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

CONTINUING NEED/QUALITY MEASURES ANNUAL REPORTING FORM
ANNUAL REVIEW FOLLOWING PROJECT COMPLETION

Project Name: _____ Certificate of Need #: _____

Date Project Completed: _____

Project Description as listed on CON:

_____

- Please compare the current staffing of the project to the staffing chart for Year 2 in the referenced CON application:

Position Classification	**FTEs (Current Year)**	**FTEs (as Projected in CON Application)**		
a) Direct Patient Care Positions				
Position 1				
Position 2				
Position "etc."				
Total Direct Patient Care Positions				
b) Non-Patient Care Positions				
Position 1				
Position 2				
Position "etc."				
Total Non-Patient Care Positions				
Total Employees (A+B)				
Contractual Staff				
Total Staff (a+b+c)				

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- Please complete the chart below that pertains to licensure, certification, and accreditation:

	Type	License/ Certification/ Accreditation		Expiration Date	Date of Last Survey
		Number	Status		
Health Care License	□ Dept. of Health □ Dept. of Mental Health & Substance Abuse Services □ Dept. of Intellectual & Developmental □ Disabilities □ Not Applicable				
Certification	□ TennCare/Medicaid □ Medicare □ Other_____				
Accreditation	Identify Whom?_____				

- Please document how this project's current year's utilization compare to projections reported in the CON application and to the State Health Plan standards, if applicable:

Actual current year utilization	**Projected Utilization Reported in CON Application**	**~~Comparison to~~ State Health Plan Standard in effect at time of CON approval (if applicable)**

- Please document how this project's current year payor mix compare to projections reported in the CON application based on gross operating revenue

Payor Source	%Total (Current Year)	% Total (As Projected in CON Application
Medicare/Medicare Managed Care		
TennCare/Medicaid		
Commercial/Other Managed Care		
Self-Pay		
Charity Care		
Other (Specify)_____		
Total		

- For each ~~applicable~~ facility/service approved in the CON ~~and,~~ please discuss whether or not the CON is in compliance with the applicable and corresponding rule listed below:

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- Freestanding emergency departments -- Agency Rules 0720---11---.01(3)(f)(1.)(i.) and 0720---11---.01(3)(q.)

- Ambulatory surgical treatment center -- Agency Rules 0720---11---.01(3)(f)(1.)(ii.), and 0720---11---.01(3)(g.)

- Comprehensive inpatient rehabilitation services -- Agency Rules 0720---11---.01(3)(f)(1.)(iii) and 0720---11---.01(3)(j.)

- Inpatient psychiatric programs -- Agency Rule 0720---11---.01(3)(f)(1.)(iii) and 0720---11---.01(3)(p.)(1.-3.)

- Megavoltage radiation therapy services -- Agency Rules 0720---11---.01(3)(f)(1.)(iv.) and 0720---11---.01(3)(m.)

- Positron emission tomography services -- Agency Rule 0720---11---.01(3)(f)(1.)(v.)

- Magnetic resonance imaging services -- Agency Rule 0720---11---.01(3)(f)(1.)(v.)

- Outpatient diagnostic centers -- Agency Rule 0720---11---.01(3)(f)(1.)(v.)

- Hospice services -- Agency Rules 0720---11---.01(3)(f)(1.)(vi and xiii) 0720---11---.01(3)(l.)

- Nonresidential substitution based treatment centers for opiate addiction -- Agency Rule 0720---11---.01(3)(f)(1.)(vii)

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- Organ transplant services -- Agency Rules 0720---11---.01(3)(f)(1.)(viii) and 0720---11---.01(3)(r.)

- Cardiac catheterization services -- Agency Rules 0720---11---.01(3)(f)(1.)(ix-x.) and 0720---11---.01(3)(h.)(1.-3.)

- Open heart surgery services -- Agency Rule 0720---11---.01(3)(i.)(1.-3.)

- Burn unit services -- Agency Rule 0720---11---.01(3)(f)(1.)(xi.)

- Home health services -- Agency Rule 0720---11---.01(3)(f)(1.)(xii.) and 0720---11---.01(3)(k.)

- Neonatal intensive care services -- Agency Rule 0720---11---.01(3)(n.)

- Nursing homes -- Agency Rules 0720---11---.01(3)(f)(1.)(xiv.) and 0720---11---.01(3)(o.)

- Relocation and/or replacement of health care institutions -- Agency Rule 0720---11---.01(3)(s.)(1. or 2.)

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_____
Name of Authorized Agent or Chief Operating Officer

_____ _____
Signature of Authorized Agent or Chief Operating Officer Date

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