comparative Review – Batching Cycles. In order that applications pertaining to similar types of services or facilities affecting the same service district or subdistrict may be considered in relation to each other for purposes of comparative review, letters of intent and applications shall be received by the agency no later than dates prescribed in the following schedule:

Hospital Beds and Facilities
2nd Batching Cycle – 2011

Summary Need Projections Published in F.A.W.	7-22-11
Letter of Intent Deadline	8-08-11
Application Deadline	9-07-11
Completeness Review Deadline	9-14-11
Application Omissions Deadline	10-12-11
Agency Initial Decision Deadline	12-09-11

Hospital Beds and Facilities
1st Batching Cycle – 2012

Summary Need Projections Published in F.A.W.	1-20-12
Letter of Intent Deadline	2-06-12
Application Deadline	3-07-12
Completeness Review Deadline	3-14-12
Application Omissions Deadline	4-11-12
Agency Initial Decision Deadline	6-08-12

Hospital Beds and Facilities
2nd Batching Cycle – 2012

Summary Need Projections Published in F.A.W.	7-20-12
Letter of Intent Deadline	8-06-12
Application Deadline	9-05-12
Completeness Review Deadline	9-12-12
Application Omissions Deadline	10-10-12
Agency Initial Decision Deadline	12-07-12

Hospital Beds and Facilities
1st Batching Cycle – 2013

Summary Need Projections Published in F.A.W.	1-18-13
Letter of Intent Deadline	2-04-13
Application Deadline	3-06-13
Completeness Review Deadline	3-13-13
Application Omissions Deadline	4-10-13
Agency Initial Decision Deadline	6-07-13

Hospital Beds and Facilities
2nd Batching Cycle – 2013

Summary Need Projections Published in F.A.W.	7-19-13
Letter of Intent Deadline	8-05-13
Application Deadline	9-04-13
Completeness Review Deadline	9-11-13
Application Omissions Deadline	10-09-13
Agency Initial Decision Deadline	12-06-13

Other Beds and Programs
1st Batching Cycle – 2011

Summary Need Projections Published in F.A.W.	4-01-11
Letter of Intent Deadline	4-18-11
Application Deadline	5-18-11
Completeness Review Deadline	5-25-11
Application Omissions Deadline	6-22-11
Agency Initial Decision Deadline	8-19-11

Other Beds and Programs
2nd Batching Cycle – 2011

Summary Need Projections Published in F.A.W.	9-30-11
Letter of Intent Deadline	10-17-11
Application Deadline	11-16-11
Completeness Review Deadline	11-23-11
Application Omissions Deadline	12-21-11
Agency Initial Decision Deadline	2-17-12

Other Beds and Programs
1st Batching Cycle – 2012

Summary Need Projections Published in F.A.W.	3-30-12
Letter of Intent Deadline	4-16-12
Application Deadline	5-16-12
Completeness Review Deadline	5-23-12
Application Omissions Deadline	6-20-12
Agency Initial Decision Deadline	8-17-12

Other Beds and Programs
2nd Batching Cycle – 2012

Summary Need Projections Published in F.A.W.	9-28-12
Letter of Intent Deadline	10-15-12
Application Deadline	11-14-12
Completeness Review Deadline	11-21-12
Application Omissions Deadline	12-19-12
Agency Initial Decision Deadline	2-15-13

Other Beds and Programs
1st Batching Cycle – 2013

Summary Need Projections Published in F.A.W.	3-29-13
Letter of Intent Deadline	4-15-13
Application Deadline	5-15-13
Completeness Review Deadline	5-22-13
Application Omissions Deadline	6-19-13
Agency Initial Decision Deadline	8-16-13

Other Beds and Programs
2nd Batching Cycle – 2013

Summary Need Projections Published in F.A.W.	9-27-13
Letter of Intent Deadline	10-14-13
Application Deadline	11-13-13
Completeness Review Deadline	11-20-
13	
Application Omissions Deadline	12-18-
13	
Agency Initial Decision Deadline	2-14-14

- (h) An applicant for a project subject to Certificate of Need review which affects an existing licensed health care facility, an existing licensed hospice, or an existing licensed intermediate care facility for the developmentally disabled must be the license holder. The legal name of the license holder must be stated. In addition, the license number and date of expiration must be stated. It is the responsibility of the person issued a license to keep licensure information current. If agency records indicate information different from that presented in the letter of intent with respect to the identification of the holder of the license and the licensure status, then the agency records create a rebuttable presumption as to the correctness of those records and therefore the application will be rejected.
- (i) The applicant for a project shall not change from the time a letter of intent is filed, or from the time an application is filed in the case of an expedited review project, through the time of the actual issuance of a Certificate of Need. Properly executed corporate mergers or changes in the corporate name are not a change in the applicant.

(2) Fixed Need Pools.

(a) Publication of Fixed Need Pools.

1. The agency shall publish in the Florida Administrative Weekly at least 15 days prior to the letter of intent deadline for a particular batching cycle the fixed need pools for the applicable planning horizon specified for each service in applicable agency rules contained in Rules 59C-1.031 to 59C-1.044, F.A.C.
2. Any person who identifies an error in the fixed need pool numbers must advise the agency of the error within 10 days of the date the fixed need pool was published in the Florida Administrative Weekly. If the agency concurs in the error, the fixed need pool number will be adjusted and republished in the first available edition of the Florida Administrative Weekly. Failure to notify the agency of the error during this time period will result in no adjustment to the fixed need pool number for that batching cycle.
3. Except as provided in subparagraph 2. above, the batching cycle specific fixed need pools shall not be changed or adjusted in the future regardless of any future changes in need methodologies, population estimates, bed inventories, or other factors which would lead to different projections of need, if retroactively applied.

(b) Counting Beds and Services. For the purpose of establishing a fixed need pool, all existing and approved beds at the time the fixed need pool is computed will be included in the beds or services inventory. If a specific substantive rule addresses the date upon which existing and approved beds and services will be counted, those rules will take precedence over this rule. In all other cases:

1. Beds and services will be counted as approved on the date a Certificate of Need is issued or a written decision of intent to award a Certificate of Need is made, whichever occurs first.
2. Beds or services initially denied by the agency and subsequently granted in administrative hearing or by stipulated agreement will be counted as approved when the final order granting them is rendered. No beds or services previously denied will be included in the inventory based on a recommended order.

(c) Deleting Beds or Services. Beds or services will be included in the inventory as long as there is a valid intent to grant or a valid certificate of need outstanding. Beds or services will not be deleted from the inventory until an intent to grant is overturned in a final order or judicial review of the final order. Beds or services will not be deleted from the inventory until a Certificate of Need is rescinded, revoked, modified, voided, or voluntarily surrendered by an applicant. Licensed beds and services will be deleted when the license is no longer in effect. The effective date for the deletion will be the date the license was

voluntarily surrendered by the license holder, the date of final agency action in the case of a final order or the date of a court order if a final order is appealed.

- (d) The agency will follow these procedures when awarding beds or services identified in a fixed need pool:
1. Beds or services will be awarded based on the availability of a qualified applicant and proposed project which meets statutory review criteria.
 2. In the absence of a qualified applicant and a project which meets statutory review criteria, the agency may elect not to approve any applications for beds or services.
 3. If a qualified applicant exists but the proposed project exceeds the beds or services identified in the fixed need pool, the agency may award beds or services in excess of the pool when warranted by special circumstances as defined in the applicable section of Chapter 59C-1, F.A.C., for the particular type of bed or service.
- (e) Comparative Review. Applications submitted to the agency in the same batching cycle for the same service or beds having the same Certificate of Need methodology in the same district or subdistrict, as defined in applicable rules, shall be comparatively reviewed through final agency action against the same fixed need pools in existence at the initial review. The fixed need pools and other relevant planning information shall be used by the agency to review the application against all applicable statutory review criteria contained in Section 408.035, F.S., and applicable rules, and policies. If an agency need methodology does not exist for the proposed project:
1. The agency will provide to the applicant, if one exists, any policy upon which to determine need for the proposed beds or service. The applicant is not precluded from using other methodologies to compare and contrast with the agency policy.
 2. If no agency policy exists, the applicant will be responsible for demonstrating need through a needs assessment methodology which must include, at a minimum, consideration of the following topics, except where they are inconsistent with the applicable statutory or rule criteria:
 - a. Population demographics and dynamics;
 - b. Availability, utilization and quality of like services in the district, subdistrict or both;
 - c. Medical treatment trends; and
 - d. Market conditions.
 3. The existence of unmet need will not be based solely on the absence of a health service, health care facility, or beds in the district, subdistrict, region or proposed service area.
- (3) Filing Fees. Certificate of need applications shall not be accepted by the agency at the time of filing unless accompanied by the minimum base certificate of need application filing fee in accordance with Section 408.038, F.S. The minimum base fee shall be \$10,000. In addition to the base fee of \$10,000, the fee shall be 0.015 of each dollar of the proposed expenditure, except that no fee shall exceed \$50,000.
- (a) For the sole purpose of calculating the application fee, the proposed expenditure includes only the items of cost contributing to the capital expenditures of the proposed project. An application filing fee is non-refundable, unless the application is not accepted by the agency; or unless an accepted application is deemed incomplete and withdrawn by the agency as a result of the omissions review, and the withdrawal is not challenged by the applicant, in which case all but the \$10,000 base fee shall be refunded. No fees shall be refunded for applications deemed complete by the agency but subsequently voluntarily withdrawn by the applicant, or for applications deemed incomplete as a result of a legal challenge.
- (b) The agency will review the application to determine if the fee is correct.
1. If the check for an application is insufficient to cover the fee, the agency staff will notify the applicant in the omissions request letter.
 2. If the correct fee is not received by the agency staff by the close of business on the promulgated applicant omissions deadline, the application will be deemed incomplete and deemed withdrawn from further review.
 3. If the check was for more than the correct amount, the agency staff will process a request for a refund to be returned to the applicant with a letter explaining the refunded amount.
- (c) Checks that are returned by the bank for insufficient funds will be received by the agency staff.
1. For an expedited review application, the agency or designee will send the check back to the applicant, stating that the application is incomplete due to failure to pay the Certificate of Need filing fee and that, until the appropriate fee is received, the application cannot be further processed. Notification to the applicant will also state that a service charge of \$10 or 5% of the face amount of the check, whichever is less, must be added to the amount due pursuant to Section

832.07, F.S. The application will be returned to the applicant if the correct fee is not received thirty days from the date of the letter informing the applicant of the insufficient fee.

2. For a batched review application, the agency or designee will send the applicant a letter returning the check along with the application, and advising the applicant that the application is incomplete and is deemed withdrawn from review.

(4) Certificate of Need Application Contents. An application for a certificate of need shall contain the following items:

(a) All requirements set forth in Sections 408.037(1), (2) and (3), F.S.;

(b) The correct application fee;

(c) With respect to Section 408.037(1)(c), F.S., which requires an audited financial statement of the applicant the following provisions apply:

1. The audited financial statement of the applicant must be for the most current fiscal year. If the most recent fiscal year ended within 120 days prior to the application filing deadline and the audited financial statements are not yet available, then the prior fiscal year will be considered the most recent.

2. Existing health care facilities must provide audited financial statements for the two most recent consecutive fiscal years in accordance with subparagraph 1. above.

3. Only audited financial statements of the applicant will be accepted. Audited financial statements of any part of the applicant, including but not limited to subsidiaries, divisions, specific facilities or cost centers, will not qualify as an audit of the applicant. Nor shall the audited financial statements of the applicant's parent corporation qualify as an audit of the applicant.

(d) To comply with Section 408.037(1)(b)1., F.S., which requires a listing of all capital projects, the applicant shall provide the total approximate amount of anticipated expenditures for capital projects which meet the definition in subsection 59C-1.002(7), F.A.C., at the time of initial application submission, or state that there are none. An itemized list or grouping of capital projects is not required, although an applicant may choose to itemize or group its capital projects. The applicant shall also indicate the actual or proposed financial commitment to those projects, and include an assessment of the impact of those projects on the applicant's ability to provide the proposed project; and

(e) Responses to applicable questions contained in the application forms.

(5) Identifiable Portions. If an applicant would like to be considered for an award of an identifiable portion of the project, the application, at the time of submission, must include responses to the applicable questions on the identifiable portion. The agency may make a partial award only if the applicant included responses to the applicable questions in the application.

Rulemaking Authority 408.034(6), 408.15(8) FS. Law Implemented 408.033, 408.034, 408.036(2), 408.037, 408.038, 408.039, 408.042 FS. History—New 1-1-77, Amended 11-1-77, 9-1-78, 6-5-79, 2-1-81, 4-1-82, 7-29-82, 9-6-84, Formerly 10-5.08, Amended 11-24-86, 3-2-87, 6-11-87, 11-17-87, 3-23-88, 5-30-90, 12-20-90, 1-31-91, 9-9-91, 5-12-92, 7-1-92, 8-9-92, Formerly 10-5.008, Amended 4-19-93, 6-23-94, 10-12-94, 10-18-95, 2-12-96, 7-18-96, 9-16-96, 11-4-97, 7-21-98, 12-12-00, 4-2-01, 1-10-02, 6-26-03, 12-13-04, 9-28-05, 10-9-07, 4-21-10, 2-13-12.