Facility Type: Hospice File A License #: 630 West App#6535 file#630 Date Completed_____

INITIAL APPLICATION STAFF CHECKLIST & SUPERVISORY REVIEW

✓ 1. If a Certificate of Need (CON) is required, received CON

✓ 2. Received appropriate and most recent application with all areas completed including signature, date, & notarization verifying the application.

✓ 3. Correct Fees Received 1/31/24 Online

✓ 4. Applicant provides proof of ability to meet financial obligationss **(Note: For Assisted Care Living Facilities, Adult Care Homes Level II, and Traumatic Brain Injury (TBI) Residential Homes the financial statements are required be prepared and signed by a Certified Public Account in accordance with Standards for ACLF's, ACH Level II and TBI rules).**

✓ 5. In LARS open "application" under application choose "initial approval" to begin processing initial application. **(Note: Application in process will be good up to one (1) year upon receipt before the LARs system will automatically close the application. At 45 days out from the initial application expiration, send Application 45 day Expire Letter to applicant. If the facility is under a Certificate of Need, the initial application will expire when the CON is due to expire).**

✓ 6. Enter all fields in the PSD (Basic Data) section

✓ 7. Enter all Modifiers (as required)

✓ 8. Enter all section (MA, ML, AA, EC, OW, OB, MAFX under list of addresses and if required PA, HO, MF) information in LARS, provide a LARS "letter of acknowledgment" to the facility.

✓ 9. Provide a copy of the initial application to Regional Office, Plans Review (if required), and Information Services Technology Division

✓ 10. Signed Occupancy Approval form received from the Regional Office including verification CD received by Plans Review

✓ 11. Finalize the "initial application" by entering in LARs PSD (Basic Date) the survey date and ensure all transactions have been completed and hit approve. This will then assign the License Number as an "Initial Approval".

_____ 12. Generate LARs "Initial Approval" letter with an effective date and provide the ratification dates for when the next ~~Board~~ Commission meeting is scheduled.

_____ 13. Provide a copy of Initial Application package to Board administrator for placement to the agenda for ratification

_____ **14. After ratification by the Board, submit final initial packet to supervisor for supervisory review**

_____ 15. After receipt of a completed & signed supervisory review, complete the Board ratified "initial application" in LARs by going to application, under Ratified by the Board, finalize and provide a LARs generated letter approving license with the effective date of the initial approval date and ratified by the Board approval date.

_____ 16. LARs system generates Wall Certificate. Once received from the data center affix with a gold seal and provide to the facility via mail.

Items numbered 1 – 14 have been verified as accurate & complete.

_____ _____

Supervisor Signature Date

Notes: _____

_____

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: Hospice License # (if applicable): _____ County: Montgomery

Initial X Renovation _____ Satellite/Off Campus Location _____

Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) **(Circle One)**

Facility Name: Interim Healthcare of Montgomery County

Address: 540 Heritage Pointe Dr., Suite A City: Clarksville, TN Zip Code: 37042

Application and fee on file in Central Office (CO)?: Yes ____ No ____ CON #: _____

Project #: _____ Phase: _____ of _____

Facility approved for (if satellite/off campus site include address): To provide in-home hospice services with the service area of Cheatham, Montgomery, and Robertson Counties

Sprinklered: _____(Full 100%) Partial: _____(%)

Licensed bed count from: _____ to _____ Number of beds increased/decreased: _____

If secured unit, number of beds in unit: _____ If Alzheimer's unit, number of beds in unit: _____
(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)

Health Surveyor: Karissa Blake, PHNC1 Date: 5/28/2024

Fire Safety: _____ Date: _____

CD Approved: Yes____ No____ N/A____ Health Survey Required: Yes____ No____

Facility's Letter of Notification received in Licensure: Yes ____ No ____
(Completed by Central Office Licensure Staff)

CMS Paperwork (855, etc) approved and received in regional office: Yes ____ No ____
(NOTE: With exception of Initial Licensure Approvals)

Effective date: ~~5/28/2024~~ 8/14/2024 Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

Kathy Zeigler, RA/DPM 8/8/2024
Regional Administrator/Facilities Construction Director or Designee Date

Licensure Program Unit Staff 8/14/2024 Date

State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-7221

January 31, 2024 **Sent Via Email**

Erica Pahua
Interim Healthcare of Montgomery County
540 Heritage Pointe Drive, Suite A
Clarksville, Tennessee 37042-1006

Dear Erica Pahua:

This is to acknowledge receipt of your application and fee to apply for licensure of Interim Healthcare of Montgomery County. Please review the instruction sheet that you received with the application to apply for licensure so that you are aware of the process for obtaining licensure of your facility. If a certificate of need is required to provide services, you will need to contact *Health Services and Developmental Agency* at (615) 741-2364.

Please remember that if you are applying for licensure of a facility that requires an architectural plans review contact Plans Review for complete and details and procedures at (615) 741-6998. You must submit those plans along with the plans review fee prior to scheduling a survey. **For Homes for the Aged facilities specifically; TCA-368-11-202 allows "schematics shall be submitted to the department for approval of plans and specifications, converting and existing single family dwelling" with six (6) or less beds.**

It is your responsibility to contact the West Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to West Tennessee, Regional Administrator, 295 Summar Drive, Floor 2, Jackson, Tennessee 38301. If you would like to fax the request to Kathy Zeigler) the fax number is 731-427-0407.

Your application and fee will be held in a pending status until you are recommended by the Regional Office for licensure. Once the recommendation for licensure is received from the regional office, your facility will receive a letter for "Initial Approval." Admission of patients MAY NOT occur until the facility's receipt of the "Initial Approval" letter. Your application will be presented before the Board for Licensing Health Care Facilities for ratification and final approval at the next regularly scheduled board meeting. Your facility CAN operate once you receive the "Initial Approval."

This application will only be good for one (1) years from the date of receipt. If the initial licensure has not occurred within that one (1) year period you will be required to submit a new application and fee unless you have contacted our office in writing extending your application.

In the event that a certificate of need is required prior to obtaining a license for this facility the application file will be closed the day following the expiration date of the certificate of need.

Should you have any questions or if I can be of assistance to you please call me at (615) 741-7202 or you may email me at Mary.2.Clark@tn.gov.

Sincerely,

Mary Louise Clark

Mary Louise Clark, ASA 2

ITSD/ West file# 630 App#6535

Application Summary

Application Detail

License Type:	**Hospice Services: Licensed**
Application:	**Hospice Services: Initial Application**
Application Date:	**01/30/2024 (mm/dd/yyyy)**

Organization Detail

Organization Name:	**Interim Healthcare of Montgomery County**
Organization Type:	**Corporation**

Addresses

Main Address

Address:	**540 Heritage Pointe Dr.** **Suite A** **MONTGOMERY** **Clarksville, TN** **37042-1006** **US**
Phone Number:	**615-989-6753**
Extension:	
E-mail Address:	**epahua@interimhealthcare.com**

Administrative

Name:	**Interim Healthcare of Montgomery County**
Address:	**540 Heritage Pointe Dr.** **Suite A** **MONTGOMERY** **Clarksville, TN** **37042** **US**
Phone Number:	**818-317-3013**

Extension:	
E-mail Address:	**epahua@interimhealthcare.com**

Emergency Contact

Name:	**Interim Healthcare of Montgomery County**
Address:	**4484 N Pinson Rd** **ROBERTSON** **Portland, TN** **37148** **US**
Phone Number:	**818-201-5001**
Extension:	
E-mail Address:	**fpahua@interimheathcare.com**

Ownership of Building

Name:	**Sunrise Properties**
Address:	**540 Heritage Pointe Dr.** **MONTGOMERY** **Clarksville, TN** **37042-1006** **US**
Phone Number:	**931-980-7500**
Extension:	
E-mail Address:	**ttower@bellsouth.net**

Legal Entity

Name:	**Pahua Health Inc**
Address:	**540 Heritage Pointe Dr.** **Suite A** **MONTGOMERY** **Clarksville, TN**

	37042-1006
	US
Phone Number:	**615-989-6753**
Extension:	
E-mail Address:	**fpahua@interimhealthcare.com**

License Attributes Selected

Qualification/Certification	**Cheatham**
	Montgomery
	Robertson
Additional License Information	**For Profit**

Basic License Data

Enter number of branch offices, if none enter 00	**00**
Provide Administrator's Name:	**Erica Pahua**
Provide the Ownership's Name:	**Pahua Health Inc**
Is your facility accredited by a federally approved accrediting body?	**No**
What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?	**Other**
Provide a Yes or No, if your facility is Chain Affiliated:	**No**
Provide a Yes or No, if your facility has a Holding Company	**No**
Do you have Other Licensed Facilities in the state of Tennessee and/or other states?	**No**
Provide a Yes or No, if your facility has a Parent Company:	**No**
Do you have a contract with a management firm to operate this facility?	**No**
Have any owners ever been denied a license, had a license suspended or revoke,	**No**

had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state?	
Certificate of Need Number:	**CN2311-026A**
Provide a Yes or No, if your facility is under a court ordered receivership:	**No**

Administrator's Conviction Information

Administrator convicted of crime?:	**No**

Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?:	**No**
Have any of owners of the disclosing entity had a suspension of admissions?:	**No**
Have any of the owners of the disclosing entity paid any civil monetary penalties for a health care facility in Tennessee or any other state?:	**No**

File Attachments

Hospice Approval Letter.pdf

Statement.pdf

Fees

Initial License Fee	**$1404.00**
Total Amount Due:	**$1404.00**

Attestation

I, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a Hospice Services facility in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Hospice Services facility. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without

malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

TN Department of Health

Online Payment Receipt

Receipt Issued By:
Board for Licensing Health Care Facilities

Receipt Issued To:
Pahua Health Inc
540 Heritage Pointe Dr.
Clarksville, TN 37042-1006

Date: 01/30/2024
Transaction Identifier: 3866675158
Trace Number: 1876727

License Type	Licensee	Transaction	Application #	Account #	Amount
Hospice Services	Pahua Health Inc DBA Interim Healthcare of Montgomery County	Hospice Services: Initial Application	549-6535	**********1687	$1404.00

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

February 28, 2024

Erica Pahua, Owner
Interim Healthcare of Montgomery County
4484 N Pinson Rd.
Portland, TN 37148

RE: Interim Healthcare of Montgomery County – CN2311-026A

Dear Ms. Pahua:

As referenced in our recent letter, please find enclosed your Certificate of Need for the above-referenced application that was approved at the January 24, 2024, meeting of the Tennessee Health Facilities Commission.

The Health Facilities Commission Rules require that an *Annual Progress Report be submitted each year* and a *Final Project Report form is to be submitted within ninety (90) days after completion of a project* which shall include completion date, final costs, and other relevant information in regard to the project, per § 68-11-1611.

The aforementioned forms can be found on the Commission's website at www.tennessee.gov/HSDA. Should you have any questions or require further information regarding this Certificate, please do not hesitate to contact this office.

Sincerely,

Logan Grant
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA
Ann R. Reed, HFC

STATE OF TENNESSEE
Health Facilities Commission

Certificate of Need # **CN2311-026A** is hereby granted under the provisions of T.C.A. § 68-11-1601, *et seq.*, and rules and regulations issued thereunder by this Commission.

To: **Pahua Health Inc.**
4484 N Pinson Rd.
Portland, TN 37148

For: **Interim Healthcare of Montgomery County**

This Certificate is issued for:

For the establishment of a home care organization and the initiation of in-home hospice services. The proposed service area will consist of Cheatham, Davidson, Montgomery, Robertson, Rutherford, and Williamson Counties. The applicant is owned in equal partnership between Erica Pahua (50%) and Francisco Pahua (50%).

On the premises located at: **540 Heritage Pointe Dr.**
Clarksville (Montgomery County), TN 37042

For an estimated project cost of **$23,400.00**

LIMITATION: Limited to Cheatham, Montgomery, and Robertson Counties.

The Expiration Date for this Certificate of Need is **March 1, 2026,** or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the expiration date, this Certificate of Need is null and void.

Date Approved: January 24, 2024

Chairman

Date Issued: February 28, 2024

Executive Director

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

January 24, 2024

Erica Pahua, Owner
Interim Healthcare of Montgomery County
4484 N Pinson Rd.
Portland, TN 37148

RE: Certificate of Need Application – Interim Healthcare of Montgomery County – CN2311-026A

Dear Ms. Pahua,

On January 24, 2024, the Tennessee Health Facilities Commission met in regular session to consider your application. The application proposed the following:

> For the establishment of a home care organization and the initiation of in-home hospice services. The hospice's principal office will be located at 540 Heritage Pointe Drive, Clarksville (Montgomery County), Tennessee 37042. The proposed service area will consist of Cheatham, Davidson, Montgomery, Robertson, Rutherford, and Williamson Counties. The applicant is owned in equal partnership between Erica Pahua (50%) and Francisco Pahua (50%). Estimated project cost: $23,400.

This letter is to advise you that the Commission voted to ***approve*** the Certificate of Need for the referenced project with service area of **Cheatham, Montgomery, and Robertson Counties.**

Per TCA § 68-11-1609(b) the Commission found the application should be approved because the action proposed in the application is necessary to provide needed health care in the area to be served, *will provide health care that meets appropriate quality standards*, and the effects attributed to competition or duplication would be positive for consumers. Please note consumer advantage language was added as the third criterion necessary for a Certificate of Need to be granted, effective October 1, 2021.

Commission members made this decision after full consideration of all the information provided to them including but not limited to the original application and supplemental responses; staff summary and licensing Commission comments, if applicable; support and opposition letters, if applicable; consideration of the criteria and standards. Commission Rules; and all additional evidence gathered during the presentation of the application. The HFC maintains a publicly available detailed written record that fully documents the factual and legal basis for this decision.

In accordance with T.C.A. § 68-11-1609(g)(1) (as amended by Public Chapter 780, Acts of 2002), the applicant or any person who filed directly with the Commission a prior objection to the granting of a Certificate of Need may petition the Commission in writing for a hearing. To be timely filed, the petition must be filed within fifteen (15) days from the date of the Commission's meeting at

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

which the challenged action was taken. You are encouraged to review T.C.A. § 68-11-1610(a) and the Commission Rules so that you may fully understand your rights.

Your Certificate of Need will be issued to you within the next sixty (60) days and transmitted under separate letter. Please note that the Certificate of Need has an expiration date on its face, after which time the Certificate is null and void. The expiration date is strictly enforced, and the certification period can only be extended by the Commission upon written application and for good cause shown, as defined by Commission Rules.

T.C.A. § 68-11-1611 requires that the Commission review annual progress of each project. Commission Rules require that within ninety (90) days after completion of a project that a Final Project Form be submitted to this office. The Annual Progress Report form is available on the Commission website at http://www.tn.gov/hsda/article/con-forms. The Final Project Form, which shall include completion date, final costs, and other relevant information, is also available on the Commission website at http://www.tn.gov/hsda/article/con-forms. These forms may be filled-in, printed, and submitted with any applicable supporting documentation. These forms may also be obtained by contacting us at the phone number or address listed above.

Please note an additional requirement was added per PC 1043, effective July 1, 2016. It is codified at TCA § 68-11-1609 (h) and it directs the Health Facilities Commission to maintain continuing oversight of certificates of need approved after July 1, 2016 by requiring applicants to submit annual reports concerning continued need and appropriate quality measures as determined by the Commission. The Commission may impose conditions that require the demonstration of compliance with continued need and quality measures; provided, that the conditions for quality measures may not be more stringent than those measures identified in the applicant's submitted application. **Continuing oversight of this project will begin one year after project completion and will continue each year thereafter. The Annual Reporting Form will be available on the Commission's website.** The form may be filled-in, printed, and submitted with any applicable supporting documentation. It may also be obtained by contacting us at the phone number or address listed above.

If you have questions or require additional information, please feel free to contact this office.

Sincerely,

Logan Grant
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA
Ann R. Reed, HFC

bluevine

BlueVine Inc.
401 Warren St, Suite 300
Redwood City, CA 94063
www.bluevine.com
+1 (888) 216-9619

PAHUA HEALTH INC
Erica Pahua
540 Heritage Pointe Drive
Clarksville, TN 37042

Account statement

Account Number:
875103760968

Statement Period:
December 2023 (Dec. 1, 2023 - Dec. 31, 2023)

Activity summary

Beginning Balance on 12/01/2023	$542,950.19
Deposits/credits	$79,322.35
Withdrawals/debits	$-69,376.44
Ending balance on 12/31/2023	**$552,896.10**

Transactions

Date	Description	Amount
12/01/23	Interest earned in November 2023	$546.94
12/01/23	Tapcheck Inc., 8666976016	$-195.00
12/01/23	IHC, Payment	$-529.54
12/02/23	GOOGLE *GSUITE_INTERIM, Mountain View, USA	$-94.61
12/02/23	A PLACE FOR MOM INC, LEAWOOD, KS	$-175.00
12/04/23	SUNSHINE DREAMS, ACH , 931-980-7500	$-1,700.00
12/04/23	STATE OF TENNESS, GOVT NOTAX	$-3,000.00
12/05/23	PROG HAWAII INS, INS PREM	$-148.00
12/05/23	WPY*SMALL TOWN STARTUP, 855-999-3729, TN	$-892.50

12/05/23	Upwork -645143466REF, Upwork.com/bi, CA	$-535.50
12/05/23	INTERIM HEALTHCA, Settlement	$8,327.50
12/07/23	CONNECTEAM.COM, NEW YORK, NY	$-282.30
12/07/23	FRANKCRUM, PAYROLL	$-13,441.45
12/07/23	AXXESS TECHNOLOGIES, DALLAS, TX	$-625.00
12/08/23	AXXESS TECHNOLOGIES, DALLAS, TX	$-482.00
12/08/23	VSHP TN CARE SEL, HCCLAIMPMT	$2,312.00
12/08/23	VSHP VOL II FUND, HCCLAIMPMT	$9,814.10
12/08/23	VSHP VOL II FUND, HCCLAIMPMT	$3,850.00
12/08/23	Tapcheck Inc., 8666976016	$-429.00
12/08/23	IHC, Payment	$-644.13
12/08/23	IHC, Payment	$-2,000.00
12/12/23	Upwork -647311874REF, Upwork.com/bi, CA	$-534.27
12/13/23	INTERIM HEALTHCA, Settlement	$9,630.00
12/14/23	FRANKCRUM, PAYROLL	$-12,589.39
12/15/23	VSHP TN CARE SEL, HCCLAIMPMT	$1,054.00
12/15/23	Mobile Deposit 48be2952633eed	$936.84
12/15/23	Mobile Deposit 4bd51e29eceea0	$253.20
12/15/23	IHC, Payment	$-540.75
12/15/23	Tapcheck Inc., 8666976016	$-380.00
12/15/23	VSHP VOL II FUND, HCCLAIMPMT	$7,343.69
12/15/23	VSHP VOL II FUND, HCCLAIMPMT	$1,575.00
12/19/23	Upwork -649468103REF, Upwork.com/bi, CA	$-535.50
12/20/23	INTERIM HEALTHCA, Settlement	$8,565.00
12/20/23	PINNACLE INVESTI, SALE ,	$-148.22
12/20/23	PINNACLE INVESTI, SALE	$-347.30
12/20/23	PINNACLE INVESTI, SALE	$-419.06
12/20/23	PINNACLE INVESTI, SALE	$-77.05

12/20/23	PINNACLE INVESTI, SALE	$-2.00
12/21/23	FRANKCRUM, PAYROLL	$-12,482.99
12/22/23	Tapcheck Inc., 8666976016	$-533.00
12/22/23	VSHP VOL II FUND, HCCLAIMPMT	$7,601.61
12/22/23	VSHP VOL II FUND, HCCLAIMPMT	$2,100.00
12/22/23	VSHP TN CARE SEL, HCCLAIMPMT	$507.46
12/22/23	IHC, Payment	$-959.97
12/26/23	Upwork -651510327REF, Upwork.com/bi, CA	$-535.50
12/28/23	INTERIM HEALTHCA, Settlement	$4,530.00
12/29/23	IHC, Payment	$-959.97
12/29/23	VSHP TN CARE SEL, HCCLAIMPMT	$1,768.00
12/29/23	VSHP VOL II FUND, HCCLAIMPMT	$6,227.01
12/29/23	VSHP VOL II FUND, HCCLAIMPMT	$2,380.00
12/29/23	Tapcheck Inc., 8666976016	$-322.00
12/29/23	FRANKCRUM, PAYROLL	$-12,810.44
12/29/23	JACK HENRY & ASC, EPS	$-25.00

In case of errors or questions about your electronic funds transfers or non-electronic transactions, contact Customer Support at **1-888-216-9619** or via email at **banking.support@bluevine.com**. For additional information regarding the error or dispute process, review your Account Agreement, located in your Documents page at app.bluevine.com/dashboard/documents/.

Banking services provided by Coastal Community Bank, Member FDIC. This BlueVine Card is issued by Coastal Community Bank, Member FDIC, pursuant to license by Mastercard International.

Bluevine Business Checking Account Sweep Program Monthly Statement
Demand or Savings Option (formerly known as ICS®)

The following is a summary of your deposit balance held at each Program Bank as of the date indicated. These deposits have been placed by us, as your agent and custodian, in deposit accounts as described in the Bluevine Business Checking Account Agreement Sweep Disclosure.

Summary of balances as of December 31,2023

FDIC-Insured institution	Amount
Coastal Community Bank	$556,720.19

State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

August 15, 2024 Sent Via Email

Erica Pahua
Interim Healthcare of Montgomery County
540 Heritage Pointe Dr.
Suite A
Clarksville, Tennesee 37042

Facility Type: Hospice

Dear Erica Pahua:

It is my pleasure to inform you that your application for licensure of Interim Healthcare of Montgomery County located at 540 Heritage Pointe Dr., Ste. A, Clarksville, Tennessee 37042-1006 has been initially approved August 14, 2024. The license number shall be 630. For this initial approval to become final and permanent, your application must be ratified by the Commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for August 28, 2024. **You are hereby authorized to commence operation pending the final decision of the Commission**. No further action is necessary on your part currently.

For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The West Tennessee Regional Office phone number is 731-427-0407 .

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days, notifying you of the Commission final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,

Angela Tyler

Angela Tyler

cc: West Tennessee Regional Administrator
Office for Information Technology Services
Nerissa Harvey- Policy of Planning
Amanda Schaefer- Medicaid Prover Enrollment
Office of Health Statistics
Alecia Craighead- Health Facilities Commission