Tennessee Health Facilities Commission User Guide

Community Portal

Table of Contents

Table of Contents

Registering/Logging In

Overall High-Level Process

Applicant

1

Applicant Registers for a TN HFC login.

Applicant

2

Applicant creates a new Certificate of Need Letter of Interest application

TN HFC

3

TN HFC will review and accept the application.

TN HFC

6

TN HFC will approve the Certificate of Need application

Patient

5

Applicant will provide payment and submit the application

Patient

4

Applicant will create a Certificate of Need application

Applicant

7

Applicant Can create a Relocation application

TN HFC

8

TN HFC will approve the relocation application

5

1. Click **Create Account** or **Register button**.

As a new user for the Health Facilities Commissions portal, you will need to register for an account. Follow the steps in the following slides to complete registration.

Don't have an Account ?

To create your account, use the Registration link below to fill in your information. Once finished, use your log-in credentials to access your account.

Register →

Contact Us ?

If there are any questions regarding the sign in or registration process, please contact staff at **615-741-2364** or email at **hsda.staff@tn.gov**

LOGIN

Hello there, login to the screen below

Required fields are marked with an asterisk *

* User Name ⓘ

* Password

Forgot Password?

LOGIN

or

Don't have an account? **Create Account**

2. Enter the required information.

3. Click on the Captcha checkbox.

4. Click Register.

Provide the required information, please note fields that require an asterisk *, must be completed in order to register.

REGISTER

Hello there, Register to the screen below

Required field are marked with an asterisk *

* First Name

Enter First Name

* Last Name

Enter Last Name

* Email Address

Enter Email Address

* Company Name

Enter Company Name

* Phone Number

Enter Phone Number

* Street Address

Enter Street Address

* City

Enter City

* Zip Code

Enter Zip Code

* State

Enter State

I'm not a robot — reCAPTCHA
Privacy - Terms

REGISTER

Already have an Account?

Please use the same username and password you created to sign in.

Login →

Contact Us ?

If there are any questions regarding the sign in or registration process, please contact staff at **615-741-2364** or email at **hsda.staff@tn.gov**.

Health Facilities Commission
HFC

5. Click **Back To Login**.

6. A confirmation email will be send to your listed email address

- Once you have registered, you will receive an email with your new username and a link to create a password.

- The email will be sent to the one you have added when you registered.

Health Facilities Commission
HFC

Already have an Account?

Please use the same username and password you created to sign in.

Login →

Contact Us ?

If there are any questions regarding the sign in or registration process, please contact staff at **615-741-2364** or email at **hsda.staff@tn.gov**.

REGISTER

Hello there, Register to the screen below

✓ Thank you for registering. An email has been sent to your provided email address.

BACK TO LOGIN

© 2022 HFC | All Rights Reserved   Contact Us | Privacy & Terms

8

7. Click on the link to complete your registration and set up your password.

- Notice in the email you have received a username. This username is your email + ".tnhfc"
- When you login you must provide the username provided in the email.

TN Health Facilities e-Portal via gd8jxjy9x3kuwv.bz-8hir2ai.cs234.bnc.sandb... 10:21 AM (1 minute ago)

to imran.chowdhury+1@mtxb2b.com

This is an automated email. Please do not reply to this message.

Hi Imran Chowdhury,

Welcome to TN Health Facilities e-Portal! To get started, go to https://tnhfc--uat.sandbox.my.site.com/license/login?c=xe0qM s7fENZS0axk23Qhz_QltlBmWXrdTCnLCnBBdcy3jlz0AgzgdSmzQRJtUS_YslyHlMhNhGg3ZWMjdjPCBaQMs65Bq24 pxExToHTNkyzGE2DU.Lx0PlNWjl7.dhD9bwldCLGi.ZKvdZ0kNIyU3Uqy9o1RlfA5SVU0aiQLcQs_xe29RyV_aQ2H bTigNJhMOGKr4zwml0.AK1KhQZtYSgDwlR6jgQ%3D%3D

Username: imran.chowdhury+1@mtxb2b.com.tnhfc

Reply   Reply all   Forward

8. Enter your **New Password**.

9. Confirm the new password.

10. Click **Change Password**.

Follow the guidelines in order to create your password.

11. Enter your **User Name**.

12. Enter your **Password**.

Please enter the username that was provided on the email.

LOGIN

Hello there, login to the screen below

Required fields are marked with an asterisk *

*User Name ⓘ

imran.chowdhury+1@mtxb2b.com.tnhfc

*Password

••••••••••••

Forgot Password?

LOGIN

or

Don't have an account? **Create Account**

Health Facilities Commission

HFC

Don't have an Account ?

To create your account, use the Registration link below to fill in your information. Once finished, use your log-in credentials to access your account.

Register →

Contact Us ?

If there are any questions regarding the sign in or registration process, please contact staff at **615-741-2364** or email at **hsda.staff@tn.gov**

Dashboard

Key Points

The **Dashboard** of the Health Facilities Commissions portal will be the homepage once you login. Here you will be able to start new applications, view your application information, and view your application statuses.

Click on different status to view the current letters of intents and applications.

Dashboard

1. Click on a status. (for this guide we will click on **Open Application**)

From the dashboard you can click on different status to view the current applications.

14

2. View the applications.

3. If an application is not completed click on the Edit button.

Under each application, you can perform different actions. The most common will be to download an application. You may download applications even if it is in **Draft** status.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   **New Application**

Open Applications

Dashboard > Open Applications

All applications associated with the account holder that involves unimplemented applications are listed below

Search here for applications 🔍   All ▾

APPLICATION NUMBER	PROJECT NAME	APPLICATION TYPE	CERTIFICATE NUMBER	STATUS	CREAT	Download
PAR-0000000605	-	Certificate Of Need - LOI	-	Draft	2/6/2023	Edit

1

© 2022 HFC | All Rights Reserved   Contact Us | Privacy & Terms

about:blank

15

15

Letters of Intent

Certificate of Need

1. From the **Dashboard**, click **New Application**.

2. Click the **Application Type** drop-down menu to select the type of application to begin.
3. Click **Apply.**

- This flow will focus on the **Certificate of Need** application type. The **Relocation Exemption** application will be detailed in the next section.

4. Complete all required information.

- All fields marked with an * are required.

Scott Vance

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

○ Basic Information
● Project Cost
● Attestation

Basic Information

Application Name : PAR-0000002148

* indicates required field

Please complete every requested field. Use the accompanying worksheet to assist in calculating the estimated project cost. All fields will populate similar field in the accompanying application. For general instructions, click here

*Project Name
Enter Project Name

*Street or Route
Enter Street or Route

*State
[▼]

*County
Enter County

*City
Enter City

*Zip
Enter Zip

*Facility Type
[▼]

*Owner Name
Enter Owner Name

*Ownership Type
[▼]

*Management Name
[▼]

*Project Description
Enter Project Description

*Anticipated date of publication
Enter Anticipated date of publication

*Anticipated date of submitting CoN application
Enter Anticipated date of submitting CoN application

5. Click on the drop-down arrow under the simultaneous review question.

6. Select Yes, if there is simultaneous review.

- If an application has been submitted for the same service, service area, location, or facility, you must select yes to simultaneous review.
- Once you select yes and click **Save and Next**, the application will be updated. This will mean you will have till the 16th to the end of the month to complete your application.

Certificate of Need

7. Enter the information that is revealed.

8. Answer the questions that follow.

9. Click Upload File.

If you select **No**, to any of the additional questions, you will enter an explanation to why it is marked as **No**.

22

10. Click on the upload files button.

11. Select an image or more and click open.

You can enter a document one at a time or add all of them together by selecting the files before uploading.

24
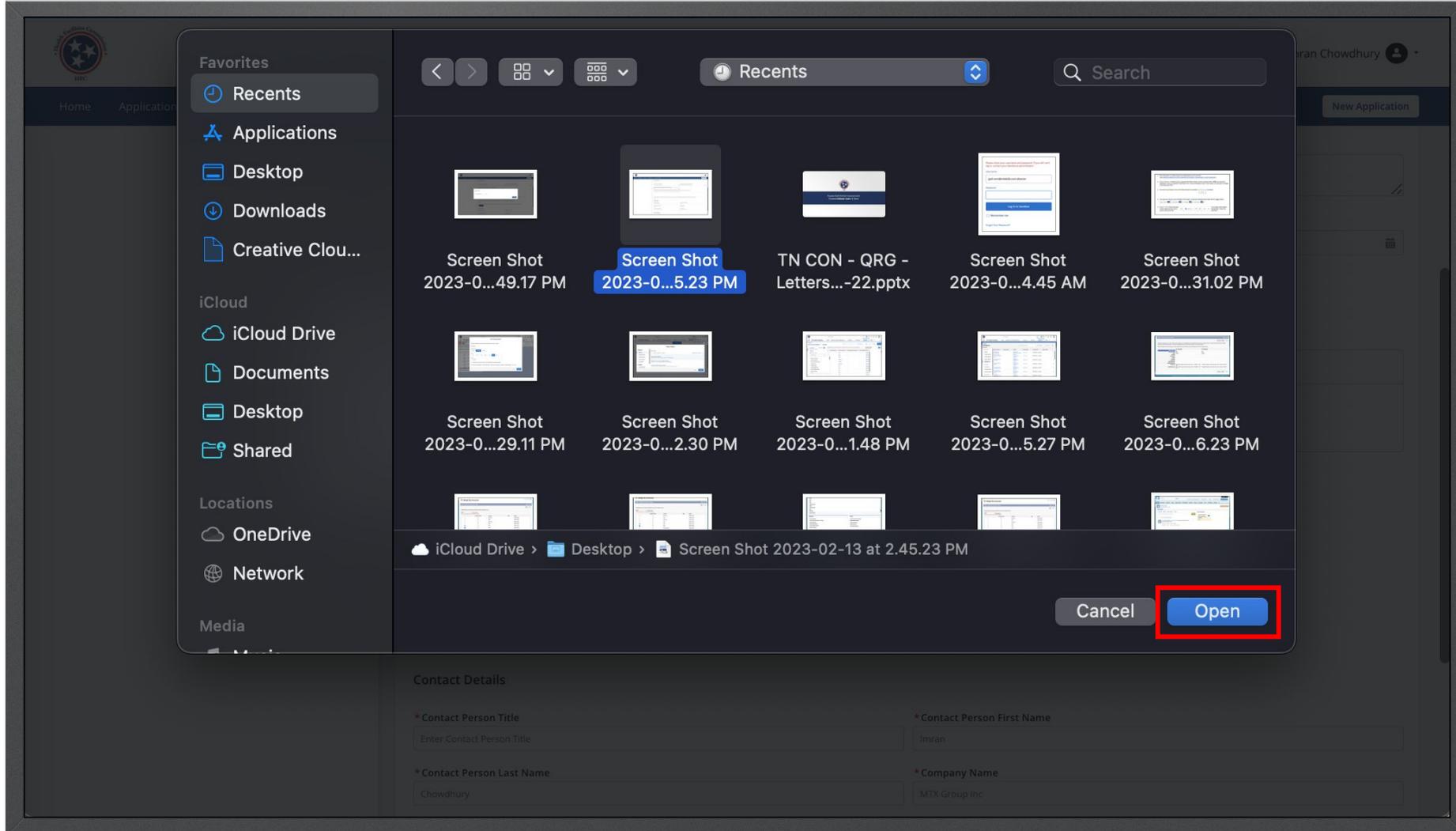
12. Click Save once you are done.

You can click on upload files to add more files.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

* Project Description

Enter Project Description

* Anticipated date of publication

Enter Anticipated date of publication

* Anticipated date of submitting CoN application

Enter Anticipated date of submitting CoN application

* Are you seeking to submit this application for Simultaneous Review?

Upload File

*

⬆ Upload Files   Or drop files

Screen Shot 2023-02-13 at 2.45.23 PM.png   🗑

0720-10-.02?

Save

* Was the Notice of Simultaneous Review received by the original applicant between the sixteenth and last day of the month of publication?
● Yes
○ No

* Please upload confirmation that the Notice was received by the original applicant between the sixteenth day and last of the month of publication by the original applicant.

Upload File

Contact Details

* Contact Person Title

Enter Contact Person Title

* Contact Person First Name

Imran

* Contact Person Last Name

Chowdhury

* Company Name

MTX Group Inc

25

13. Complete all required information.

14. Click **Save & Next**.

- All fields marked with an * are required.

Certificate of Need

15. Complete all required information.

16. There is a worksheet to help calculate market value of property and/or medical equipment related to the project. Link (The link is in section B)

Scott Vance

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

- Basic Information
- Project Cost
- Attestation

Project Cost

Application Name : PAR-0000002148

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)   Specify Construction

Total $0.00

B. Acquisition by gift, donation, or lease: (For Fair market value and lease value for land and/or equipment calculation information, click here)

27

17. Complete all required information.

18. Click **Save & Next**.

Scott Vance

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

Total	$0.00

C. Financing Costs and Fees:

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

Total	$0.00

D. Estimated Project Cost (A + B + C)	$0.00
E. CON Filing Fee	$3,000.00
F. Total Estimated Project Cost (D + E)	$3,000.00

Previous   Cancel   **Save & Next**

Contact Us | Privacy & Terms

19. Check the **attestation box.**

20. Click **Submit**.

- Your name and date will be auto-populated in the gray fields.

Scott Vance

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need

New Application

- Basic Information
- Project Cost
- Attestation

Attestation

Application Name : PAR-0000002150

* indicates required field

☐ I am the applicant or his/her/its legal agent, duly swear 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 Facilities Commission, and T.C.A. §68-11-1601, et seq., and the responses to this application or any other questions deemed appropriate by the Health Facilities Commission are true and complete.

Name
Scott Vance

Date
12-14-2022

Previous

Cancel   Submit

29

21. To return to the dashboard, click **Back To Home**.

- You can download your application file by clicking the **Download** button.

Scott Vance

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

Acknowledgement

Thank you for submitting your Letter of intent, you will be notified if you can proceed.

Download   Back To Home

30

Key Points

- Your application will appear under the **Applications Under Review** tile.

Relocation Exemption

Instructions

1. From the **Dashboard**, click **New Application** or the **Applications** tab to start new application.

2. Click the **Application Type** drop-down menu to select the type of application to begin.

3. Click **Apply.**

- This flow will focus on the **Relocation Exemption** application type. The **Certificate of Need** application was detailed in the previous section.

4. Complete all required information.

• All fields marked with an * are required.

Scott Vance

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

Basic Information   Application Name : PAR-0000002149

○ Basic Information
● Attestation

* Indicates required field

> Please complete every requested field. All fields will populate similar field in the accompanying request. For general instructions, click here

* Project Name

Enter Project Name

* Street or Route   * County

Enter Street or Route   Enter County

* City   * State

Enter City   ▾

* Zip   * Facility Type

Enter Zip   ▾

* Owner Name   * Ownership Type

Enter Owner Name   ▾

* Management Name

▾

* Relocation Description

Enter Relocation Description

* Anticipated Date of RE Filing   * Publication date

Enter Anticipated Date of RE Filing 📅   Enter Publication date 📅

Contact Details

35

5. Complete all required information.

6. Click **Save & Next**.

• All fields marked with an * are required.

Instructions

7. Check the **attestation box.**

8. Click **Submit**.

Key Points

- Your name and date will be auto-populated in the gray fields.

Scott Vance

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

✓ Basic Information
○ Attestation

Attestation

Application Name : PAR-0000002149

* Indicates required field

* ☐ I hereby declare that the information furnished above is true, complete, and correct to the best of my knowledge and belief. I understand that in the event of my information being found false or incorrect at any stage, my application shall be liable to cancellation.

Name
Scott Vance

Date
12-14-2022

Previous   Cancel   Submit

37

9. To return to the dashboard, click **Back To Home**.

- You can download your application file by clicking the **Download** button.

Relocation Exemption

- Your application will appear under the **Applications Under Review** tile.

- If you have not submitted the LOI, the application will be in the draft status. Open the Draft application from the dashboard, click on three dots and download it even before submitting to CON Director.

Prakruthi Kairamkonda

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

All Applications

All applications associated with the account holder are listed below

Dashboard > All Applications

APPLICATION NUMBER	PROJECT NAME	APPLICATION TYPE	CERTIFICATE NUMBER	STATUS	CREATED	
						Download
PAR-0000000672	Test	Certificate Of Need - LOI	-	Draft	2/14/2023	Edit ⋮

1

© 2022 HFC | All Rights Reserved

Contact Us | Privacy & Terms

about:blank

40

Certificate Of Need Application

CON Application

1. From the Dashboard, click on **All Applications**.

Find the **Certificate Of Need –LOI** application.

Click on the 3 dots under **Actions**.

43

Click on **Start CON**

To create the certificate Of Need application you do not need the LOI to be accepted. LOI must be accepted once it is time to make payments.

44

CON Application

Enter the **Website Address** of the Facility, Agency, or Institution.

Click **Save and Next**.

- You will begin the application with Facility, Agency, or Institution.
- Notice all but Website Address have been auto-populated as they were captured in the LOI.
- Please note your application name can be found on the top right of the application.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need

New Application

○ Facility, Agency, or Institution
• Contact Person
• Institution Details
• Owner/Management Information
• Facility Information
• Executive Summary
• Project Cost
• General Criteria
• Consumer Advantage
• Quality Standards
• Development Schedule
• Proof of Publication
• Document Upload
• Payment

Facility, Agency, or Institution

Application Name - PAR-0000000606

* Indicates required field

1A. Name of Facility, Agency, or Institution

*Project Name

Test Project

*Street or Route

test 123

*County

Test County

*City

TEst

*State

Tennessee

*Zip

12345

*Website Address

Enter 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.

Cancel   **Save and Next**

45

Instructions

1. Complete the required fields for 2A. The Information on Contact Person page is auto-populated with the account holder's information and not the Point of Contact listed in the LOI. Update the information, if necessary.
2. Click **Save and Next**.

Key Points

- Once you are on the second page, you are able to click on the **Previous** button to go back to the other page.
- Click **Save and Next** to save your data and continue the application.
- Click **Cancel** if you need to close the application.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

- Facility, Agency, or Institution
- Contact Person
- Institution Details
- Owner/Management Information
- Facility Information
- Executive Summary
- Project Cost
- General Criteria
- Consumer Advantage
- Quality Standards
- Development Schedule
- Proof of Publication
- Document Upload
- Payment

Contact Person

Application Name : PAR-0000000606

* Indicates required field

2A. Contact Person Available for Responses to Questions

*First Name	*Last Name
Imran	Chowdhury

*Title
Test

*Company Name	*Email Address
Test	imran.chowdhury+1@mtxb2b.com

*Street or Route	*City
Test street	Test

*State	*Zip
Tennessee	12345

*Association With Owner	*Phone Number
Tester	123-123-1234

Previous   Cancel   Save & Next

46

Instructions

Answer the required fields.

Key Points

For 4A., you may select multiple check-boxes.

For 5A., use the drop-down button to select the appropriate response.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need

New Application

✓ Facility, Agency, or Institution
✓ Contact Person
● **Institution Details**
○ Owner/Management Information
○ Facility Information
○ Executive Summary
○ Project Cost
○ General Criteria
○ Consumer Advantage
○ Quality Standards
○ Development Schedule
○ Proof of Publication
○ Document Upload
○ Payment

Institution Details

Application Name : PAR-0000000606

* indicates required field

Check appropriate box(es) – more than one response may apply

*4A. Purpose of Review

☐ Establish New Health Care Institution
☐ Relocation
☐ Change in Bed Complement
☐ Addition of a Specialty to an Ambulatory Surgical Treatment Center (ASTC)
☐ Initiation of MRI Service
☐ MRI Unit Increase
☐ Satellite Emergency Department
☐ Addition of Therapeutic Catheterization
☐ Positron Emission Tomography (PET) Service
☐ Initiation of Health Care Service as Defined in §TCA 68-11-1607(3)

*5A. Type Of Institution

[▾]

Previous   Cancel   Save & Next

47

If you select, "Initiation of Health Care Service", a list of related options will appear on the page.

Select one or more options form the list.

Selections made for 4A and 5A will import links for templates for the General Criteria Section, Items 1N, 5N and 6N which are specific to the project type identified. These templates are also available online on the HFC website under the Criteria and Standards page: Criteria and Standards (tn.gov)

Prakruthi Kairamkonda

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

Owner/Management Information

Facility Information

Executive Summary

Project Cost

General Criteria

Consumer Advantage

Quality Standards

Development Schedule

Proof of Publication

Document Upload

Payment

Check appropriate box(es) – more than one response may apply

*4A. Purpose of Review

☐ Establish New Health Care Institution
☐ Relocation
☐ Change in Bed Complement
☐ Addition of a Specialty to an Ambulatory Surgical Treatment Center (ASTC)
☐ Initiation of MRI Service
☐ MRI Unit Increase
☐ Satellite Emergency Department
☐ Addition of Therapeutic Catheterization
☐ Positron Emission Tomography (PET) Service
☑ Initiation of Health Care Service as Defined in §TCA 68-11-1607(3)

☐ Burn Unit
☐ Neonatal Intensive Care Unit
☐ Open Heart Surgery
☐ Organ Transplantation
☐ Cardiac Catheterization
☐ Linear Accelerator
☐ Home Health
☐ Hospice
☐ Opiate Addiction Treatment Provided through a Non-Residential Substitution-Based Treatment Section for Opiate Addiction

*5A. Type Of Institution

▼

48

If you select Hospital for 5A section, specify the Hospital name in the subsequent field.

Click **Save and Next**.

Prakruthi Kairamkonda

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   **New Application**

Owner/Management Information

Facility Information

Executive Summary

Project Cost

General Criteria

Consumer Advantage

Quality Standards

Development Schedule

Proof of Publication

Document Upload

Payment

Check appropriate box(es) – more than one response may apply

*4A. Purpose of Review

☐ Establish New Health Care Institution
☐ Relocation
☐ Change in Bed Complement
☑ Addition of a Specialty to an Ambulatory Surgical Treatment Center (ASTC)
☐ Initiation of MRI Service
☐ MRI Unit Increase
☐ Satellite Emergency Department
☐ Addition of Therapeutic Catheterization
☐ Positron Emission Tomography (PET) Service
☐ Initiation of Health Care Service as Defined in §TCA 68-11-1607(3)

*5A. Type Of Institution

Hospital ▼

*Specify Hospital

TN Hospital

Previous   Cancel   **Save & Next**

© 2022 HFC | All Rights Reserved   Contact Us | Privacy & Terms

49

Instructions

Answer the required fields.

Key Points

Please note 7A. will be pre-populated from the LOI.

50

Answer the required fields.

Click **Save and Next**.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

* 8A. Management Information

Itself ▾

* 9A. Legal Interest in the Site

☐ Ownership (Applicant or applicant's parent company/owner) – Attach a copy of the title/deed.
☐ Lease (Applicant or applicant's parent company/owner) – Attach a fully executed lease that includes the terms of the lease and the actual lease expense.
☐ Option to Purchase - Attach a fully executed Option that includes the anticipated purchase price.
☐ Option to Lease - Attach a fully executed Option that includes the anticipated terms of the Option and anticipated lease expense.
☐ Letter of Intent, or other document showing a commitment to lease the property - attach reference document
☐ Other

* Please explain

* TCA §68-11-1607(c)(9)(B) states that "… If an application involves a healthcare facility in which a county or municipality is the lessor of the facility or real property on which it sits, then within ten (10) days of filing the application, the applicant shall notify the chief executive officer of the county or municipality of the filing, by certified mail, return receipt requested." Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

○ Notification Attached
○ Notification in process, attached at a later date
○ Notification not in process, contact HFC Staff
○ Not Applicable

Previous   Cancel   Save & Next

51

Answer the required fields.

Click **Save and Next**.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need

New Application

Facility Information

Application Name - PAR-0000000606

* **Facility, Agency, or Institution**
* **Contact Person**
* **Institution Details**
* **Owner/Management Information**
* **Facility Information**
* Executive Summary
* Project Cost
* General Criteria
* Consumer Advantage
* Quality Standards
* Development Schedule
* Proof of Publication
* Document Upload
* Payment

* indicates required field

*10A. Floor Plan

If the facility has multiple floors, submit one page per floor. If more than one page is needed, label each page.(Attachment 10A)
* Patient care rooms (Private or Semi-private),
* Ancillary areas
* Other (Specify)

*11A. Public Transportation Route

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 11A)

*12A. Plot Plan

Unless relating to home care organization, briefly describe the following and attach a simple plot plan legibly labeling all requested information. It must include:
* Size of site (in acres);
* Location of structure on the site;
* Location of the proposed construction/renovation;
* Names of streets, roads, or highways that cross or border the site. (Attachment 12A)

CON Application

Answer the required fields.

Click **Save and Next**.

This page consists of Rich Text and Text field types and the character limit for both the field types is 10,000.

The Rich Text field consists of Rich Text Editor that is used to format text (Font Type, Bold, Italic, Underline).

HFC

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need

New Application

Executive Summary

Application Name - PAR-0000000606

* indicates required field

⚠ Please fill all the required fields marked with asterisk(*).

1E. Overview

*Description: Address the establishment of a health care institution, initiation of health services, and/or bed complement changes

Salesforce Sans ▾ | 12 ▾ | B I U S ☰ ☰ ⇥ ⇤ ☰ ☰ ☰ 🔗 🖼 I×

*Ownership Structure

*Service Area

*Existing Similar Service Providers

Facility, Agency, or Institution

Contact Person

Institution Details

Owner/Management Information

Facility Information

Executive Summary

Project Cost

General Criteria

Consumer Advantage

Quality Standards

Development Schedule

Proof of Publication

Document Upload

Payment

53

You may add images to provide better descriptions to your response.

Click on the image icon.

- On the application you will come across **Rich Text** fields. Here you may add images to provide better descriptions to your response.
- Please note, **do not** copy and paste images onto the rich text fields only use the image icon.

Select the image file you want to upload.

Click **Open**.

Please note this image in based on the device you are using not the application. You may see a different view than this image.
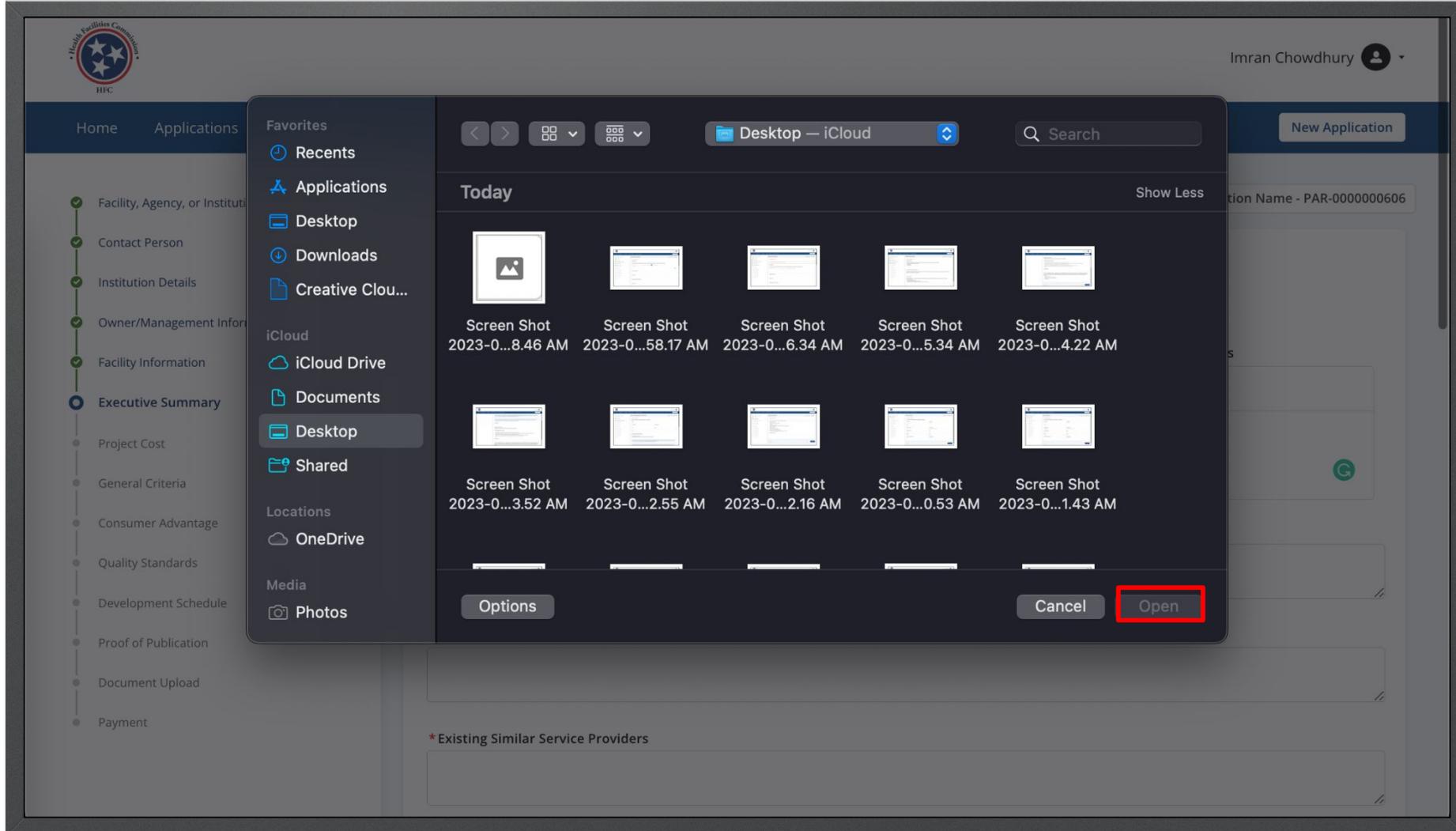
You can add multiple images to the rich text field. You can view the image as it will now populate on the field.

- Uploading image in the Rich Text field will impact the character limit.
- The image should not be greater than 1 MB.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need

New Application

Executive Summary

Application Name - PAR-0000000606

*indicates required field

1E. Overview

*Description: Address the establishment of a health care institution, initiation of health services, and/or bed complement changes

| Salesforce Sans ▼ | 12 ▼ | B | I | U | S | ... |

Test Description

*Ownership Structure

*Service Area

Answer the required fields.

Click **Save and Next**.

If you exit the application without saving, date entered in the fields will be not be saved except the date entered in the RichText field.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need

New Application

* Choice

* Improved access/availability to health care service(s)

* Affordability

* 3E. Consent Calendar Justification

○ Letter to Executive Director Requesting Consent Calendar (Attach Rationale that includes addressing the 3 criteria)

○ Consent Calender NOT Requested

> If Consent Calendar is requested, please attach the rationale for an expedited review in terms of Need, Quality Standards, and Consumer Advantage as a written communication to the Agency's Executive Director at the time the application is filed.

Previous   Cancel   Save & Next

57

Instructions

View the **Project Cost**.

Key Points

The project cost will be auto populated based on the LOI. If changes need to be made update the fields.

Imran Chowdhury

Home | Applications ▾ | Payments | My Letter of Intent | My Certificate of Need

New Application

Project Cost

Application Name : PAR-0000000606

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Institution Details
- ✓ Owner/Management Information
- ✓ Facility Information
- ✓ Executive Summary
- ● **Project Cost**
- General Criteria
- Consumer Advantage
- Quality Standards
- Development Schedule
- Proof of Publication
- Document Upload
- Payment

Enter currency in whole $ amounts

A. Construction and equipment acquired by purchase:

1. Architectural and Engineering Fees	$1,200
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$1,200
3. Acquisition of Site	$121,200
4. Preparation of Site	$1,200
5. Total Construction Costs	$1,200
6. Contingency Fund	$1,200
7. Fixed Equipment (Not included in Construction Contract)	$1,200

CON Application

View the **Project Cost**.

Click **Save and Next**.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

1. Interim Financing	$1,200
2. Underwriting Costs	$1,200
3. Reserve for One Year's Debt Service	$1,200
4. Other (Specify) $1,200	$1,200
Total	**$4,800.00**
D. Estimated Project Cost (A + B + C)	**$141,600.00**
E. CON Filing Fee	**$3,000.00**
F. Total Estimated Project Cost (D + E)	**$144,600.00**

Previous   Cancel   Save & Next

59

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Institution Details
- ✓ Owner/Management Information
- ✓ Facility Information
- ✓ Executive Summary
- ✓ Project Cost
- ⦿ General Criteria
- Consumer Advantage
- Quality Standards
- Development Schedule
- Proof of Publication
- Document Upload
- Payment

General Criteria

Application Name - PAR-0000000606

* indicates required field

⚠ Please fill all the required field marked with asterisk(*)

In accordance with TCA §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, will provide health care that meets appropriate quality standards, and the effect attributed to completion or duplication would be positive for consumers." In making determinations, the Agency uses as guidelines the goals, objectives, criteria, and standards adopted to guide the agency in issuing certificates of need. Until the agency adopts its own criteria and standards by rule, those in the state health plan apply.

Additional criteria for review are prescribed in Chapter 11 of the Agency Rules, Tennessee Rules and Regulations 01730-11.

The following questions are listed according to the three criteria: (1) Need, (2) the effects attributed to competition or duplication would be positive for consumers (Consumer Advantage), and (3) Quality Standards.

Need

The responses to this section of the application will help determine whether the project will provide needed health care facilities or services in the area to be served.

*1N. Provide responses as an attachment to the applicable criteria and standards for the type of institution or service requested. A word version and pdf version for each reviewable type of institution or service are located at the following website. https://www.tn.gov/content/dam/tn/hsda/documents/Magnetic_Resonance_Imaging.docx (Attachment 1N, see template here)

Answer the required fields.

Templates in 1N, 5N, and 6N should reflect the specific criteria and standards that apply to the your project, and if they do not, to please recheck the selections made in 4A and 5A. Additional information can be incorporated to the application through Attachments for each question on this page

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   **New Application**

*1N. Provide responses as an attachment to the applicable criteria and standards for the type of institution or service requested. A word version and pdf version for each reviewable type of institution or service are located at the following website. https://www.tn.gov/content/dam/tn/hsda/documents/Magnetic_Resonance_Imaging.docx (Attachment 1N, see template here)

Salesforce Sans ▾   12 ▾   B I U S ≔ ≔ ⁝≡ ⁝≡ ≡ ≡ ≡ ⬚ 𝖨ₓ

*2N. Identify the proposed service area and provide justification for its reasonable ness. Submit a county level map for the Tennessee portion and counties bordering the state of the service area using the supplemental map, clearly marked, and shaded 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 2N)

Salesforce Sans ▾   12 ▾   B I U S ≔ ≔ ⁝≡ ⁝≡ ≡ ≡ ≡ ⬚ 𝖨ₓ

Complete the following utilization tables for each county in the service area, if applicable.

Historical Utilization (Not Applicable to a new facility)

*Choose if Applicable or Not Applicable

▾

61

Instructions

Select the drop-down under **Historical Utilization**.

Select a <mark>Unit Type (aka Utilization Type)</mark>.

User the Drop down under **Most Recent Year** to select a year.

Click **Add a County**.

Key Points

- You will have to option to choose Applicable or not Applicable from the drop-down. If you choose **Applicable**, you will need to provide more information.
- When you click on **Add a County** you will receive a box to add more information.

CON Application

Enter the required Fields.

Click **Save**.

You need to include ZIP codes for the projects that have service areas defined at the ZIP code level.

CON Application

You are able to **Edit** or **Delete** the county under **Action**.

You may add more than 1 county.

Select a **Unit Type** under Projected Utilization.

User the Drop-down under **Year** 1 to select a year.

Click **Add a County**.

When you click on **Add a County** you will receive a box to add more information.

CON Application

Enter the required Fields.

Click **Save**.

You are able to **Edit** or **Delete** the county under **Action**.

You may add more than 1 county.

Specific instructions for incorporating the demographic table in Item 3N need to be included

All fields are savable individually on this page so you can save and exit without losing information.

Additional information can be incorporated to the application through Attachments for each Item on this page.

Prakruthi Kairamkonda

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

*3N. A. Describe the demographics of the population to be served by the proposal.
• Use this chart as an example

| Salesforce Sans ▾ | 12 ▾ | B | I | U | S | ≡ | ≡ | ▸≡ | ≡◂ | ≡ | ≡ | ≡ | 🔗 | 🖼 | I× |

*B. Provide the following data for each county in the service area:
• Using current and projected population data from the Department of Health. (www.tn.gov/health/health-program-areas/statistics/health-data/population.html);
• the most recent enrollee data from the Division of TennCare (https://www.tn.gov/tenncare/information-statistics/enrollment-data.html),
• and US Census Bureau demographic information(https://www.census.gov/quickfacts/fact/table/US/PST045219).

| Salesforce Sans ▾ | 12 ▾ | B | I | U | S | ≡ | ≡ | ▸≡ | ≡◂ | ≡ | ≡ | ≡ | 🔗 | 🖼 | I× |

*4N. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly those who are uninsured or underinsured, the elderly, women, racial and ethnic minorities, TennCare or Medicaid recipients, and low income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

| Salesforce Sans ▾ | 12 ▾ | B | I | U | S | ≡ | ≡ | ▸≡ | ≡◂ | ≡ | ≡ | ≡ | 🔗 | 🖼 | I× |

68

Answer the required questions.

Templates in 1N, 5N, and 6N should reflect the specific criteria and standards that apply to the your project, and if they do not, to please recheck the selections made in 4A and 5A. Additional information can be incorporated to the application through Attachments for each question on this page

Prakruthi Kairamkonda

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

*5N. 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. This does not apply to projects that are solely relocating a service.

Salesforce Sans   12   B I U S

*6N. Provide applicable utilization and/or occupancy statistics for your institution services for each of the past three years and the project 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.

Salesforce Sans   12   B I U S

*7N. Complete the chart below by entering information for each applicable outstanding CON by applicant or share common ownership; and describe the current progress and status of each applicable outstanding CON and how the project relates to the applicant, and the percentage of ownership that is shared with the applicant's owners.

Salesforce Sans   12   B I U S

69

Click on **Add CoN** if applicable.

When you click on **Add a CoN** you will receive a box to add more information.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

*7N. Complete the chart below by entering information for each applicable outstanding CON by applicant or share common ownership; and describe the current progress and status of each applicable outstanding CON and how the project relates to the applicant, and the percentage of ownership that is shared with the applicant's owners.

Salesforce Sans   12   B I U S ≡ ≡ ≡ ≡ ≡ ≡ ≡ 🔗 🖼 Tₓ

Add a CON

CON NUMBER	PROJECT NAME	PROJECT STATUS	DATE APPROVED	EXPIRATION DATE	PERCENT OF OWNERSHIP
Add CoN					**Click here** for outstanding CoN List

Previous   Cancel   Save & Next

Enter the required Fields.

Click **Save**.

You are able to **Edit** or **Delete** the CoN under **Action**.

You may add more than 1 CoN.

*7N. Complete the chart below by entering information for each applicable outstanding CON by applicant or share common ownership; and describe the current progress and status of each applicable outstanding CON and how the project relates to the applicant, and the percentage of ownership that is shared with the applicant's owners.

PROJECT NAME	PROJECT STATUS	DATE APPROVED	EXPIRATION DATE	PERCENT OF OWNERSHIP	ACTION
Test	Draft	02-09-2023	02-16-2023		▼

Edit

Delete

72

Click **Click here** to download the outstanding CoN List.

Click **Save and Next.**

You may view outstanding CoN Lists. Once you click on the link you will see a spreadsheet has been downloaded.

73

Answer the required fields.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

✓ Facility, Agency, or Institution
✓ Contact Person
✓ Institution Details
✓ Owner/Management Information
✓ Facility Information
✓ Executive Summary
✓ Project Cost
✓ General Criteria
◉ **Consumer Advantage**
○ Quality Standards
○ Development Schedule
○ Proof of Publication
○ Document Upload
○ Payment

Consumer Advantage

Application Name : PAR-0000000606

* indicates required field

⚠ **Please fill all the required field marked with asterisk(*)**

The responses to this section of the application helps determine whether the effects attributed to competition or duplication would be positive for consumers within the service area

*1C. List all transfer agreements relevant to the proposed project.

*2C. List all commercial private insurance plans contracted or plan to be contracted by the applicant

☐ Aetna Health Insurance Company
☐ Ambetter of Tennessee Ambetter
☐ Blue Cross Blue Shield of Tennessee
☐ Blue Cross Blue Shield of Tennessee Network S
☐ Blue Cross Blue Shiled of Tennessee Network P
☐ BlueAdvantage
☐ Bright HealthCare
☐ Cigna PPO
☐ Cigna Local Plus
☐ Cigna HMO - Nashville Network
☐ Cigna HMO - Tennessee Select

Instructions

Answer the required fields.

Key Points

Notice these fields are Rich Text. (View slide 40 for more information).

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   **New Application**

*3C. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact upon consumer charges and consumer choice of services.

Salesforce Sans ▾ | 12 ▾ | B I U S | ≡ ≡ ⊹≡ ⊹≡ | ≡ ≡ ≡ | 🔗 🖼 T_x

*4C. 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, CMS, and/or accrediting agencies requirements, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Salesforce Sans ▾ | 12 ▾ | B I U S | ≡ ≡ ⊹≡ ⊹≡ | ≡ ≡ ≡ | 🔗 🖼 T_x

*5C. Document the category of license/certification that is applicable to the project and why. 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.

Salesforce Sans ▾ | 12 ▾ | B I U S | ≡ ≡ ⊹≡ ⊹≡ | ≡ ≡ ≡ | 🔗 🖼 T_x

6C: Historical and Projected Data Charts

75

1. Click on the arrow to expand the Historical Data Chart section and enter the data in the text fields.

2. **Historical Data Chart** needs to be completed if it is applicable to this project, else check the **Not Applicable** box.

- Under Historical Data Chart, you must report the last 3 years that are available for the facility or agency, unless no history exists.
- If you don't want to specify Other Operating Revenue, enter NA in the field.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

ˇ **Historical Data Chart**

Give information for the last three (3) years for which complete data are available for the facility or agency.

Historical Project Only   ☐ Not Applicable

		*Year 1	*Year 2	*Year 3
A. Utilization Data		▼	▼	▼
*Specify Unit of Measure	☐ Procedures ☐ Case ☐ Patients ☐ Other			
B. Revenue from Services to Patients				
*Inpatient Services				
*Outpatient Services				
*Emergency Services				
*Other Operating Revenue	Please Specify			
Total Gross Operating Revenue		$0.00	$0.00	$0.00

76

Enter the data in the text fields.

Click **Save**.

Use the **Save** button located after the table to save your data before proceeding to Historical Total Facility. Please note clicking **Save** only saves the table data and not the information you may have provided for the entire page

* Emergency Services	$1,200.00	$1,200.00	$1,200.00
* Other Operating Revenue	n/a	$1,200.00	$1,200.00	$1,200.00
Total Gross Operating Revenue	**$4,800.00**	**$4,800.00**	**$4,800.00**
C. Deductions from Gross Operating Revenue			
* Contractual Adjustments	$1,200.00	$1,200.00	$1,200.00
* Provision for Charity Care	$1,200.00	$1,200.00	$1,200.00
* Provisions for Bad Debt	$1,200.00	$1,200.00	$1,200.00
Total Deductions	$3,600.00	$3,600.00	$3,600.00
Net Operating Revenue	**$1,200.00**	**$1,200.00**	**$1,200.00**

Save

Historical Total Facility

☐ Not Applicable

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

Imran Chowdhury

Enter the data in the text fields.

Click **Save**.

If this portion is not applicable click on the **Not Applicable** check box.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   **New Application**

Historical Total Facility   ☐ Not Applicable

A. Utilization Data		*Year 1	*Year 2	*Year 3
		▾	▾	▾
*Specify Unit of Measure	☐ Procedures ☐ Case ☐ Patients ☐ Other			

B. Revenue from Services to Patients

		Year 1	Year 2	Year 3
*Inpatient Services				
*Outpatient Services				
*Emergency Services				
*Other Operating Revenue	Please Specify			
Total Gross Operating Revenue		$0.00	$0.00	$0.00

C. Deductions from Gross Operating Revenue

	Year 1	Year 2	Year 3
*Contractual Adjustments			

78

Click on the arrow to expand the Projected Data Chart section and enter the data in the text fields.

Click **Save**.

Key Points

- The **Total Gross Operating Revenue** and **Provision for Charity Care** amounts listed in the Projected Project Only Data Chart must match the amounts listed in Item 10C – Payor Mix Chart. If the totals do not match, you will not be able to save and proceed with the application.

Instructions

Enter the data in the text fields.

Click **Save**.

Key Points

Use the **Save** button located after the table to save your data before proceeding to Projected Total Facility. Please note clicking **Save** only saves the table data and not the information you may have provided for the entire page

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

*Outpatient		
*Emergency Services		
*Other Operating Revenue Please Specify		
Total Gross Operating Revenue	$0.00	$0.00
C. Deductions from Gross Operating Revenue		
*Contractual Adjustments		
*Provision for Charity Care		
*Provisions for Bad Debt		
Total Deductions	$0.00	$0.00
Net Operating Revenue	$0.00	$0.00

Save

Enter the data in the text fields.

Click **Save**.

If this portion is not applicable click on the **Not Applicable** check box.

If there is no revenue for any particular item, enter zero (0) amounts in the field in order to save and proceed.

82

Key Points

7C contains calculated results based on entries from the Historical and Projected Data Charts.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

| Net Operating Revenue | $0.00 | $0.00 |

Save

7C.Project's Average Gross Charge, Average Deduction from Operating Revenue, and Average Net Charge

A. Utilization Data	Previous Year to Most Recent Year	Most Recent Year	Recent Year	Year One	Year Two
Gross Charge(Gross Operating Revenue/Utilization Data)	$400.00	$400.00	$400.00	$0.00	$0.00
Deduction from Revenue (Total Deduction/Utilization Data)	$300.00	$300.00	$300.00	$0.00	$0.00
Average Net Charge(Net Operating Revenue/Utilization Data)	$100.00	$100.00	$100.00	$0.00	$0.00

*8C. Provide the proposed charges 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.

| Salesforce Sans ▾ | 12 ▾ | B | I | U | S | ≡ | ≡ | ⊹≡ | ⊹≡ | ≡ | ≡ | ≡ | ⊘ | ▤ | Iₓ |

83

Enter the required Fields.

Prakruthi Kairamkonda

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

*9C. Compare the proposed project charges to those of similar facilities/services in the service area/adjoining services areas, or to proposed charges of recently approved Certificates of Need. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).(Attachment 9C)

Salesforce Sans ▼   12 ▼   **B** *I* U̲ S̶   ⋮≡ ≡ ⇥ ⇤   ≡ ≡ ≡   🔗 🖼 Iₓ

*10C. Report the estimated gross operating revenue dollar amount and percentage of project gross operating revenue anticipated by payor classification for the first and second year of the project by completing the table below.

Payor Source	Year 1		Year 2	
	▼			
	Gross	% of Total	Gross	% of To
Medicare/Medicare Managed Care		0		
TennCare/Medicaid		0		
Commercial/Other Managed Care		0		

84

Enter the required Fields.

Notice 10C. The information must match those from the Projected Utilization charts.

Percentage of total columns and the Total rows will be auto-calculated.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

*10C. Report the estimated gross operating revenue dollar amount and percentage of project gross operating revenue anticipated by payor classification for the first and second year of the project by completing the table below.

Payor Source	Year 1		Year 2	
	Gross	% of Total	Gross	% of Total
Medicare/Medicare Managed Care		0		0
TennCare/Medicaid		0		0
Commercial/Other Managed Care		0		0
Self-Pay		0		0
Other (Specify)	Please Specify	0		0
Total	$0.00	0	$0.00	0
Charity Care				

*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.

85

CON Application

- The Total of Payor Mix and Charity Care amounts listed in 10C Payor Mix Chart should be equivalent to the **Total Gross Operating Revenue** and **Provision for Charity Care** in 6C Projected Project Only Data Chart respectively.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

*10C. Report the estimated gross operating revenue dollar amount and percentage of project gross operating revenue anticipated by payor classification for the first and second year of the project by completing the table below.

Payor Source	Year 1		Year 2	
	Gross	% of Total	Gross	% of Total
Medicare/Medicare Managed Care		0		0
TennCare/Medicaid		0		0
Commercial/Other Managed Care		0		0
Self-Pay		0		0
Other (Specify) Please Specify		0		0
Total	$0.00	0	$0.00	0
Charity Care				

*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.

86

Enter the required Fields.

Click **Save and Next**.

Imran Chowdhury

| Home | Applications ▼ | Payments | My Letter of Intent | My Certificate of Need | | New Application |

Medicare/Medicare Managed Care		0		0
TennCare/Medicaid		0		0
Commercial/Other Managed Care		0		0
Self-Pay		0		0
Other (Specify) — Please Specify		0		0
Total	$0.00	0	$0.00	0
Charity Care				

* 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.

Save

Previous

Cancel

Save & Next

Enter the required Fields.

- Certain questions on this page require additional explanation upon selecting your answer as either Yes/No.
- All the mandatory fields must be filled in to save and exit the application. This is applicable across the fields in the application except for Rich Text fields.

Prakruthi Kairamkonda

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   **New Application**

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Institution Details
- ✓ Owner/Management Information
- ✓ Facility Information
- ✓ Executive Summary
- ✓ Project Cost
- ✓ General Criteria
- ✓ Consumer Advantage
- ⦿ **Quality Standards**
- Development Schedule
- Proof of Publication
- Document Upload
- Payment

Quality Standards

Application Name - PAR-0000000673

* indicates required field

*1Q. Per PC 1043, Acts of 2016, any receiving a CON after July 1, 2016, must report annually using forms prescribed by the Agency concerning appropriate quality measures. Please attest that the applicant will submit an annual Quality Measure report when due.

○ Yes
⦿ No

Please Explain

Explanation

2Q. The proposal shall provide health care that meets appropriate quality standards. Please address each of the following questions.

*Does the applicant commit to maintaining the staffing comparable to the staffing chart presented in its CON application?

○ Yes
○ No

*Does the applicant commit to obtaining and maintaining all applicable state licenses in good standing?

○ Yes
○ No

*Does the applicant commit to obtaining and maintaining TennCare and Medicare certification(s), if participation in such programs are indicated in the application?

○ Yes
○ No

3Q. Please complete the chart below on accreditation, certification, and licensure plans.

88

Click on a check box if a field needs to be updated.

Fields under **Licensure & Certification** are not editable unless you click on the check box by each field.

Prakruthi Kairamkonda

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

● Yes
○ No

3Q. Please complete the chart below on accreditation, certification, and licensure plans.

Licensure

Agency

☐ Health Facilities Commission/Licensure Division

Status   Provider Number or Certification Type

⌄   Enter Value

☐ Intellectual & Developmental Disabilities

Status   Provider Number or Certification Type

⌄   Enter Value

☐ Mental Health & Substance Abuse Services

Status   Provider Number or Certification Type

⌄   Enter Value

Certification

Agency

☐ Medicare

Status   Provider Number or Certification Type

89

Instructions

Click on a check box if a field needs to be updated.

Key Points

Fields under **Licensure & Certification** are not editable unless you click on the check box by each field.

Prakruthi Kairamkonda

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

Certification

Agency

☐ Medicare

Status

Provider Number or Certification Type

Enter Value

☐ TennCare/Medicaid

Status

Provider Number or Certification Type

Enter Value

☐ Other

Please Specify

Enter Value

Status

Provider Number or Certification Type

Enter Value

Accreditation(s)

Agency

Agency Name

Enter the required Fields.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need

New Application

Accreditation(s)

Agency

Agency Name

Status

Provider Number or Certification Type

* if the applicant does not plan to participate in these type of assessments, explain why since quality healthcare must be demonstrated.

* 4Q. Please list all Managed Care organizations currently or will be contracted.

☐ AMERIGROUP COMMUNITY CARE- East Tennessee
☐ AMERIGROUP COMMUNITY CARE - Middle Tennessee
☐ AMERIGROUP COMMUNITY CARE - West Tennessee
☐ BLUECARE - East Tennessee
☐ BLUECARE - Middle Tennessee
☐ BLUECARE - West Tennessee
☐ UnitedHealthcare Community Plan - East Tennessee
☐ UnitedHealthcare Community Plan - Middle Tennessee
☐ UnitedHealthcare Community Plan - West Tennessee
☐ TENNCARE SELECT HIGH - All
☐ TENNCARE SELECT LOW - All
☐ PACE
☐ KBB under DIDD waiver

please specify

Enter the required Fields.

- Certain questions on this page require additional explanation upon selecting your answer as either Yes/No.

Prakruthi Kairamkonda

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

*5Q. Do you attest that you will submit a Quality Measure Report annually to verify the license, certification, and/or accreditation status of the applicant, if approved?

○ Yes
● No

Please Explain

Explanation

6Q. For an existing healthcare institution applying for a CON

*6Q.A. Has it maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action should be discussed to include any of the following: 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 and what measures the applicant has or will put into place to avoid similar findings in the future.

● Yes
○ No
○ N/A

*6Q.B. Has the entity been decertified within the prior three years? If yes, please explain in detail. (This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility.)

● Yes
○ No
○ N/A

Please Explain

Test

7Q. Respond to all of the following and for such occurrences, identify, explain, and provide documentation if occurred in last five (5) years.

Enter the required Fields.

- Certain questions on this page require additional explanation upon selecting your answer as either Yes/No.

Prakruthi Kairamkonda

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

7Q. Respond to all of the following and for such occurrences, identify, explain, and provide documentation if occurred in last five (5) years.

7Q.A. Has any of the following:
1. Any person(s) or entity with more than 5 percent 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 percent 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 percent; and/or.

7Q.B. Been subject to any of the following:
*7Q.B.1. Final Order or Judgement in a state licensure action;
○ Yes
● No

*7Q.B.2. Criminal fines in cases involving a Federal or State health care offense;
○ Yes
● No

*7Q.B.3. Civil monetary penalties in cases involving a Federal or State health care offense;
○ Yes
● No

*7Q.B.4. Administrative monetary penalties in cases involving a Federal or State health care offense
○ Yes
● No

*7Q.B.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
○ Yes
● No

*7Q.B.6. Suspension or termination of participation in Medicare or TennCare/Medicaid programs; and/or
○ Yes
● No

CON Application

Click on **Add Position** to create a new position information.

Enter the required fields.

- Once you click on the position buttons you will receive a pop-up to add information on the position click save to continue.
- You may add more than 1 position.
- Enter the Existing and Projected FTEs as 0, if you don't have any contractual staff.

Enter required fields

Click **Save and Next**.

-

Prakruthi Kairamkonda

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

Add Position

Total Direct Patient Care Positions	2	4

☑ Non Patient Care Not Applicable

Total Non-Patient Care Positions	0	0
Total Employees(A+B)	2	4
* **C. Contractual Staff**	2	2
Total Staff(A+B+C)	4	6

*If applicable, please discuss below contractual positions. If no contractual staff will be employed, please explain.

Contractual positions

Previous   Cancel   **Save & Next**

Read the **Development Schedule** information.

Read the information on this page to understand the correct information that is required.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need

New Application

Development Schedule

Application Name - PAR-0000000606

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Institution Details
- ✓ Owner/Management Information
- ✓ Facility Information
- ✓ Executive Summary
- ✓ Project Cost
- ✓ General Criteria
- ✓ Consumer Advantage
- ✓ Quality Standards
- ⦿ Development Schedule
- Proof of Publication
- Document Upload
- Payment

* indicates required field

TCA §68-11-1609(c) provides that activity authorized by a Certificate of Need is valid for a period not to exceed three (3) years (for hospital and nursing home projects) or two (2) years (for all other projects) from the date of its issuance and after such time authorization expires; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificate 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 authorization which has been extended shall expire at the end of the extended time period. The decision whether to grant an extension is within the sole discretion of the Commission, and is not subject to review, reconsideration, or appeal.

1.Complete the Project Completion Forecast Chart below. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.

2. If the CON is granted and the project cannot be completed within the standard completion time period (3 years for hospital and nursing home projects and 2 years for all others), please document why an extended period should be approved and document the "good cause" for such an extension

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

Project Completion Forecast Chart

Phase	Days Required (From Decision Date)	Anticipated Date
* 1. Initial HFC Decision Date		🗓
2. Building Construction Commenced		
3. Construction 100% Complete (Approval for Occupancy)		
* 4. Issuance of License		

Enter the required fields.

Click **Save and Next**.

- The Anticipated Date field(s) will be auto-calculate based on the value entered in the Days Required (from the decision date) field(s).

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   **New Application**

2. If the CON is granted and the project cannot be completed within the standard completion time period (3 years for hospital and nursing home projects and 2 years for all others), please document why an extended period should be approved and document the "good cause" for such an extension

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

Project Completion Forecast Chart

Phase	Days Required (From Decision Date)	Anticipated Date
* 1. Initial HFC Decision Date		🗓
2. Building Construction Commenced		
3. Construction 100% Complete (Approval for Occupancy)		
* 4. Issuance of License		
* 5. Issuance of Service		
* 6. Final Project Report Form Submitted (Form HR0055)		

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

Consumer Advantage
Quality Standards
Development Schedule
Proof of Publication
Document Upload
Payment

Previous   Cancel   **Save & Next**

Enter the required fields.

Click **Save and Next**.

The Date of the published LOI must be equal to or greater than the date it was submitted.

Proof of Publication must be attached on the Document Upload Page and should match the date entered into the Date LOI Published field.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   **New Application**

Proof of Publication

Application Name - PAR-0000000606

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Institution Details
- ✓ Owner/Management Information
- ✓ Facility Information
- ✓ Executive Summary
- ✓ Project Cost
- ✓ General Criteria
- ✓ Consumer Advantage
- ✓ Quality Standards
- ✓ Development Schedule
- ○ **Proof of Publication**
- ○ Document Upload
- ○ Payment

* indicates required field

3A. Proof of Publication

Attach the full page of newspaper(s) 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. (Attachment 3A)

* Date LoI was Submitted

02-06-2023

* Date LoI Published

Enter Date LoI Published

* Response

Previous   Cancel   **Save & Next**

Instructions

Click on **Upload Files**.

Key Points

On this page you will upload files as documents. Follow the steps to upload a file.

Imran Chowdhury

| Home | Applications ▾ | Payments | My Letter of Intent | My Certificate of Need | | New Application |

Document Upload

Application Name : PAR-0000000606

✓ Facility, Agency, or Institution
✓ Contact Person
✓ Institution Details
✓ Owner/Management Information
✓ Facility Information
✓ Executive Summary
✓ Project Cost
✓ General Criteria
✓ Consumer Advantage
✓ Quality Standards
✓ Development Schedule
✓ Proof of Publication
⬤ **Document Upload**
Payment

*** indicates required field**

DOCUMENT NAME	UPLOAD	ACTIONS
*Attachment - Medical Equipment	⬆ Upload Files	
*Attachment - State Map with Counties Highlight the counties in the project's service area.	⬆ Upload Files	
*Attachment 10A - Floor plan If the facility has multiple floors, submit one page per floor. If more than one page is needed, label each page. Patient care rooms (Private or Semi-private) Ancillary areas Other (Specify)	⬆ Upload Files	
*Attachment 2N - County level map Identify the proposed service area and provide justification for its reasonable ness. Submit a county level map for the Tennessee portion and counties boarding the state of the service area using the supplemental map, clearly marked, and shaded 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.	⬆ Upload Files	

Select the image file you want to upload.

Click **Open**.

Please note this image in based on the device you are using not the application. You may see a different view than this image.

100

If the file is in correct you can delete it by clicking **Delete**.

Provide all the required files.

You may also download the file to view what was uploaded.

You can upload JPEG, PNG, PDF, DOCX, DOC, XLSX, XLS, PPT, and PPTX file types.

Attachments cannot be bulk downloaded so individual files that are uploaded will need to be saved separately.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Institution Details
- ✓ Owner/Management Information
- ✓ Facility Information
- ✓ Executive Summary
- ✓ Project Cost
- ✓ General Criteria
- ✓ Consumer Advantage
- ✓ Quality Standards
- ✓ Development Schedule
- ✓ Proof of Publication
- ○ **Document Upload**
- · Payment

Document Upload

Application Name : PAR-0000000606

* indicates required field

DOCUMENT NAME	UPLOAD	ACTIONS
*Attachment - Medical Equipment	Screen Shot 2023-02-06 at 11.27.55 AM	Download | Delete
*Attachment - State Map with Counties Highlight the counties in the project's service area.	⬆ Upload Files	

*Attachment 10A - Floor plan
If the facility has multiple floors, submit one page per floor. If more than one page is needed, label each page.
 	
   Patient care rooms (Private or Semi-private)
   Ancillary areas
   Other (Specify)
	⬆ Upload Files	

*Attachment 2N - County level map Identify the proposed service area and provide justification for its reasonable ness. Submit a county level map for the Tennessee portion and counties boarding the state of the service area using the supplemental map, clearly marked, and shaded 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	⬆ Upload Files	

Instructions

Provide all the required files.

Key Points

- Additional attachments fields are optional.
- Optional attachments should each be labeled and numbered (Optional Attachment – Additional Information #1, #2 etc.)
- Consolidate and include a cover sheet with a table of contents when you have multiple documents in the attachment.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

the project. Please include a discussion of the inclusion of counties in the border states, if applicable.

Attachment 3A - Proof of publication   ⬆ Upload Files

Attachment 3N.B. Service area demographic chart
For a template to assist in reporting required documents, please go to a foll owing website. **(Link)**   ⬆ Upload Files

Attachment 5N - Existing & Approved Unimplemented Services Utilization
Submit 3 years worth of information for service area   ⬆ Upload Files

Attachment 6N - 3 Year Utilization   ⬆ Upload Files

Attachment 8C - Charges of Service   ⬆ Upload Files

Attachment 9C   ⬆ Upload Files

Additional Documents   ⬆ Upload Files

Previous   Cancel   Save & Next

- Provide all the required files.
- Click **Save and Next**.

- If supplemental revisions are required for any attached documents, the previous version of the document will need to be deleted. Note the HFC will preserve versions of each application as submitted, but the applicant should do so as well, but it cannot be done directly through the system.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   **New Application**

the project. Please include a discussion of the inclusion of counties in the border states, if applicable.

Attachment 3A - Proof of publication   ⬆ Upload Files

Attachment 3N.B. Service area demographic chart
For a template to assist in reporting required documents, please go to a foll owing website. **(Link)**   ⬆ Upload Files

Attachment 5N - Existing & Approved Unimplemented Services Utilization
Submit 3 years worth of information for service area   ⬆ Upload Files

Attachment 6N - 3 Year Utilization   ⬆ Upload Files

Attachment 8C - Charges of Service   ⬆ Upload Files

Attachment 9C   ⬆ Upload Files

Additional Documents   ⬆ Upload Files

Previous   Cancel   **Save & Next**

View the **Payment** page.

Imran Chowdhury

Home　　Applications ▼　　Payments　　My Letter of Intent　　My Certificate of Need　　**New Application**

Application Name - PAR-0000000606

Payment

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Institution Details
- ✓ Owner/Management Information
- ✓ Facility Information
- ✓ Executive Summary
- ✓ Project Cost
- ✓ General Criteria
- ✓ Consumer Advantage
- ✓ Quality Standards
- ✓ Development Schedule
- ✓ Proof of Publication
- ✓ Document Upload
- ⦿ **Payment**

Filling Fee

$3,000.00

Key Points

If the LOI has not been accepted, you will not be able to pay/submit the application. Once the LoI is accepted the error message at the bottom of the application will not be visible.

105

Instructions

Click on the **Attestation** check box.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

✓ Project Cost

✓ General Criteria

✓ Consumer Advantage

✓ Quality Standards

✓ Development Schedule

✓ Proof of Publication

✓ Document Upload

○ Payment

Filling Fee

$3,000.00

☐ am the applicant or his/her/its legal agent, duly swear 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 Facilities Commission, and T.C.A. §68-11-1601, et seq., and the responses to this application or any other questions deemed appropriate by the Health Facilities Commission are true and complete.

Previous   Cancel   Pay / Submit

106

Once you are complete, click **Pay/Submit**.

You will get additional fields that are auto populated you may not edit these

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

Quality Standards

Development Schedule

Proof of Publication

Document Upload

Payment

Filling Fee

$3,000.00

☑ I am the applicant or his/her/its legal agent, duly swear 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 Facilities Commission, and T.C.A. §68-11-1601, et seq., and the responses to this application or any other questions deemed appropriate by the Health Facilities Commission are true and complete.

Name

Imran Chowdhury

Date

02-06-2023

Previous

Cancel   Pay / Submit

107

CON Application

Enter your **Bank Account Information**.

Enter your **Billing Information**.

Click **Continue**.

Once you click continue you are able to pay the application fee and submit the application.

All payments must be by e-check. No debit or credit cards will be accepted.

Certificate of Need

Payment Entry

Payment Method: E-Check

Bank Account Information

Type of Check	E-Check Personal
Routing Number	
Account Number	
Re-enter Account Number	

echeck

Billing Information

Name	
Address	
City	
State	Tennessee
Zip	
Phone	
Email	

Relocation Exemption Application

1. From the Dashboard, click on **All Applications**.

For information on Letter of Intent, please review the full Community portal user guide or LOI quick reference guide.

Find the **Relocation Exemption –LOI** application.

Click on the 3 dots under **Actions**.

111

Click on **Start RE**.

To create the Relocation Exemption application, you do not need the LOI to be accepted. LOI must be accepted in order to submit the Relocation Exemption application.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need

New Application

All Applications

All applications associated with the account holder are listed below

Dashboard > All Applications

Search here for applications

All

APPLICATION NUMBER	PROJECT NAME	APPLICATION TYPE	CERTIFICATE NUMBER	STATUS	CREATED
					Download
					Start RE
PAR-0000000670	test	Relocation Exemption - LOI	-	Submitted	2/13/2023
					Withdraw

1

© 2022 HFC | All Rights Reserved

Contact Us | Privacy & Terms

out:blank

112

Relocation Exemption

Enter the **Website Address** of the Facility, Agency, or Institution.

Click **Save and Next**.

- You will begin the application with Facility, Agency, or Institution.
- Notice all but Website Address have been auto-populated as they were captured in the LOI.
- Please note your application name can be found on the top right of the application.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need

New Application

○ **Facility, Agency, or Institution**
• Contact Person
• Owner Information
• Executive Summary
• Document Upload
• Attestation

Facility, Agency, or Institution

Application Name - PAR-0000000671

* indicates required field

1A. Name of Facility, Agency, or Institution

* Project Name

test

* Street or Route

test

* County

test

* City

test

* State

Tennessee

* Zip

12345

* Website Address

Enter Website Address

License Number (If Applicable)

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

Complete the required fields for 2A.

Click **Save and Next**.

- Once you are on the second page, you are able to click on the **Previous** button to go back to the other page.
- Click **Save and Next** to continue the application.
- Click **Cancel** if you need to close the application.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need

New Application

- ✓ Facility, Agency, or Institution
- ◉ **Contact Person**
- Owner Information
- Executive Summary
- Document Upload
- Attestation

Contact Person

Application Name : PAR-0000000671

2A. Contact Person Available for Responses to Questions

* First Name
Imran

* Last Name
Chowdhury

* Title

* Company Name
MTX Group Inc

* Email Address
imran.chowdhury+1@mtxb2b.com

* Street or Route
4102 Admiralty way

* City
Irving

* State
Tennessee

* Zip
75061

* Association With Owner

* Phone Number
214-803-4743

Previous

Cancel   Save & Next

Answer the required fields for the remainder of the application.

Click **Save and Next** for the pages you complete.

Fields that are shaded grey are pre-populated and cannot be edited.

Review the full Community portal user guide for a full breakdown of the application process.

Relocation Exemption

Answer the required fields.

Click **Save and Next**.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Owner Information
- ● Executive Summary
- ○ Document Upload
- ○ Attestation

Executive Summary

Application Name - PAR-0000000671

* indicates required field

1E. Overview

For all Executive Summary items together, please limit your response to the topics to 1800 characters in total.

*Service Area - Address if at least ninety-five percent (95%) of patients to be served are reasonably expected to reside in the same zip codes as the existing patient population.

Placeholder

*Medicaid/TennCare Participation - Address any changes as a result of the relocation.

Placeholder

*Access To Consumers - Address if the relocation will reduce or impact access to consumers, particularly those in underserved communities; those who are uninsured or underinsured; women and racial and ethnic minorities; TennCare or Medicaid recipients; and low income groups.

Placeholder

2E. Patients by Zip Code

First, enter the total utilization. Next, enter every zip code and its utilization until the total percent calculates to 95% or more. With each entered zip code/utilization, the percentage will be automatically calculated.

Current Location (Latest Full Year)

Read the **Patients by zip code** information.

Enter the **Year** and **Beginning Month**.

Click on **Add Zip code Data**.

In this section you will add zip code based on historical utilization.

If this portion does not pertain to you, select the **Not Applicable** check box.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need   New Application

2E. Patients by Zip Code

First, enter the total utilization. Next, enter every zip code and its utilization until the total percent calculates to 95% or more. With each entered zip code/utilization, the percentage will be automatically calculated.

Current Location (Latest Full Year)

☐ Not Applicable

*Year

Enter Year

*Beginning Month

Add Patients By Zip Code Information

SERVICE AREA ZIPCODE	HISTORICAL UTILIZATION-ZIP CODE PATIENTS	% OF TOTAL CURRENT PATIENTS	ACTION

Add Zip Code Data

Proposed Location (2nd Full Year of Operation)

☐ Not Applicable

*Year

Enter Year

*Beginning Month

Enter the required information.

Click **Save** to continue.

118

Key Points

You are able to **Edit** or **Delete** the county under **Action**.

You may add more than 1 county.

Follow the same instructions for the second full year of operation.

If this section does not pertain to you, click on the check box next to **Not Applicable**.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need

New Application

Add Patients By Zip Code Information

SERVICE AREA ZIPCODE	HISTORICAL UTILIZATION-ZIP CODE PATIENTS	% OF TOTAL CURRENT PATIENTS	ACTION
12345	12	100	▾

Add Zip Code Data

Total	12	75% or More

Proposed Location (2nd Full Year of Operation)

☐ Not Applicable

*Year

Enter Year

*Beginning Month

▾

Add Patients By Zip Code Information

SERVICE AREA ZIPCODE	PROJECTED UTILIZATION-ZIP CODE PATIENTS	% OF TOTAL PROJECTED PATIENTS	ACTION

Add Zip Code Data

3E. Payor Mix

Enter the data in the text fields.

Click **Save and Next.**

When the **Payor Mix Current Location** Revenue, the percent of total fields will auto calculate.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

Payor Mix, Current Location (Latest Full Year)

*Year

Enter Year

*Beginning Month

PAYOR SOURCE		GROSS REVENUE	% OF TOTAL
Medicare/Meducare Managed Care			0
TennCare/Medicaid			0
Commercial/Other Managed Care			0
Self-Pay			0
Other	Please Specify		0
Total		**$0.00**	**0**
Charity Care			

Payor Mix, Proposed Location (2nd Full Year of Operation)

Click on **Upload Files**.

On this page you will upload files as documents. Follow the steps to upload a file.

Imran Chowdhury

Home | Applications ▾ | Payments | My Letter of Intent | My Certificate of Need

New Application

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Owner Information
- ✓ Executive Summary
- ◉ Document Upload
- ○ Attestation

Document Upload

Application Name : PAR-0000000671

*** indicates required field**

DOCUMENT NAME	UPLOAD	ACTIONS
*Attachment 5A - Legal Interest in the Site - A fully executed Option that includes the anticipated purchase price.	⬆ Upload Files	
*Attachment 5A - Legal Interest in the Site - Reference Document	⬆ Upload Files	
Attachment 4E - Proof of publication	⬆ Upload Files	
Additional Documents	⬆ Upload Files	

Previous

Cancel | Save & Next
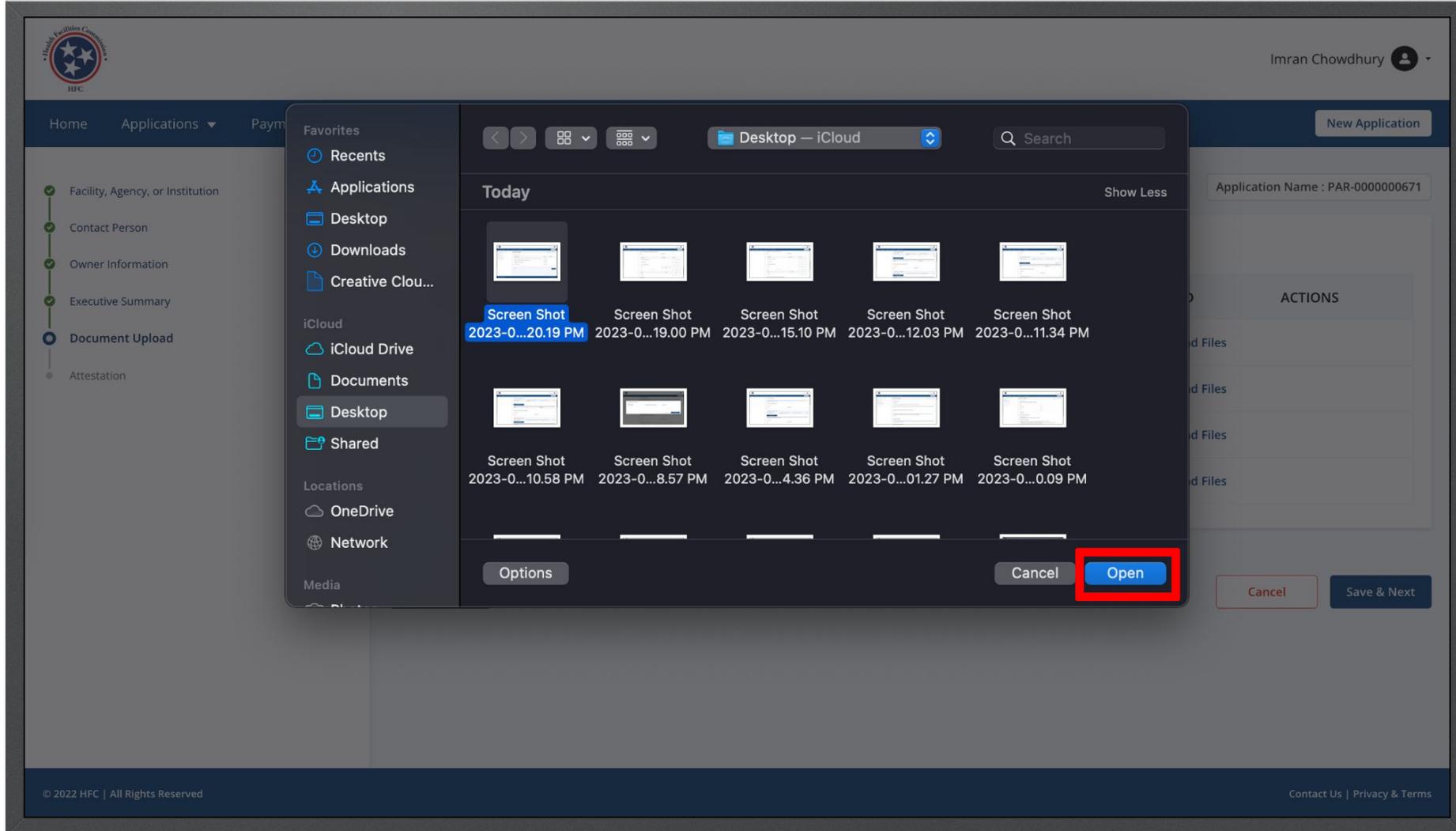
© 2022 HFC | All Rights Reserved

Contact Us | Privacy & Terms

Select the image file you want to upload.

Click **Open**.

Please note this image in based on the device you are using not the application. You may see a different view than this image.

If the file is in correct you can delete it by clicking **Delete**.

Provide all the required files.

Click **Save and Next**.

You may also download the file to view what was uploaded.

You can upload spreadsheets, documents, text, pdf, and jpg.

Imran Chowdhury

Home   Applications ▾   Payments   My Letter of Intent   My Certificate of Need   New Application

- ✓ Facility, Agency, or Institution
- ✓ Contact Person
- ✓ Owner Information
- ✓ Executive Summary
- ○ Document Upload
- ○ Attestation

Document Upload

Application Name : PAR-0000000671

* indicates required field

DOCUMENT NAME	UPLOAD	ACTIONS
*Attachment 5A - Legal Interest in the Site - A fully executed Option that includes the anticipated purchase price.	Screen Shot 2023-02-13 at 4.20.19 PM	Download | Delete
*Attachment 5A - Legal Interest in the Site - Reference Document	⬆ Upload Files	
Attachment 4E - Proof of publication	⬆ Upload Files	
Additional Documents	⬆ Upload Files	

Previous   Cancel   **Save & Next**

© 2022 HFC | All Rights Reserved   Contact Us | Privacy & Terms

Key Points

If the LOI has not been accepted, you will not be able to submit the application. Once the LoI is accepted the error message at the bottom of the application will not be visible.

Imran Chowdhury

Home   Applications ▼   Payments   My Letter of Intent   My Certificate of Need

New Application

Attestation

Application Name : PAR-0000000671

* Indicates required field

* ☐ I hereby declare that the information furnished above is true, complete, and correct to the best of my knowledge and belief. I understand that in the event of my information being found false or incorrect at any stage, my application shall be liable to cancellation.

Name

Imran Chowdhury

Date

02-13-2023

🚫 **You cannot Submit the RE application until LOI is Accepted**

Previous   Cancel   Submit

© 2022 HFC | All Rights Reserved   Contact Us | Privacy & Terms

125

Click on the **Attestation** check box.

Click **Submit**.

126

This concludes the User Guide for the HFC Portal

THANK YOU