GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia
Certificate of Need Application

FOR OFFICE OF HEALTH PLANNING USE ONLY	
PROJECT NUMBER **GA**	*DATE STAMP*
COUNTY:	Signed Original _____ Fee Verified _____

GENERAL INFORMATION:

The Certificate of Need (CON) application is the required document that the Department reviews in the analysis and evaluation of proposed projects to establish or expand healthcare services and facilities in accordance with CON Administrative Rule 111-2-2. Requests to develop or offer new institutional health services must be completed and submitted ***only*** on the Department's application and supplemental forms, which are available at the Department's website: https://dch.georgia.gov/con-applications-and-forms.

1. Applicants must submit one (1) copy of the signed application. The application must be submitted electronically using the Department's web portal available here: https://dch.georgia.gov/office-health-planning-applications-and-requests-forms-0.

2. The filing fee shall be made payable to the "State of Georgia" and shall be remitted by Certified Check or Money Order. A copy of the Certified Check or Money Order must be included with your web portal submission.

3. Failure to submit the required filing fee and a complete copy of the application will result in non-acceptance of the application.

4. Applications received after 3 p.m. will be deemed accepted the next business day.

PLEASE COMPLETE THE FOLLOWING TABLE TO VERIFY PROPER SUBMISSION OF YOUR APPLICATION	
Applicant Legal Name:	
1. Have you submitted one (1) copy of this signed application via the Department's web portal?	☐ **Yes** ☐ **No**
2. Is this application being filed by or on behalf of a hospital in a rural county? *("Rural County" means a county having a population of less than 50,000 according to the United States decennial census of 2010 or any future such census. Ga. Comp. R. & Regs. r. 111-2-2-.01(52))* If **YES** ➔No filing fee is due. Enter $0 at Line 4. If **NO** ➔ Continue to next question.	☐ **Yes** ☐ **No**
3. Enter Total Cost Applicable to Filing Fee *(From Line 16, Question 22, Page 13)*	**$**
4. Calculate the Filing Fee and Total Amount Due *(Check one of the following and enter the amount in the column to the right)* ☐ Line 3 is between 0 to $1 million ➔ Enter $1,000.00 ☐ Line 3 is between $1million and $50 million ➔ Enter Line 2 x .001 ☐ Line 3 is greater than $50 million ➔ Enter $50,000.00	**$**
5. Have you submitted payment by Certified Check or Money Order made payable to the "State of Georgia" for the amount listed in Line 4 above?	☐ **Yes** ☐ **No** ☐ **N/A**

COMPLETENESS CHECKLIST

Please complete the following checklist to ensure that you have included all necessary materials to deem your application complete. Please note that completion of this checklist does not mean that your application is indeed complete as the Department will need to verify the adequacy and completeness of the materials provided. Nevertheless, this checklist should prove helpful as a way to double check before submission of your application.

Item Required	Location	Check if Included	Check if N/A
Copy of Licenses/Permits (for existing facilities)	Question 3, Page 1 & 🗁 Attached at **APPENDIX B**	☐	☐
Authorization to Conduct Business	Question 8, Page 3-4 & 🗁 Attached at **APPENDIX C**	☐	
Lobbyist Disclosure	Question 13, Page 6	☐	
Documentation of Site Entitlement	Question 17, Page 8 & 🗁 Attached at **APPENDIX D**	☐	
Detailed Description of the Proposed Project	Question 18, Page 9	☐	
Financial Program	Questions 22, Page 13	☐	
Equipment Purchase Orders/Invoices	Question 22, Page 13 & 🗁 Attached at **APPENDIX G**	☐	☐
Proof of Necessary Financing	Question 23, Page 14 & 🗁 Attached at **APPENDIX G**	☐	
Financial Statements	Question 24, Page 14 & 🗁 Attached at **APPENDIX G**	☐	
Financial Pro Forma	Question 25, Pages 15-19	☐	
Architect Cost Estimates (Certified within 60 days)	Question 32, Page 26 & 🗁 Attached at **APPENDIX I**	☐	☐
Schematic Plans	Question 32, Page 26 & 🗁 Attached at **APPENDIX I**	☐	☐
All Applicable Service-Specific Review Considerations	Question 48, Page 37 et seq. & 🗁 Attached at **APPENDIX N** etc.	☐	☐
Signature (In Blue Ink)	Page 39	☐	☐

Have you submitted a copy of this application to the County Commission in the County where the project will be located? Proof of such submission must be included with this application. 🗁 Attach such proof at **APPENDIX A**.	☐ YES ☐ NO
Have you submitted a complete copy of said application? The application must include a copy of the signature at Page 39.	☐ YES ☐ NO
Have you included the appropriate filing fee as calculated and reported on the cover page of this application? The filing fee must be made payable by Certified Check or Money Order.	☐ YES ☐ NO ☐ N/A
Have all required surveys of the Applicant and any and all affiliate organizations been submitted to the Office of Health Planning for the most recent three (3) years?	☐ YES ☐ NO
Has post-approval reporting for any and all previous Certificate of Need projects of the Applicant and any and all affiliate organizations been submitted to the Certificate of Need Program, if such reporting is due?	☐ YES ☐ NO
Has the Applicant and any and all affiliate organizations satisfied previous indigent and charity care commitments?	☐ YES ☐ NO
Has the Applicant satisfied any and all fines, if any, which have been levied by the Department for violation of the Certificate of Need Rules or Statute?	☐ YES ☐ NO

INSTRUCTIONS

1. **Please read all instructions and review the application form before attempting to complete and submit the application.**

2. **A CON application must be submitted on the Department's application and supplemental forms only. Supplemental forms are provided for letters of opposition, additional and amended information. These forms may be obtained on the Department's website: https://dch.georgia.gov/con-applications-and-forms.**

3. **In completing the CON application, if a particular rule or consideration requires substantiating documents such as a finance letter or architect's letter as an appendix, the requested documents must be placed with the noted appendix without exception and must conform to the Instructions for Organization of Appendices on the next page of these instructions.**

4. **This application must be typewritten or completed and printed in this MS Word format. Handwritten responses must not be submitted and will not be accepted.**

5. **All questions must be answered. If a question is not applicable, so indicate.**

6. **Throughout this application, the following symbols are utilized for emphasis:**

   🗁 **Emphasizes instances where supporting documentation is requested and required to be attached into an Appendix; and**

   ☞ **Emphasizes important instructions or notes that should be adhered to.**

7. **A signed application (in the correct organizational structure) is required in addition to the appropriate filing fee for an application to be accepted by the Department. Please review the CON administrative rules for detailed explanation of appropriate fees, filing dates, and times.**

8. **Please remit the following items to the address below: a copy of the web portal submission confirmation form; and, the filing fee in the form of a Certified Check or Money Order made payable to the "State of Georgia."**

   Department of Community Health
   Office of Health Planning
   CON Application
   2 Peachtree Street, NW, 5th Floor
   Atlanta, Georgia 30303

9. **Faxed copies of documents and information are not official submissions. All submissions must be via the Department's web portal.**

10. **If you are seeking an emergency review per Rule 111-2-2-.07(1)(k), include a cover letter behind the main cover page of this application expressing the reasons that an emergency review should be granted.**

INSTRUCTIONS FOR
ORGANIZATION OF APPENDICES

The organization of appendices is mandated by this application and the Table of Appendices that follows.

APPLICANTS MUST NOT VARY FROM THIS ORGANIZATIONAL STRUCTURE.

1. Appendices must be separated by lettered tabs.

2. Each Appendix may have more than one document in which case the Appendix must be separated by dividing sheets. Dividing sheets must be appropriately labeled with the Appendix Letter and the name of the document that follows the sheet. The documents within such an Appendix should be organized in the order in which they are requested in this application.

3. In the event there are no applicable documents pertaining to a specified Appendix in the table below, include the appropriate lettered tab with a sheet of paper indicating "Not Applicable."

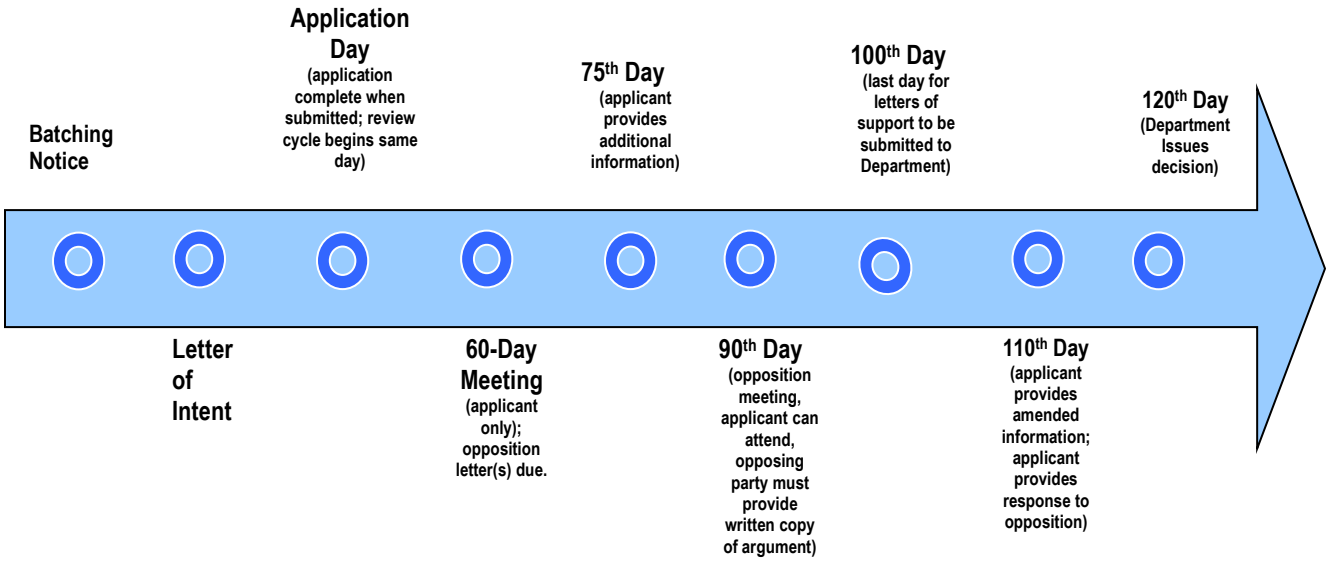
TABLE OF APPENDICES	
Appendix Name	**Appendix Letter**
Proof of Submission to County Commission	A
Licenses/Permits	B
Organizational Structure	C
Site Entitlement	D
Supplemental Need Documentation	E
Supplemental Existing Alternatives Documentation	F
Required Financial Feasibility Documentation	G
Supplemental Effects on Payors Documentation	H
Architectural Documentation	I
Required Financial Accessibility Documentation	J
Supplemental Documentation re: Relationship to Health Care Delivery System	K
Supplemental Documentation re: Efficient Utilization, Non-Resident Services, Research Projects, Assistance to Health Professional Programs, Improvements and Innovation, Needs of HMOs, Quality Standards, Resources and Provision of Underreported health services, if applicable.	L
Letters of Support	M
Required Documentation for Service-Specific Review Considerations (See Page 37 and 38 for Explanation)	N, O, etc.

☞ **NOTE:** *Supplemental documentation is documentation such as magazine articles, research papers, newspaper articles, etc., which cannot be reproduced or created in MS Word format.*

OVERVIEW OF REVIEW PROCESS

BATCHED APPLICATIONS

SEQUENCE OF CERTIFICATE OF NEED APPLICATION REVIEW ACTIVITIES



► Batching Notice issued 30 days before Letter of Intent Due

► Letter of Intent received by Department 30 days before application is submitted

► Applications submitted; deemed complete; review cycle begins

► 60-Day meeting (applicant only); deadline for receipt of opposition letter(s)

► 75th day – applicant provides additional information

► 90th day – Opposition Meeting(s) scheduled; applicant can be in attendance; opposing parties must provide written statement of opposition arguments presented to the Department via the online web portal and provide a copy to the applicant; presentation time will be limited; Department reserves the right to make additional inquiries subsequent to the 60-day meeting and following the opposition meeting.

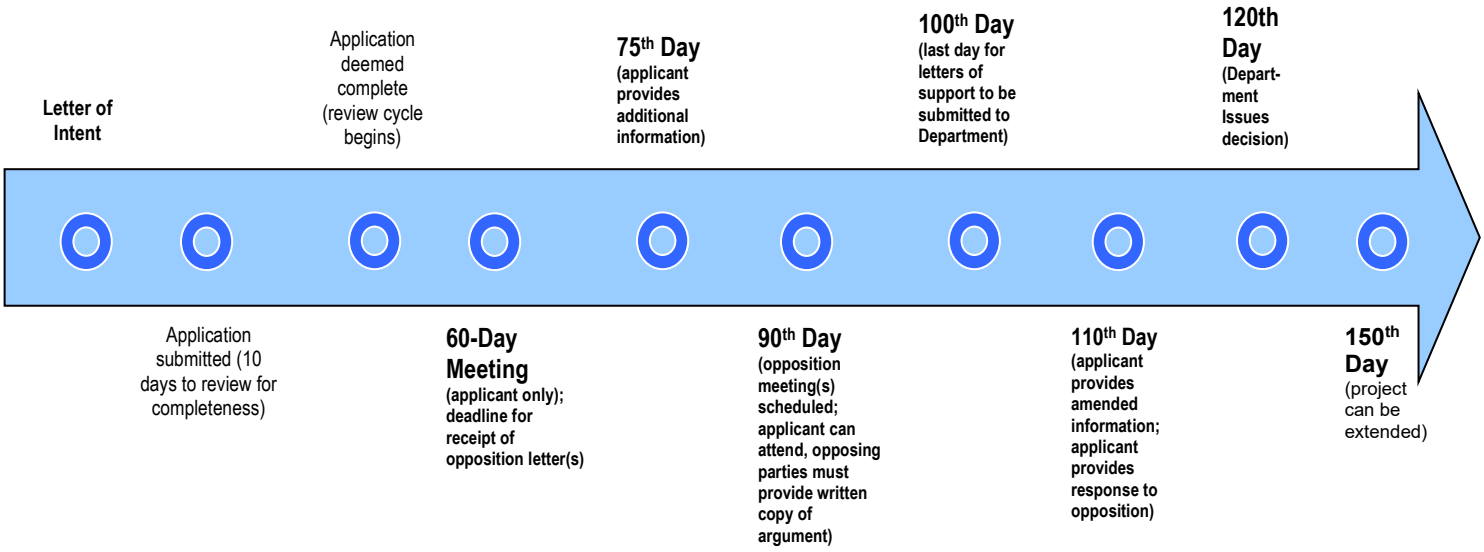
► 100th day last day for letters of support to be submitted to the Department

► 110th day applicant deadline for submitting amended information; applicant deadline for providing written response to opposition due to Department; applicant deadline for providing written response to Department's inquiries subsequent to opposition meeting

► 120th day Decision issued (No discretion to extend)

NON-BATCHED APPLICATIONS

SEQUENCE OF CERTIFICATE OF NEED APPLICATION REVIEW ACTIVITIES



► Letter of Intent received by Department 30 days before application is submitted

► Application submitted (10 working days to review for completeness)

► Application deemed complete; 120-day review cycle begins

► 60-day meeting (applicant only); deadline for receipt of opposition letter(s)

► 75th day applicant provides additional information

► 90th day – Opposition Meeting(s) scheduled; applicant can be in attendance; opposing parties must provide written statement of opposition arguments presented to the Department via the online web portal and provide a copy to the applicant; presentation time will be limited; Department reserves the right to make additional inquiries subsequent to the 60-day meeting and following the opposition meeting.

► 100th day last day for letters of support to be submitted to the Department

► 110th day applicant deadline for submitting amended information; applicant deadline for providing written response to opposition; applicant deadline for providing written response to Department's inquiries subsequent to opposition meeting

► 120th day Decision issued (Department has discretion to extend to 150th day)

Section 1: General Identifying Information

1. Enter the following information for the person or entity that will offer or develop the new institutional health service. If applicable, this information should correspond with the information submitted to the Department's Healthcare Facility Regulation Division as the "Name of the Governing Body." The contact person should be a person directly affiliated with the Applicant and not a consultant or attorney.

APPLICANT		
Applicant Legal Name:		
d/b/a (if applicable):		
Address:		
City:	State:	Zip:
County:	Main Business Phone:	
Parent Organization:		
CONTACT PERSON		
Name:	Title or Position:	
Phone:	Fax:	
E-mail Address:		

2. Is the name of the facility or proposed facility different than the Applicant's legal name? ☐ **YES** ☐ **NO**

If **YES** ➔ Enter the facility information below. If applicable, this information should correspond to the "Name of Facility" maintained by the Department's Healthcare Facility Regulation Division.

If **NO** ➔ Continue to the next question.

FACILITY		
Facility Name:		
Facility Address:		
City:	State:	Zip:
County:	Phone:	

3. If the facility is currently existing, is it currently licensed or permitted by the Department's Healthcare Facility Regulation Division?

☐ **YES** ☐ **NO** ☐ **Not Applicable**

If **YES** ➔ 🗁 Attach a copy of any and all licenses and permits at **APPENDIX B**.

If **NO** ➔ Continue to the next question.

If **Not Applicable** ➔ Check one of the following: ☐ Not Currently Existing (Proposed Only)
☐ No License or Permit Required

4. Is the legal owner of the facility different than the Applicant? ☐ **YES** ☐ **NO**

If **YES** ➔ Identify the legal owner and all individuals or entities that own 10 percent interest or more in the facility. Include complete names, addresses, and telephone numbers.

If **NO** ➔ Continue to the next question.

OWNER #1		
Name:		
Address:		
City:	State:	Zip:
Phone:		
OWNER #2		
Name:		
Address:		
City:	State:	Zip:
Phone:		
OWNER #3		
Name:		
Address:		
City:	State:	Zip:
Phone:		

5. Check the appropriate box to indicate the type of **ownership of the Facility**. Check only **one** box.

TAX EXEMPT	☐ Not-for-Profit Corporation		
	☐ Public (Hospital Authority or Government)		
TAX PAYING	☐ General Partnership	☐ Business Corporation	☐ Sole Proprietor
	☐ Limited Liability Partnership	☐ Limited Liability Corporation	

6. Will the **entire** facility be operated by an entity other than the Applicant or the legal owner?

☐ **YES** ☐ **NO**

If **YES** ➔ Identify the operator and include the complete name, address, and telephone number.

If **NO** ➔ Continue to Question 8.

OPERATOR		
Name:		
Address:		
City:	State:	Zip:
Phone:		

7. Check the appropriate box to indicate the type of **operator**. Check only **one** box.

TAX EXEMPT	☐ Not-for-Profit Corporation		
	☐ Public (Hospital Authority or Government)		
TAX PAYING	☐ General Partnership	☐ Business Corporation	☐ Sole Proprietor
	☐ Limited Liability Partnership	☐ Limited Liability Corporation	

8. Please provide documentation of the organizational and legal structure of the Applicant as indicated in the table below. 🗁 Attach this documentation as **APPENDIX C**. Please attach the documents in the order they are listed.

ORGANIZATIONAL STRUCTURE	
Not-for-Profit Corporation	☐ Name of Each Officer and Director ☐ Articles of Incorporation ☐ Certificate of Existence ☐ Bylaws ☐ Organizational Chart(s) ☐ Application/Authorization to do Business in Georgia (for Non-Resident Corporations)
Public (Hospital Authority or Government)	☐ All Governing Authority Approvals for this Application and Project ☐ Bylaws ☐ Organizational Chart(s)

ORGANIZATIONAL STRUCTURE	
Sole Proprietor	☐ County and Municipal Government Business Authorization Documents (e.g. Licenses, Permits, Etc.) ☐ Bylaws ☐ Organizational Chart(s)
General Partnership	☐ Name, Partnership Interest, and Percentage Ownership of Each Partner ☐ Partnership Agreement ☐ Certificate of Existence ☐ Bylaws ☐ Organizational Chart(s)
Limited Liability Partnership	☐ Name, Partnership Interest, and Percentage Ownership of Each Partner ☐ Partnership Agreement ☐ Certificate of Existence ☐ Certificate of Registration ☐ Articles of Organization ☐ Bylaws ☐ Organizational Chart(s)
Business Corporation	☐ Name of Each Officer and Director ☐ Articles of Incorporation ☐ Certificate of Existence ☐ Bylaws ☐ Organizational Chart(s) ☐ Application/Authorization to do Business in Georgia (for Non-Resident Corporations)
Limited Liability Corporation	☐ Name of Each Officer and Director ☐ Articles of Incorporation ☐ Operating Agreement ☐ Certificate of Existence ☐ Bylaws ☐ Organizational Chart(s) ☐ Application/Authorization to do Business in Georgia (for Non-Resident Corporations)

9. If you have identified the Applicant as a Not-for-Profit Corporation, Business Corporation, or Limited Liability Corporation, explain the corporate structure and the manner in which all entities relate to the Applicant.

☞ **NOTE:** *Do not exceed the allotted space for your response.*

10. Does the Applicant have Legal Counsel to whom legal questions regarding this application may be addressed?

☐ **YES** ☐ **NO**

If **YES** ➔ Identify the lead attorney below.

If **NO** ➔ Continue to the next question.

LEGAL COUNSEL		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

11. Did a Consultant prepare and/or provide information in this application? ☐ **YES** ☐ **NO**

If **YES** ➔ Identify the Consultant below.

If **NO** ➔ Continue to the next question.

CONSULTANT		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

12. Does the Applicant wish to designate and authorize an individual other than the Applicant Contact listed in response to Question 1 to act as the representative of the Applicant for purposes of this application?

☐ **YES** ☐ **NO**

If **YES** ➔ Please complete the information in the table on the next page. By doing so, the Applicant authorizes the representative to submit this CON application and make amendments thereto; to provide the Department of Community Health with all information necessary for a determination on this application; to enter into agreements with the Department of Community Health in connection with this CON; and to receive and respond, if applicable, to notices in matters relating to this CON.

If **NO** ➔ Continue to the next question.

AUTHORIZED REPRESENTATIVE		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

☞ **NOTE:** *This authorization will remain in effect for this application until written notice of termination is sent to the Department of Community Health that references the specific CON application number. Any such termination <u>must</u> identify a new authorized representative. Also, if the authorized representative's contact information changes at any time, the Applicant must immediately notify the Department of Community Health of any such change.*

13. Does the Applicant have any lobbyist employed, retained, or affiliated with the Applicant directly or through its contact person or authorized representative?

☐ **YES** ☐ **NO**

If **YES** ➔ Please complete the information in the table below for each lobbyist employed, retained, or affiliated with the Applicant. Be sure to check the box indicating that the Lobbyist has been registered with the State Ethics Commission. Executive Order 10.01.03.01 and Rule 111-1-2-.03(2) require such registration.

If **NO** ➔ Continue to the next question.

LOBBYIST DISCLOSURE STATEMENT		
Name of Lobbyist	**Affiliation with Applicant**	**Registered with State Ethics Commission?**
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No

Section 2: Project Description

14. Indicate the type of facility that will be involved in the project.

FACILITY TYPE	
☐ Birthing Center	☐ Hospital
☐ Continuing Care Retirement Community (CCRC)	☐ Nursing or Intermediate Care Facility
☐ Freestanding Ambulatory Surgery Center	☐ Personal Care Home
☐ Home Health Agency	☐ Traumatic Brain Injury Facility
☐ Freestanding Emergency Department	
☐ Diagnostic, Treatment or Rehabilitation Center (DTRC) ☐ Freestanding Single-Modality Imaging Center ☐ Freestanding Multi-Modality Imaging Center ☐ Mobile Imaging ☐ Practice-Based Imaging ☐ Other:	

15. Indicate the services that will be involved or affected by this project.

SERVICES		
ACUTE	***Hospital Inpatient***	***Diagnostic Services***
	☐ Medical/Surgical ☐ Open Heart Surgery ☐ Pediatric ☐ Obstetrics ☐ ICU/CCU ☐ Newborn, ICU/INT ☐ Newborn/Nursery ☐ Rehabilitation ☐ Acute, Burn, Other Specialty ☐ Long Term Acute Care ☐ Inpatient, Other ☐ Psychiatric, Adult ☐ Substance Abuse, Adult ☐ Psychiatric, Child/Adolescent ☐ Substance Abuse, Child/Adolescent ☐ Psychiatric, Extended Care ☐ Destination Cancer Hospital	☐ Computerized Tomography (CT) Scanner ☐ Magnetic Resonance Imaging (MRI) ☐ Positron Emission Tomography (PET) ☐ Diagnostic Center, Cancer/Specialty ***Other Outpatient Services*** ☐ Ambulatory Surgery ☐ Birthing Center ***Clinical/Surgical*** ☐ Emergency Medical ☐ Emergency Medical, Trauma Center ☐ Adult Cardiac Catheterization ☐ Gamma Knife ☐ Lithotripsy ☐ Pediatric Cardiac Catheterization ☐ Megavoltage Radiation Therapy
LONG-TERM	☐ Skilled Nursing Care ☐ Intermediate Nursing Care ☐ Continuing Care Retirement Community (CCRC)	☐ Personal Care Home ☐ Traumatic Brain Injury (TBI) ☐ Home Health
OTHER	☐ Administrative Support ☐ Non-Patient Care, Other	☐ Grounds/Parking ☐ Medical Office Building

16. Check the most appropriate category(ies) for this project. Check all that apply.

PROJECT CATEGORY	
Construction	***Service Change***
☐ New Facility	☐ New Service
☐ Expansion of Existing Facility	☐ Expansion of Service
☐ Renovation of Existing Facility	☐ Expansion or Acquisition of Service Area
☐ Replacement of Existing Facility	☐ Consolidation of Service
Procurement of Medical Equipment	☐ Relocation of Facility
☐ Purchase	☐ Other
☐ Lease	
☐ Donation (fair market value must be used)	

17. Please provide the following site information for the facility and services identified in this application. Check the appropriate box to indicate the current status of the site acquisition. 🗁 Attach the appropriate documents that provide for the Applicant's entitlement to the site at **APPENDIX D**.

☞ **NOTE:** *If an unsigned lease is attached, include a letter documenting both parties' commitment to participate in the lease once the CON is approved, if applicable*.

PROJECT SITE INFORMATION		
Street Address:		
City:	County:	Zip:
Number of Acres:		
Status of Site Acquisition		
☐ Purchased (attach deed)	☐ Leased (attach lease)	
☐ Under Option (attach option agreement)	☐ Under Contract (attach contract or bill of sale)	
☐ Other; please specify:		
Zoning		
Is the site appropriately zoned to permit its use for the purpose stated within the application?	☐ YES ☐ NO	
If NO ➔ Describe what steps have been taken to obtain the correct zoning and the anticipated date of re-zoning:		
Encumbrances		
Are there any encumbrances that may interfere with the use of the site, such as mortgages, liens, assessments, easements, rights-of-way, building restrictions, or flood plains?	☐ YES ☐ NO	

18. Provide a detailed description of the proposed project including a listing of the departments (e.g. ED, ICU), services, (e.g. Home Health, Cardiac Cath), and equipment (e.g. MRI, PET, Cath) involved.

☞ **NOTE:** *If your description exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 9.1, the second Page 9.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 9.1, etc. behind this Page 9.*

Section 3: General Review Considerations

All Certificate of Need applications are evaluated to determine their compliance with the general review considerations contained in Rule 111-2-2-.09. Please document how the proposed project conforms with the following general review considerations.

Rule 111-2-2-.09(1)(a): Consistency with State Health Plan

The proposed new institutional health service is reasonably consistent with the relevant general goals and objectives of the State Health Plan.

19. Explain how the project is consistent with the State Health Plan or why it does not apply. Also explain how the application is consistent with the Applicant's own long range plans.

☞ **NOTE:** *If your explanation exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 10.1, the second Page 10.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 10.1, etc. behind this Page 10.*

Rule 111-2-2-.09(1)(b): Need

The population residing in the area served, or to be served, by the new institutional health service has a need for such services.

20. Please explain the need for your particular project or service. For services for which a need methodology exists in the State Health Plan, please use the said methodology. In submitting information to explain the need for your project, please also use the following guidelines:

- For any population projections, the official projections of the Office of Planning and Budget should be utilized;
- Include maps that clearly define both the primary and secondary service areas and identify all other providers of the proposed service that lie within the primary and secondary service area on such maps;
- 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, visitors, and employees; and
- For services that already have documented utilization rates, include such historical utilization data, and projections for future utilization.

☞ **NOTE:** *If your explanation exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 11.1, the second Page 11.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 11.1, etc. behind this Page 11.*

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that supports the need for your project into **APPENDIX E**. All documents such as tables, charts, and maps that support your need analysis and that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in the note above.

Rule 111-2-2-.09(1)(c): Existing Alternatives

Existing alternatives for providing services in the service area the same as the new institutional health service proposed are neither currently available, implemented, similarly utilized, nor capable of providing a less costly alternative, or no Certificate of Need to provide such alternative services has been issued by the Department and is currently valid.

21. Identify existing health care facilities and services and those approved for development in the service or planning area. Describe how your service differs in terms of population served from the existing and approved services. Describe how the proposed project will enhance service delivery in the service or planning area. Also, explain the internal organizational alternatives that the Applicant considered.

☞ **NOTE:** *If your explanation exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 12.1, the second Page 12.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 12.1, etc. behind this Page 12.*

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of existing alternatives into **APPENDIX F**. All documents such as tables, charts, and maps that you wish to use to analyze the existing alternatives and that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in the note above.

Rule 111-2-2-.09(1)(d): Financial Feasibility

The project can be adequately financed and is, in the immediate and long-term, financially feasible.

22. Provide project cost estimates for the following categories. *Enter in whole dollar amounts except Cost / Sq. Ft.*

PROJECT COST ESTIMATES			
Type of Cost	**Amount**	**Sq. Ft.**	**Cost / Sq. Ft.**
COSTS APPLICABLE TO FILING FEE			
Construction			
(1) New Facility Costs			
(2) Expansion Costs			
(3) Renovation Costs			
(4) Architectural and Engineering Fees			
(5) Subtotal Construction			
Equipment			
(6) Fixed Equipment (not in construction contract)			
(7) Moveable Equipment			
(8) Subtotal Equipment			
Other			
(9) Contingency			
(10) Legal and Administrative Fees			
(11) Interim Financing			
(12) Underwriting Costs			
(13) Building and Fire Code Compliance			
(14) Other:			
(15) Subtotal Other			
(16) TOTAL COST APPLICABLE TO FILING FEE			
COSTS EXCLUDED FROM FILING FEE			
(17) Site Acquisition Cost			
(18) Predevelopment Costs			
(a) Preparation of Site			
(b) Development and Preparation of CON Application			
(19) Subtotal Predevelopment			
(20) Escrow for Debt Service			
(21) TOTAL COST EXCLUDED FROM FILING FEE			
(22) GRAND TOTAL ESTIMATED PROJECT COST			

← *Add Lines 1 through 4*

🗁 Attach Purchase Orders or Quotes for All Major Medical Equipment at **APPENDIX G**.

← *Add Lines 6 through 7*

← *Add Lines 9 through 14*

← *Add Lines 5, 8 and 15*

☞ **NOTE:** *Enter the Amount of Line 16 on the Cover Page at Item 2 of the Submission Table.*

← *Add Lines 18a and 18b*

← *Add Lines 17, 19, and 20*

← *Add Lines 16 and 21*

☞ **NOTE:** *Use the amount of Line 22 for all responses throughout this application except for calculating the filing fee.*

23. Indicate the anticipated sources of **funds** for the proposed capital expenditures if any. Specify the amount received from each source. Round to whole dollar amounts. 🗁 Attach documentation indicating the current availability of grants, private contributions, and unrestricted reserves, if any, at **Appendix G**.

Fund Sources	
Source	**Amount**
DEBT	
(1) Revenue Certificates (Bonds)	
(2) General Obligation Bonds	
(3) Commercial Loans	
(4) Government Loans	
EQUITY	
(5) Grants	
(6) Private Contributions (Philanthropy)	
(7) Public Campaign	
(8) Unrestricted Reserves on Hand (Cash)	
(9) Other (please specify):	
(10) TOTAL ESTIMATED FUNDS	

🗁 If you enter debt financing sources, provide the following in **APPENDIX G**:

1. Contingency letters of commitment from a bank or other reputable lending institution(s) indicating its interest in financing the project if a Certificate of Need is issued to the Applicant that states the anticipated terms, including the interest rate, frequency of payments, total amount to be borrowed, and the duration of the financial obligation.
2. Amortization schedules including the interest, principal, depreciation and amortization by year.

← *Add Lines 1 through 9*

☞ **NOTE:** *The amount of Line 10 should equal the amount of Line 22 of Question 22 above.*

24. Does the Applicant undergo annual financial audits? ☐ **YES** ☐ **NO**

If **YES** ➔ 🗁 Attach the most recent financial audit at **APPENDIX G**.

If **NO** ➔ Please provide Balance Sheets, Bank Statements, Tax Returns, or other financial statements verifying income. 🗁 Attach this documentation in **APPENDIX G**.

25. Provide pro forma income and expense projections for the first two years of operation following the anticipated completion of the project. Identify all the assumptions used to develop the pro forma statement. Indicate the period covered for the first and second years.

Pro Forma Income and Expense Projections		
Type of Income or Expense	**First Year** (mm/yy)	**Second Year** (mm/yy)
Period Covered (Month and Year)	*to*	*to*
(1) Number of Beds/Rooms/Procedures/Patients		
(2) Projected Percent Occupied or Utilized	%	%
REVENUES		
(3) Inpatient Revenues		
(4) Outpatient Revenues		
Add Lines 3 and 4 (5) Patient Revenues		
(6) Other Revenues		
Add Lines 5 and 6 **(7) GROSS REVENUES**		
Deductions From Revenues		
(8) Indigent and Charity Care		
(9) Bad Debt		
(10) Contractual Adjustments		
Medicaid		
Medicare		
Other		
(11) Other Free Care		
Add Lines 8, 9, 10 & 11 **(12) TOTAL DEDUCTIONS**		
Subtract Line 12 from Line 7 **(13) NET REVENUES**		
EXPENSES		
Direct Expenses		
(14) Salaries and Benefits		
(15) Supplies		
(16) Other		
Add Lines 14 through 16 **(17) DIRECT EXPENSES**		
Indirect Expenses		
(18) Depreciation		
(19) Amortization		
(20) Interest		

Pro Forma Income and Expense Projections		
Type of Income or Expense	**First Year** (mm/yy)	**Second Year** (mm/yy)
Period Covered (Month and Year)	*to*	*to*
(21) Other		
Add Lines 18 through 21 **(22) INDIRECT EXPENSES**		
Add Lines 17 & 22 **(23) TOTAL EXPENSES**		
INCOME / (LOSS)		
Subtract Line 23 from Line 13 **(24) Income / (Loss)**		
(25) Income Taxes		
Subtract Line 25 from Line 24 **(26) NET INCOME / (LOSS)**		
GROSS PATIENT REVENUE BY SOURCE		
Government		
(27) Medicare		
(28) Medicaid		
(29) Other Government		
Add Lines 27 through 29 **(30) Government**		
Nongovernmental		
(31) Third Party Payors		
(32) Self-Pay		
(33) Other Nongovernmental		
Add Lines 31 through 33 **(34) Nongovernmental**		
Add Lines 30 and 34 **(35) TOTAL, ALL SOURCES**		

☞ **NOTE:** These amounts must equal *"Patient Revenues"* under line 5 on Page 15

Briefly outline the assumptions made for each line item of statistics entered in the Pro Forma Income and Expense Projections above.

PRO FORMA ASSUMPTIONS
(1) Number of Beds/Rooms/Procedures/Patients:
(2) Projected Percent Occupied or Utilized:
(3) Inpatient Revenues:
(4) Outpatient Revenues:
(6) Other Revenues:
(8) Indigent and Charity Care:
(9) Bad Debt:

PRO FORMA ASSUMPTIONS
(10) Contractual Adjustments:
(11) Other Free Care:
(14) Salaries and Benefits:
(15) Supplies:
(16) Other:
(18) Depreciation:
(19) Amortization:
(20) Interest:

PRO FORMA ASSUMPTIONS
(21) Other Indirect Expense:
(25) Income Taxes:
(27) Medicare:
(28) Medicaid:
(29) Other Government:
(31) Third Party Payors:
(32) Self-Pay:

26. Provide details of the Applicant's total existing indebtedness in the following table:

Lender Name	Origination Date	Due Date	Outstanding Principal	Interest Rate	Associated Capital Project CON/LNR # (if applicable)
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	

27. Please provide the following information about staffing levels. Indicate the number of existing and proposed employees for the second operating year following the project's completion. Please express in full-time equivalents.

Staffing Levels (Full-Time Equivalents)			
Position	**Existing**	**Proposed**	**Total**
Registered Nurse			
Licensed Practical Nurse			
Licensed Nurse Practitioner or Other Advanced Practice Nurse			
Nurse Midwife			
Nursing Assistant			
Physician			
Pharmacist			
Dentist			
Social Worker			
Certified Addiction Counselor			
Audiologist			
Radiological Technician			
Surgical Technician			
Physical Therapist			
Respiratory Therapist			
Occupational Therapist			
Psychologist			
Speech - Language Pathologist			
Medical Laboratory Technologist			
Personal Care Aide			
Home Health Aide			
Total Other Staff			

28. Describe plans for securing the services of professional, administrative, and paramedical personnel. Describe the current availability of staff as well as plans for training and recruiting the required personnel. Include institutional agreements and other supporting documents. Do not exceed the space provided.

Rule 111-2-2-.09(1)(e): Effects on Payors

The effects of the new institutional health service on payors for health services, including governmental payors, are reasonable.

29. Provide data to show the trend in **current** and **projected** charges under the facility's existing operations. For proposed new facilities or services, provide data to show the trend in charges at other facilities that are owned and/or operated by the Applicant, if applicable.

☞ **NOTE:** *If your explanation exceeds this blocked space or you need to attach tables or graphs, attach additional 8-½ by 11-inch pages, number the first sheet Page 23.1, the second Page 23.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 23.1, etc. behind this Page 23.*

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of the effect on payors of your project into **APPENDIX H**. All documents such as tables, charts, and maps that you wish to use to analyze the effect on payors and that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in the note above.

Rule 111-2-2-.09(1)(f): Construction Methods and Costs

The costs and methods of a proposed construction project, including the costs and methods of energy provision and conservation, are reasonable and adequate for quality health care.

30. Provide the following information about the architect or engineer who has been engaged to design this project. Include documentation of the architect or engineer's registration in Georgia.

CHIEF ARCHITECT/ENGINEER		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:		
Registration Number:		

31. Project Completion Forecast. Complete the following project completion forecast. It is important that you supply feasible and well-planned dates because if you do not complete your project or implement your project in a timely fashion, your Certificate of Need will be subject to revocation. For projects that do not involve construction, enter days and dates for those events that are applicable; for example, Equipment Installed and Final Progress Report Submitted.

PROJECT COMPLETION FORECAST		
Event	**Days Required to Complete**	**Proposed Completion Date**
1. Final Architectural Plans and Specifications		
2. Plans approved by State Architect		
3. Enforceable Construction Contract Signed		
4. Building Permit Secured		
5. Materials on Site		
6. Site Preparation Completed		
7. Construction 25% Complete		
8. Construction 50% Complete		
9. Construction 75% Complete		
10. Equipment Installed (If Applicable)		
11. Construction 100% Complete		
12. License Obtained from DCH's Healthcare Facility Regulation Division		
13. New Institutional Health Service Offered		
14. Final Progress Report Submitted		

In addition to the table above, if major components of the proposed project will be completed and become operational prior to the overall completion of the project (for example department or services will be developed in phases) indicate below the anticipated date of completion for each component.

Will major components of the proposed project be developed in phases? ☐ **YES** ☐ **NO**

If **YES** ➔ Complete the following table. ☞ **NOTE:** *If your components or phases exceed the number of rows in the table, attach an additional 8-½ by 11-inch sheet containing a replica of this table, number the first sheet Page 25.1, the second Page 25.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 25.1, etc. behind this Page 25.*

If **NO** ➔ Continue to the next question.

COMPONENT/PHASED COMPLETION FORECAST		
Component, Department, or Phase	**Days Required to Complete**	**Proposed Completion Date**

☞ **NOTE:** *If litigation regarding this application, and approval thereof, occurs, the completion forecast will be adjusted at the time of the final resolution to reflect the actual effective date, if the final resolution is in favor of the application.*

32. Please provide the information in the chart below if your project involves any construction or remodeling. 🗁 Attach the requested information in **APPENDIX I** in the order listed in the chart below.

Architectural Documents	
1. Architect Certification	Provide a letter from the architect certifying the construction and/or renovation costs for the project. The letter must include the total square footage, the total cost of construction, the cost per square foot for construction, and the cost per square foot for renovations. These amounts should match the amounts shown on Lines 1 through 5 of Question 22. ***This letter must be prepared within 60 days of submission of the application.***
2. Schematic Plans	Provide schematic plans for the project and include at least the following information: • Plans for each floor that clearly show the relationship between departments and services and the room arrangements for each. Indicate the function of each room or space. • Proposed roads, walkways, service courts, entrance courts, parking, and orientation should be shown on either a plot plan or the first floor plan. • Provide a cross-sectional diagram that indicates the type of construction and building materials. • If the proposed construction is an addition or if it is otherwise related to existing buildings on the site, the schematic plans should show the facilities and the general arrangement of those buildings. ☞ **NOTE:** *These plans should be provided on paper no larger than 8 ½- in. by 11-in. If such plans cannot be reproduced legibly at this size, the plans must be submitted as a high-resolution PDF document included with the application.*
3. Plot Plan	Provide a plot plan of the site including at least the following: dimensions of the property lines; the locations of major structures, easements, rights-of-way, and encroachments; the location of the proposed facility or expansion; and the relationship of the facility to additional structures, if any, on the campus.

Rule 111-2-2-.09(1)(g): Financial Accessibility

The new institutional health service proposed is reasonably financially and physically accessible to the residents of the proposed service area and will not discriminate by virtue of race, age, sex, handicap, color, creed or ethnic affiliation.

33. In order for the Department to evaluate the extent to which each Applicant proposes to provide, or has provided, health care services for those unable to pay, address each of the following review considerations concerning such financial accessibility by providing written narrative as well as documentation:

a. The Applicant should have policies and directives related to the acceptance of financially indigent, medically indigent, Medicaid, PeachCare, and Medicare patients for necessary treatment. Explain how the Applicant meets this requirement. Limit your response to the space provided.

🗁 Attach the requested policies and directives as **APPENDIX J**.

b. The Applicant should have policies ensuring that medical staff privileges allow a reasonable acceptance of referrals of Medicaid patients, PeachCare patients, and all other patients who are unable to pay all or a portion of their health care costs. Explain how the Applicant meets this requirement. Limit your response to the space provided.

🗁 Attach the requested policies and directives as **APPENDIX J**.

c. The Applicant must provide evidence of specific efforts made to provide information to patients regarding arrangements for satisfying incurred health care charges. Explain how the Applicant meets this requirement. Limit your response to the space provided.

d. The Applicant should, if applicable, have documented records of funds received from the county, city, philanthropic agencies, donations, and any other source of funds (other than from direct operations) for the provision of health care services to indigent, Medicaid, and PeachCare patients. Explain how the Applicant meets this requirement. Limit your response to the space provided.

e. The Applicant should have documented records as evidence of the Applicant's commitment to participate in the Medicaid, Medicare, and PeachCare programs, as well as the Applicant's commitment to provide health care services to all presenters regardless of race, gender, disability, or ability to pay, and the Applicant's commitment to providing charity care. Explain how the Applicant meets this requirement. Limit your response to the space provided.

f. The Applicant should have documented records as evidence that the levels of health care provided correspond to a reasonable proportion of those persons who are medically indigent and those who are eligible for Medicare, Medicaid or PeachCare within the service area. Attached records of care provided to patients unable to pay should include Medicare and Medicaid adjustments, PeachCare, other indigent care, and other itemized deductions from revenue, including bad debt. Explain how the Applicant meets this requirement. Limit your response to the space provided.

🗁 Attach any evidence directly supporting your explanation as **APPENDIX J**.

34. Has the Applicant made any previous indigent and charity care commitments associated with a **previous** Certificate of Need application?

☐ **YES** ☐ **NO**

If **YES** ➔ Complete the following table. Specify the information requested for each applicable facility and/or service. Also, attach sheets to indicate how the amount of the commitment was determined.

If **NO** ➔ Continue to the next question.

Previous Indigent/Charity Care Commitments				
Facility/Service	**Project Number**	**Date of Approval**	**Percent of Adjusted Gross Revenue**	**Outcome**
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met

35. Is the Applicant making an indigent and charity care commitment for **this** project?

☐ **YES** ☐ **NO**

If **YES** ➔ Complete the information requested below. Note that failure to meet an indigent and charity care commitment could result in fines and constitute grounds for an adverse ruling on a future Certificate of Need application.

If **NO** ➔ Continue to the next question.

Is the commitment voluntary, or is it required by a specific Certificate of Need rule?

☐ Voluntary ☐ Mandatory

Is the commitment service-specific or hospital-wide?

☐ Service-Specific ☐ Hospital-Wide

In the space provided below, describe the commitment and include its amount and effective date(s). Indicate what percentage of adjusted gross revenues the commitment represents.

Rule 111-2-2-.09(1)(h): Relationship to Health Care Delivery System

The proposed new institutional health service has a positive relationship to the existing health care delivery system in the service area.

36. In the space provided below, explain how the proposed new institutional health service will complement existing services, provide services for which there is a target population, provide an alternative to existing services, or provide services for which there is an unmet need. You may wish to list referral arrangements and working relationships with other providers.

☞ **NOTE:** *If your explanation exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 31.1, the second Page 31.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 31.1, etc. behind this Page 31.*

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of the relationship of your project to the health care delivery system into **APPENDIX K**. All documents such as tables, charts, and maps that you wish to use to analyze the relationship with the health care delivery system and that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in the note above.

Rule 111-2-2-.09(1)(i): Efficient Utilization

The proposed new institutional health service encourages more efficient utilization of the health care facility proposing such service.

37. State how your proposed project will enhance delivery of the services within your facility. Do not exceed the space provided for your response.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of the effect your project on utilization into **APPENDIX L**.

Rule 111-2-2-.09(1)(j): Non-Resident Services

The proposed new institutional health service provides, or would provide a substantial portion of its services to individuals not residing in its defined service area or the adjacent service area.

38. State how your proposed project provides or will provide a substantial portion of the proposed services to individuals not residing in the defined service area or the adjacent service area. Limit your response to the space provided. If this consideration is not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you wish to use to demonstrate how your project conforms to this rule into **APPENDIX L**.

Rule 111-2-2-.09(1)(k): Research Projects

The proposed new institutional health service conducts biomedical or behavioral research projects or a new service development, which is designed to meet a national, regional, or statewide need.

39. State how your proposed project includes research projects or develops new services that will meet a national, regional, or statewide need. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you wish to use to demonstrate how your project conforms with this rule on research projects into **APPENDIX L**.

Rule 111-2-2-.09(1)(l): Assistance to Health Professional Programs

The proposed new institutional health service meets the clinical needs of health professional training programs.

40. State how your proposed project will meet the clinical needs of health professional programs, which request assistance. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of how your project addresses the needs of health professional programs into **APPENDIX L**.

Rule 111-2-2-.09(1)(m): Improvements and Innovation

The proposed new institutional health service fosters improvements or innovations in the financing or delivery of health services; promotes health care quality assurance that can be documented with outcomes greater than those which are generally in keeping with accepted clinical guidelines, peer review programs and comparable state rates for similar populations; promotes cost effectiveness; or fosters improvements or innovations in the financing or delivery of health services; or fosters competition that is shown to result in lower patient costs without a significant deterioration in the quality of care;

41. State how your proposed project fosters improvements or innovations in the financing or delivery of health services, promotes health care quality assurance or cost effectiveness, or fosters competition. Limit your response to the space provided.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize to demonstrate your projects compliance with this rule consideration into **APPENDIX L**.

Rule 111-2-2-.09(1)(n): Needs of HMOs

The proposed new institutional health service fosters the special needs and circumstances of Health Maintenance Organizations.

42. State how your proposed project fosters the special needs of HMOs. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of the effect of your project on the needs of HMOs into **APPENDIX L**.

Rule 111-2-2-.09(1)(o): Minimum Quality Standards

The proposed new institutional health service meets the Department's minimum quality standards, including, but not limited to, standards relating to accreditation, minimum volumes, quality improvements, assurance practices, and utilization review procedures.

43. State how your proposed new institutional health service meets the department's minimum quality standards. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis into **APPENDIX L**.

Rule 111-2-2-.09(1)(p): Necessary Resources

The proposed new institutional health service can obtain the necessary resources, including health care management personnel.

44. State how your proposed new institutional health service meets the department's requirement to be able to obtain the necessary resources. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis into **APPENDIX L**.

Rule 111-2-2-.09(1)(q): Underrepresented Health Service

The proposed new institutional health service is an underrepresented health service, as determined annually by the Department. The Department shall, by rule, provide for an advantage to equally qualified applicants that agree to provide an underrepresented service in addition to the services for which the application was originally submitted.

45. State how your proposed new institutional health service meets the department's requirement regarding provision of an underrepresented health service. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis into **APPENDIX L**.

Rule 111-2-2-.09(2): Destination Cancer Hospital

46. State how your proposed new institutional health service meets the department's requirements for a destination cancer hospital under the rule cited above. Include your response in **Appendix L.**

Rule 111-2-2-.09(4): Basic Perinatal Services

47. State how your proposed new institutional health service meets the department's requirements for Basic Perinatal Services under the rule cited above. Include your response in **Appendix L.**

Section 4: Service-Specific Review Considerations

48. The following table documents the service-specific review considerations currently utilized by the Department.

a) Carefully review this table and place a checkmark in the box provided for any and all service-specific review considerations that apply to your project.

SERVICE-SPECIFIC CONSIDERATIONS				
	Service	**Rule Number**	**Check if Applicable & Included**	**Appendix Letter** See instructions at (d) on next page
ACUTE CARE	Short Stay General Hospital Services	111-2-2-.20	☐	
	Adult Cardiac Catheterization Services	111-2-2-.21	☐	
	Open Heart Surgical Services	111-2-2-.22	☐	
	Pediatric Cardiac Catheterization and Open Heart Services	111-2-2-.23	☐	
	Perinatal Services	111-2-2-.24	☐	
	Freestanding Birthing Center Services	111-2-2-.25	☐	
	Psychiatric and Substance Abuse Inpatient Services	111-2-2-.26	☐	
LONG-TERM CARE	Skilled Nursing and Intermediate Care Facility Services	111-2-2-.30	☐	
	Personal Care Home Services	111-2-2-.31	☐	
	Home Health Services	111-2-2-.32	☐	
	Life Plan Community Sheltered Nursing Facilities	111-2-2-.33	☐	
	Traumatic Brain Injury Services	111-2-2-.34	☐	
	Comprehensive Inpatient Physical Rehabilitation Services	111-2-2-.35	☐	
OTHER	Ambulatory Surgical Services	111-2-2-.40	☐	
	Positron Emission Tomography Services	111-2-2-.41	☐	
	MegaVoltage Radiation Therapy Services/Units	111-2-2-.42	☐	

CONTINUED ON NEXT PAGE

b) After reviewing the table above and indicating the applicable considerations by placing a check mark in the appropriate rows, obtain a copy of each set of service-specific review considerations that apply to this Certificate of Need application and project. These considerations are available on the Department's website at www.dch.georgia.gov.

c) After obtaining the service-specific review considerations, the Applicant should document the project's compliance with each of the applicable rule standards. Attach the applicable considerations to this document. Number the pages of your service-specific considerations starting at Page 38.1, 38.2, etc. and insert them once printed behind this Page 38. If more than one set of service-specific considerations is applicable to your project include them behind this Page starting at Page 38.1 in the order that the considerations appear in the table above. Clearly label each new set of service-specific considerations at the top of page.

d) 🗁 Attach all substantiating documents and supplemental information required by a set of service-specific review considerations in **APPENDIX N**. If addressing more than one set of service-specific considerations place the substantiating documents in response to the first set of service-specific considerations in **APPENDIX N**, documents relating to the second set in **APPENDIX O**, and so forth until each applicable set of service-specific considerations has its own appendix for substantiating documents and supplemental information. Enter the corresponding letter in the Appendix Letter column in the table on the previous page. Within each Appendix, place the documents and supplemental information in the order in which such items are asked for in the applicable service-specific review standards.

NOTE: The Appendices described in (d) above should only be utilized for substantiating documents and supplemental information required by the service-specific review considerations that cannot be reproduced or created as an MS Word document, e.g. QA Policies, Referral Agreements, etc. All documents such as tables, charts, and maps that you wish to use to utilize in your analysis of particular service-specific review considerations that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in (c) above.

THE REMAINDER OF THIS PAGE LEFT BLANK.

CERTIFICATION OF APPLICANT

By signing below,

a) I hereby certify that the contained statements and all addenda, appendices, or attachments hereto are true and complete to the best of my knowledge and belief and that I possess the authority to submit this application and bind the Applicant to promises made herein;

b) I understand that a representative of the Office of Health Planning may make a direct request of me for additional information in order to deem this application complete;

c) I further understand that if awarded a Certificate of Need, information must be provided to the Office of Health Planning regarding the progress, scope, and costs associated with the project. Consequently, I agree and certify that the Applicant will submit progress reports as required by Rule 111-2-2-.04(2), which specifies the frequency and the content of the progress reports. I understand that failure to comply with these reporting requirements may result in penalties, up to and including revocation of the Certificate of Need;

d) I further understand that if issued a Certificate of Need, the Applicant is bound to any representations that have been made within this application and any and all supplemental information; and

e) I certify that the Applicant will accept a condition or conditions on the award of a Certificate of Need based upon any representation of intent contained herein.

APPLICANT CERTIFICATION	
Signature of Authorized Signatory (BLUE INK ONLY):	
Name:	
Title:	Date: