State of Tennessee
Health Facilities Commission
502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 hsda.staff@tn.gov

CERTIFICATE OF NEED
RELOCATION EXEMPTION REQUEST

1A. Name of Facility, Agency, or Institution

Name

Street or Route | **County**

City | **State** | **Zip**

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 Intent.

2A. Submitter

Name | **Title**

Company Name | **Email Address**

Street or Route

City | **State** | **Zip**

Association with Owner | **Phone Number**

3A. Name of Owner of the Facility, Agency, or Institution

Name

Street or Route | **Phone Number**

City | **State** | **Zip**

4A. Type of Ownership of Control *(Check One)*

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Limited Partnership
- ☐ Corporation (For Profit)
- ☐ Corporation (Not-for-Profit)
- ☐ Government (State of TN or Political Subdivision)
- ☐ Joint Venture
- ☐ Limited Liability Company
- ☐ Other (Specify):_____

5A. Legal Interest in the Site

Check the appropriate box and submit the following documentation.

The legal interest described below must be valid on the date of the Executive Director considers the exemption request.

- ☐ 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.
- ☐ Other (Specify) _____

EXECUTIVE SUMMARY

1E. Overview

Please provide an overview not to exceed **ONE PAGE** in total explaining each item point below.

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

2E. Patients by Zip Code

Complete the following tables, if applicable.

Current Location (Latest Full Year) Year _____ Beginning Month _____

Service Area ZIP Codes	Historical Utilization-ZIP Code Patients	% of Total Current Patients
ZIP Code #1		
ZIP Code #2		
Etc.		
Total		95% or More

Proposed Location (2nd Full Year of Operation) Year _____ Beginning Month _____

Service Area ZIP Codes	Projected Utilization-ZIP Code Patients	% of Total Projected Patients
ZIP Code #1		
ZIP Code #2		
Etc.		
Total		95% or More

3E. Payor Mix

List the provider's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients that are currently being served at the current location. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the second full year of new proposed location by completing the table below.

Payor Mix, Current Location (Latest Full Year) Year _____ Beginning Month _____

Payor Source	Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care		
TennCare/Medicaid		
Commercial/Other Managed Care		
Self-Pay		
Other (Specify)_____		
Total		
Charity Care		

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

Payor Source	Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care		
TennCare/Medicaid		
Commercial/Other Managed Care		
Self-Pay		
Other (Specify)_____		
Total		
Charity Care		

4E. Publication

A proof of publication of notice of the exemption request is required in a newspaper of general circulation in both the county of the existing facility or service and the county where the service or facility is to be relocated.

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.