



State of Tennessee

Health Services and Development Agency

Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243

www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

Name

Street or Route

County

City

State

Zip Code

Website address: _____

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. Contact Person Available for Responses to Questions

Name

Title

Company Name

Email address

Street or Route

City

State

Zip Code

Association with Owner

Phone Number

Fax Number

NOTE: **Section A** is intended to give the applicant an opportunity to describe the project. **Section B** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care.

Please answer all questions on **8½" X 11" white paper, clearly typed and spaced, single-sided, in order and sequentially numbered. In answering, please type the question and the response.** All questions must be answered. If an item does not apply, please indicate "N/A" (not applicable). **Attach appropriate documentation as an Appendix at the end of the**

application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed affidavit.

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

- 1) Description – Address the establishment of a health care institution, initiation of health services, the acquisition of major medical equipment, construction/renovation, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;
- 2) Ownership structure;
- 3) Service area;
- 4) Existing similar service providers;
- 5) Project cost;
- 6) Funding;
- 7) Financial Feasibility including when the proposal will realize a positive financial margin; and
- 8) Staffing.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please address the following:

- 1) Need;
- 2) Economic Feasibility; and
- 3) Orderly Development to adequate and effective health care.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

Note: A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

SECTION A: PROJECT DETAILS

4A. Owner of the Facility, Agency or Institution

_____		_____
Name		Phone Number
_____		_____
Street or Route		County
_____	_____	_____
City	State	Zip Code
Website address: _____		

4B. Type of Ownership of Control (Check One)

- | | |
|---------------------------------------|---|
| A. Sole Proprietorship _____ | F. Government (State of TN _____
or Political Subdivision) |
| B. Partnership _____ | G. Joint Venture _____ |
| C. Limited Partnership _____ | H. Limited Liability Company _____ |
| D. Corporation (For Profit) _____ | I. Other (Specify) _____ |
| E. Corporation (Not-for-Profit) _____ | _____ |

*Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at <https://tnbear.tn.gov/ECommerce/FilingSearch.aspx>. **Attachment Section A-4A.***

Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership (direct or indirect) interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, § 68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified. **Attachment Section A-4B**

5A. Name of Management/Operating Entity (If Applicable)

Name

Street or Route

County

City

State

Zip Code

Website address: _____

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract. Attachment Section A-5A.

5B. Briefly describe the management company's experience with similar projects and identify similar facilities currently being managed. Attachment Section A-5B.

5C. Briefly describe the management company's ownership structure/interest, if any, with the applicant. Attachment Section A-5C.

6A. Legal Interest in the Site of the Institution (Check One)

- A. Ownership _____ D. Option to Lease _____
B. Option to Purchase _____ E. Other (Specify) _____
C. Lease of _____ Years _____

Check appropriate line above: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements **must include** anticipated purchase price. Lease/Option to Lease Agreements **must include** the actual/anticipated term of the agreement **and** actual/anticipated lease expense. The legal interests described herein **must be valid** on the date of the Agency's consideration of the certificate of need application.

6B. Attach a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site on an 8 1/2" x 11" sheet of white paper, single-sided. DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.

(1) Plot Plan **must include**:

- a. Size of site (***in acres***);
- b. Location of structure on the site;
- c. Location of the proposed construction/renovation; and

d. Names of streets, roads or highway that cross or border the site.

- (2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc.
- (3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

7. Type of Institution (Check as appropriate--more than one response may apply)

- | | | | |
|---|-------|--|-------|
| A. Hospital (Specify) _____ | _____ | I. Nursing Home | _____ |
| B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty | _____ | J. Outpatient Diagnostic Center | _____ |
| C. ASTC, Single Specialty | _____ | K. Rehabilitation Facility | _____ |
| D. Home Health Agency | _____ | L. Residential Hospice | _____ |
| E. Hospice | _____ | M. Nonresidential Substitution-Based Treatment Center for Opiate Addiction | _____ |
| F. Mental Health Hospital | _____ | N. Birthing Center | _____ |
| G. Intellectual Disability Institutional Habilitation Facility | _____ | O. Other Outpatient Facility | _____ |
| H. (IDIHF) (ICF/ID formerly ICF/MR) | _____ | P. Other (Specify) _____ | _____ |

Check appropriate lines(s).

8. Purpose of Review (Check appropriate lines(s) – more than one response may apply)

- | | | | |
|--|-------|---|-------|
| A. New Institution | _____ | G. Change in Bed Complement | _____ |
| B. Replacement/Existing Facility | _____ | [Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation] | |
| C. Modification/Existing Facility | _____ | H. Change of Location | _____ |
| D. Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify) _____ | _____ | I. Other (Specify) _____ | _____ |
| E. Discontinuance of OB Services | _____ | | |
| F. Acquisition of Equipment | _____ | | |

9. Medicaid/TennCare, Medicare Participation

MCO Contracts [Check all that apply]

___AmeriGroup ___United Healthcare Community Plan ___BlueCare ___TennCare Select

Medicare Provider Number _____

Medicaid Provider Number _____

Certification Type _____

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare ___Yes ___No ___N/A **Medicaid/TennCare** ___Yes ___No ___N/A

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

	<u>Current Licensed</u>	<u>Beds Staffed</u>	<u>Beds Proposed</u>	<u>TOTAL Beds at Completion</u>	<u>*Beds Approved</u>
1) Medical	_____	_____	_____	_____	_____
2) Surgical	_____	_____	_____	_____	_____
3) ICU/CCU	_____	_____	_____	_____	_____
4) Obstetrical	_____	_____	_____	_____	_____
5) NICU	_____	_____	_____	_____	_____
6) Pediatric	_____	_____	_____	_____	_____
7) Adult Psychiatric	_____	_____	_____	_____	_____
8) Geriatric Psychiatric	_____	_____	_____	_____	_____
9) Child/Adolescent Psychiatric	_____	_____	_____	_____	_____
10) Rehabilitation	_____	_____	_____	_____	_____
11) Adult Chemical Dependency	_____	_____	_____	_____	_____
12) Child/Adolescent Chemical Dependency	_____	_____	_____	_____	_____
13) Long-Term Care Hospital	_____	_____	_____	_____	_____
14) Swing Beds	_____	_____	_____	_____	_____
15) Nursing Home – SNF (Medicare only)	_____	_____	_____	_____	_____
16) Nursing Home – NF (Medicaid only)	_____	_____	_____	_____	_____
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)	_____	_____	_____	_____	_____
18) Nursing Home – Licensed (non-certified)	_____	_____	_____	_____	_____
19) IDIHF	_____	_____	_____	_____	_____
20) Residential Hospice	_____	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____	_____

**Beds approved but not yet in service*

B. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

<u>CON Number(s)</u>	<u>CON Expiration Date</u>	<u>Total Licensed Beds Approved</u>	<u>No. Licensed Beds Added That Are Associated with Other Projects Before This Project Completion</u>	<u>Unimplemented Beds Associated with Other Projects after This Project Completion</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

C. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. Attachment Section A-10.

11. Home Health Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lauderdale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedford	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lawrence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lewis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bledsoe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lincoln	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loudon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bradley	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	McMinn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campbell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	McNairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carroll	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Madison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheatham	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marshall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chester	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Claiborne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monroe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Montgomery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crockett	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morgan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cumberland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Davidson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decatur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DeKalb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pickett	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dickson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Putnam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fayette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Roane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Franklin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Robertson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gibson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rutherford	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scott	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grainger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sequatchie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sevier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grundy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shelby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hamblen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smith	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hamilton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stewart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hancock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sullivan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hardeman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sumner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hardin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tipton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hawkins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trousdale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haywood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unicoi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Henderson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Union	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Henry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Van Buren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hickman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Warren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Houston	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Washington	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Humphreys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wayne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jackson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakley	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jefferson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	White	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Johnson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Williamson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wilson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

13. Medical Equipment

Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of \$2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

A. Complete the chart below for acquired equipment.

<input type="checkbox"/> Linear Accelerator	Mev _____	Types:	<input type="checkbox"/> SRS <input type="checkbox"/> IMRT <input type="checkbox"/> IGRT <input type="checkbox"/> Other _____ <input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) ____ <input type="checkbox"/> If not new, how old? (yrs) _____
	Total Cost*:		<input type="checkbox"/> New <input type="checkbox"/> Refurbished
<input type="checkbox"/> Lithotripter	<input type="checkbox"/> Fixed <input type="checkbox"/> Mobile/Arrive with Vendor <input type="checkbox"/> Mobile/Stored On Site		<input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) ____ <input type="checkbox"/> If not new, how old? (yrs) _____
	Total Cost*:		<input type="checkbox"/> New <input type="checkbox"/> Refurbished
<input type="checkbox"/> MRI	Tesla: _____	Magnet:	<input type="checkbox"/> Breast <input type="checkbox"/> Extremity <input type="checkbox"/> Open <input type="checkbox"/> Short Bore <input type="checkbox"/> Other _____ <input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) ____ <input type="checkbox"/> If not new, how old? (yrs) _____
	Total Cost*:		<input type="checkbox"/> New <input type="checkbox"/> Refurbished
<input type="checkbox"/> PET	<input type="checkbox"/> PET only <input type="checkbox"/> PET/CT <input type="checkbox"/> PET/MRI		<input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) ____ <input type="checkbox"/> If not new, how old? (yrs) _____
	Total Cost*:		<input type="checkbox"/> New <input type="checkbox"/> Refurbished
<input type="checkbox"/> Other	_____		<input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) ____ <input type="checkbox"/> If not new, how old? (yrs) _____
	Total Cost*:		<input type="checkbox"/> New <input type="checkbox"/> Refurbished

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

D. Schedule of Operations:

Location	Days of Operation (Sunday through Saturday)	Hours of Operation (example: 8 am – 3 pm)
Fixed Site (Applicant)	_____	_____
Mobile Locations (Applicant)		
(Name of Other Location)	_____	_____
(Name of Other Location)	_____	_____
(Name of Other Location)	_____	_____
(Name of Other Location)	_____	_____

E. Identify the clinical applications to be provided that apply to the project.

F. Documentation of FDA approval.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), “no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care.” The three (3) criteria are further defined in Agency Rule 0720-411-.01. Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the three criteria: (1) Need, (2) Economic Feasibility, and (3) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2” x 11” white paper, single-sided. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. **If a question does not apply to your project, indicate “Not Applicable (NA).”**

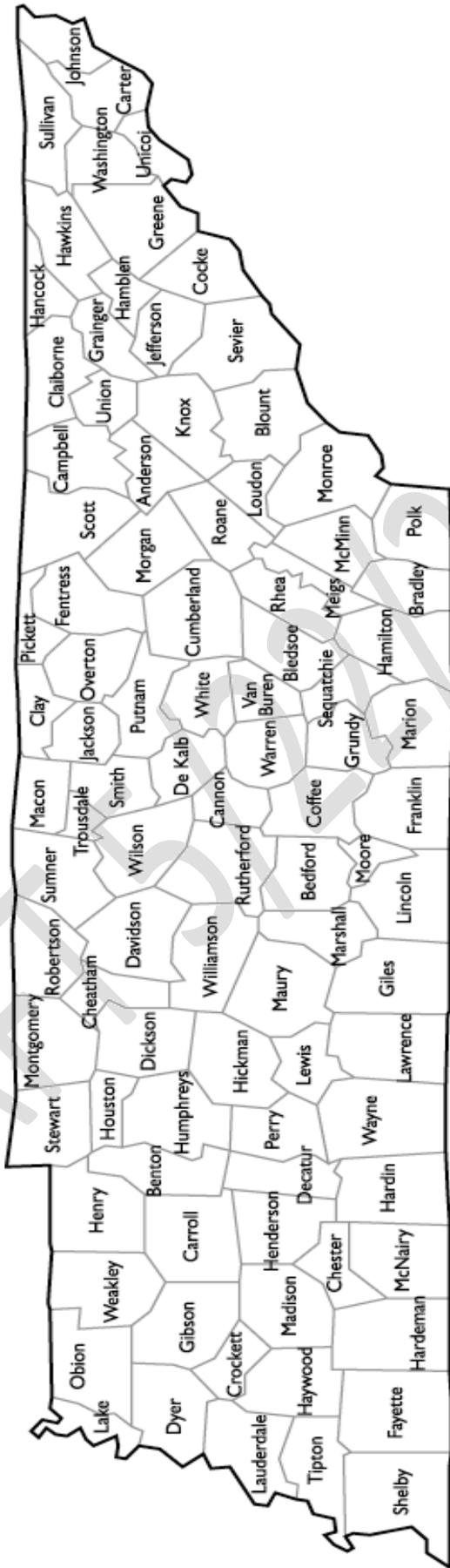
QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at www.tennessee.gov/hsda/con_standards.shtml. Do not provide responses to General Criteria and Standards here. **Attachment – Section B – Need-1.**
2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects. **Attachment – Section B – Need-2.**
3. A. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment – Section B – Need-3.**
3. B. Please complete the following table:

Service Area Counties	Historical Utilization-County Residents	Projected Utilization-County Residents	% of total projected procedures
County #1			
County #2			
Etc.			
Total			100%

County Level Map



4. A. 1) Describe the demographics of the population to be served by the proposal.
- 2) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Demographic Variable/Geographic Area	Total Population-Current Year	Total Population-Projected Year	Total Population-% change	*Target Population-Current Year	*Target Population-Projected Year	Target Population-% change	Target Population-Projected Year as % of Total	Median Age	Median Household Income	TennCare Enrollees	TennCare Enrollees as % of Total	Persons Below Poverty Level	Persons Below Poverty Level as % of Total
County A													
County B, etc.													
Service Area Total													
State of TN Total													

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2015, then default Projected Year is 2019.*

- D. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.
5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.
6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.
 - A. All projects should have a project cost of at least \$3,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)
 - B. The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
 - C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
 - D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.
 - E. For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:
 - 1) A general description of the project;
 - 2) An estimate of the cost to construct the project; and
 - 3) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

PROJECT COST CHART

A. Construction and equipment acquired by purchase:

1. Architectural and Engineering Fees _____
2. Legal, Administrative (Excluding CON Filing Fee),
Consultant Fees _____
3. Acquisition of Site _____
4. Preparation of Site _____
5. Total Construction Costs _____
6. Contingency Fund _____
7. Fixed Equipment (Not included in Construction Contract) _____
8. Moveable Equipment (List all equipment over \$50,000 as
separate attachments) _____
9. Other (Specify) _____

B. Acquisition by gift, donation, or lease:

1. Facility (inclusive of building and land) _____
2. Building only _____
3. Land only _____
4. Equipment (Specify) _____
5. Other (Specify) _____

C. Financing Costs and Fees:

1. Interim Financing _____
2. Underwriting Costs _____
3. Reserve for One Year's Debt Service _____
4. Other (Specify) _____

D. Estimated Project Cost (A+B+C) _____

E. CON Filing Fee _____

F. Total Estimated Project Cost (D+E) _____

TOTAL _____

2. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. **(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)**

- A. Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
 - B. Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
 - C. General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;
 - D. Grants – Notification of intent form for grant application or notice of grant award;
 - E. Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or
 - F. Other – Identify and document funding from all other sources.
3. Complete Historical Data Charts on the following two pages—**Do not modify the Charts provided or submit Chart substitutions!**

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable.

Note that “Management Fees to Affiliates” should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. “Management Fees to Non-Affiliates” should include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services that have been consolidated/centralized for the subsidiaries of a parent company, e.g., fees for financial, human resources, information technology, legal, managed care, planning and marketing, quality assurance services.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

	Year _____	Year _____	Year _____
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	\$ _____	\$ _____	\$ _____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue (Specify) _____	_____	_____	_____
Gross Operating Revenue	\$ _____	\$ _____	\$ _____
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	\$ _____	\$ _____	\$ _____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	\$ _____	\$ _____	\$ _____
NET OPERATING REVENUE	\$ _____	\$ _____	\$ _____
D. Operating Expenses			
1. Salaries and Wages	\$ _____	\$ _____	\$ _____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Rent	_____	_____	_____
5. Management Fees:			
a. Fees to Affiliates	_____	_____	_____
b. Fees to Non-Affiliates	_____	_____	_____
6. Other Operating Expenses	_____	_____	_____
Total Operating Expenses	\$ _____	\$ _____	\$ _____
E. Earnings Before Interest, Taxes and Depreciation, and Capital Expenditures	\$ _____	\$ _____	\$ _____
F. Non-Operating Expenses			
1. Taxes	\$ _____	\$ _____	\$ _____
2. Depreciation	_____	_____	_____
3. Interest other than capital	_____	_____	_____
4. Other Non-Operating Expenses	_____	_____	_____
Total Non-Operating Expenses	\$ _____	\$ _____	\$ _____
NET OPERATING INCOME (LOSS)	\$ _____	\$ _____	\$ _____
G. Capital Expenditures			
1. Retirement of Principal	\$ _____	\$ _____	\$ _____
2. Interest	_____	_____	_____
Total Capital Expenditures	\$ _____	\$ _____	\$ _____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	\$ _____	\$ _____	\$ _____

- Total Facility
- Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

<u>OTHER EXPENSES CATEGORIES</u>	Year _____	Year _____	Year _____
1. _____	\$ _____	\$ _____	\$ _____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
Total Other Expenses	\$ _____	\$ _____	\$ _____

4. Complete Projected Data Charts on the following two pages – **Do not modify the Charts provided or submit Chart substitutions!**

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the **Proposal Only** (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services that have been consolidated/centralized for the subsidiaries of a parent company, e.g., fees for financial, human resources, information technology, legal, managed care, planning and marketing, quality assurance services.

- Total Facility
 Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

	Year _____	Year _____
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	_____	_____
B. Revenue from Services to Patients		
1. Inpatient Services	\$ _____	\$ _____
2. Outpatient Services	_____	_____
3. Emergency Services	_____	_____
4. Other Operating Revenue (Specify) _____	_____	_____
	Gross Operating Revenue \$ _____	\$ _____
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	\$ _____	\$ _____
2. Provision for Charity Care	_____	_____
3. Provisions for Bad Debt	_____	_____
	Total Deductions \$ _____	\$ _____
NET OPERATING REVENUE	\$ _____	\$ _____
D. Operating Expenses		
1. Salaries and Wages	\$ _____	\$ _____
2. Physician's Salaries and Wages	_____	_____
3. Supplies	_____	_____
4. Rent	_____	_____
5. Management Fees:		
a. Fees to Affiliates	_____	_____
b. Fees to Non-Affiliates	_____	_____
6. Other Operating Expenses	_____	_____
	Total Operating Expenses \$ _____	\$ _____
E. Earnings Before Interest, Taxes and Depreciation, and Capital Expenditures.	\$ _____	\$ _____
F. Non-Operating Expenses		
1. Taxes	_____	_____
2. Depreciation	_____	_____
3. Interest other than capital	_____	_____
4. Other Non-Operating Expenses	_____	_____
	Total Non-Operating Expenses \$ _____	\$ _____
NET OPERATING INCOME (LOSS)	\$ _____	\$ _____
F. Capital Expenditures		
1. Retirement of Principal	\$ _____	\$ _____
2. Interest	_____	_____
	Total Capital Expenditures \$ _____	\$ _____
NET OPERATING INCOME (LOSS)		
LESS CAPITAL EXPENDITURES	\$ _____	\$ _____

Total Facility

Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

Total Other Expenses

Year _____ Year _____

\$ _____ \$ _____

\$ _____ \$ _____

DRAFT 5/22/2015

5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge (<i>Gross Operating Revenue/Utilization Data</i>)					
Deduction from Revenue (<i>Total Deductions/Utilization Data</i>)					
Average Net Charge (<i>Net Operating Revenue/Utilization Data</i>)					

- B. Provide the proposed charge schedules for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.
- C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties involved with the project. **Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility.**

- B. Using the applicant's financial statements and/or the financial statements of the entity(ies) that will be funding the proposed project, please complete the following tables by identifying the applicant's current ratio, operating margin, long-term debt to capitalization, and days cash on hand. Please also briefly describe how each measure compares to generally recognized health industry standards.

Current Ratio

Evaluates the applicant's ability to meet its current liabilities with its current assets.	Current Assets	Current Liabilities	Current Ratio
Current Ratio Formula: (Current Assets ÷ Current Liabilities)	\$	\$	

Operating Margin Ratio

Operating margin ratio demonstrates how much revenues are left over after all the variable or operating costs have been paid.	Net Operating Revenue	Total Revenue	Operating Margin Ratio
Operating Margin Ratio Formula: (Net Operating income ÷ Total Revenue)	\$	\$	

Capitalization (long-term debt to capitalization) ratio

Measures the proportion of debt financing in a business's permanent (long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions.	Long-Term Debt	Total Equity (Net Assets)	Capitalization Ratio
Capitalization Ratio Formula: $(\text{Long-term debt} \div (\text{Long-term debt} + \text{Total equity (net assets)}) \times 100)$	\$	\$	

Days cash on hand

Measures the number of days that the organization could continue to pay its average daily cash obligations with no new cash resources becoming available.	Cash	Short-term Investments	Total Expenses	Depreciation	Days cash on hand
Days Cash on Hand Formula: $\text{Cash} + \text{Short-term Investments} \div (\text{Total expenses} - \text{Depreciation}) \div 365$	\$	\$	\$	\$	

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care		
TennCare/Medicaid		
Commercial/Other Managed Care		
Self-Pay		
Charity Care		
Other		
Total		

8. Complete the following chart that will detail the extent the applicant will serve the indigent.

Year One					
A	B	C	D	E	F
Utilization Data Unit of Measure from line A. of the Projected Data Chart (days, cases, procedures, etc.)	Total Units	Total Gross Charges	Charge per Unit of Measure (C/B)	Total \$ Budgeted for Charity Care	Number of units provided for Charity Care (E/D)
Total					
Year Two					
A	B	C	D	E	F
Utilization Data Unit of Measure from line A. of the Projected Data Chart (days, cases, procedures, etc.)	Total Units	Total Gross Charges	Charge per Unit of Measure (C/B)	Total \$ Budgeted for Charity Care	Number of units provided for Charity Care (E/D)
Total					

9. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Position Title	Existing FTEs (enter year)	Projected FTEs Year 1	Total FTEs Year 1	Average Wage	Area-wide Average Wage
Total					

10. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:
- Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.
 - Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

- List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.
- Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

B. Negative Effects

3. A. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.
- B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

4. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure:

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.):

Accreditation (i.e., Joint Commission, CARF, etc.):

- A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.
- B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.
- C. Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.
- 1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.
5. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

- A. Has any of the following:

- 1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);
 - 2) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or
 - 3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.
- B. Been subjected to any of the following:
- 1) Final Order or Judgment in a state licensure action;
 - 2) Criminal fines in cases involving a Federal or State health care offense;
 - 3) Civil monetary penalties in cases involving a Federal or State health care offense;
 - 4) Administrative monetary penalties in cases involving a Federal or State health care offense;
 - 5) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or
 - 6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.
- C. Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.
- D. Is presently subject to a corporate integrity agreement
6. If the proposal is approved, please discuss whether the applicant will provide HSDA and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required or requested.

7. Outstanding Projects:

- a. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

<u>Outstanding Projects</u>					
<u>CON Number</u>	<u>Project Name</u>	<u>Date Approved</u>	<u>*Annual Progress Report(s)</u>		<u>Expiration Date</u>
			<u>Due Date</u>	<u>Date Received</u>	

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

- b. Provide a brief description of the current progress, and status of each applicable outstanding CON.

8. Equipment Registry – For the applicant and all entities in common ownership with the applicant.:

- a. Do you own a Computed Tomography scanner (CT), Linear Accelerator, Lithotripter, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)?

- b. If yes, how many units of the following are currently owned/leased:
Linear Accelerator _____ Lithotripter _____ MRI _____ PET _____
CT _____

- c. If yes, when did you last submit your updated medical equipment registration and utilization to Health Services and Development Agency? _____

STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at <http://Health.state.tn.us/healthplanning>). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Each Principle is listed below with example questions to help the applicant in its thinking.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.
 - a. How will this proposal protect, promote, and improve the health of Tennesseans over time?
 - b. What health outcomes will be impacted and how will the applicant measure improvement in health outcomes?
 - c. How does the applicant intend to act upon available data to measure its contribution to improving health outcomes?
2. People in Tennessee should have access to health care and the conditions to achieve optimal health.
 - a. How will this proposal improve access to health care? You may want to consider geographic, insurance, use of technology, and disparity issues (including income disparity), among others.
 - b. How will this proposal improve information provided to patients and referring physicians?
 - c. How does the applicant work to improve health literacy among its patient population, including communications between patients and providers?
3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.
 - a. How will this proposal lower the cost of health care?
 - b. How will this proposal encourage economic efficiencies?
 - c. What information will be made available to the community that will encourage a competitive market for health care services?
4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.
 - a. How will this proposal help health care providers adhere to professional standards?
 - b. How will this proposal encourage continued improvement in the quality of care provided by the health and health care workforce?
5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.
 - a. How will this proposal provide employment opportunities for the health and health care workforce?
 - b. How will this proposal complement the existing Service Area workforce?

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(3) states that "...Within ten (10) days of filing an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the member(s) of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the "good cause" for such an extension.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	<u>Days Required</u>	<u>Anticipated Date</u> [Month/Year]
1. Initial HSDA decision date		
2. Architectural and engineering contract signed		
3. Construction documents approved by the Tennessee Department of Health		
4. Construction contract signed		
5. Building permit secured		
6. Site preparation completed		
7. Building construction commenced		
8. Construction 40% complete		
9. Construction 80% complete		
10. Construction 100% complete (approved for occupancy)		
11. *Issuance of License		
12. *Issuance of Service		
13. Final Architectural Certification of Payment		
14. Final Project Report Form submitted (Form HR0055)		

*For projects that **DO NOT** involve construction or renovation, complete Items 11 & 12 only.

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

AFFIDAVIT

STATE OF _____

COUNTY OF _____

_____, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this _____ day of _____, _____ a Notary
(Month) (Year)

Public in and for the County/State of _____.

NOTARY PUBLIC

My commission expires _____, _____.
(Month/Day) (Year)