GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Letter of Intent Form - Batching Cycle
Georgia Certificate of Need

FOR CERTIFICATE OF NEED OFFICE USE ONLY

LETTER NUMBER

DATE STAMP

LOI#

GENERAL INFORMATION:

In accordance with CON Administrative Rule 111-2-2-.08(1)(c), *all parties interested in applying for the particular unmet need in a given service area must notify the Department of that party's intent to apply*. This Letter of Intent Form – Batching Cycle is the required notice of intent to submit an application for Certificate of Need during the batching review cycle for the following service:

SERVICES: Check the **one** service for which you are submitting this Letter of Intent.

- ☐ **Adult Open Heart Surgery**
- ☐ **Ambulatory Surgery Center**
- ☐ **Freestanding Birthing Centers**
- ☐ **Home Health Agency**
- ☐ **Intermediate Care Facilities**
- ☐ **Inpatient Physical Rehabilitation**
- ☐ **Skilled Nursing Facilities**
- ☐ **Megavoltage Radiation Therapy**
- ☐ **Pediatric Cardiac Cath/Open Heart Surgery**
- ☐ **PET Scanner Services**
- ☐ **Psych/Substance Abuse Services**
- ☒ **Perinatal Service :**
  - ☐ **Neonatal Intermediate** ☒ **Neonatal Intensive Care**
  - ☐ **Obstetrical Services**

Prospective applicants must submit a Letter of Intent only for a service as called for and specified in the applicable Batching Cycle Public Notice.

Failure to submit the required 3-page Letter of Intent Batching Cycle Form OR failure to complete all required fields on the form will result in non-acceptance of the Letter of Intent.

If the due date for the Letter of Intent falls on a weekend or holiday – when the Office of Health Planning is closed – the Letter of Intent will be accepted on the first business day following the weekend or holiday and is termed the "Rollover Day". Rollover Days will be specified on the Batching Cycle Public Notice in most instances.

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.

Submit the original form to:

Certificate of Need Program
Letter of Intent
Georgia Department of Community Health
Office of Health Planning
2 Peachtree Street, NW, 5th Floor
Atlanta, Georgia 30303

Requesting Party Identification

1. Please complete the following information identifying the party submitting this Letter of Intent.

Legal Applicant – Name and Address		
Legal Entity or Person: **Kennestone Hospital, Inc.**		
d/b/a (if applicable): **Wellstar Kennestone Hospital**		
Address 1: **677 Church Street**		
Address 2:		
City: **Marietta**	State: **Georgia**	Zip: **30060**
County: **Cobb**		
Parent Organization: **Wellstar Health System, Inc.**		
CONTACT PERSON (Person to whom inquiries concerning this Letter of Intent may be addressed)		
Name: **April Austin**	Title: **Manager, Strategic Planning**	
Address 1: **793 Sawyer Road**		
Address 2:		
City: **Marietta**	State: **Georgia**	Zip: **30062**
Phone: **470-644-0057**	Fax: **770-509-4217**	
E-mail: **april.austin@wellstar.org**		
Name, address of facility, if different from legal applicant		
Name:	Title:	
Address 1:		
Address 2:		
City:	State:	Zip:

Proposed Project Site Location		
Name, if applicable Wellstar Kennestone Hospital		
Address 1: **677 Church Street**		
Address 2:		
City: **Marietta**	State: **Georgia**	Zip: **30060**
County: **Cobb**		

Brief Summary/ Description of Proposal

Description of Proposal (300 words or less). *Please include the applicant's current service area, if applicable.*

Kennestone Hospital, Inc. d/b/a Wellstar Kennestone Hospital ("WKH") is proposing to expand its Neonatal Intensive Care Service (Level III) by adding 5 beds. WKH will apply pursuant to the exceptions to the need methodology referenced in Rule 111-2-2-.24(3)(b).

Planning Area (if applicable):

SSDR # ☐ **Neonatal Intensive Care #** ☑ 1 **HPA #** ☐ **Inpatient Physical Rehabilitation #** ☐

New Service? ☐ **Expanded Service?** ☒ **Total Projected Cost** **$264,000.00**

Proposed Service Area (List **All** Counties you propose to serve, if applicable)					
Cobb	Paulding	Cherokee	Bartow	Fulton	Douglas

Signature: (Print Name **and** Sign) Aviral Singh, VP, Marketing and Brand Strategy Aviral Singh

Date: m/d/yyyy 10/16/2020

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Certificate of Need Application and Form Submission

Use this form to upload and submit all Certificate of Need applications and forms.

Requesting Party Identification

Requesting Party Name * Kennestone Hospital, Inc. d/b/a Wellstar Kennestone Hospital
Legal entity or person

Address 1: 677 Church Street

Address 2:

City: Marietta **State:** Georgia **Zip:** 30060

County: Cobb

Contact Name: * April Austin

Contact Email: * april.austin@wellstar.org

Application or Form Submission

Application/Form or Letter Type * CON Batching Application Letter of Intent
Select the type of application or form that you are submitting.

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Prospective applicants must submit a Letter of Intent only for a service as called for and specified in the applicable Batching Cycle Public Notice.

Services: Check the **one** service for which you are submitting this Letter of Intent Form

Fall Batching Cycle Services

- ○ Ambulatory Surgery Center
- ○ Intermediate Care Facilities
- ○ Skilled Nursing Facilities
- ◉ Perinatal Service:
- ○ Home Health Agency
- ○ Inpatient Physical Rehabilitation
- ○ Obstetrical Services

File Upload * Kennestone LOI 5 Level III NICU Bed Addition.pdf 653.87KB
Click to browse and attach an electronic copy of your application/form and any other required attachments.

Additional attachments such as the check image should be included as a secondary or last page of the CON form or uploaded as separate files. Please do not add any pages before the first page of the CON form.

Submission Date/Time 10/16/2020
11:00:29 AM

Attestation

I state, certify and attest that this application for Certificate of Need, 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. I further state, certify and attest that with this submission, I have included a copy of the check or money order that will be remitted to the State of Georgia in connection with the filing fee associated with this application for Certificate of Need in the amount determined by the applicable fee schedule. I understand that with any failure to remit the required filing fee, the Department reserves the right to cease to review any pending Certificate of Need application. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Enter the text you want this field to display

Signature *

Signature Date *

10/16/2020