Original Application

Saint Thomas Highlands Hospital

CN1706-020

JUN 14 '17 PM 3:42

Senior Care

SAINT THOMAS HIGHLANDS HOSPITAL, LLC

SPARTA (WHITE COUNTY), TN

GEROPSYCHIATRIC 4-BED CONVERSION

CERTIFICATE OF NEED APPLICATION
JUNE 2017

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. *Name of Facility, Agency, or Institution*

Saint Thomas Highlands Hospital, LLC
Name

401 Sewell Road — White
Street or Route — County

Sparta — Tennessee — 38583
City — State — Zip Code

Website address: www.sthealth.com

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

2. *Contact Person Available for Responses to Questions*

Blake Estes — Exec. Dir., Strategy & Planning
Name — Title

Saint Thomas Health — blake.estes@sth.org
Company Name — Email address

102 Woodmont Blvd., Suite 800 — Nashville — TN — 37205
Street or Route — City — State — Zip Code

Authorized representative — 615-222-7235 — 615-284-7403
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

RESPONSE: Due to high patient utilization of an existing ten-bed geropsychiatric program, this project proposes to convert four existing medical-surgical beds to geropsychiatric beds. This approach is "bed neutral" and will not result in an increase in total licensed beds at the hospital.

Since 1992, the Senior Care program at Saint Thomas Highlands Hospital ("STHH") has been providing geropsychiatric inpatient services. Senior Care is a unit that provides optimum psychiatric care. The center specializes in working with older adults so that each person is treated as a unique and valuable individual by staff and physicians sensitive to the distinctive needs of seniors. Common diagnoses include dementia and Alzheimer's (65%) and depression and anxiety (16%).

The STHH Senior Care program is the only such inpatient program in the four county service area. STHH provides care to all patients regardless of sex, race, ethnicity or income. It also provides care to uninsured and low-income populations as well as TennCare patients. As a geropsychiatric program, the patient population is highly skewed toward Medicare patients and patients with medical comorbidities.

The ten-bed STHH Senior Care program has experienced steady and rapid (12.5%) growth in patient utilization over the past three years. It recorded 2,821 patient days in 2014, 3,080 patient days in 2015 and 3,175 patient days in 2016. The average daily census increased from 7.7 to 8.4 to 8.7 over this period. With ten beds, this amounts to utilization rates of 77%, 84% and 87%, respectively.

Even more significantly, recent data for the 181 days ending April 30, 2017 indicates that the Senior Care program operated at 90% to 100% capacity three-quarters of the time.

Provider support letters not only document STHH's existing community linkages, but they offer additional reasons to approve the four-bed conversion.

- The senior population is growing in the Upper Cumberland region.
- More patients are suffering from Alzheimer's, dementia, etc.
- Extra capacity at STHH Senior Care will allow more patient s to be served.
- Extra capacity at STHH Senior Care will allow patients to be served more quickly.

Since the STHH Senior Care program is the only such inpatient program in the service area, there is no duplication of services and there are no negative effects associated with this project. Converting four existing medical-surgical beds adjacent to the existing ten Senior Care beds at STHH was deemed the least costly, most effective and most efficient alternative to address the very high utilization of inpatient geropsychiatric beds.

There are no outstanding or unimplemented certificates of need held by the applicant.

2) Ownership structure;

RESPONSE: Highlands Hospital entered into a partnership with Saint Thomas Health in 2012 and was acquired outright in 2015. Saint Thomas Highlands Hospital, LLC is owned by Saint Thomas Regional Hospitals which is, in turn, owned by Saint Thomas Health. Saint Thomas is part of Ascension, the largest non-profit health system in the United States and the world's largest Catholic health system.

3) Service area;

RESPONSE: STHH Senior Care will continue to serve residents of White County (61% of STHH patients) and adjacent Putnam, Cumberland and Van Buren Counties (29% of STHH patients).

In 2017, the service area had an estimated senior population (age 65 and older) of 42,303. Official sources indicate that the service area senior population will grow by approximately 15.4% or 6,524 persons by 2021. This is somewhat lower growth than the 16.0% projected for Tennessee. The service area senior population is projected to comprise 26.3% of the total population, which is much greater than the 18.3% for Tennessee.

Given these population growth projections, demand for the services at STHH Senior Care is expected to increase.

4) Existing similar service providers;

RESPONSE: Since the STHH Senior Care program is the only such inpatient program in the service area, there is no duplication of services and there are no negative effects associated with this project.

5) Project cost;

RESPONSE: The cost to renovate 900 square feet of existing space is $358,226. On a square footage basis, the project is slightly above the Tennessee median cost and compares favorably to other hospital renovation projects.

6) Funding;

RESPONSE: Funding for the project will come from STHH's corporate parent organizations (i.e., Saint Thomas Health), where the hospital cash flows are consolidated.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

RESPONSE: As indicated in the Historical Data Chart and the Projected Data Chart, the STHH Senior Care program was financially feasible with 10 beds and is expected to remain financially feasible with 14 beds.

8) Staffing.

RESPONSE: The STHH Senior Care program is currently and appropriately staffed for a census of ten patients. A census of 12.6 patients is projected for Year 2 and will require approximately 4.6 more FTEs over the existing 15.9 FTEs. Additional staff will be recruited using the existing resources of both STHH and Saint Thomas Health.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

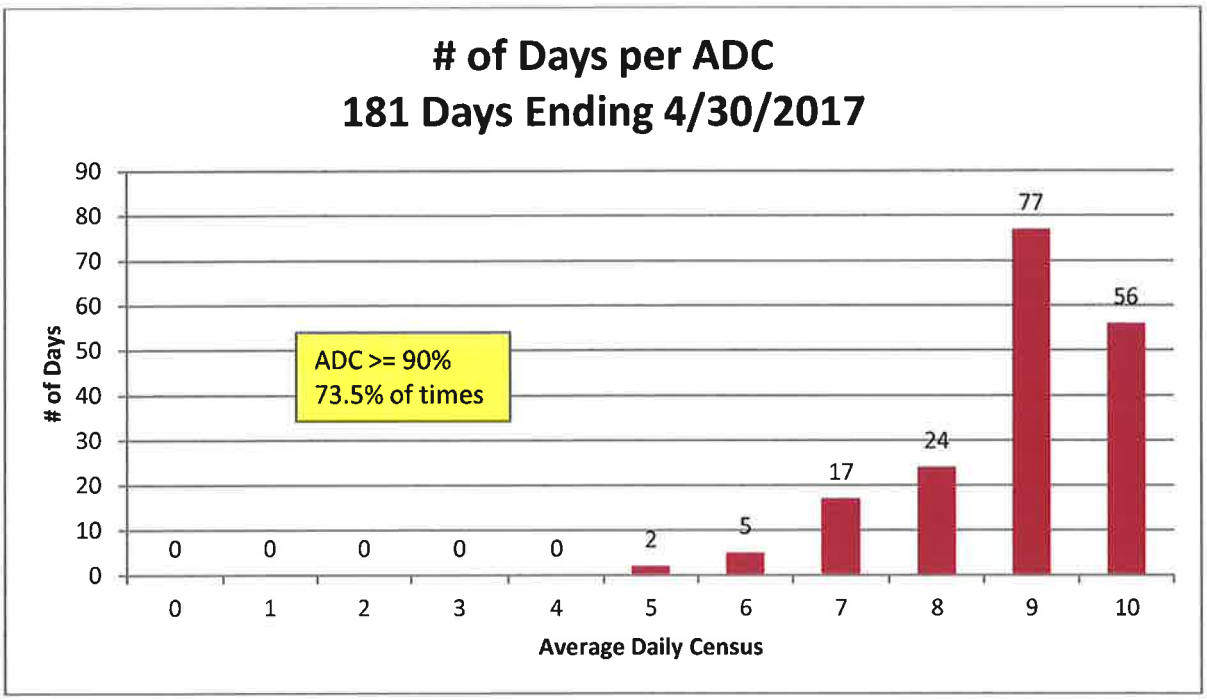
RESPONSE: Based upon STHH's existing patient origin, this project will continue to serve four counties – White, Cumberland, Putnam and Van Buren. Using the methodology in the State Health Plan for psychiatric inpatient services, there is a projected need for 4.6 additional geriatric (i.e., adults age 65+) psychiatric beds.

In addition to serving the 65+ population, 8.5% of the patients at the STHH Senior Care program are age 55-64. There is a projected need for 30.3 psychiatric beds for the 18-64 population.

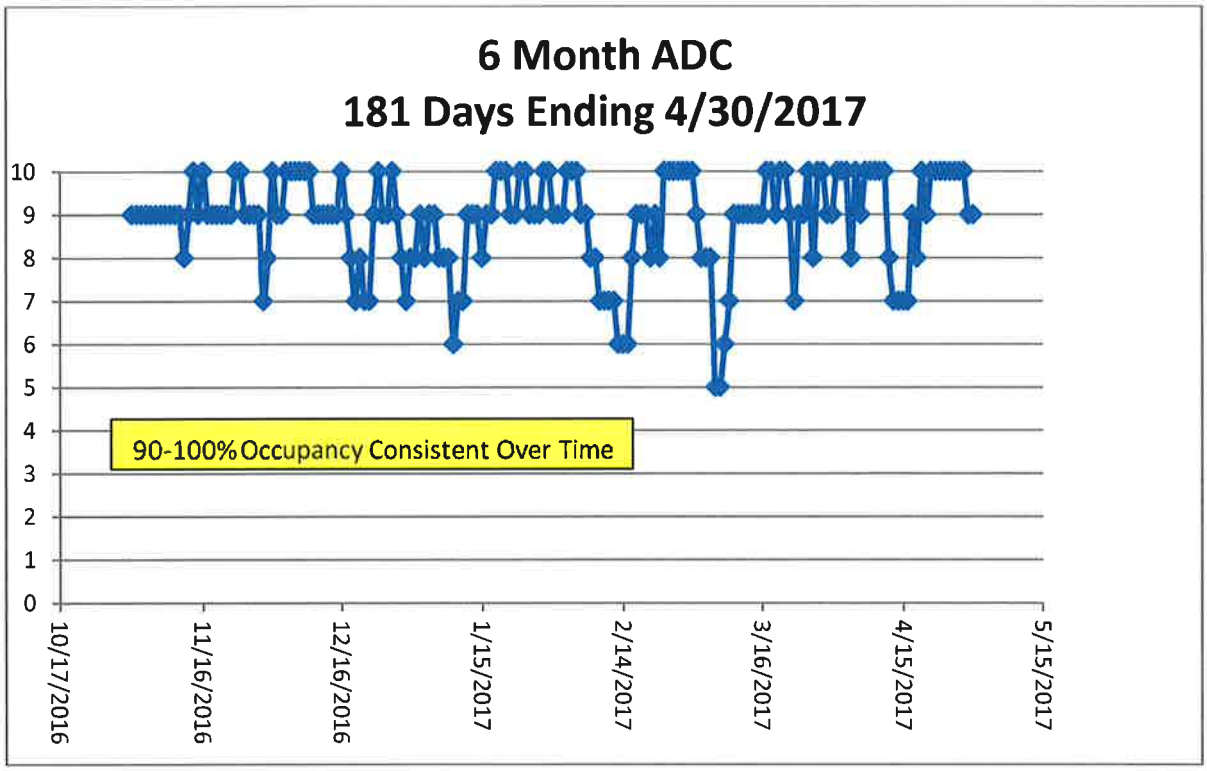
STHH is proposing to increase its geriatric psychiatric beds from 10 to 14 by converting 4 existing medical-surgical beds. This approach is "bed neutral" and will not result in an increase in total licensed beds at the hospital. STHH's project is consistent with the State Health Plan guidelines.

The ten-bed STHH Senior Care program has experienced steady and rapid (12.5%) growth in patient utilization over the past three years. It recorded 2,821 patient days in 2014, 3,080 patient days in 2015 and 3,175 patient days in 2016. The average daily census increased from 7.7 to 8.4 to 8.7 over this period. With ten beds, this amounts to utilization rates of 77%, 84% and 87%, respectively.

Even more significantly, recent data for the 181 days ending April 30, 2017 indicates that the Senior Care program operated at 90% to 100% capacity three-quarters of the time.



Furthermore, this high utilization was present throughout the entire six-month period.



Given this more recent experience, first year utilization (2018) is projected at 3,535 patient days (9.7 ADC) and second year utilization (2019) is projected at 4,615 patient days (12.6 ADC). With the four-bed conversion, the 9.7 ADC will be easily achieved with just existing patient demand. The 12.6 ADC in 2019 is certainly reasonable given that the STHH Senior Care program has been turning patients away due to a lack of available capacity. An ADC of 12.6 will result in 90% utilization on 14 beds, which is still well above the Agency's 80% target.

2) Economic Feasibility;

RESPONSE: As indicated in the Historical Data Chart and the Projected Data Chart, the STHH Senior Care program was financially feasible with 10 beds and is expected to remain financially feasible with 14 beds.

The cost to renovate 900 square feet of existing space is $358,226. On a square footage basis, the project is slightly above the Tennessee median cost and compares favorably to other hospital renovation projects.

STHH provides care to all patients regardless of sex, race, ethnicity or income. It also provides care to uninsured and low-income populations as well as TennCare patients. As a geropsychiatric program, the patient population is highly skewed toward Medicare patients and patients with medical comorbidities.

3) Appropriate Quality Standards; and

RESPONSE: STHH is licensed by the state of Tennessee and is accredited by The Joint Commission. As part of the Saint Thomas Health network, STHH also has access to a full range of quality and utilization management resources.

4) Orderly Development to adequate and effective health care.

RESPONSE: The STHH Senior Care program is the only such inpatient program in the service area. Thus, there is no duplication of services and there are no negative effects associated with this project. Converting four existing medical-surgical beds adjacent to the existing ten Senior Care beds at STHH was deemed the least costly, most effective and most efficient alternative to address the very high utilization of inpatient geropsychiatric beds.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

RESPONSE: Not applicable.

4. SECTION A: PROJECT DETAILS

A. ***Owner of the Facility, Agency or Institution***

Saint Thomas Highlands Hospital, LLC — 931-738-9211
Name — Phone Number

401 Sewell Road — White
Street or Route — County

Sparta — TN — 38583
City — State — Zip Code

B. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship	_____	F.	Government (State of TN or Political Subdivision)	_____
B.	Partnership	_____	G.	Joint Venture	_____
C.	Limited Partnership	_____	H.	Limited Liability Company	X
D.	Corporation (For Profit)	_____	I.	Other (Specify)_____	_____
E.	Corporation (Not-for-Profit)	_____			

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx.

RESPONSE: See **TAB 1, Attachment Section A-4AB-1.**

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

RESPONSE: See **TAB 2, Attachment Section A-4B-2.**

5. ***Name of Management/Operating Entity (If Applicable)***

Not Appliable
Name

_____ — _____
Street or Route — County

_____ — _____ — _____
City — State — Zip Code

Website address: _____

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.*

RESPONSE: Not Applicable

6A. ***Legal Interest in the Site of the Institution*** ***(Check One)***

A.	Ownership	X	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify) _____	
C.	Lease of 15 Years			_____	

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

RESPONSE: See **TAB 3, Attachment Section A-6A**.

6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1) Plot Plan **must include**:

   a. Size of site (***in acres***);

   b. Location of structure on the site;

   c. Location of the proposed construction/renovation; and

   d. Names of streets, roads or highway that cross or border the site.

   RESPONSE: See **TAB 4, Attachment Section A-6B-1**.

2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

   RESPONSE: See **TAB 5, Attachment Section A-6B-2**.

3) 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.

   RESPONSE: The Upper Cumberland Human Resource Agency ("UCHRA") operates a public transit system in 14 counties, including White County and the surrounding service area counties. According to the UCHRA web site, "This service is available to rural residents of all ages, giving first priority to elderly, handicapped and economically disadvantaged with medical needs while providing deviated fixed route and demand-response service."

   STHH and the city of Sparta are centrally located in White County. Nearby State Highway 111 provides north-south access to Putnam and Van Buren counties. US Highway 70 provides east-west access to Cumberland and DeKalb counties.

7. *Type of Institution* *(Check as appropriate--more than one response may apply)*

A.	Hospital (Specify) Geropsych	X	H	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		I.	Outpatient Diagnostic Center	
			J.	Rehabilitation Facility	
C.	ASTC, Single Specialty		K.	Residential Hospice	
D.	Home Health Agency		L.	Nonresidential Substitution-Based Treatment Center for Opiate Addiction	
E.	Hospice				
F.	Mental Health Hospital				
G.	Intellectual Disability Institutional Habilitation Facility ICF/IID		M.	Other (Specify)	

Check appropriate lines(s).

8. Purpose of Review *(Check appropriate lines(s) – more than one response may apply)*

A.	New Institution		F.	Change in Bed Complement *[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*	X
B.	Modifying an ASTC with limitation still required per CON				
C.	Addition of MRI Unit				
D.	Pediatric MRI				
E.	Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify)		G.	Satellite Emergency Dept.	
			H.	Change of Location	
			I.	Other (Specify)	

9. Medicaid/TennCare, Medicare Participation

MCO Contracts [Check all that apply]

X AmeriGroup X United Healthcare Community Plan X BlueCare X TennCare Select

Medicare Provider Number Hospital 440192, Psych Subprovider 44S192

Medicaid Provider Number Hospital 440192, Psych Subprovider 44S192

Certification Type General Hospital, Psychiatric Unit

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare __Yes __No X N/A Medicaid/TennCare __Yes __No X N/A

10. Bed Complement Data

A. **Please indicate current and proposed distribution and certification of facility beds.**

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical	46	12	-4			42
2) Surgical	"	"				"
3) ICU/CCU	4	4				4
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric	10	10	+4			14
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL	60	26	0			60

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

RESPONSE: As described more fully throughout this application, the existing 10 geriatric psychiatric beds at STHH have been operating at 90-100% utilization. Four additional beds are required to meet current and projected patient demand. At the time these four additional geriatric psychiatric beds open for patients, Highlands will de-license four medical-surgical beds. This approach will result in a "bed neutral" project, consistent with Saint Thomas' long standing goal to maximize existing resources to the fullest extent possible before increasing service capacity. See **Tab 6 – Attachment Section A-10,** for a letter from Mr. Andy Wachtel, President and CEO of Saint Thomas Highlands Hospital, attesting to these conditions.

C. **Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.**

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved
N/A		

11. Home Health Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply: – **RESPONSE: N/A**

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage and Cost Per Square Footage Chart

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Geropsych Unit	1st Floor	10 beds	N/A	1st Floor	900	0	900
Unit/Department GSF Sub-Total					900	0	900
Other GSF Total							
Total GSF					900	0	900
*Total Cost					$204,701	$0	$204,701
**Cost Per Square Foot					$227.45	0	$227.45
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)* **Response**: 2014-2016 Hospital Renovation Median = $218.86, 3rd Quartile = $287.95					☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☒ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☒ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator – RESPONSE: Not Applicable

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or
2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

A. Complete the chart below for acquired equipment.

☐ Linear Accelerator	Mev _____	Types:	☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____
	Total Cost*: _____		☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___
	☐ New	☐ Refurbished	☐ If not new, how old? (yrs) _____
☐ MRI	Tesla: _____	Magnet:	☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____
	Total Cost*: _____		☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___
	☐ New	☐ Refurbished	☐ If not new, how old? (yrs) _____
☐ PET	☐ PET only	☐ PET/CT	☐ PET/MRI
	Total Cost*: _____		☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___
	☐ New	☐ Refurbished	☐ If not new, how old? (yrs) _____

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*	Monday through Friday	8am - 5pm
Mobile Locations *(Applicant)*		
(Name of Other Location)		
(Name of Other Location)		

E. Identify the clinical applications to be provided that apply to the project.

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

QUESTIONS

SECTION B: NEED

A. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

RESPONSE: Two sets of criteria and standards are applicable to this project – Psychiatric Inpatient Services and Construction, Renovation, Expansion and Replacement of Health Care Institutions. See responses, below.

1) Psychiatric Inpatient Services

1. **Determination of Need:** The population-based estimate of the total need for psychiatric inpatient services is a guideline of 30 beds per 100,000 general population, using population estimates prepared by the TDH and applying the applicable data in the Joint Annual Report (JAR). These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds including certified beds in outstanding CONs operating in the area as counted by the TDH in the JAR. For adult programs, the age group of 18-64 years shall be used in calculating the estimated total number of beds needed; additionally, if an applicant proposes a geriatric psychiatric unit, the age range 65+ shall be used. For child inpatients, the age group is 12 and under, and if the program is for adolescents, the age group of 13-17 shall be used. The HSDA may take into consideration data provided by the applicant justifying the need for additional beds that would exceed the guideline of 30 beds per 100,000 general population. Special consideration may be given to applicants seeking to serve child, adolescent, and geriatric inpatients. Applicants may demonstrate limited access to services for these specific age groups that supports exceeding the guideline of 30 beds per 100,000 general population. An applicant seeking to exceed this guideline shall utilize TDH and TDMHSAS data to justify this projected need and support the request by addressing the factors listed under the criteria "Additional Factors".

   Rationale: Many communities in Tennessee have unique needs for inpatient psychiatric beds. The above formula functions as a "base criteria" that allows

applicants to provide evidence supporting a need for a higher number of beds in the proposed service area. The HSDA may take into account all evidence provided and approve applications that request beds that exceed the 30 beds per 100,000 guideline when needed. An analysis of admissions and discharges by age category performed by the HSDA suggests there may be limited access for inpatients under the age of 18 and inpatients aged 65 and over. However, the applicable JAR form does not provide occupancy rates by age category. Health Planning believes developing determination of need formulas specific to each age category is not possible at this time due to these limitations in available data. The current need formula is to be utilized as a guideline allowing applicants the opportunity to apply to serve the unique needs of the intended service area.

RESPONSE: Based upon STHH's existing patient origin, this project will continue to serve four counties – White, Cumberland, Putnam and Van Buren. Using the methodology described above, there is a projected need for 4.6 additional geriatric psychiatric beds.

2021 Projected Inpatient Psychiatric Bed Need
White, Cumberland, Putnam & Van Buren Counties

	Adult 18-64	Adult 65+	Adult 18+
Population, 2021	101,079	48,826	149,922
Gross Bed Need at 30/100,000 Population	30.3	14.6	45.0
Current Beds	-	10.0	-
Net Bed Need	30.3	4.6	45.0

In addition to serving the 65+ population, 8.5% of the patients at the STHH Senior Care program are age 55-64. There is a projected need for 30.3 psychiatric beds for the 18-64 population.

STHH is proposing to increase its geriatric psychiatric beds from 10 to 14 by converting 4 existing medical-surgical beds. This approach is "bed neutral" and will not result in an increase in total licensed beds at the hospital. STHH's project is consistent with these need guidelines.

2. Additional Factors: An applicant shall address the following factors:

a. The willingness of the applicant to accept emergency involuntary and non-emergency indefinite admissions;

RESPONSE: Although STHH treats emergency patients who present, the geropsychiatric program is not designed for emergency involuntary and non-emergency indefinite admissions. In these rare situations, patients are referred to other more appropriate facilities.

b. The extent to which the applicant serves or proposes to serve the TennCare population and the indigent population;

RESPONSE: The STHH Senior Care program currently serves and will continue to serve the TennCare and indigent populations.

c. The number of beds designated as "specialty" beds (including units established to treat patients with specific diagnoses);

RESPONSE: The STHH Senior Care program is designed to serve geropsychiatric patients aged 55 and older.

d. The ability of the applicant to provide a continuum of care such as outpatient, intensive outpatient treatment (IOP), partial hospitalization, or refer to providers that do;

RESPONSE: The STHH Senior Care program focuses on geropsychiatric inpatients aged 55 and older. Kim Neal, NP, is a caregiver on the Senior Care unit and also hosts an outpatient clinic for geropsychiatric patients in the area. Patients are referred to other providers, as necessary, for other services in the continuum of care.

e. Psychiatric units for patients with intellectual disabilities;

RESPONSE: The STHH Senior Care program does not focus on patients with intellectual disabilities.

f. Freestanding psychiatric facility transfer agreements with medical inpatient facilities;

RESPONSE: Not applicable. The STHH Senior Care program is contained within a general acute care facility. If a level of care that is higher than what can be provided at STHH is necessary, then patients can be transferred to other inpatient facilities within the Saint Thomas network.

g. The willingness of the provider to provide inpatient psychiatric services to all populations (including those requiring hospitalization on an involuntary basis, individuals with co-occurring substance use disorders, and patients with comorbid medical conditions); and

RESPONSE: Although STHH treats emergency patients who present, the geropsychiatric program is not designed for involuntary admissions or individuals with co-occurring substance abuse disorders. Since the STHH Senior Care program is contained within a general acute care facility, certain patients with comorbid medical conditions can be treated.

h. The applicant shall detail how the treatment program and staffing patterns align with the treatment needs of the patients in accordance with the expected length of stay of the patient population.

RESPONSE: As an existing provider of geropsychiatric services, the STHH Senior Care program maintains treatment protocols and staffing patterns consistent with the treatment needs and the expected length of stay of the patient population.

i. Special consideration shall be given to an inpatient provider that has been specially contracted by the TDMHSAS to provide services to uninsured patients in a region

that would have previously been served by a state operated mental health hospital that has closed.

RESPONSE: Not applicable. The STHH Senior Care program is not seeking special consideration under this criterion.

j. Special consideration shall be given to a service area that does not have a crisis stabilization unit available as an alternative to inpatient psychiatric care.

RESPONSE: Not applicable. The STHH Senior Care program is not seeking special consideration under this criterion. A crisis stabilization unit is available at Volunteer Behavioral Health in Cookeville, Putnam County.

3. **Incidence and Prevalence:** The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.

Rationale: The rate of incidence and prevalence of mental illness in the service area may indicate a need for a higher number of psychiatric inpatient beds in the designated area.

RESPONSE: The rates below reflect mental health admissions to TDMHSAS-funded mental health services in regional mental health institutes and private psychiatric hospitals that contract with the agency.

TDMHSAS Mental Health Admission Rates Per 1,000 Pop Age 18+
July 2016, Updated May 2017

County	FY2013	FY2014	FY2015
White	1.5	1.0	1.4
Cumberland	0.9	1.1	1.2
Putnam	1.2	1.7	2.3
Van Buren	small	2.9	small
Tennessee	2.2	2.4	2.5

These rates are below the Tennessee average. Based on extremely high utilization at STHH and a lack of beds elsewhere in the service area, this could suggest a lack of access to inpatient services.

4. **Planning Horizon:** The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.

Rationale: The Division believes that projecting need two years into the future is more likely to accurately reflect the coming trends and less likely to overstate potential future need.

RESPONSE: As calculated previously for 2021, there is a projected net need for 4.6 psychiatric inpatient beds for the 65+ population in the service area. Based on a 2017

population of 42,302 persons, there is a projected net need for 2.7 psychiatric inpatient beds for the 65+ population in the service area. In 2019, there is a projected net need for 3.7 psychiatric inpatient beds for the 65+ population in the service area, which rounds up to the 4 beds requested by STHH. In addition, 8.5% of the patients utilizing STHH's Senior Care services are age 55-64 and would generate demand for even more beds.

5. **Establishment of Service Area:** The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The proposal's sensitivity and responsiveness to the special needs of the service area shall be considered, including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, other medically underserved populations, and those who need services involuntarily. The applicant may also include information on patient origination and geography and transportation lines that may inform the determination of need for additional services in the region.

   Applicants should be aware of the Bureau of TennCare's access requirement table, found under "Access to Behavioral Health Services" on pages 93-94 at http://www.tn.gov/assets/entities/tenncare/attachments/operationalprotocol.pdf.

   Rationale: In many cases it is likely that a proposed psychiatric facility's service area could draw more significantly from only a portion of a county. When available, the Division would encourage the use of sub-county level data that are available to the general public (including utilization, demographic, etc.) to better inform the HSDA in making its decisions. Because psychiatric patients often select a facility based on the proximity of caregivers and family members, as well as the proximity of the facility, factors other than travel time may be considered by the HSDA. Additionally, geography and transportation lines may limit access to services and necessitate the availability of additional psychiatric inpatient beds in specific service areas.

   RESPONSE: Like the existing STHH Senior Care program, the four-bed conversion will serve the same four-county service area – White, Cumberland, Putnam and Van Buren. In 2017, the service area had an estimated population of 177,127. Official sources indicate that the service area population will grow by approximately 5.0% or 8,802 persons by 2021. This is somewhat higher growth than the 4.4% projected for Tennessee.

   In 2017, the service area had an estimated senior population (age 65 and older) of 42,303. Official sources indicate that the service area senior population will grow by approximately 15.4% or 6,524 persons by 2021. This is somewhat lower growth than the 16.0% projected for Tennessee. The service area senior population is projected to comprise 26.3% of the total population, which is much greater than the 18.3% for Tennessee.

   The STHH Senior Care program is the only such inpatient program in the service area. STHH provides care to all patients regardless of sex, race, ethnicity or income. It also provides care to uninsured and low-income populations as well as TennCare patients. As a geropsychiatric program, the patient population is highly skewed toward Medicare patients and patients with medical comorbidities.

6. **Composition of Services:** Inpatient hospital services that provide only substance use services shall be considered separately from psychiatric services in a CON application; inpatient hospital services that address co-occurring substance use/mental health needs shall be considered collectively with psychiatric services. Providers shall also take into account concerns of special populations (including, e.g., supervision of adolescents, specialized geriatric, and patients with comorbid medical conditions).

   The composition of population served, mix of populations, and charity care are often affected by status of insurance, TennCare, Medicare, or TriCare; additionally, some facilities are eligible for Disproportionate Share Hospital payments based on the amount of charity care provided, while others are not. Such considerations may also result in a prescribed length of stay.

   Rationale: Because patients with psychiatric conditions often experience co-morbid conditions, it is important that providers be capable of addressing such patients' potential medical needs. The accessibility of psychiatric services to various populations and for appropriate lengths of stay are important considerations for the HSDA when reviewing psychiatric inpatient services applications.

   RESPONSE: STHH currently operates a very highly utilized 10-bed Senior Care program. Substance abuse services are not provided. The conversion of four medical-surgical beds to geropsychiatric beds is not expected to significantly change the payor mix or charity care.

7. **Patient Age Categorization:** Patients should generally be categorized as children (0-12), adolescents (13-17), adults (18-64), or geriatrics (65+). While an adult inpatient psychiatric service can appropriately serve adults of any age, an applicant shall indicate if they plan to only serve a portion of the adult population so that the determination of need may be based on that age-limited population. Applicants shall be clear regarding the age range they intend to serve; given the small number of hospitals who serve younger children (12 and under), special consideration shall be given to applicants serving this age group. Applicants shall specify how patient care will be specialized in order to appropriately care for the chosen patient category.

   Rationale: Based on stakeholder input, the Division has categorized the patient population into children, adolescents, adults, and geriatric. Each age category may require unique care.

   RESPONSE: Though the STHH Senior Care program focuses on geropsychiatric inpatients aged 65 and older, 8.5% of the patients are age 55-64.

8. **Services to High-Need Populations:** Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are involuntarily committed, uninsured, or low-income.

   RESPONSE: The STHH Senior Care program provides care to all patients, including uninsured and low-income populations. As a geropsychiatric program, the patient population is highly skewed toward Medicare patients and patients with medical

comorbidities.

9. **Relationship to Existing Applicable Plans; Underserved Area and Populations:** The proposal's relationships to underserved geographic areas and underserved population groups shall also be a significant consideration. The impact of the proposal on similar services in the community supported by state appropriations shall be assessed and considered; the applicant's proposal as to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, shall also be assessed and considered. The degree of projected financial participation in the Medicare and TennCare programs shall be considered.

   RESPONSE: The STHH Senior Care program is the only such inpatient program in the service area. It provides care to all patients, including uninsured and low-income populations as well as TennCare patients. As a geropsychiatric program, the patient population is highly skewed toward Medicare patients and patients with medical comorbidities.

   Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall also include how the applicant's services may differ from existing services (e.g., specialized treatment of an age-limited group, acceptance of involuntary admissions, and differentiation by payor mix). Accessibility to specific special need groups shall also be discussed in the application.

   Rationale: Based on stakeholder input, a number of factors, including occupancy, shall be considered in the context of general utilization trends. Additionally, several factors may be necessary to consider when determining occupancy including staffed beds verses licensed beds, the target patient population, and the operation of specialty units.

   RESPONSE: The STHH Senior Care program is the only such inpatient program in the service area. It provides care to all patients, including uninsured and low-income populations, as well as TennCare patients. As a geropsychiatric program, the patient population is highly skewed toward Medicare patients and patients with medical comorbidities.

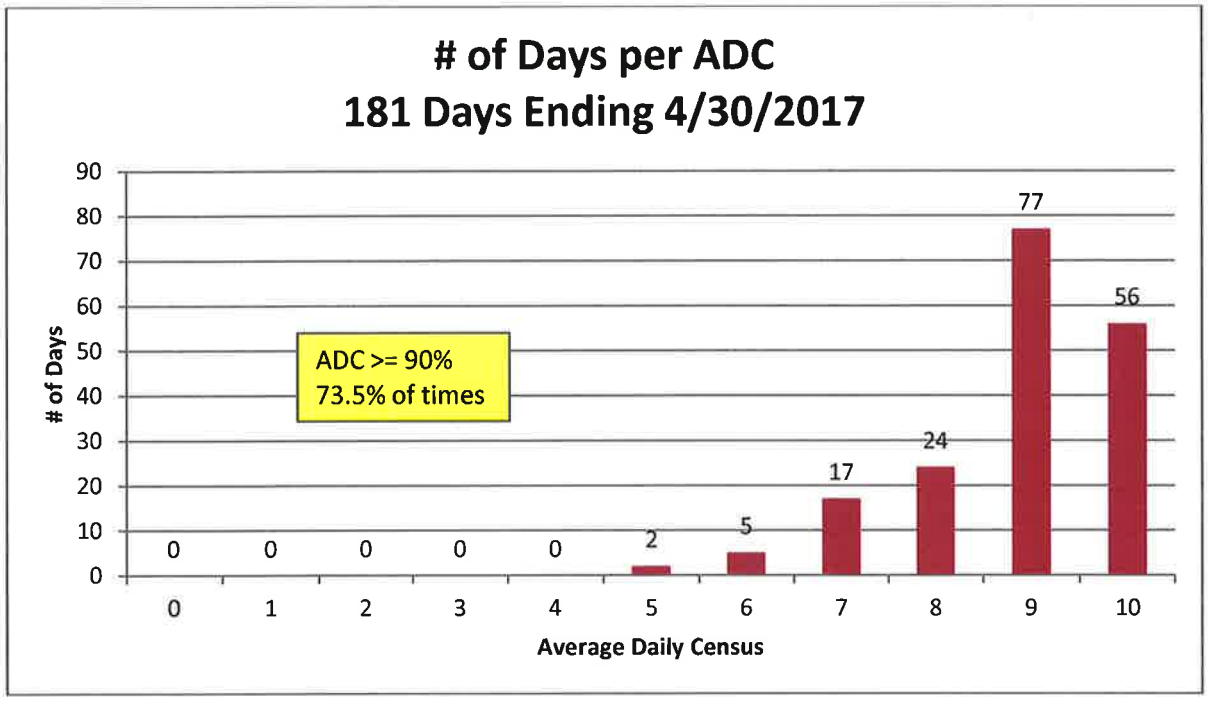
10. **Expansion of Established Facility:** Applicants seeking to add beds to an existing facility shall provide documentation detailing the sustainability of the existing facility. This documentation shall include financials, and utilization rates. A facility seeking approval for expansion should have maintained an occupancy rate for all licensed beds of at least 80 percent for the previous year. The HSDA may take into consideration evidence provided by the applicant supporting the need for the expansion or addition of services without the applicant meeting the 80 percent threshold. Additionally, the applicant shall provide evidence that the existing facility was built and operates, in terms of plans, service area, and populations served, in accordance with the original project proposal.

    Rationale: Based on stakeholder input, the implementation of an 80 percent threshold for the approval may serve as an indicator of economic feasibility for the expansion of

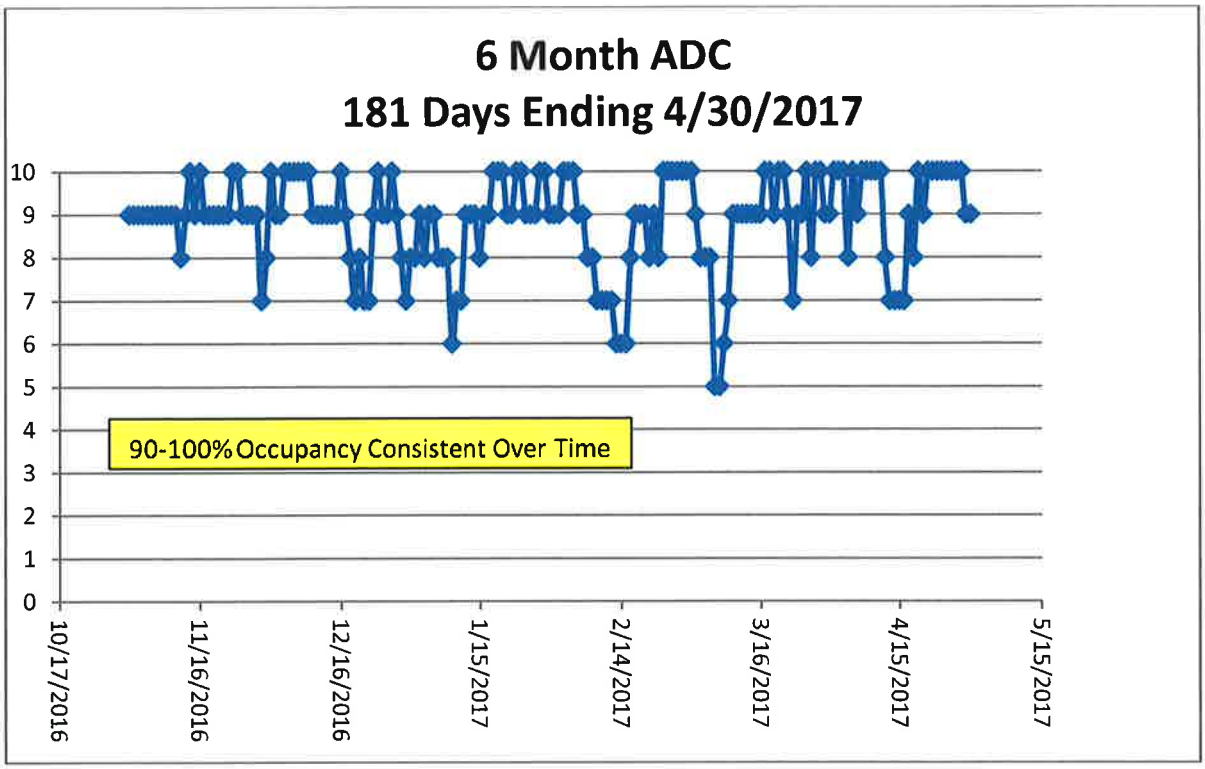
the facility. The 80 percent occupancy requirement may limit an applicant's ability to add specialty services that require separation from other units. Examples include geriatric psychiatry, services for patients with co-occurring mental health needs and substance use disorders. Additionally, the majority of the programs in the state are currently operating under this threshold. The communities these programs serve may have needs that require an expansion of services. An applicant may provide evidence of the economic feasibility of expansion despite not operating at or above 80 percent of capacity.

RESPONSE: Compared to the majority of programs in the state, the STHH Senior Care program has been operating at well over 80% of capacity. According to the 2016 Joint Annual Report, the program averaged 84% utilization on 10 beds. This is unusually high given that all the beds are in semiprivate rooms, which limits STHH's ability to match patients of the same sex, general age range, etc.

More recent data for the 181 days ending April 30, 2017 indicates that the Senior Care program operated at 90% to 100% capacity three-quarters of the time.



Furthermore, this high utilization was present throughout the entire six-month period.



11. **Licensure and Quality Considerations:** Any existing applicant for this CON service category shall be in compliance with the appropriate rules of the TDH and/or the TDMHSAS. The applicant shall also demonstrate its accreditation status with the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or other applicable accrediting agency. Such compliance shall provide assurances that applicants are making appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems, and children who need quiet space). Applicants shall also make appropriate accommodations so that patients are separated by gender in regards to sleeping as well as bathing arrangements. Additionally, the applicant shall indicate how it would provide culturally competent services in the service area (e.g., for veterans, the Hispanic population, and LBGT population).

    RESPONSE: As an existing provider of geropsychiatric services, STHH is currently licensed by the Tennessee Department of Health. It is also accredited by The Joint Commission. The request to convert four medical-surgical beds to the complement of ten existing geropsychiatric beds will make it easier to accommodate special patient needs. The STHH Senior Care program does not utilize seclusion or restraints. STHH provides care to all patients regardless of sex, race, ethnicity or income.

12. **Institution for Mental Disease Classification:** It shall also be taken into consideration whether the facility is or will be classified as an Institution for Mental Disease (IMD). The criteria and formula involve not just the total number of beds, but the average daily census (ADC) of the inpatient psychiatric beds in relation to the ADC of the facility. When a facility is classified as an IMD, the cost of patient care for

Bureau of TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds, with no matching federal funds provided; consequently, this potential impact shall be addressed in any CON application for inpatient psychiatric beds.

RESPONSE: This four-bed conversion project will not result in a change in classification.

13. **Continuum of Care:** Free standing inpatient psychiatric facilities typically provide only basic acute medical care following admission. This practice has been reinforced by Tenn. Code Ann. § 33-4-104, which requires treatment at a hospital or by a physician for a physical disorder prior to admission if the disorder requires immediate medical care and the admitting facility cannot appropriately provide the medical care. It is essential, whether prior to admission or during admission, that a process be in place to provide for or to allow referral for appropriate and adequate medical care. However, it is not effective, appropriate, or efficient to provide the complete array of medical services in an inpatient psychiatric setting.

    RESPONSE: Not applicable. The STHH Senior Care program is not based in a freestanding inpatient psychiatric setting.

14. **Data Usage:** The TDH and the TDMHSAS data on the current supply and utilization of licensed and CON-approved psychiatric inpatient beds shall be the data sources employed hereunder, unless otherwise noted. The TDMHSAS and the TDH Division of Health Licensure and Regulation have data on the current number of licensed beds. The applicable TDH JAR provides data on the number of beds in operation. Applicants should utilize data from both sources in order to provide an accurate bed inventory.

    Rationale: Using these sources for data is the only way to ensure consistency across the evaluation of all applications. Data provided by the TDH and the TDMHSAS shall be relied upon as the primary sources of data for CON psychiatric inpatient services applications. Each data source has specific caveats. Requiring the use of both licensed beds and operating beds will provide a more comprehensive bed inventory analysis.

    RESPONSE: Both data sources were consulted. The ten geropsychiatric beds at STHH Senior Care program are the only psychiatric beds in the service area.

15. **Adequate Staffing:** An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. Each applicant shall outline planned staffing patterns including the number and type of physicians. Additionally, the applicant shall address what kinds of shifts are intended to be utilized (e.g., 8 hour, 12 hour, or Baylor plan). Each unit is required to be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times. This staffing level is the minimum necessary to provide safe care. The applicant shall state how the proposed staffing plan will lead to quality care of the patient population served by the project.

    However, when considering applications for expansions of existing facilities, the HSDA may determine whether the existing facility's staff would continue without significant

change and thus would be sufficient to meet this standard without a demonstration of efforts to recruit new staff.

RESPONSE: The STHH Senior Care program is currently and appropriately staffed for a census of ten patients. A census of 12.6 patients is projected for Year 2 and will require approximately 4.6 more FTEs over the existing 15.9 FTEs. Additional staff will be recruited using the existing resources of both STHH and Saint Thomas Health.

16. **Community Linkage Plan:** The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care (e.g., agreements between freestanding psychiatric facilities and acute care hospitals, linkages with providers of outpatient, intensive outpatient, and/or partial hospitalization services). If they are provided, letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of an application shall detail specific instances of unmet need for psychiatric inpatient services. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

Rationale: The Division recognizes that participation in community linkage plans is an important element in the provision of quality psychiatric inpatient services; therefore, it is important for applicants to demonstrate such connections with other community providers. The 2014 update to the State Health Plan moved from a primary emphasis of health care to an emphasis on "health protection and promotion". The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

RESPONSE: The STHH Senior Care program currently maintains a census of 90% to 100% three-quarters of the time, thus demonstrating effective community linkages. STHH is also a member of Saint Thomas Health and the referral resources available in Nashville.

Three provider support letters are provided in **Tab 7 – Attachment Section B-A1**. Not only do these letters further document STHH's existing community linkages, but they offer additional reasons to approve the four-bed conversion.

- The senior population is growing in the Upper Cumberland region.
- More patients are suffering from Alzheimer's, dementia, etc.
- Extra capacity at STHH Senior Care will allow more patient s to be served.
- Extra capacity at STHH Senior Care will allow patients to be served more quickly.

17. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the patients related to the application of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that

there is limited access in the proposed service area.

RESPONSE: As the only provider of inpatient psychiatric services in the four-county service area, the STHH Senior Care program will strive to meet the growing needs of the community.

18. **Quality Control and Monitoring:** The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

    Rationale: This section supports the State Health Plan's Fourth Principle for Achieving Better Health regarding quality of care.

    RESPONSE: The STHH Senior Care program will continue to monitor quality and outcomes, and report data to the appropriate regulatory and accreditation agencies.

19. **Data Requirements:** Applicants shall agree to provide the TDH, the TDMHSAS, and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

    RESPONSE: The STHH Senior Care program will continue to monitor quality and outcomes, and report data to the appropriate regulatory and accreditation agencies.

2) Construction, Renovation, Expansion and Replacement of Health Care institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

   RESPONSE: The standards for Psychiatric Inpatient Services are addressed immediately above. The STHH Senior Care program meets the requirements for the approval of the four-bed conversion from medical-surgical to geropsychiatric services.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

   RESPONSE: Not applicable. The STHH Senior Care program merely proposes a four-bed conversion from medical-surgical to geropsychiatric services.

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

   RESPONSE: Not applicable. The STHH Senior Care program merely proposes a four-bed conversion from medical-surgical to geropsychiatric services. No major renovations or expansion is proposed.

B. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

   RESPONSE: Highlands Hospital entered into a partnership with Saint Thomas Health in 2012 and was acquired outright in 2015. This project represents the right-sizing of assets at the facility. No previously approved projects are related to this proposed four-bed conversion.

C. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment Section B - Need-C.**

   Please complete the following tables, if applicable:

Saint Thomas Highlands Hospital – Medical and Psychiatric Inpatients
Actual,2016 JAR

Service Area Counties	Historical Utilization-County Residents	% of Total Patients
White	628	61.3%
Putnam	137	13.4%
Cumberland	93	9.1%
Van Buren	69	6.7%
Subtotal	927	90.5%
Other	98	9.5%
Total	1,025	100.0%

Source: 2016 JAR

Saint Thomas Highlands Hospital – Geropsychiatric Inpatients Only
Projected, Year 2

Service Area Counties	Projected Utilization-County Residents	% of Total Patients
White	250	61.3%
Putnam	55	13.5%
Cumberland	37	9.1%
Van Buren	27	6.6%
Subtotal	369	90.5%
Other	39	9.5%
Total	408	100.0%

RESPONSE: While Saint Thomas Health serves a number of counties in Kentucky and other states, no border state counties are part of the primary or secondary service areas of STHH. The proposed four-bed conversion is not expected to materially alter existing patient referral patterns.

STHH 4 County Service Area with Upper Cumberland Region for Reference

D. 1). a) Describe the demographics of the population to be served by the proposal.

RESPONSE: Like the existing STHH Senior Care program, the four-bed conversion will serve the same four-county service area – White, Cumberland, Putnam and Van Buren. In 2017, the service area had an estimated population of 177,127. Official sources indicate that the service area population will grow by approximately 5.0% or 8,802 persons by 2021. This is somewhat higher growth than the 4.4% projected for Tennessee.

In 2017, the service area had an estimated senior population (age 65 and older) of 42,303. Official sources indicate that the service area senior population will grow by approximately 15.4% or 6,524 persons by 2021. This is somewhat lower growth than the 16.0% projected for Tennessee. The service area senior population is projected to comprise 26.3% of the total population, which is much greater than the 18.3% for Tennessee.

Compared to the overall Tennessee median household income ("MHI") of $45,219, the service area MHIs are significantly lower – White ($34,901), Cumberland ($38,576), Putnam ($35,343) and Van Buren ($40,439). Similarly, three of the four service area counties have a higher percentage of residents in poverty than Tennessee's 17.6%. In addition, 22.0% of the service area's population is enrolled in TennCare compared to 21.5% for Tennessee.

b) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year	Total Population-Projected Year	Total Population-% Change	*Target Population-Current Year	*Target Population-Project Year	*Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
County A													
County B, etc.													
Service Area Total													
State of TN Total													

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve- the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards.*

If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.

RESPONSE: This table is provided on the following page, using the data sources and format requested.

2) Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE: The STHH Senior Care program is the only such inpatient program in the service area. STHH provides care to all patients regardless of sex, race, ethnicity or income. It also provides care to uninsured and low-income populations as well as TennCare patients. As a geropsychiatric program, the patient population is highly skewed toward Medicare patients and patients with medical comorbidities.

In 2017, the service area had an estimated population of 177,127. Official sources indicate that the service area population will grow by approximately 5.0% or 8,802 persons by 2021. This is somewhat higher growth than the 4.4% projected for Tennessee.

In 2017, the service area had an estimated senior population (age 65 and older) of 42,303. Official sources indicate that the service area senior population will grow by approximately 15.4% or 6,524 persons by 2021. This is somewhat lower growth than the 16.0% projected for Tennessee. The service area senior population is projected to comprise 26.3% of the total population, which is much greater than the 18.3% for Tennessee.

Given these population growth projections, demand for the services at STHH Senior Care is expected to increase.

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Bureau of the Census - 2015				TennCare	
	Total Population Current Year - 2017	Total Population Projected year - 2021	Total Population - % Change	*Target Population (Age 65+) - Current Year 2017	*Target Population (Age 65+) - Projected Year 2021	*Target Population % Change	Target Pop Projected Year as % of Total	Median Age	Median Household Income	Persons Below Poverty Level	Persons Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
White	27,781	28,782	3.6%	6,070	6,967	14.8%	24.2%	42.5	$34,901	N/A	19.6%	7,264	26.1%
Cumberland	62,847	66,447	5.7%	20,691	23,896	15.5%	36.0%	49.7	$38,576	N/A	16.5%	12,801	20.4%
Putnam	80,838	84,954	5.1%	14,160	16,322	15.3%	19.2%	36.1	$35,343	N/A	25.2%	17,546	21.7%
Van Buren	5,661	5,746	1.5%	1,381	1,641	18.8%	28.6%	45.8	$40,439	N/A	18.0%	1,340	23.7%
Service Area Total	177,127	185,929	5.0%	42,302	48,826	15.4%	26.3%	N/A	N/A	N/A	N/A	38,951	22.0%
State of TN Total	6,886,441	7,188,358	4.4%	1,133,722	1,314,803	16.0%	18.3%	37.6	$45,219	N/A	17.6%	1,480,077	21.5%

Source:TN DOH Health Statistics, Bureau of the Census - 2015, and Bureau of TennCare - November 2016

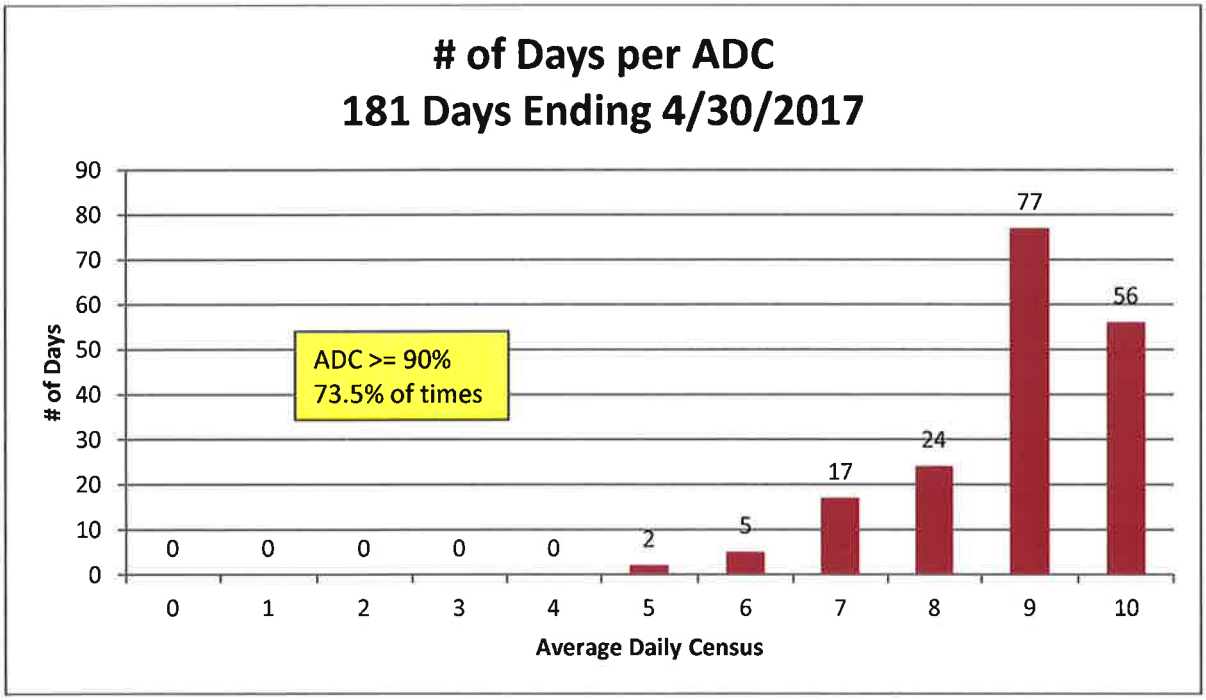
E. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

RESPONSE: The STHH Senior Care program is the only such inpatient program in the service area. There are no similar healthcare providers in the service area, existing or approved.

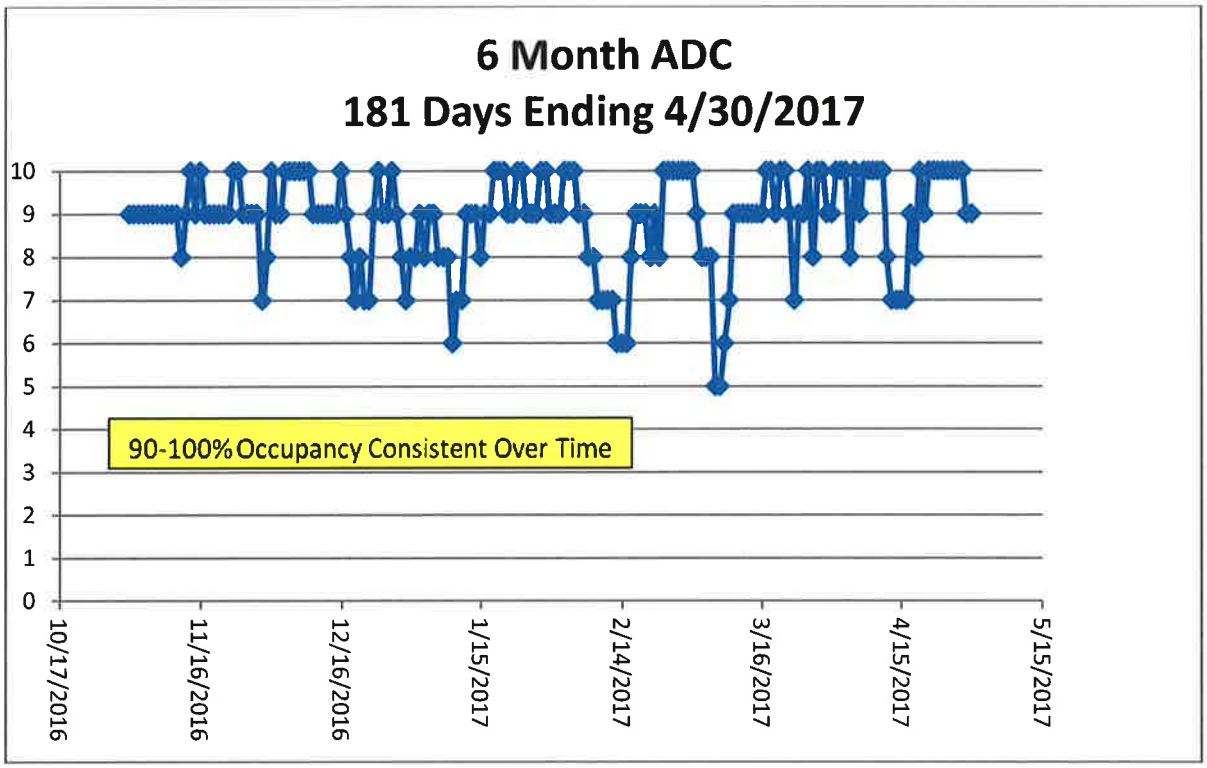
F. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

RESPONSE: The ten-bed STHH Senior Care program has experienced steady and rapid (12.5%) growth in patient utilization over the past three years. It recorded 2,821 patient days in 2014, 3,080 patient days in 2015 and 3,175 patient days in 2016. The average daily census increased from 7.7 to 8.4 to 8.7 over this period. With ten beds, this amounts to utilization rates of 77%, 84% and 87%, respectively.

Even more significantly, recent data for the 181 days ending April 30, 2017 indicates that the Senior Care program operated at 90% to 100% capacity three-quarters of the time.



Furthermore, this high utilization was present throughout the entire six-month period.



Given this more recent experience, first year utilization (2018) is projected at 3,535 patient days (9.7 ADC) and second year utilization (2019) is projected at 4,615 patient days (12.6 ADC). With the four-bed conversion, the 9.7 ADC will be easily achieved with just existing patient demand. The 12.6 ADC in 2019 is certainly reasonable given that the STHH Senior Care program has been turning patients away due to a lack of available capacity. An ADC of 12.6 will result in 90% utilization on 14 beds, which is still well above the Agency's 80% target.

SECTION B: ECONOMIC FEASIBILITY

A. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

1) All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)

   RESPONSE: The applicant acknowledges that the filing fee shall be an amount equal to $5.75 per $1,000 of the estimated project cost involved, but in no case shall the fee be less than $15,000 or more than $95,000. The filing fee check for $15,000 is made payable to the Health Services and Development Agency.

2) The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

   RESPONSE: Not applicable. This project does not involve any leases.

3) The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

   RESPONSE: Not applicable. This project involves only minimal equipment costs.

4) Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

   RESPONSE: The applicant has completed the Square Footage Chart as required.

5) For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

   a) A general description of the project;
   b) An estimate of the cost to construct the project;
   c) A description of the status of the site's suitability for the proposed project; and
   d) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

RESPONSE: Please see the contractor's construction cost verification letter in **Tab 8 – Attachment Section B-A5**. These costs pertain to only the hard construction costs (e.g., site work, building shell, interiors, parking deck).

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PROJECT COST CHART

A. Construction and equipment acquired by purchase:

1.	Architectural and Engineering Fees	$45,525
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$26,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Total Construction Costs	$204,701
6.	Contingency Fund	$35,000
7.	Fixed Equipment (Not included in Construction Contract)	
8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	$25,000
9.	Other (Specify) FFE, IT	$7,000

B. Acquisition by gift, donation, or lease:

1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify)	
5.	Other (Specify)	

C. Financing Costs and Fees:

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

D.	Estimated Project Cost (A+B+C)	$343,226
E.	CON Filing Fee	$15,000
F.	Total Estimated Project Cost (D+E) **TOTAL**	358,226

B. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-2.)***

__ 1) Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ 2) Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ 3) General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ 4) Grants – Notification of intent form for grant application or notice of grant award;

X 5) Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

__ 6) Other – Identify and document funding from all other sources.

RESPONSE: The relatively minimal project costs will be paid from existing cash reserves at Saint Thomas Health. Please see **Tab 9 – Attachment Section B-B5**.

C. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

RESPONSE: Please refer to the completed projected data chart for the existing STHH Senior Care geropsychiatric inpatient unit on the following pages.

HISTORICAL DATA CHART

□ Total Facility
■ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month). **RESPONSE: Data for Highlands inpatient psych unit only.**

	Year 2014	Year 2015	Year 2016
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	2,821	3,080	3,175
B. Revenue from Services to Patients			
1. Inpatient Services	$9,335,966	$10,775,843	$10,891,668
2. Outpatient Services			
3. Emergency Services			
4. Other Operating Revenue (Specify)			
Gross Operating Revenue	$9,335,966	$10,775,843	$10,891,668
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$2,517,199	$2,907,291	$3,545,781
2. Provision for Charity Care			
3. Provisions for Bad Debt	35,675	53,126	11,765
Total Deductions	$2,552,874	$2,960,417	$3,557,546
NET OPERATING REVENUE	$6,783,092	$7,815,426	$7,334,122
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	669,332	620,066	724,807
b. Non-Patient Care	78,000	78,000	80,000
2. Physician's Salaries and Wages	105,000	105,000	105,000
3. Supplies	19,570	12,486	12,934
4. Rent			
a. Paid to Affiliates			
b. Paid to Non-Affiliates			
5. Management Fees:			
a. Paid to Affiliates			
b. Paid to Non-Affiliates			
6. Other Operating Expenses	221,282	223,326	240,669
Total Operating Expenses	$1,093,184	$1,638,878	$1,163,410
E. **Earnings Before Interest, Taxes and Depreciation**	$5,689,908	$6,776,548	$6,170,712
F. Non-Operating Expenses			
1. Taxes	$	$	$
2. Depreciation	588	588	588
3. Interest			
4. Other Non-Operating Expenses			
Total Non-Operating Expenses	$ 588	$ 588	$ 588
NET INCOME (LOSS)	$5,689,320	$6,775,960	$6,170,124

Chart Continues Onto Next Page

NET INCOME (LOSS)	$5,689,320	$6,775,960	$6,170,124
G. Other Deductions			
1. Annual Principal Debt Repayment	$_____	$_____	$_____
2. Annual Capital Expenditure	_____	_____	_____
Total Other Deductions	$_____	$_____	$_____
NET BALANCE	$5,689,320	$6,775,960	$6,170,124
DEPRECIATION	$ 588	$ 588	$ 588
FREE CASH FLOW (Net Balance + Depreciation)	$5,689,908	$6,776,548	$6,170,712

☐ Total Facility

■ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2014	Year 2015	Year 2016
1. Professional Services Contract	$156,000	$156,000	$156,000
2. Contract Labor			
3. Imaging Interpretation Fees			
4. Dues	970		
5. Benefits	60,920	59,697	67,716
6. T & E	3,392	7,629	10,737
7. Minor Equipment			6,216
Total Other Expenses	**$221,282**	**$223,326**	**$240,669**

D. Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

RESPONSE: Please refer to the completed projected data chart for the proposed STHH Senior Care geropsychiatric inpatient unit (after the four-bed conversion) on the following pages.

□ Total Facility
■ Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

	Year 2018	Year 2019
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	3,535	4,615
B. Revenue from Services to Patients		
1. Inpatient Services	$12,064,955	$15,750,995
2. Outpatient Services		
3. Emergency Services		
4. Other Operating Revenue (Specify)_____		
Gross Operating Revenue	$12,064,955	$15,750,995
C Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$4,058,123	$5,402,901
2. Provision for Charity Care		
3. Provisions for Bad Debt	46,012	61,259
Total Deductions	$ 4,104,135	$ 5,464,160
NET OPERATING REVENUE	$ 7,960,820	$10,286,835
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	806,991	1,053,538
b. Non-Patient Care	80,000	80,000
2. Physician's Salaries and Wages	105,000	105,000
3. Supplies	14,400	18,800
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
5. Management Fees:		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
6. Other Operating Expenses	267,957	349,822
Total Operating Expenses	$ 1,274,348	$ 1,607,160
E. **Earnings Before Interest, Taxes and Depreciation**	$ 6,686,472	$ 8,679,675
F. Non-Operating Expenses		
1. Taxes	$	$
2. Depreciation	50,588	50,588
3. Interest		
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	$50,588	$50,588
NET INCOME (LOSS)	$6,635,884	$8,629,087

Chart Continues Onto Next Page

NET INCOME (LOSS)	$6,635,884	$8,629,087
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure	100,000	100,000
Total Other Deductions	$	$
NET BALANCE	$6,535,884	$8,529,087
DEPRECIATION	$50,588	$50,588
FREE CASH FLOW (Net Balance + Depreciation)	$6,586,472	$8,579,087

☐ Total Facility

■ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Professional Services Contract	$156,000	$210,000
2. Contract Labor		
3. Imaging Interpretation Fees		
4. Dues	1,000	1,000
5. Benefits	73,407	91,652
6. T & E	11,000	12,000
7. Minor Equipment	26,550	35,170
Total Other Expenses	**$267,957**	**$349,822**

E. 1) Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	3,430	3,413	3,413	3,413	0%
Deduction from Revenue *(Total Deductions/Utilization Data)*	1,117	1,139	1,161	1,184	4%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	2,314	2,274	2,252	2,229	-2%

2) Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

RESPONSE: As indicated in the table above, the charges for services at STHH Senior Care will not be impacted by the four-bed conversion project.

3) Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE: There are no comparable charges in the service area. A comparison of the 2015 JAR data indicate an average gross charge per admission of $38,902 at STHH compared to $42,874 at Saint Thomas West in Davidson County.

F. 1) Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment Section B-Economic Feasibility-F1**. **NOTE: Publicly held entities only need to reference their SEC filings.**

RESPONSE: As indicated in the Historical Data Chart and the Projected Data Chart, the STHH Senior Care program was financially feasible with 10 beds and is expected to remain financially feasible with 14 beds.

Funding for the project will come from STHH's corporate parent organizations, where the hospital cash flows are consolidated. The substantial resources of these organizations are documented in the attachments. See **Tab 10 – Attachment Section B-F1**.

2) Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	86.7%	84.1%	83.8%	83.4%	83.9%

3) Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

RESPONSE: Ascension, the parent of STHH and Saint Thomas Health is appropriately capitalized to undertake the four-bed conversion project. Please refer to the table below.

Ascension Capitalization Ratio Calculation

Dollars in ($000s)	**2016**	**2015**
Long-term debt	$ 5,427,616	$ 5,010,084
Total net assets	18,593,040	18,932,662
Capitalization Ratio	**22.6%**	**20.9%**

Source: Audited Financial Statements, Consolidated Balance Sheet

G. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

RESPONSE: STHRH will maintain the same payor relationships, including contracts with Medicare and all TennCare MCOs, that are currently in place for the Senior Care program. Furthermore, STHH will follow the same financial assistance policies that are currently in place. Please refer to **Tab 11 – Attachment Section B-G** for a copy of the STHH financial assistance policies.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$10,824,718	89.7%
TennCare/Medicaid	1,222,419	10.1%
Commercial/Other Managed Care	17,818	0.2%
Self-Pay		
Charity Care		
Other (Specify)_____		
Total	$12,064,954	100.0%

H. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

RESPONSE: The following table compares the staffing for the STHH Senior Care program before and after the proposed four-bed conversion.

Position Classification	Existing FTEs (enter year) 2017	Projected FTEs Year 1 2018	Average Wage (Contractual Rate) 2019	Area Wide/Statewide Average Wage 2016
A. Direct Patient Care Positions				
RNs	7.3	11.5	30.33	28.94
LPNs	3.4	3.4	17.60	18.78
Tech	1.9	1.9	11.28	10.39
Rec Therapists	1.0	1.0	18.12	21.31
Social Worker	1.0	1.4	25.00	28.47
Total Direct Patient Care Positions	14.6	19.2		
B. Non-Patient Care Positions				
Management	1.3	1.3	39.19	39.34
Total Non-Patient Care Positions	1.3	1.3		
Total Employees *(A+B)*	15.9	20.5		
C. Contractual Staff				
Total Staff *(A+B+C)*	15.9	20.5		

RESPONSE: STHH will continue to provide competitive pay for its various employees.

I. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

1) Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

RESPONSE: Converting four existing medical-surgical beds adjacent to the existing ten Senior Care beds at STHH was deemed the least costly, most effective and most efficient alternative to address the very high utilization of inpatient geropsychiatric beds.

2) Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

RESPONSE: The proposed bed conversion is an alternative to new construction.

SECTION B: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

A. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

RESPONSE: STHH has many active managed care contracts in place to provide for seamless care of its patients. These contracts are part of the Saint Thomas Health network and include:

- Aetna
  - Commercial plans only
  - Aetna Medicare Advantage
- AMERIGROUP Community Care
  - TennCare
- Alive Hospice
- Avalon Hospice
- BC/BS of TN (BCBST)
  - Network P
  - Network S
  - Network M
  - BlueCare (TennCare)
  - TennCare Select
  - Cover Kids
  - D-SNP
  - Blue Advantage (Medicare Advantage)
- Bluegrass Family Health
- Caris Healthcare (Hospice)
- CenterCare Managed Care Programs
- CIGNA
  - Commercial plans
  - CIGNA Connect (Exchange Plan) *(beginning Jan 1, 2017)*
  - STHe does not participate in Cigna Local Plus (Narrow Network)

- CIGNA HealthSpring
    - Medicare Advantage
- Community Health Plan (fka Americhoice)
- TennCare
- CorVel Corporation (Workers' Compensation)
- Coventry Health Care
- Tennessee Division of Rehabilitation Services
- FOCUS Healthcare Management (Workers' Compensation)
- Humana Health Care Plans
    - Commercial Plans
    - Medicare Advantage
- KY Medicaid
    - Standard Medicaid only
- Kentucky Health Cooperative
    - Kentucky ACO for the Exchange/Marketplace that uses the Coventry network
- Mission Point Health Partners
    - Network M
    - Network E
- MultiPlan
- National Rural Electric Cooperative Association Group
- Nexcaliber (fka Associated Administrators Group, Inc.
- NovaNet
- OccuComp (Workers' Compensation)
- Odyssey Healthcare (Hospice)
- Prime Health
    - Workers' Compensation
    - Commercial Network
- Private Healthcare Systems (PHCS)
- TriCare for Life
- TRICARE North
    - HealthNet Federal Services
- TRICARE South
    - Humana Military
- TriWest
- United Behavioral Health (UBH)
- United Healthcare
    - Commercial plans
    - Medicare Advantage plans
- USA Managed Care Organization
- VHAN (Vanderbilt Health Affiliated Networks
    - Saint Thomas Midtown Hospital
    - Saint Thomas Rutherford Hospital
- Wellcare / Windsor HealthCare
    - Medicare Advantage

B. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

1) Positive Effects

RESPONSE: The STHH Senior Care program is the only such inpatient program in the service area. Converting four existing medical-surgical beds adjacent to the existing ten Senior Care beds at STHH will not duplicate resources in the health care system. Instead, it will better utilize existing resources at STHH.

These and other positive effects of the STHH project are described in the letters of support submitted with this application. Please refer to **Tab 7 – Attachment Section B-A1**. Not only do these letters further document STHH's existing community linkages, but they offer additional reasons to approve the four-bed conversion.

- The senior population is growing in the Upper Cumberland region.
- More patients are suffering from Alzheimer's, dementia, etc.
- Extra capacity at STHH Senior Care will allow more patient s to be served.
- Extra capacity at STHH Senior Care will allow patients to be served more quickly.

2) Negative Effects

RESPONSE: The STHH Senior Care program is the only such inpatient program in the service area. Thus, there is no duplication of services and there are no negative effects associated with this project. Converting four existing medical-surgical beds adjacent to the existing ten Senior Care beds at STHH was deemed the least costly, most effective and most efficient alternative to address the very high utilization of inpatient geropsychiatric beds.

C. 1) Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

RESPONSE: The STHH Senior Care program is currently and appropriately staffed for a census of ten patients. A census of 12.6 patients is projected for Year 2 and will require approximately 4.6 more FTEs over the existing 15.9 FTEs. Additional staff will be recruited using the existing resources of both STHH and Saint Thomas Health.

2) Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

RESPONSE: STHH already maintains a ten-bed geropsychiatric inpatient unit and understands the licensure and certification requirements for medical and clinical staff.

Please see **Tab 12 – Attachment Section B-C2** for a copy of the medical director's qualifications.

Please see **Tab 13 – Attachment Section B-C2** for copies of the quality management and utilization management plans.

3) Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

RESPONSE: Unlike the Saint Thomas Nashville hospitals, STHH is a much smaller rural facility where student training is not a priority

D. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: TDOH Board for Licensing Health Care Facilities

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.): TDOH Medicare, TennCare

Accreditation (i.e., Joint Commission, CARF, etc.): The Joint Comission

RESPONSE: STHH already maintains a ten-bed geropsychiatric program and understands the licensure and certification requirements necessary to implement this four-bed conversion.

1) If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

RESPONSE: STHH is fully licensed and accredited.

Please see **Tab 14 – Attachment Section B-D1** for a copy of STHH's hospital license.

Please see **Tab 15 – Attachment Section B-D1** for a copy of STHH's accreditation letters.

2) For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

RESPONSE: A plan of correction was recently submitted by STHH and accepted by TDOH. STHH has no outstanding deficiencies. Please see **Tab 16 – Attachment Section B-D2** for documentation.

3) Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

a) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

RESPONSE: Not applicable. STHH has had no state, federal, or accrediting body actions

within the last three survey cycles.

E. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

1) Has any of the following:

a) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

b) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

c) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

RESPONSE: Acknowledged. Entities and persons with more than 5% ownership in the applicant have been identified and are addressed below.

2) Been subjected to any of the following:

a) Final Order or Judgment in a state licensure action;

b) Criminal fines in cases involving a Federal or State health care offense;

c) Civil monetary penalties in cases involving a Federal or State health care offense;

d) Administrative monetary penalties in cases involving a Federal or State health care offense;

e) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

f) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

g) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

h) Is presently subject to a corporate integrity agreement.

RESPONSE: The applicant, Saint Thomas Highlands Hospital, LLC, is not subject to any of the actions identified above.

Similarly, Saint Thomas Health is not subject to any of the actions identified above.

F. Outstanding Projects:

1) Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	**Project Name**	**Date Approved**	***Annual Progress Report(s)**		**Expiration Date**
			Due Date	**Date Filed**	
CN1608-031A	Providence Surgery Center	12/14/16	12/14/17		2/1/19
CN1307-029AM	Baptist Plaza Surgicare	10/23/13 7/23/14	Operational	Final project report pending	6/30/17

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

2) Provide a brief description of the current progress, and status of each applicable outstanding CON.

RESPONSE: CN1608-031A was recently approved. CN1307-029AM has been open and operating since March 13, 2017. A final project report is pending.

G. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

1) Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? Yes, Saint Thomas Health is a joint venture owner in Middle Tennessee Imaging

2) If yes, have you submitted their registration to HSDA? If you have, what was the date of submission? Yes, various dates.

3) If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? Yes, various dates.

SECTION B: QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

RESPONSE: Yes, STHH will continue to provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

A. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

RESPONSE: Since 1992, the Senior Care program at Saint Thomas Highlands Hospital has been providing geropsychiatric inpatient services. Senior Care is a unit that provides optimum psychiatric care. The center specializes in working with older adults so that each person is treated as a unique and valuable individual by staff and physicians sensitive to the distinctive needs of seniors.

Senior Care has developed a special program designed for seniors suffering from depression and/or anxiety. These conditions are silent epidemics in our country today, and some studies suggest that at least one in five seniors is currently battling clinical depression.

Senior Care also has developed a special program to treat individuals suffering from problems with memory. Alzheimer's disease and other dementias occur in a greater number of people as more live to see an older age. While there is no cure there are medications that can slow the progressive decline. STHH utilizes both medication and behavioral modification techniques to minimize behaviors that cause risks to the patient or the caregivers. The goal is to improve quality of life. Senior Care provides close supervision with a secure unit that ensures the safety and security of each individual. STHH strives to bring peace of mind and partner with the families of patients to deliver hope, education, and resources.

B. People in Tennessee should have access to health care and the conditions to achieve optimal health.

RESPONSE: Provider support letters succinctly explain the reasons to approve the four-bed conversion at STHH.

- The senior population is growing in the Upper Cumberland region.
- More patients are suffering from Alzheimer's, dementia, etc.
- Extra capacity at STHH Senior Care will allow more patient s to be served.
- Extra capacity at STHH Senior Care will allow patients to be served more quickly.

C. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

RESPONSE: The STHH Senior Care program is the only such inpatient program in the service area. Thus, there is no duplication of services and there are no negative effects associated with this project. Converting four existing medical-surgical beds adjacent to the existing ten Senior Care beds at STHH was deemed the least costly, most effective and most efficient alternative to address the very high utilization of inpatient geropsychiatric beds.

D. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

RESPONSE: STHH maintains very active utilization review and quality improvement programs. STHH is licensed and fully accredited.

E. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

RESPONSE: The STHH Senior Care program is currently and appropriately staffed for a census of ten patients. A census of 12.6 patients is projected for Year 2 and will require approximately 4.6 more FTEs over the existing 15.9 FTEs. Additional staff will be recruited using the existing resources of both STHH and Saint Thomas Health.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

RESPONSE: Please see **Tabs 17 and 18 – Proof of Publication**.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

RESPONSE: Please see the project forecast completion chart, below.

PROJECT COMPLETION FORECAST CHART

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

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		10/2017
2. Architectural and engineering contract signed	10	11/2017
3. Construction documents approved by the Tennessee Department of Health	10	11/2017
4. Construction contract signed	10	11/2017
5. Building permit secured	10	12/2017
6. Site preparation completed	N/A	12/2017
7. Building construction commenced	5	12/2017
8. Construction 40% complete	10	12/2017
9. Construction 80% complete	10	12/2017
10. Construction 100% complete (approved for occupancy	10	01/2018
11. *Issuance of License	10	01/2018
12. *Issuance of Service	10	01/2018
13. Final Architectural Certification of Payment	30	02/2018
14. Final Project Report Form submitted (Form HR0055)	30	03/2018

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

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

JUN 14 '17 PM3:02

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Davidson

Blake Estes, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

EXECUTIVE DIRECTOR, PLANNING
SIGNATURE/TITLE

Sworn to and subscribed before me this 14 day of June (Month), 2017 (Year) a Notary

Public in and for the County/State of Davidson County, TN

Diane Franklin
NOTARY PUBLIC

My commission expires 01/09 (Month/Day), 2018 (Year).

DIANE FRANKLIN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.

JUN 14 '17 PM3:42

SECURITY FEATURES INCLUDE TRUE WATERMARK PAPER, HEAT SENSITIVE ICON AND FOIL HOLOGRAM.

FIRST CITIZENS BANK

3421

64-9184/611
913

CHECK ARMOR

THE STRATEGY HOUSE, INC.
71 VICKERY STREET
ROSWELL, GA 30075

6/12/2017

PAY TO THE ORDER OF TN Health Services and Development Agency $ **15,000.00

Fifteen Thousand and 00/100********** DOLLARS

TN Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

MEMO

AUTHORIZED SIGNATURE

JUN 14 '17 PM2:48

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Section A

Tab 1 - Corporate Organization Documents
Tab 2 - Organizational Charts
Tab 3 - Site Entitlement Documentation
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Tab 6 - 'Bed Neutral' Certification Letter

Tab 1

TAB 1, Attachment Section A-4B-1

Articles of Organization

Certificate of Existence

Operating Agreement

BILL GARRETT, Davidson County
Trans:T20150039419 CHARTER
Recvd: 05/20/15 15:28 3 pgs
Fees:7.00 Taxes:0.00
20150520-0046761

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Saint Thomas Highlands Hospital, LLC
4220 HARDING PIKE
NASHVILLE, TN 37205-2005

May 20, 2015

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**000800605**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	05/20/2015
Filing Date:	05/20/2015 2:34 PM	Fiscal Year Close:	6
Status:	Active	Annual Report Due:	10/01/2015
Duration Term:	Perpetual	Image # :	B0101-2122
Business Type:	Non-Profit Limited Liability Company		
Managed By:	Member Managed		
Business County:	DAVIDSON COUNTY		

Document Receipt

Receipt # : 002065294	Filing Fee:	$300.00
Payment-Check/MO - BRADLEY ARANT BOULT CUMMINGS LLP, Nashville, TN		$300.00

Registered Agent Address:
E BERRY HOLT III
STE 800
102 WOODMONT BLVD
NASHVILLE, TN 37205-2221

Principal Address:
4220 HARDING PIKE
NASHVILLE, TN 37205-2005

Congratulations on the successful filing of your **Articles of Organization** for **Saint Thomas Highlands Hospital, LLC** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and recieve it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Charmayne Blair

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: Saint Thomas Highlands Hospital, LLC

   (NOTE: Pursuant to the provisions of T.C.A. §48-249-106, each Limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. Name Consent: (Written Consent for Use of Indistinguishable Name)

   ☐ This entity name already exists in Tennessee and has received name consent from the existing entity.

3. This company has the additional designation of: Non-Profit Limited Liability Company

4. The name and complete address of ithe Limited Liability Company's initial registered agent and office located in the state of Tennessee is:

   Name: E. Berry Holt, III

   Address: 102 Woodmont Blvd., Suite 800

   City: Nashville State: TN Zip Code: 37205-2005 County: Davidson

5. Fiscal Year Close Month: June 30

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)

   Effective Date: ____/____/____ (Month / Day / Year) Time: _____

7. The Limited Liability Company will be: ☒ Member Managed ☐ Manager Managed ☐ Director Managed

8. Number of Members at the date of filing: 1

9. Period of Duration: ☒ Perpetual ☐ Other ____/____/____ (Month / Day / Year)

10. The complete address of the Limited Liability Company's principal executive office is:

    Address: 4220 Harding Pike

    City: Nashville State: TN Zip Code: 37205-2221 County: Davidson

B0101-2122 05/20/2015 2:34 PM Received by Tennessee Secretary of State Tre Hargett

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

The name of the Limited Liability Company is: Saint Thomas Highlands Hospital, LLC

11. The complete mailing address of the entity (If different from the principal office) is:

Address: _____

City: _____ State: _____ Zip Code: _____

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)

☒ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)

☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.

Licensed Profession: _____

14. Series LLC (required only if the Additional Designation of "Series LLC" is entered in section 3.)

☐ I certify that this entity meets the requirements of T.C.A. §48-249-309(a) & (b)

15. Obligated Member Entity (list of obligated members and signatures must be attached)

☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: ____/____/____ (Month Day Year)

☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.

16. This entity is prohibited from doing business in Tennessee:

☐ This entity, while being formed under Tennessee law, is prohibited from engaging in business in Tennessee.

17. Other Provisions: _____

5/15/2[illegible]
Signature Date

Jay Hardcastle
Signature

Organizer
Signer's Capacity (if other than individual capacity)

Jay Hardcastle
Name (printed or typed)

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

ROBERT LIMYANS□Y
THE STRATEGY HOUSE,INC.
71 □IC□ERY ST
ROSWELL, GA 30005

May 8, 2017

Request Type: Certificate of Existence/Authorization
Request □: 0237206

Issuance Date: 05/08/2017
Copies Requested: 1

Document Receipt

Receipt □□: 003365970 — Filing Fee: □20.00

Payment-Credit Card - State Payment Center - CC □: 3701727553 — □20.00

Regarding:	Saint Thomas Highlands Hospital, LLC		
Filing Type:	Limited Liability Company - Domestic	Control □□:	800605
Formation/Qualification Date:	05/20/2015	Date Formed:	05/20/2015
Status:	Active	Formation Locale:	TENNESSEE
Duration Term:	Perpetual	Inactive Date:	
Business County:	DA□IDSON COUNTY		

CERTIFICATE OF E□ISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

Saint Thomas Highlands Hospital, LLC

□is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;

□has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

□has filed the most recent annual report required with this office;

□has appointed a registered agent and registered office in this State;

□has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Tre Hargett
Secretary of State

Processed By: Cert Web User

□erification □: 022349631

OPERATING AGREEMENT
of
SAINT THOMAS HIGHLANDS HOSPITAL, LLC

This **OPERATING AGREEMENT** is made effective as of the 20th day of May, 2015, and is made by the sole member, Saint Thomas Regional Hospitals (the "Member").

WHEREAS, on the 20th day of May, 2015, Jay Hardcastle, as sole organizer, formed a nonprofit limited liability company pursuant to the provisions of the Tennessee Revised Limited Liability Company Act (the "Act") by having Articles of Organization of Saint Thomas Highlands Hospital, LLC (the "Company") filed with the Secretary of State of the State of Tennessee.

NOW, THEREFORE, in order to establish the Company and to provide for its authority to transact business, the Member hereby declares as follows:

ARTICLE I
Formation and Adoption of Organizational Documents

1.1 Formation. The Member hereby forms a limited liability company under and pursuant to the Act, subject to the terms and conditions set forth in this Operating Agreement.

1.2 Name. The name of the Company shall be Saint Thomas Highlands Hospital, LLC. The Company may adopt and conduct its business under such assumed or trade names as the Member may from time to time determine. The Company shall file any assumed or fictitious name certificates as may be required to conduct business in any state.

1.3 Articles of Organization. The Articles of Organization as filed with the Secretary of State of the State of Tennessee on May 20, 2015, by Jay Hardcastle, as organizer, are hereby adopted and ratified by the Member. In the event of a conflict between the terms of this Operating Agreement and the terms of the Articles of Organization, the terms of the Articles of Organization shall prevail.

1.4 Term. The term of the Company shall commence as of May 20, 2015, and shall have perpetual existence.

1.5 Powers. In furtherance of the foregoing purposes, the Company shall have the full power and authority to conduct its business as provided by the Act and applicable law.

ARTICLE II
Management

2.1 Member-Managed. The Company shall be a "member-managed" limited liability company as such term is defined in the Act. Unless otherwise required by the Act or other provisions of this Operating Agreement or the Articles of Organization, all decisions shall be made and actions taken by the Member, who shall act as an agent of the Company and who shall have the power to bind the Company through the exercise of such powers.

2.2 Execution of Documents. Any deed, deed of trust, bill of sale, lease agreement, security agreement, financing statement, contract of purchase or sale, partnership agreement or joint venture agreement, or other contract or instrument purporting to bind the Company or to convey or encumber any of the assets of the Company in the ordinary course of business may be signed by the Member, and no other signature shall be required.

2.3 Appointment of Officers. The Member may appoint one or more officers, or other designees, to act on behalf of the Company.

ARTICLE III
Tax Characterization

3.1 The Member acknowledges that for any time that two or more persons or entities hold equity interests in the Company for federal income tax purposes (i) it is the intention of the Company to be treated as a "partnership" for federal and all relevant state tax purposes and (ii) the Company will be treated as a "partnership" for federal and all relevant state tax purposes and shall make all available elections to be so treated. Until such time, however, it is the intention of the Member that the Company be disregarded for federal and all relevant state tax purposes and that the activities of the Company be deemed to be activities of the Member for such purposes. All provisions of the Company's Articles of Organization and this Operating Agreement are to be construed so as to preserve that tax status under those circumstances.

ARTICLE IV
General Provisions

4.1 Fiscal Year. The fiscal year of the Company shall end on the 30th day of June each year.

4.2 Indemnification. The Member shall have rights to indemnification from the Company and to the advancement of expenses in connection therewith to the fullest extent permitted by law, including but not limited to, indemnification of the Member for judgments, settlements, penalties, fines or expenses incurred in any proceeding because he was or is a member.

4.3 Binding Effect. This Operating Agreement and all of the terms and provisions hereof shall be binding upon Saint Thomas Highlands Hospital, LLC and its successors and permitted assigns.

4.4 Severability. Every provision of this Operating Agreement is intended to be severable. If any term or provision hereof is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity or legality of the remainder of this Operating Agreement.

4.5 Headings. Section and other headings contained in this Operating Agreement are for reference purposes only and are not intended to describe, interpret, define, or limit the scope, extent, or intent of this Operating Agreement or any provision hereof.

4.6 Governing Law. The laws of the State of Tennessee shall govern the validity of this Operating Agreement, the construction of its terms, and the interpretation of the rights and duties of the Member.

IN WITNESS WHEREOF, this Operating Agreement is executed by the sole Member of the Company as of the date first written above.

SAINT THOMAS REGIONAL HOSPITALS

By:_____
Name: Michael Schatzlein, M.D.
Title: Chair

Tab 2

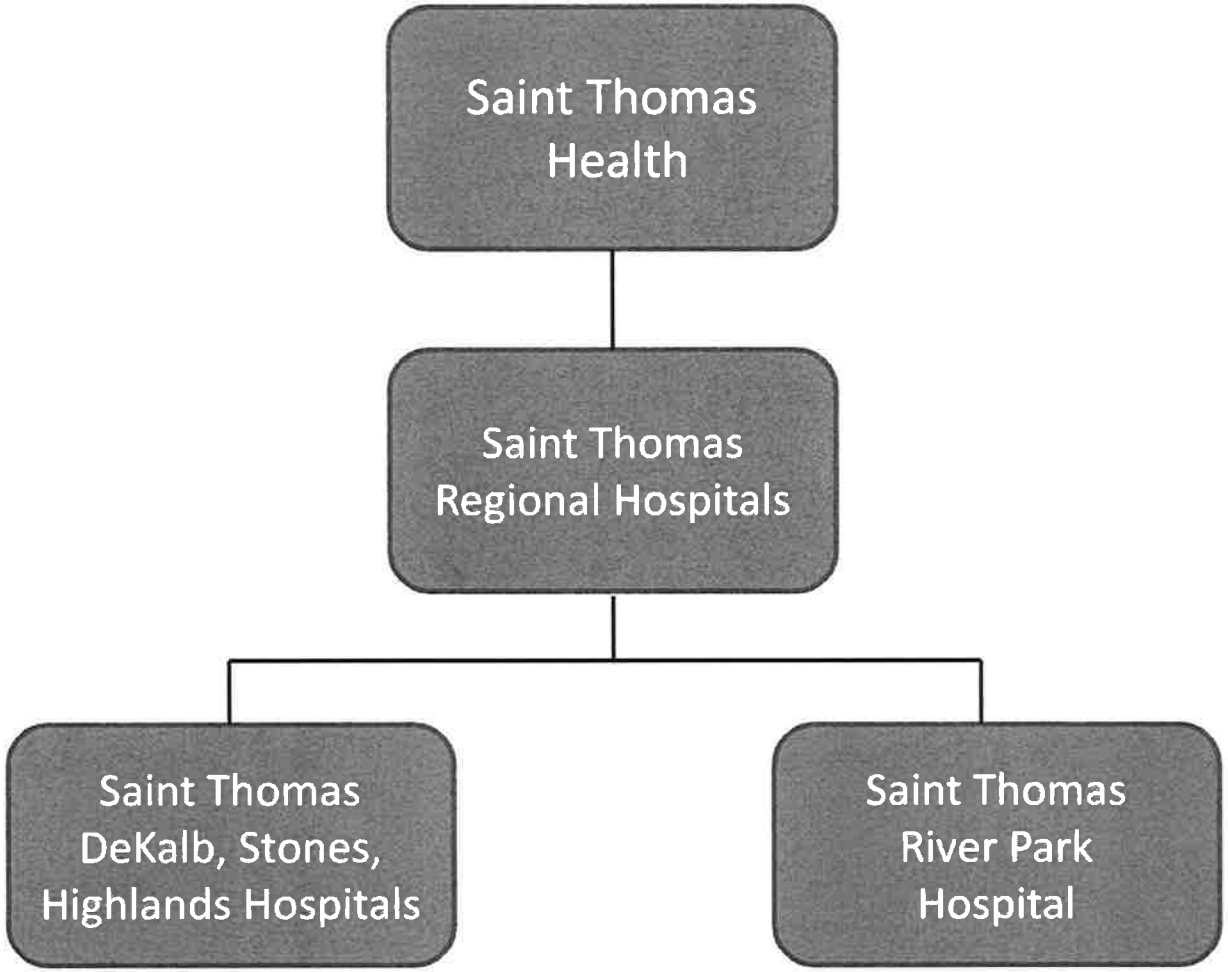
TAB 2, Attachment Section A-4B-2

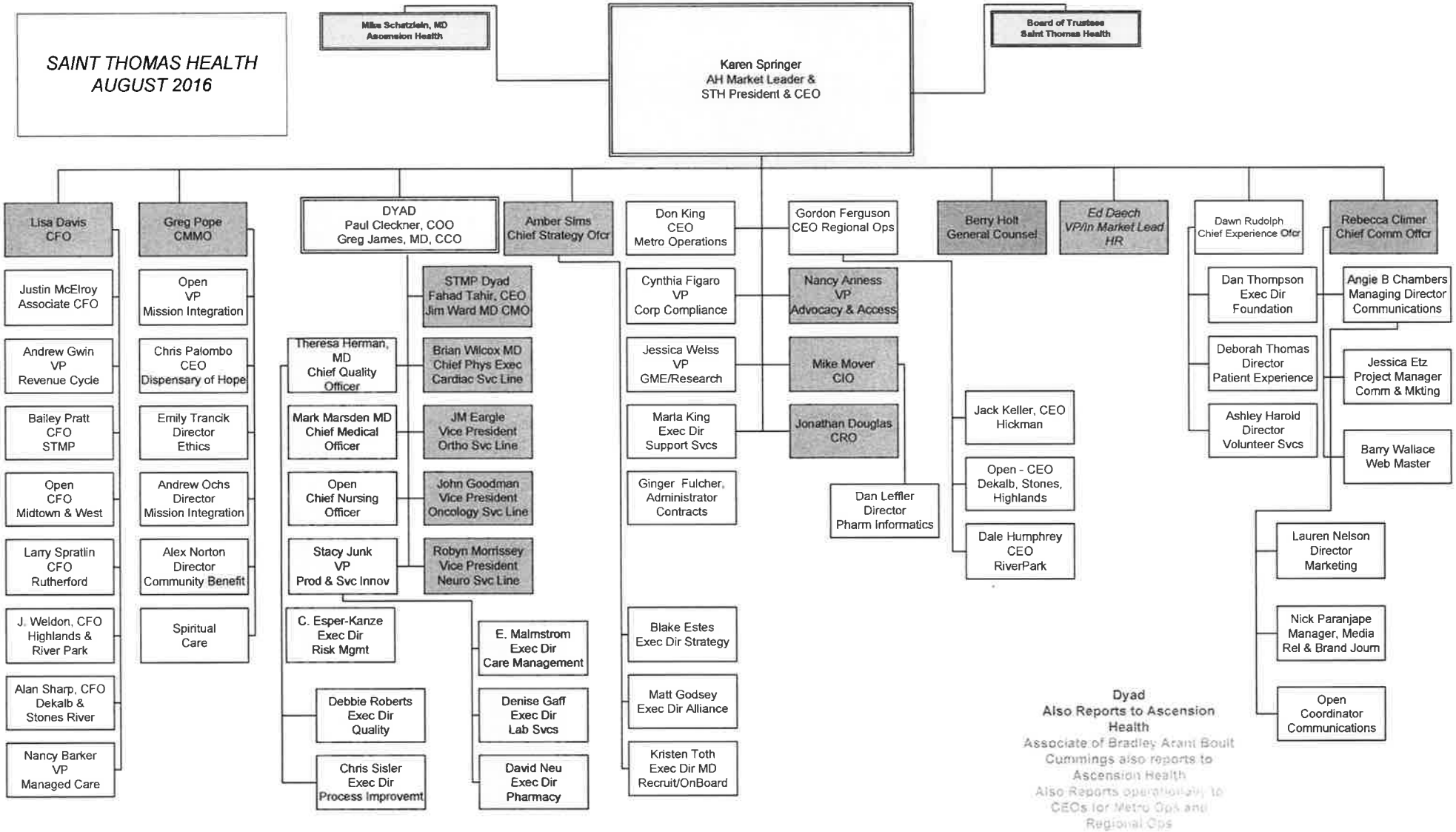
Saint Thomas Regional Hospitals

Saint Thomas Health

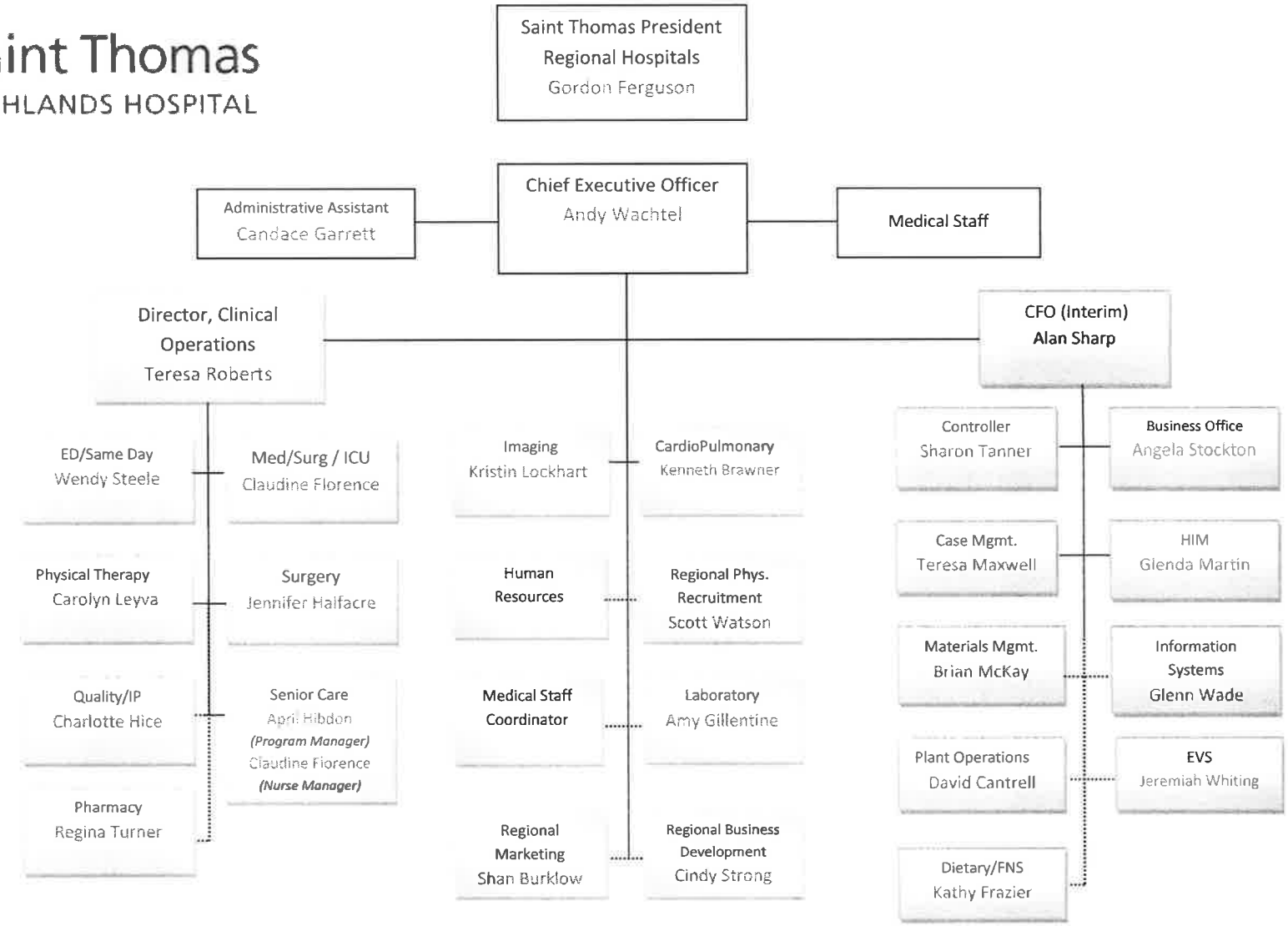
Saint Thomas Highlands Hospital

Saint Thomas Highlands Organizational Structure




SAINT THOMAS HEALTH
AUGUST 2016
Mike Schatzlein, MD
Ascension Health
Karen Springer
AH Market Leader &
STH President & CEO
Board of Trustees
Saint Thomas Health
Lisa Davis
CFO
Justin McElroy
Associate CFO
Andrew Gwin
VP
Revenue Cycle
Bailey Pratt
CFO
STMP
Open
CFO
Midtown & West
Larry Spratlin
CFO
Rutherford
J. Weldon, CFO
Highlands &
River Park
Alan Sharp, CFO
Dekalb &
Stones River
Nancy Barker
VP
Managed Care
Greg Pope
CMMO
Open
VP
Mission Integration
Chris Palombo
CEO
Dispensary of Hope
Emily Trancik
Director
Ethics
Andrew Ochs
Director
Mission Integration
Alex Norton
Director
Community Benefit
Spiritual
Care
DYAD
Paul Cleckner, COO
Greg James, MD, CCO
STMP Dyad
Fahad Tahir, CEO
Jim Ward MD CMO
Theresa Herman,
MD
Chief Quality
Officer
Brian Wilcox MD
Chief Phys Exec
Cardiac Svc Line
Mark Marsden MD
Chief Medical
Officer
JM Eargle
Vice President
Ortho Svc Line
Open
Chief Nursing
Officer
John Goodman
Vice President
Oncology Svc Line
Stacy Junk
VP
Prod & Svc Innov
Robyn Morrissey
Vice President
Neuro Svc Line
C. Esper-Kanze
Exec Dir
Risk Mgmt
E. Malmstrom
Exec Dir
Care Management
Debbie Roberts
Exec Dir
Quality
Denise Gaff
Exec Dir
Lab Svcs
Chris Sisler
Exec Dir
Process Improvemt
David Neu
Exec Dir
Pharmacy
Amber Sims
Chief Strategy Ofcr
Don King
CEO
Metro Operations
Cynthia Figaro
VP
Corp Compliance
Jessica Weiss
VP
GME/Research
Marla King
Exec Dir
Support Svcs
Ginger Fulcher,
Administrator
Contracts
Blake Estes
Exec Dir Strategy
Matt Godsey
Exec Dir Alliance
Kristen Toth
Exec Dir MD
Recruit/OnBoard
Gordon Ferguson
CEO Regional Ops
Nancy Arness
VP
Advocacy & Access
Mike Mover
CIO
Jonathan Douglas
CRO
Dan Leffler
Director
Pharm Informatics
Berry Holt
General Counsel
Jack Keller, CEO
Hickman
Open - CEO
Dekalb, Stones,
Highlands
Dale Humphrey
CEO
RiverPark
Ed Daech
VP/In Market Lead
HR
Dawn Rudolph
Chief Experience Ofcr
Dan Thompson
Exec Dir
Foundation
Deborah Thomas
Director
Patient Experience
Ashley Harold
Director
Volunteer Svcs
Rebecca Climer
Chief Comm Offcr
Angie B Chambers
Managing Director
Communications
Jessica Etz
Project Manager
Comm & Mkting
Barry Wallace
Web Master
Lauren Nelson
Director
Marketing
Nick Paranjape
Manager, Media
Rel & Brand Journ
Open
Coordinator
Communications
Dyad
Also Reports to Ascension
Health
Associate of Bradley Arant Boult
Cummings also reports to
Ascension Health
Also Reports operationally to
CEOs for Metro Ops and
Regional Ops

Saint Thomas
HIGHLANDS HOSPITAL



Effective: April 13, 2017

Tab 3

TAB 3, Attachment Section A-6A

Full Release of Deed of Trust

Release of Collateral Assignment of Deed of Trust

Special Warranty Deed, Highlands

Quitclaim Deed, Highlands

THIS INSTRUMENT PREPARED BY:
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, Tennessee 37219

FULL RELEASE OF DEED OF TRUST

The undersigned, for good and valuable consideration, does hereby terminate and release in full the lien of that certain of Deed of Trust dated August 31, 2009, executed by White County Community Hospital, LLC, in favor of Capella Healthcare, Inc., of record in Record Book 271, Page 354, Register's Office for White County, Tennessee, as assigned to Capella Healthcare, Inc., of record in Record Book 285, Page 133, Register's Office for White County, Tennessee. The legal description encumbered by said instruments is attached as Exhibit A hereto.

IN WITNESS WHEREOF, the undersigned has caused this instrument to be executed on this the 30th day of July, 2015.

CAPELLA HEALTHCARE, INC.,
a Delaware corporation

By: _____
Print Name: D. Andrew Slusser
Print Title: Exec. Vice-President

STATE OF TENNESSEE)
)
COUNTY OF Davidson)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared D. Andrew Slusser, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged himself to be Exec. Vice-President of Capella Healthcare, Inc., the within named bargainor, a corporation, and that he, as such Exec. Vice-Pres. being authorized so to do, executed the foregoing instrument for the purposes therein contained.

Witness my hand and seal, at office in Nashville, Tennessee, this the 30th day of July, 2015.

D. Claybrook
STATE OF TENNESSEE
NOTARY PUBLIC
Davidson County

_____
Notary Public
My commission expires: 11/3/15

MY COMMISSION EXPIRES:
November 3, 2015

4837-4148-0230.2
FILE NO. 15124

EXHIBIT A

TRACT 1

Beginning at a concrete R.O.W. monument in the western margin of Tennessee State Highway #289 (formerly State Highway #42), said monument being the southeast corner of the W. E. Broyles property and being the northeast corner of the property herein described; thence along Highway #289 the following courses and distances: S. 20° 03' 55" E., 17.70 feet to a 1/2" rebar; S. 25° 58' 28" E., 122.82 feet to a 3/8" iron rod; S. 23° 52' 40" E., 124.74 feet to a 3/8" iron rod' S. 22° 41' 30" E., 129.76 feet to a 3/8" iron rod at the intersection of the western margin of Highway #289 and the northern margin of Sewell Road; thence along the margin of Sewell Road S. 33° 38' 33" W. a distance of 33.69 feet to a 3/8" iron rod; thence continuing along Sewell Road S. 71° 47' 49" W. a distance of 476.25 feet to a 1/2" rebar; thence continuing along Sewell Road S. 60° 22' 30" W. a distance of 46.75 feet to a point in the eastern edge of the entrance to H.C.A. Hospital; thence along the eastern line of the Health and Educational Facilities Board of White County, Tennessee property the following courses and distances: N. 43° 16' 28" W., 60.32 feet to a point; N. 13° 16' 24" W., 15.00 feet to a point; N. 16° 43' 39" E., 72.23 feet to a point; N. 43° 16' 28" W., 28.47 feet to a point; N. 46° 43' 32" E., 193.16 feet to a point; N. 43° 16' 28" W., 368.98 feet to a 3/4" iron pipe in a fence line and W. E. Broyles' southern line; thence along the fence and Broyles' southern line N. 88° 43' 32" E. a distance of 507.24 feet to the point of beginning, containing 5.016 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

TRACT 2

Beginning at a 3/4" iron pipe in a fence line and W. E. Broyles' southern line, said pipe being S. 88° 43' 32" W. a distance of 507.24 feet from a concrete R.O.W. monument in the western margin of Tennessee Highway #289 (formerly Highway #42) and also being the northwest corner of Tract 2 of this property and the northeast corner of the property herein described; thence leaving the fence and Broyles' line and along the northwestern line of the Health and Educational Facilities Board of White County, Tennessee property S. 46° 44' 37" W. a distance of 757.56 feet to a 3/4" iron pipe in a fence line and R. A. Sewell heirs' eastern line; thence along the Sewell heirs' eastern line and the fence N. 05° 21' 15" E. a distance of 512.52 feet to a 3/4" iron pipe at a fence corner; thence along the Sewell heirs' southern line and a fence N. 89° 19' 30" E. a distance of 212.76 feet to a 3/4" iron pipe at a fence corner, being the southwest corner of the W. E. Broyles' property; thence along Broyles' southern line and a fence N. 88° 45' 05" E. a distance of 291.23 feet to the point of beginning, containing 2.940 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

TRACT 3

Beginning at a 3/4" iron pipe in a fence line and Wagner Electric Corporation's northern line, said pipe being N. 84° 42' 41" W. a distance of 263.89 feet from a ½" rebar in the northern margin of Sewell Road (the northeast corner of Wagner Electric) and being the northeast corner of the property herein described; thence along Wagner Electric's line S. 32° 23' 01" W. a distance of 161.48 feet to a metal fence post; thence continuing along Wagner Electric's line N. 04° 25' 06" E. a distance of 143.65 feet to a 3/4" iron pipe in a fence line; thence along the Health

and Educational Facilities' southern line and a fence S. 84° 48' 16" E. a distance of 75.73 feet to the point of beginning, containing 0.125 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee and being a small triangular tract as surveyed by J & K Surveying dated July 11, 1986.

TRACT 4

Beginning at a 1/2" rebar at a fence corner in the northern margin of Sewell Road, said rebar being the northeast corner of the Wagner Electric Corporation property and being the southernmost corner of the property herein described; thence leaving Sewell Road and along a fence line and Wagner Electric Corporation's northern line N. 84° 42' 41" W. a distance of 263.89 feet to a 3/4" iron pipe; thence continuing along H.C.A.'s line and the fence N. 84° 48' 16" W. a distance of 75.73 feet to a 3/4" iron pipe; thence continuing along Wagner's line and the fence N. 84° 41' 36" W. a distance of 212.52 feet to a 3/4" iron pipe at a fence corner, being the R. A. Sewell heirs southeastern corner; thence along the Sewell heirs' eastern line and a fence line N. 05° 11' 28" E. a distance of 104.89 feet to a 3/4" iron pipe; thence leaving the Sewell line and along the Hospital Corporation of America's southeastern line N. 46° 44' 37" E. a distance of 757.56 feet to a 3/4" iron pipe in a fence and W. E. Broyles southern line; thence leaving the Broyles' line and along the western line of a tract owned by the Hospital Corporation of America the following courses and distances: S. 43° 16' 28" E., 368.98 feet to a point; S. 46° 43' 32" W., 193.16 feet to a point; S. 43° 16' 28" E., 28.47 feet to a point; S. 16° 43' 39" W., 72.23 feet to a point; S. 13° 16' 24" E., 15.00 feet to a point; S. 43° 16' 28" E., 60.32 feet to a point in the northern margin of Sewell Road; thence along Sewell Road S. 60° 22' 30" W. a distance of 31.20 feet to a P.K. nail in the western edge of a paved entrance to the H.C.A. Hospital; thence continuing along Sewell Road S. 51° 59' 11" W. a distance of 177.85 feet to the point of beginning, containing 6.914 acres and being the same property as described in Warranty Deed Book 162, Page 291 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

Tract Nos. 1 - 4 being the same property conveyed to White County Community Hospital, LLC, a Delaware limited liability company, by deed from Sparta Hospital Corporation, a Tennessee corporation, of record in Record Book 271, page 350, Register's Office for White County, Tennessee.

BK/PG: RB366/54-56

15002442

3 PGS:AL-RELEASE	
TINA BATCH: 42966	08/03/2015 - 01:20 PM
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	15.00
ARCHIVE FEE	0.00
DP FEE	2.00
REGISTER'S FEE	0.00
TOTAL AMOUNT	17.00

STATE OF TENNESSEE, WHITE COUNTY
MARTHA BUMBALOUGH
REGISTER OF DEEDS

4837-4148-0230.2
FILE NO. 15124

MARTHA BUMBALOUGH

Register of Deeds
White County, TN

Payment Receipt
Batch# 42966

08/03/2015

RCVD OF: BRADLEY ARANT BOULT CUMMINGS LLP

When Revenue Is Paid By Check,
Receipt Is Not Valid Until Check Is
Paid By Bank

Check(s)	27744.06
Inst # 15002442	01:20 PM
RELEASE	
Book: RB366 Page: 54	
Recording Fee	15.00
DP Fee	2.00
Document Total:	$17.00
Inst # 15002443	01:20 PM
RELEASE	
Book: RB366 Page: 57	
Recording Fee	15.00
DP Fee	2.00
Document Total:	$17.00
Inst # 15002444	01:20 PM
WARRANTY DEED	
Book: RB366 Page: 60	
Transfer Tax	27640.06
Recording Fee	45.00
Register's Fee	1.00
DP Fee	2.00
Document Total:	$27688.06
Inst # 15002445	01:20 PM
QUITCLAIM DEED	
Book: RB366 Page: 69	
Recording Fee	20.00
DP Fee	2.00
Document Total:	$22.00
Batch Total:	27744.06

THIS INSTRUMENT PREPARED BY:
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, Tennessee 37219

FULL RELEASE OF COLLATERAL ASSIGNMENT OF DEED OF TRUST, SECURITY AGREEMENT, ASSIGNMENT OF RENTS AND LEASES AND FIXTURE FILING

The undersigned, for good and valuable consideration, does hereby terminate and release in full the lien of that certain of Collateral Assignment of Deed of Trust, Security Agreement, Assignment of Rents and Leases and Fixture Filing dated August 31, 2009, executed by White County Community Hospital, LLC, in favor of Capella Healthcare, Inc., of record in Record Book 271, Page 379, Register's Office for White County, Tennessee. The legal description encumbered by said instrument is attached as Exhibit A hereto.

IN WITNESS WHEREOF, the undersigned has caused this instrument to be executed on this the 30th day of July, 2015.

CAPELLA HEALTHCARE, INC.,
a Delaware corporation

By: _____
Print Name: D. Andrew Slusser
Print Title: Exec. Vice-President

STATE OF TENNESSEE)
)
COUNTY OF Davidson)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared D. Andrew Slusser, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged himself to be Exec. Vice President of Capella Healthcare, Inc., the within named bargainor, a corporation, and that he, as such Exec. Vice. Pres. being authorized so to do, executed the foregoing instrument for the purposes therein contained.

Witness my hand and seal, at office in Nashville, Tennessee, this the 30th day of July, 2015.

John D. Claybrook
NOTARY PUBLIC STATE OF TENNESSEE
Davidson County
MY COMMISSION EXPIRES: November 3, 2015

_____
Notary Public
My commission expires: 11/3/15

4828-0156-3174.2
FILE NO. 151524

EXHIBIT A

TRACT 1

Beginning at a concrete R.O.W. monument in the western margin of Tennessee State Highway #289 (formerly State Highway #42), said monument being the southeast corner of the W. E. Broyles property and being the northeast corner of the property herein described; thence along Highway #289 the following courses and distances: S. 20° 03' 55" E., 17.70 feet to a 1/2" rebar; S. 25° 58' 28" E., 122.82 feet to a 3/8" iron rod; S. 23° 52' 40" E., 124.74 feet to a 3/8" iron rod' S. 22° 41' 30" E., 129.76 feet to a 3/8" iron rod at the intersection of the western margin of Highway #289 and the northern margin of Sewell Road; thence along the margin of Sewell Road S. 33° 38' 33" W. a distance of 33.69 feet to a 3/8" iron rod; thence continuing along Sewell Road S. 71° 47' 49" W. a distance of 476.25 feet to a 1/2" rebar; thence continuing along Sewell Road S. 60° 22' 30" W. a distance of 46.75 feet to a point in the eastern edge of the entrance to H.C.A. Hospital; thence along the eastern line of the Health and Educational Facilities Board of White County, Tennessee property the following courses and distances: N. 43° 16' 28" W., 60.32 feet to a point; N. 13° 16' 24" W., 15.00 feet to a point; N. 16° 43' 39" E., 72.23 feet to a point; N. 43° 16' 28" W., 28.47 feet to a point; N. 46° 43' 32" E., 193.16 feet to a point; N. 43° 16' 28" W., 368.98 feet to a 3/4" iron pipe in a fence line and W. E. Broyles' southern line; thence along the fence and Broyles' southern line N. 88° 43' 32" E. a distance of 507.24 feet to the point of beginning, containing 5.016 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

TRACT 2

Beginning at a 3/4" iron pipe in a fence line and W. E. Broyles' southern line, said pipe being S. 88° 43' 32" W. a distance of 507.24 feet from a concrete R.O.W. monument in the western margin of Tennessee Highway #289 (formerly Highway #42) and also being the northwest corner of Tract 2 of this property and the northeast corner of the property herein described; thence leaving the fence and Broyles' line and along the northwestern line of the Health and Educational Facilities Board of White County, Tennessee property S. 46° 44' 37" W. a distance of 757.56 feet to a 3/4" iron pipe in a fence line and R. A. Sewell heirs' eastern line; thence along the Sewell heirs' eastern line and the fence N. 05° 21' 15" E. a distance of 512.52 feet to a 3/4" iron pipe at a fence corner; thence along the Sewell heirs' southern line and a fence N. 89° 19' 30" E. a distance of 212.76 feet to a 3/4" iron pipe at a fence corner, being the southwest corner of the W. E. Broyles' property; thence along Broyles' southern line and a fence N. 88° 45' 05" E. a distance of 291.23 feet to the point of beginning, containing 2.940 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

TRACT 3

Beginning at a 3/4" iron pipe in a fence line and Wagner Electric Corporation's northern line, said pipe being N. 84° 42' 41" W. a distance of 263.89 feet from a ½" rebar in the northern margin of Sewell Road (the northeast corner of Wagner Electric) and being the northeast corner of the property herein described; thence along Wagner Electric's line S. 32° 23' 01" W. a distance of 161.48 feet to a metal fence post; thence continuing along Wagner Electric's line N. 04° 25' 06" E. a distance of 143.65 feet to a 3/4" iron pipe in a fence line; thence along the Health

and Educational Facilities' southern line and a fence S. 84° 48' 16" E. a distance of 75.73 feet to the point of beginning, containing 0.125 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee and being a small triangular tract as surveyed by J & K Surveying dated July 11, 1986.

TRACT 4

Beginning at a 1/2" rebar at a fence corner in the northern margin of Sewell Road, said rebar being the northeast corner of the Wagner Electric Corporation property and being the southernmost corner of the property herein described; thence leaving Sewell Road and along a fence line and Wagner Electric Corporation's northern line N. 84° 42' 41" W. a distance of 263.89 feet to a 3/4" iron pipe; thence continuing along H.C.A.'s line and the fence N. 84° 48' 16" W. a distance of 75.73 feet to a 3/4" iron pipe; thence continuing along Wagner's line and the fence N. 84° 41' 36" W. a distance of 212.52 feet to a 3/4" iron pipe at a fence corner, being the R. A. Sewell heirs southeastern corner; thence along the Sewell heirs' eastern line and a fence line N. 05° 11' 28" E. a distance of 104.89 feet to a 3/4" iron pipe; thence leaving the Sewell line and along the Hospital Corporation of America's southeastern line N. 46° 44' 37" E. a distance of 757.56 feet to a 3/4" iron pipe in a fence and W. E. Broyles southern line; thence leaving the Broyles' line and along the western line of a tract owned by the Hospital Corporation of America the following courses and distances: S. 43° 16' 28" E., 368.98 feet to a point; S. 46° 43' 32" W., 193.16 feet to a point; S. 43° 16' 28" E., 28.47 feet to a point; S. 16° 43' 39" W., 72.23 feet to a point; S. 13° 16' 24" E., 15.00 feet to a point; S. 43° 16' 28" E., 60.32 feet to a point in the northern margin of Sewell Road; thence along Sewell Road S. 60° 22' 30" W. a distance of 31.20 feet to a P.K. nail in the western edge of a paved entrance to the H.C.A. Hospital; thence continuing along Sewell Road S. 51° 59' 11" W. a distance of 177.85 feet to the point of beginning, containing 6.914 acres and being the same property as described in Warranty Deed Book 162, Page 291 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

Tract Nos. 1 - 4 being the same property conveyed to White County Community Hospital, LLC, a Delaware limited liability company, by deed from Sparta Hospital Corporation, a Tennessee corporation, of record in Record Book 271, page 350, Register's Office for White County, Tennessee.

BK/PG: RB366/57-59
15002443

3 PGS:AL-RELEASE	
TINA BATCH: 42968	08/03/2015 - 01:20 PM
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	15.00
ARCHIVE FEE	0.00
DP FEE	2.00
REGISTER'S FEE	0.00
TOTAL AMOUNT	17.00

STATE OF TENNESSEE, WHITE COUNTY
MARTHA BUMBALOUGH
REGISTER OF DEEDS

4828-0156-3174.2
FILE NO. 151524

THIS INSTRUMENT PREPARED BY:
John D. Claybrook, Esq.
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, Tennessee 37219

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

The actual consideration or value, whichever is greater, for this transfer is $ 7,470,286.62

Sarah Faint
Affiant

Subscribed and sworn to before me this 31 day of July, 2015.

Sue Arnett
Notary Public

My Commission Expires: 3-6-18

SUE ARNETT STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY My Commission Expires MAR. 6, 2018

****

ADDRESS OF NEW OWNER:	SEND TAX BILL TO:	MAP-PARCEL NO.
Saint Thomas Highlands Hospital, LLC c/o Saint Thomas Health 102 Woodmont Blvd., Suite 800 Nashville, TN 37205 attn: CFO	SAME	049-002.02 049-002.08

****

SPECIAL WARRANTY DEED

KNOW ALL MEN BY THESE PRESENTS, that for and in consideration of the sum of TEN DOLLARS ($10.00) cash in hand paid, and other good and valuable consideration, the receipt of which is hereby acknowledged, **White County Community Hospital, LLC**, a Delaware limited liability company ("Grantor"), has bargained and sold, and by these presents does transfer and convey unto **Saint Thomas Highlands Hospital, LLC**, a Tennessee limited liability company ("Grantee"), its representatives, successors and assigns of Grantee, a certain tract or parcel of land in White County, Tennessee, described as follows, to-wit:

See attached Exhibit A

4822-0366-9286.4
File No. 151524

TINA MILLER
ASSESSOR OF PROPERTY

DI	MAP	GP	C-MAP	PARCEL
1	49		49	2.02

2.08

COMPLETE SPLIT

TO HAVE AND TO HOLD the said real property together with all rights, easements, privileges, appurtenances and hereditaments thereunto belonging or in any wise appertaining to Grantee, its representatives, successors and assigns of Grantee, forever.

Grantor further covenants and binds itself, its representatives, successors and assigns to warrant and forever defend the title to said real estate to Grantee, its representatives, successors and assigns of Grantee, against the lawful claims of all persons claiming through or under Grantor (other than claims arising out of the matters set forth on Exhibit B attached hereto) but not further or otherwise. All exhibits referred to herein are attached hereto and incorporated herein by reference. Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

[signature page follows]

IN WITNESS WHEREOF, Grantor has caused this Special Warranty Deed to be executed on the 30th day of July, 2015.

GRANTOR:

WHITE COUNTY COMMUNITY HOSPITAL, LLC,
a Delaware limited liability company

By: _____
Name: D. Andrew Slusser
Title: Vice President

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared D. Andrew Slusser, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged himself to be Vice President of White County Community Hospital, LLC, the within named bargainor, a limited liability company, and that he, as such Vice President being authorized so to do, executed the foregoing instrument for the purposes therein contained.

Witness my hand and seal, at office in Franklin, Tennessee, this the 30th day of July, 2015.

_____
Notary Public

My Commission Expires: 5/8/18

JEANNE M. PERRI
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: MAY 8, 2018

4822-0366-9286.4

EXHIBIT A

TRACT 1

Beginning at a concrete R.O.W. monument in the western margin of Tennessee State Highway #289 (formerly State Highway #42), said monument being the southeast corner of the W. E. Broyles property and being the northeast corner of the property herein described; thence along Highway #289 the following courses and distances: S. 20° 03' 55" E., 17.70 feet to a 1/2" rebar; S. 25° 58' 28" E., 122.82 feet to a 3/8" iron rod; S. 23° 52' 40" E., 124.74 feet to a 3/8" iron rod' S. 22° 41' 30" E., 129.76 feet to a 3/8" iron rod at the intersection of the western margin of Highway #289 and the northern margin of Sewell Road; thence along the margin of Sewell Road S. 33° 38' 33" W. a distance of 33.69 feet to a 3/8" iron rod; thence continuing along Sewell Road S. 71° 47' 49" W. a distance of 476.25 feet to a 1/2" rebar; thence continuing along Sewell Road S. 60° 22' 30" W. a distance of 46.75 feet to a point in the eastern edge of the entrance to H.C.A. Hospital; thence along the eastern line of the Health and Educational Facilities Board of White County, Tennessee property the following courses and distances: N. 43° 16' 28" W., 60.32 feet to a point; N. 13° 16' 24" W., 15.00 feet to a point; N. 16° 43' 39" E., 72.23 feet to a point; N. 43° 16' 28" W., 28.47 feet to a point; N. 46° 43' 32" E., 193.16 feet to a point; N. 43° 16' 28" W., 368.98 feet to a 3/4" iron pipe in a fence line and W. E. Broyles' southern line; thence along the fence and Broyles' southern line N. 88° 43' 32" E. a distance of 507.24 feet to the point of beginning, containing 5.016 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

TRACT 2

Beginning at a 3/4" iron pipe in a fence line and W. E. Broyles' southern line, said pipe being S. 88° 43' 32" W. a distance of 507.24 feet from a concrete R.O.W. monument in the western margin of Tennessee Highway #289 (formerly Highway #42) and also being the northwest corner of Tract 2 of this property and the northeast corner of the property herein described; thence leaving the fence and Broyles' line and along the northwestern line of the Health and Educational Facilities Board of White County, Tennessee property S. 46° 44' 37" W. a distance of 757.56 feet to a 3/4" iron pipe in a fence line and R. A. Sewell heirs' eastern line; thence along the Sewell heirs' eastern line and the fence N. 05° 21' 15" E. a distance of 512.52 feet to a 3/4" iron pipe at a fence corner; thence along the Sewell heirs' southern line and a fence N. 89° 19' 30" E. a distance of 212.76 feet to a 3/4" iron pipe at a fence corner, being the southwest corner of the W. E. Broyles' property; thence along Broyles' southern line and a fence N. 88° 45' 05" E. a distance of 291.23 feet to the point of beginning, containing 2.940 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

TRACT 3

Beginning at a 3/4" iron pipe in a fence line and Wagner Electric Corporation's northern line, said pipe being N. 84° 42' 41" W. a distance of 263.89 feet from a ½" rebar in the northern margin of Sewell Road (the northeast corner of Wagner Electric) and being the northeast corner of the property herein described; thence along Wagner Electric's line S. 32° 23' 01" W. a distance of 161.48 feet to a metal fence post; thence continuing along Wagner Electric's line N. 04° 25' 06" E. a distance of 143.65 feet to a 3/4" iron pipe in a fence line; thence along the Health

and Educational Facilities' southern line and a fence S. 84° 48' 16" E. a distance of 75.73 feet to the point of beginning, containing 0.125 acres and being a portion of the property described in Warranty Deed Book 161, Page 629 in the Register's Office, White County, Tennessee and being a small triangular tract as surveyed by J & K Surveying dated July 11, 1986.

TRACT 4

Beginning at a 1/2" rebar at a fence corner in the northern margin of Sewell Road, said rebar being the northeast corner of the Wagner Electric Corporation property and being the southernmost corner of the property herein described; thence leaving Sewell Road and along a fence line and Wagner Electric Corporation's northern line N. 84° 42' 41" W. a distance of 263.89 feet to a 3/4" iron pipe; thence continuing along H.C.A.'s line and the fence N. 84° 48' 16" W. a distance of 75.73 feet to a 3/4" iron pipe; thence continuing along Wagner's line and the fence N. 84° 41' 36" W. a distance of 212.52 feet to a 3/4" iron pipe at a fence corner, being the R. A. Sewell heirs southeastern corner; thence along the Sewell heirs' eastern line and a fence line N. 05° 11' 28" E. a distance of 104.89 feet to a 3/4" iron pipe; thence leaving the Sewell line and along the Hospital Corporation of America's southeastern line N. 46° 44' 37" E. a distance of 757.56 feet to a 3/4" iron pipe in a fence and W. E. Broyles southern line; thence leaving the Broyles' line and along the western line of a tract owned by the Hospital Corporation of America the following courses and distances: S. 43° 16' 28" E., 368.98 feet to a point; S. 46° 43' 32" W., 193.16 feet to a point; S. 43° 16' 28" E., 28.47 feet to a point; S. 16° 43' 39" W., 72.23 feet to a point; S. 13° 16' 24" E., 15.00 feet to a point; S. 43° 16' 28" E., 60.32 feet to a point in the northern margin of Sewell Road; thence along Sewell Road S. 60° 22' 30" W. a distance of 31.20 feet to a P.K. nail in the western edge of a paved entrance to the H.C.A. Hospital; thence continuing along Sewell Road S. 51° 59' 11" W. a distance of 177.85 feet to the point of beginning, containing 6.914 acres and being the same property as described in Warranty Deed Book 162, Page 291 in the Register's Office, White County, Tennessee as surveyed by J & K Surveying dated July 11, 1986.

Tract Nos. 1-4 being the same property conveyed to White County Community Hospital, LLC, a Delaware limited liability company, by deed from Sparta Hospital Corporation, a Tennessee corporation, of record in Record Book 271, page 350, Register's Office for White County, Tennessee.

EXHIBIT B

Title Exceptions

1. Zoning and building laws, ordinances, resolutions and regulations.

2. Real estate taxes and assessments for public improvements which are not due and payable as of the date of recording of this instrument.

3. General or special real estate taxes and assessments required to be paid in the year 2015 and subsequent years for Map-Par. 049-002.02 and 049-002.08.

4. Easement for water pipeline granted to the Town of Sparta, Tennessee, by instrument of record in Deed Book 155, Page 477, said Register's Office.

5. Parties in possession, without purchase option or right of first refusal, under those leases referenced on Schedule 1 attached hereto that encumber any portion of the subject property.

SCHEDULE 1

Item No.	Data Site No.	Title of Agreement	Contracting Party	Seller Entity	Contract Date
1	3226-5797	Lease Agreement for Medical Office	White County Physician Services, LLC	White County Community Hospital, LLC dba Highlands Medical Center	10/01/14
2	5676	Lease Agreement	The Chapman and Ross Partnership	White County Community Hospital, LLC d/b/a Highlands Medical Center	06/01/14
3	5694	Medical Office License Agreement	STHS Heart, LLC d/b/a Saint Thomas Heart	White County Physicians Services, LLC	07/25/14
4	5695	Medical Office License Agreement	STHS Heart, LLC d/b/a Saint Thomas Heart	White County Community Hospital, LLC	07/25/14
5	5697	Sublease Agreement	White County Physician Services, LLC	White County Community Hospital, LLC d/b/a Highlands Medical Center	06/01/14
6	5780	Lease	Lou Morrison and Kendall Morrison	White County Physician Services, LLC	09/16/14
7	5797; 5797-5787	Lease Agreement For Medical Office	White County Physician Services, LLC	White County Community Hospital, LLC	10/01/14
8	5852	License Agreement	Physicians Associates, LLC	White County Physician Services, LLC	11/13/14
9	1115-1044 1115-2546 1115-3478 1115-4355 1115-5442 1115-7342 1115-7343 1115	Original Lease 4/14/2010 Lease Renewal 3/8/2011 Lease Renewal 2/12/2012 Lease Renewal 3/21/2013 Lease Renewal 4/30/2014 Lease Renewal 3/2/2015	Jeff Young and Kim Young	White County Community Hospital, LLC d/b/a White County Community Hospital	03/02/15

Item No.	Data Site No.	Title of Agreement	Contracting Party	Seller Entity	Contract Date
10	5914	Lease	Darryl Richards, Craig Maltman and Kenneth Wood	White County Physician Services, LLC	01/07/15
11	5914-7172	Assignment of Lease	M&S Properties	White County Physician Services, Inc.	02/09/15
12	5976	Renewal of Agreement or Contract known as Lease Agreement for Medical Office	White County Physician Services, LLC	White County Community Hospital, LLC d/b/a Highlands Medical Center	03/02/15
13	1122	Lease Agreement For Medical Office Space	Abhay Kemkar, M.D.	White County Community Hospital, LLC d/b/a White County Community Hospital	04/09/12
14	1123	Lease Agreement	Jeff Loveland, D.P.M.	White County Community Hospital, LLC, d/b/a Highlands Medical Center	11/15/13
15	1124	Medical Office License Agreement 03/26/2014	Oscar Spivey, M.D.	White County Community Hospital, LLC d/b/a White County Community Hospital	03/26/14
16	3093-2545 3093-3477 3093-4354 3093-5441 3093-7344 3093	Original Lease 4/14/2010 Lease Renewal 3/8/2011 Lease Renewal 2/12/2012 Lease Renewal 3/21/2013 Lease Renewal 4/30/2014 Lease Renewal 3/2/2015	Jeff Young and Kim Young	White County Community Hospital, LLC d/b/a White County Community Hospital	03/02/15
17	1163-5773; 1163	Lease Agreement For Medical Office	White County Physician Services, LLC	White County Community Hospital, LLC d/b/a Highlands Medical Center	10/01/14
18	1677	Lease Agreement For Medical Office	Chad Griffin M.D.	White County Community Hospital, LLC	02/20/14

Item No.	Data Site No.	Title of Agreement	Contracting Party	Seller Entity	Contract Date
19	N/A	Lease Agreement No. 1103047	ModSpace	Highlands Medical Center	08/22/13
20	N/A	Lease Agreement	The Chapman and Ross Partnership	White County Community Hospital, LLC d/b/a Highlands Medical Center	05/16/15
21	N/A	License Agreement	Physicians Associates, LLC	White County Physician Services, LLC	11/13/14
22	6246	Self Service Storage Facility Rental Agreement	Webb Avenue Mini Storage	Crossville Orthopaedics	01/03/12
23	6384	Lease Agreement	The Chapman and Ross Partnership	White County Community Hospital, LLC D/B/A Highlands Medical Center	04/23/15
24	6432	Medical Office License Agreement	JOSE RIVERO, M.D.	White County Community Hospital, LLC d/b/a Highlands Medical Center	06/17/15
25	15055.6308C	Lease Agreement	The Chapman and Ross Partnership	White County Community Hospital, d/b/a Highlands Medical Center	05/05/15

BK/PG: RB366/60-68

15002444

9 PGS:AL-WARRANTY DEED

TINA BATCH: 42966 08/03/2015 - 01:20 PM

VALUE	7470286.62
MORTGAGE TAX	0.00
TRANSFER TAX	27640.06
RECORDING FEE	45.00
ARCHIVE FEE	0.00
DP FEE	2.00
REGISTER'S FEE	1.00
TOTAL AMOUNT	27688.06

STATE OF TENNESSEE, WHITE COUNTY

MARTHA BUMBALOUGH

REGISTER OF DEEDS

QUITCLAIM DEED

To: Saint Thomas Highlands Hospital, LLC

From: White County Community Hospital, LLC

This instrument was prepared by:
John D. Claybrook, Esq.
Waller Lansden Dortch & Davis, LLP
511 Union St., Suite 2700
Nashville, TN 37219

Address New Owner(s) as Follows:	Send Tax Bills To:	Map/Parcel Number:
Saint Thomas Highlands Hospital, LLC c/o Saint Thomas Health 102 Woodmont Blvd., Suite 800 Nashville, TN 37205 Attn: CFO	Same	049-002.02 049-002.08

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

The actual consideration for this transfer is $0.

Affiant

Sworn to and subscribed before me, this 31 day of July, 2015.

Notary Public

My Commission Expires: 3-6-18

STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY My Commission Expires MAR. 6, 2018

QUITCLAIM DEED

FOR AND IN CONSIDERATION OF the sum of Ten Dollars, the receipt of which is hereby acknowledged, **White County Community Hospital, LLC**, a Delaware limited liability company (hereinafter called the "Grantor") by these presents does quitclaim, transfer, and convey unto **Saint Thomas Highlands Hospital, LLC**, a Tennessee limited liability company (hereinafter called the "Grantee"), and its successors and assigns, all of Grantor's right, title and interest, in and to that certain real property located in White County, State of Tennessee, more particularly described on Exhibit A attached hereto and incorporated herein by this reference (the "Property").

(Remainder of Page Intentionally Left Blank)

TINA MILLER
ASSESSOR OF PROPERTY

DI	MAP	GP	C-MAP	PARCEL
1	49		49	2.02 2.08

COMPLETE SPLIT

4826-9159-4790.1
File No. 151524

IN WITNESS WHEREOF, Seller has caused this deed to be executed effective as of the 30th day of July, 2015.

SELLER:

WHITE COUNTY COMMUNITY HOSPITAL, LLC,
a Delaware limited liability company

By: _____
Name: D. Andrew Slusser
Title: Vice President

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared D. Andrew Slusser of White County Community Hospital, LLC, a Delaware limited liability company (the "Company"), with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be the Vice President of the Company, the within named bargainor, and that he as such Vice President of the Company, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the limited liability company by himself as Vice President.

Witness my hand and seal at office in Franklin, Tennessee, this 30th day of July, 2015.

_____
Notary Public

JEANNE M. PERRI
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

MY COMMISSION EXPIRES:
MAY 8, 2018

EXHIBIT A

Legal Description

Being Tracts 1, 2, 3 and 4 as recorded in Book 271, Page 350, Register's Office of White County, Tennessee (ROWC), lying in the 1st District of White County, Sparta, Tennessee. Being bounded on the south by the northern Right of Way (ROW) of Sewell Drive and by Cooper Automotive Company as recorded in Book 49, Page 640, ROWC; bounded on the west by Brian M. Jones as recorded in Book 239, Page 465, ROWC; bounded on the north by Jeff Young and Steve Slatten as recorded in Book 141, Page 427, ROWC, and by Middle Tennessee Utility District as recorded in Book 348, Page 377, ROWC; and bounded on the east by the western ROW North Spring Street (State Route 289)Tract being more particularly described as follows:
POINT OF BEGINNING being a found 5/8" iron rod lying on the northwest ROW intersection of said Sewell Drive and North Spring Street; thence along said northern ROW of Sewell Drive with the following: South 33° 51' 58" West 33.47 feet to a found 3/8" iron rod; thence South 71° 25' 29" West 475.81 feet to a found 5/8" iron rod; thence South 59° 56' 32" West 78.39 feet to a found p.k. nail; thence South 51° 34' 14" West 177.74 feet to a found 1/2" iron rod; thence along the common line of said Cooper Automotive Company with the following: North 85° 08' 41" West 263.89 feet to a point in a found tree; thence South 32° 07' 31" West 161.48 feet to a found metal fence post; thence North 04° 06' 14" East 143.65 feet to a found 1" iron pipe; thence North 84° 57' 35" West 212.29 feet to a found 1" iron pipe; thence along the common line of said Jones with the following: North 04° 46' 39" East 104.81 feet to a set point; thence North 04° 56' 26" East 512.13 feet to a found 1" iron pipe; thence along the common line of said Young and Slatten North 88° 55' 31" East 212.67 feet to a found 3/8" iron rod; thence along the common line of said Middle Tennessee Utility District with the following; North 88° 21' 58" East 291.34 feet to a found 1" iron pipe; thence North 88° 19' 39" East 507.24 feet to a found concrete monument; thence along said ROW of North Spring Street with the following: South 20° 26' 59" East 17.70 feet to a set point; thence South 26° 22' 32" East 122.82 feet to a found 3/8" iron rod; thence South 24° 17' 00" East 124.81 feet to a found 3/8" iron rod; thence South 23° 02' 46" East 130.18 feet to the point of beginning.
Tract contains 653,086 square feet or 14.99 acres.
Bearings based on Tennessee State Plane Coordinate System.

Being the same property conveyed to White County Community Hospital, LLC by deed from Sparta Hospital Corporation, of record in Record Book 271, page 350, Register's Office for White County, Tennessee.

BK/PG: RB366/69-71
15002445

3 PGS:AL-QUITCLAIM DEED	
TINA BATCH: 42966	08/03/2015 - 01:20 PM
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	20.00
ARCHIVE FEE	0.00
DP FEE	2.00
REGISTER'S FEE	0.00
TOTAL AMOUNT	22.00

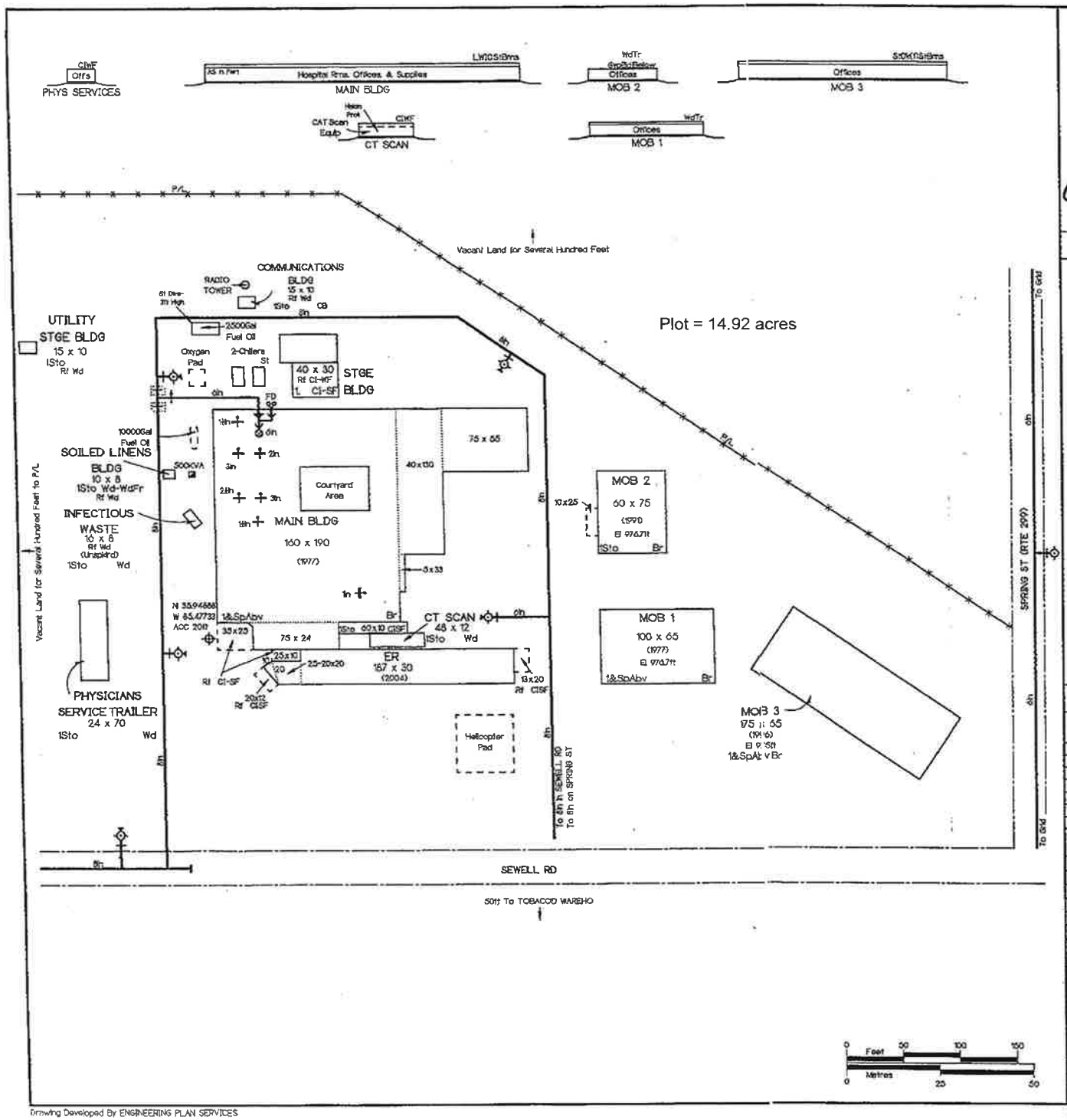
STATE OF TENNESSEE, WHITE COUNTY
MARTHA BUMBALOUGH
REGISTER OF DEEDS

Reference Book RB 366 **Page** 60

Tab 4

TAB 4, Attachment Section A-6B-1

Global Site Plan



Drawing Developed By ENGINEERING PLAN SERVICES

FM Global

LEGEND

Dry or frost proof hydrant with fire department pumper connection (number of horns indicate number of hose outlets).

DAVID -
DOES THIS APPEAR
CORRECT TO YOU?
PLEASE SHOW JOHN
M 12/5

All suspended ceilings are non-combustible on steel frame unless otherwise noted.

SPRINKLER SYSTEM DATA

RISER LOCATION	Type Sprk	Spacing (ft²)	Temp (°F)	Orif. (in)	HYDRAULICALLY DESIGNED SYSTEM DATA: Density Area (gpm/ft²) or Sq Ft	Design Area (ft²) or Inches	DEMAND BOR: Flow (gpm)	Press (psi)
MAIN	HYD	130	155	1/2	0.10	1500	100	31

OKUKUN-RADCS HYD.DESFR

REVISIONS

DR	CH	DATE	CHANGES MADE
GLS	LTB	Oct-6-05	For Baseline Risk Evaluation of C.E.McGaughin, Jun-14-05
MET		10-21-99	For F-Reg Insp of W.A. Hayes 10-8-99
DPF		12-6-96	For F-First Insp of W.A. Hayes 11-13-96 Replace A79-1074

COMMUNITY HEALTH SYSTEMS, INC.

"WHITE COUNTY COMMUNITY HOSPITAL"

Sparta, Tennessee

Sketch from W.A. Hayes
November 13, 1996

Scale: 1in = 60ft
By David P. Finneran

FACTORY MUTUAL INSURANCE COMPANY
Engineering Plan Services
151 BOSTON-PROVIDENCE TURNPIKE, NORWOOD, MASS. 02062

INDEX 84794.99

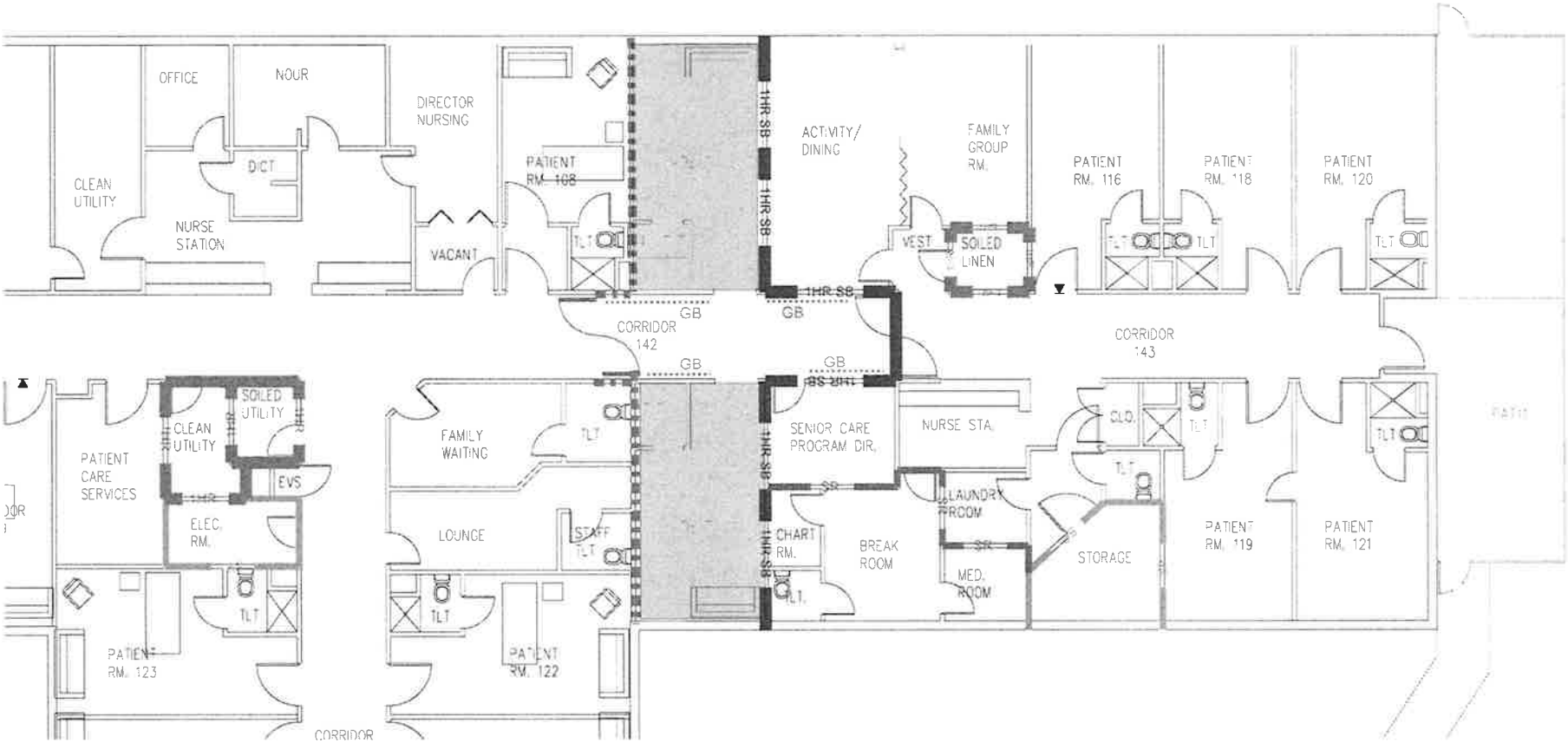
1/1

INCHES BY VID 01

Tab 5

Attachment Section A-6B-2

Floor Plan



GRESHAM SMITH AND PARTNERS

March 22, 2017
GS&P #19252.44

Saint Thomas Highlands Hospital
Geri-Psych Unit Renovation

Tab 6

Attachment Section A-10

‘Bed Neutral’ Certification Letter

Saint Thomas
HIGHLANDS HOSPITAL

May 8, 2017

Melanie Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN37243

RE: Certificate of Need Application - Saint Thomas Highlands Hospital

Dear Ms. Hill:

Saint Thomas Highlands Hospital ("Highlands") is currently licensed for a total of 60 beds, including 10 geropsychiatric beds. Upon CON approval and implementation of the proposed 4-bed geropsychiatric expansion project, Highlands will de-license 4 medical-surgical beds.

This approach will be "bed neutral" on the healthcare delivery system while improving the quality of our inpatient geropsychiatric services and patient outcomes. It is consistent with Saint Thomas' long standing goal to maximize existing resources to the fullest extent possible before increasing service capacity.

For reasons set forth in the application itself, I hope the Agency members will approve this bed reconfiguration project.

Sincerely,

Andy Wachtel
President & CEO
Saint Thomas Highlands

401 Sewell Drive • Sparta, TN 38583 • 931.738.9211 • Fax: 931.738.4180 • STHighlands.com

Section B

Tab 7 - Letters of Support
Tab 8 - Construction Cost Verification Letter
Tab 9 - Funding Letter
Tab 10 - Financial Statements
Tab 11 - Financial Assistance Policies
Tab 12 - Medical Director: qualifications & agreement
Tab 13 - Quality Management & Utilization Management
Tab 14 - Hospital License
Tab 15 - Accreditation
Tab 16 - Licensure & Regulatory Compliance
Tab 17 - HSDA Letter of Intent
Tab 18 - Evidence of Publication

Tab 7

Attachment Section B-A1

Letters of Support

May 9, 2017

Melanie M. Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

Dear Ms. Hill:

I am writing this letter of support for the conversion of four general hospital beds to four psychiatric beds (14 total) at Saint Thomas Highlands Hospital in Sparta, Tennessee.

I am a Nurse Practitioner who has been practicing in Sparta for three years. I solely treat elderly patients with psychiatric conditions who would benefit tremendously from the bed conversion proposed by Saint Thomas Highlands Hospital. Expansion of the existing Geriatric Psychiatry unit will allow more patients in the Upper Cumberland region who are suffering from Alzheimer's, Dementia, etc., to receive the treatment they need to lead healthy lives.

I urge the members of the Health Services and Development Agency to approve this project for the good of the patients we serve.

Sincerely,

Kimerly Neal NP

Kimerly Neal, NP
Highlands Senior Care

JUN 14 '17 PM 3:48

May 9, 2017

Melanie M. Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

Dear Ms. Hill:

I am writing on behalf of Saint Thomas Highlands Hospital and its CON application to expand its inpatient geropsychiatric program by four beds.

My elderly patients often require treatment of various Psychiatric conditions. The proposed bed conversion will not only improve availability of care for the patient, but will also enhance continuity of care throughout the Upper Cumberland region. With a growing senior population, the need for the services provided in the geropsychiatric unit at Saint Thomas Highlands will continue to grow.

Ms. Hill, thank you for considering Saint Thomas Highlands Hospital's application. I hope the Agency members will grant a favorable decision in this matter.

Sincerely,

Lori Austin MD

Lori Austin, M.D.
Internal Medicine

May 9, 2017

Melanie M. Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

Dear Ms. Hill:

I am an Internal Medicine physician who has been practicing in Sparta, Tennessee for 7 years. Many of my patients are elderly and experience psychiatric conditions requiring inpatient stays in the geropsychiatric unit at Saint Thomas Highlands Hospital. The proposed conversion of four general hospital beds to four psychiatric beds would benefit my patients, and other patients in the area, tremendously. Granting this CON request will allow physicians to have quicker access to these services for our aging patient population.

I am in favor of these plans and urge the members of the Health Services and Development Agency to approve this project for the greater good of the region we serve.

Thank you for your time and consideration of Saint Thomas Highlands Hospital's application.

Sincerely,

Robert Knowles, M.D.
Internal Medicine

Tab 8

Attachment Section B-A5

Construction Cost Verification Letter

GRESHAM
SMITH AND
PARTNERS

May 17, 2017

Andy Wachtel, FACHE
President and Chief Executive Officer
St Thomas Highlands
Sparta, TN 38583

RE: Verification of costs for St Thomas Highlands Hospital Renovations for Gero-Psych Unit Renovation

Dear Mr. Wachtel:

As I understand the initial scope and schedule, Highlands Hospital of Sparta, TN is planning on renovating their existing behavioral health patient unit to accommodate two (2) additional Geropsychiatric patient rooms. Additional scope has been identified to relocate the unit such as updates to a smoke-compartment assembly with penetrations, relocate of control doors and corridor renovations in addition to the patient rooms themselves for a total approximate 900 square feet. Although this initial scope is preliminary I have toured the facility along with the Owner and other General Contractor consultants and have reviewed their cost estimates for the work.

In my opinion the current construction estimate of $204,701 ($227 / SF) along with the total estimated project estimate of $336,000 including fees, equipment construction and other professional services for the above project description are reasonable, based on similar projects.

Please do not hesitate to contact me if you have any questions.

Sincerely,

David Magner, AIA NCARB
Principal
TN Registration #103032

Tab 9

Attachment Section B-B5

Funding Letter

Tab 10

Attachment Section B-F1

Saint Thomas Highlands Balance Sheet

Saint Thomas Highlands Statement of Operations

Ascension Health Audited Financial Statements

Saint Thomas Highlands Hospital
Balance Sheet
at Nine Months Ending of Fiscal Year 2017
(Dollars in Thousands)

	March 31, 2017
ASSETS	
CURRENT ASSETS:	
Cash and Cash Equivalents	$29
Gross Patient Accounts Receivable	12,461
Less Allowances	-9,063
Patient Accounts Receivable, Net	$3,398
Estimated Settlements from Third-Party Payors	300
Total Intercompany Receivables	14,552
Total Inventory	784
Total Other Current Assets	104
Total Current Assets	**$19,167**
PROPERTY AND EQUIPMENT	
Land and Improvements	$600
Buildings	7,406
Equipment	1,031
Construction in Progress	273
Less Accumulated Depreciation	-1,361
Total Property and Equipment, Net	**$7,949**
Other Assets:	
Investments in Unconsolidated Entities	0
Other	382
Total Other Assets	**$382**
Total Assets	**$27,498**

	March 31, 2017
LIABILITIES AND NET ASSETS	
CURRENT LIABILITIES	
Current Portion of Long-Term Debt	$0
Accounts Payable	984
AR Credit Balances, Net	0
Accrued Liabilities	665
Estimated Settlements to Third-Party Payors	0
Current Portion of Self-Insurance Liability	52
Total Other Current Liabilities	14,189
Total Current Liabilities	**$15,890**
NONCURENT LIABILITIES	
Long-Term Debt	
Centralized Debt Management System	0
Net Long-Term Debt	**$0**
Other Long-Term Liabilities	
Self-Insurance Liabilitiy	0
Pension and Other Post Retirement Benefits	0
Other	172
Total Noncurrent Liabilities	**$172**
Total Liabilities	**$16,062**
NET ASSETS	
Unrestricted Net Assets	$11,280
Current Year Net Income	$156
Total Liabilities and Net Assets	**$27,498**

Saint Thomas Highlands Hospital
Statement of Operations
For Nine Months Ending March 31, 2017 of 2017 Fiscal Year

GROSS PATIENT SERVICE REVENUE:	
Total Inpatient Routine Revenue	$6,586,021
Inpatient Ancillary Revenue	16,818,561
Outpatient Revenue	58,536,639
Total Gross Patient Service Revenue	**$81,941,221**
REVENUE DEDUCTIONS:	
Charity Care	$2,767,360
Medicare Deductions	32,766,466
Medicaid Deductions	11,791,917
Blue Cross Deductions	13,312,123
HMO/PPO Deductions	1,366,571
Other Revenue and Contract Deductions	4,858,594
Total Revenue Deductions	**$66,863,032**
Net Patient Service Revenue	**$15,078,189**
OTHER REVENUE:	
Other Revenue	$698,284
Gain on Sale of Assets	0
Income from Unconsolidated Entities	0
Total Other Revenue	**$698,284**
Total Operating Revenue	**$15,776,474**
OPERATING EXPENSES:	
Salaries and Wages	$5,086,004
Employee Benefits	1,438,691
Purchasd Services	3,328,631
Professional Fees	690,382
Supplies	2,562,940
Insurance	70,632
Interest	0
Income Tax	0
Depreciation	644,405
Amortization	121,635
Other Operating Expenses	1,645,078
Total Operating Expenses	**$15,588,397**
Income (Loss) From Recurring Operations	**188,077**
Recurring Op Inc before Non-Recurring Items	
Total Impair Write-Down, Restruct, Non-Recurr	18,971
Income (Loss) from Operations	**$169,106**
NONOPERATING GAINS (LOSSES):	
Other Non-Operating Activity	-13,000
Total Non-Operating Gains (Losses), Net	**-$13,000**
Income (Loss) Before Other NonOper Items	**$156,106**
Net Income (Loss)	**$156,106**

Consolidated Financial Statements and Supplementary Information

Ascension Health Alliance
d/b/a Ascension
Years Ended June 30, 2016 and 2015
With Reports of Independent Auditors

Ascension

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2016 and 2015

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Report of Independent Auditors

Board of Directors
Ascension Health Alliance d/b/a Ascension

We have audited the accompanying consolidated financial statements of Ascension Health Alliance d/b/a Ascension, which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations and changes in nets assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Ascension Health Alliance d/b/a Ascension at June 30, 2016 and 2015, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst + Young LLP

September 12, 2016

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Ascension

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2016	June 30, 2015
Assets		
Current assets:		
Cash and cash equivalents	**$ 696,237**	$ 688,228
Short-term investments	**122,545**	146,822
Accounts receivable, less allowance for doubtful accounts ($1,362,060 and $1,280,568 at June 30, 2016 and 2015, respectively)	**2,746,506**	2,520,115
Inventories	**349,077**	324,423
Due from brokers *(see Notes 4 and 5)*	**313,717**	148,865
Estimated third-party payor settlements	**186,354**	226,122
Other *(see Notes 4 and 5)*	**978,744**	973,109
Total current assets	**5,393,180**	5,027,684
Long-term investments *(see Notes 4 and 5)*	**15,069,123**	14,990,505
Property and equipment, net	**9,020,005**	8,273,930
Other assets:		
Investment in unconsolidated entities	**1,115,871**	789,693
Capitalized software costs, net	**926,710**	790,881
Other *(see Notes 4 and 5)*	**944,288**	972,197
Total other assets	**2,986,869**	2,552,771
Total assets	**$ 32,469,177**	$ 30,844,890

	June 30, 2016	June 30, 2015
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 96,193**	$ 84,985
Long-term debt subject to short-term remarketing arrangements*	**1,666,245**	1,176,790
Accounts payable and accrued liabilities *(see Notes 4 and 5)*	**2,500,748**	2,314,922
Estimated third-party payor settlements	**513,677**	416,908
Due to brokers *(see Notes 4 and 5)*	**105,660**	131,061
Current portion of self-insurance liabilities	**219,638**	247,356
Other	**292,044**	367,130
Total current liabilities	**5,394,205**	4,739,152
Noncurrent liabilities:		
Long-term debt (senior and subordinated)	**5,427,616**	5,010,084
Self-insurance liabilities	**513,985**	513,856
Pension and other postretirement liabilities	**1,298,653**	564,342
Other *(see Notes 4 and 5)*	**1,241,678**	1,084,794
Total noncurrent liabilities	**8,481,932**	7,173,076
Total liabilities	**13,876,137**	11,912,228
Net assets:		
Unrestricted		
Controlling interest	**16,498,086**	16,749,357
Noncontrolling interests	**1,429,444**	1,572,608
Unrestricted net assets	**17,927,530**	18,321,965
Temporarily restricted	**467,994**	417,909
Permanently restricted	**197,516**	192,788
Total net assets	**18,593,040**	18,932,662
Total liabilities and net assets	**$ 32,469,177**	$ 30,844,890

*Consists of variable rate demand bonds with put options that may be exercised at the option of the bondholders, with stated repayment installments through 2047, as well as certain serial mode bonds with scheduled remarketing/mandatory tender dates occurring prior to June 30, 2017. In the event that bonds are not remarketed upon the exercise of put options or the scheduled mandatory tenders, management would utilize other sources to access the necessary liquidity. Potential sources include liquidating investments, a draw on the line of credit totaling $1billion, and issuing commercial paper. The commercial paper program is supported by $500 million of the $1billion line of credit.

The accompanying notes are an integral part of the consolidated financial statements.

Ascension

Consolidated Statements of Operations and Changes in Net Assets

(Dollars in Thousands)

	Year Ended June 30, 2016	2015
Operating revenue:		
Net patient service revenue	**$ 21,301,133**	$ 19,857,725
Less provision for doubtful accounts	**1,142,289**	1,101,118
Net patient service revenue, less provision for doubtful accounts	**20,158,844**	18,756,607
Other revenue	**1,739,490**	1,782,196
Total operating revenue	**21,898,334**	20,538,803
Operating expenses:		
Salaries and wages	**9,043,625**	8,518,165
Employee benefits	**1,748,110**	1,733,798
Purchased services	**1,500,887**	1,256,530
Professional fees	**1,369,103**	1,268,911
Supplies	**3,114,261**	2,903,487
Insurance	**160,232**	158,786
Interest	**194,962**	196,013
Depreciation and amortization	**1,032,541**	949,477
Other	**2,737,244**	2,707,929
Total operating expenses before impairment, restructuring and nonrecurring losses, net	**20,900,965**	19,693,096
Income from operations before self-insurance trust fund investment return and impairment, restructuring and nonrecurring losses, net	**997,369**	845,707
Self-insurance trust fund investment return	**(16,334)**	(15,137)
Impairment, restructuring and nonrecurring losses, net	**(227,832)**	(134,022)
Income from operations	**753,203**	696,548
Nonoperating gains (losses):		
Investment return	**(358,297)**	36,455
Loss on extinguishment of debt	**(13,594)**	(992)
Losses on interest rate swaps	**(86,536)**	(23,596)
(Loss) income from unconsolidated entities	**(40,649)**	5,210
Contributions from business combinations	**304,961**	-
Other	**(81,339)**	(75,852)
Total nonoperating losses, net	**(275,454)**	(58,775)
Excess of revenues and gains over expenses and losses	**477,749**	637,773
Less noncontrolling interests	**16,365**	75,177
Excess of revenues and gains over expenses and losses attributable to controlling interest	**461,384**	562,596

Continued on next page.

Ascension

Consolidated Statements of Operations and Changes in Net Assets (continued)

(Dollars in Thousands)

	Year Ended June 30, 2016	2015
Unrestricted net assets, controlling interest:		
Excess of revenues and gains over expenses and losses	$ 461,384	$ 562,596
Transfers to sponsors and other affiliates, net	(8,654)	(14,877)
Net assets released from restrictions for property acquisitions	45,058	38,008
Pension and other postretirement liability adjustments	(729,197)	(513,220)
Change in unconsolidated entities' net assets	(6,976)	(15,874)
Other	3,344	592
(Decrease) increase in unrestricted net assets, controlling interest, before loss from discontinued operations	(235,041)	57,225
Loss from discontinued operations	(16,230)	(44,058)
(Decrease) increase in unrestricted net assets, controlling interest	(251,271)	13,167
Unrestricted net assets, noncontrolling interests:		
Excess of revenues and gains over expenses and losses	16,365	75,177
Distributions of capital	(254,788)	(195,794)
Contributions of capital	96,150	47,192
Membership interest changes, net	-	(5,824)
Other	(891)	(4,249)
Decrease in unrestricted net assets, noncontrolling interests	(143,164)	(83,498)
Temporarily restricted net assets, controlling interest:		
Contributions and grants	140,210	117,547
Investment return	(4,643)	6,491
Net assets released from restrictions	(97,392)	(98,959)
Contributions from business combinations	16,091	-
Other	(4,181)	1,604
Increase in temporarily restricted net assets, controlling interest	50,085	26,683
Permanently restricted net assets, controlling interest:		
Contributions	5,298	6,087
Investment return	(1,706)	1,278
Contributions from business combinations	2,363	-
Other	(1,227)	(6,192)
Increase in permanently restricted net assets, controlling interest	4,728	1,173
Decrease in net assets	(339,622)	(42,475)
Net assets, beginning of year	18,932,662	18,975,137
Net assets, end of year	$18,593,040	$ 18,932,662

The accompanying notes are an integral part of the consolidated financial statements.

Ascension

Consolidated Statements of Cash Flows

(Dollars in Thousands)

	Year Ended June 30, 2016	2015
Operating activities		
Decrease in net assets	**$ (339,622)**	$ (42,475)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**1,032,541**	949,477
Amortization of bond premiums	**(20,714)**	(22,657)
Loss on extinguishment of debt	**13,594**	992
Provision for doubtful accounts	**1,148,342**	1,105,816
Pension and other postretirement liability adjustments	**729,197**	513,220
Contributions from business combinations	**(323,415)**	-
Unrealized losses on investments, net	**493,528**	457,096
Change in fair value of interest rate swaps	**84,433**	21,780
Gain on sale of assets, net	**(192,042)**	(38,167)
Impairment and nonrecurring expenses	**21,271**	27,968
Transfers to sponsor and other affiliates, net	**8,654**	14,877
Restricted contributions, investment return, and other	**(165,458)**	(129,843)
Other restricted activity	**(61,162)**	(20,087)
Distributions of noncontrolling interest, net	**158,638**	148,602
Other	**(222)**	(261)
Decrease (increase) in:		
Short-term investments	**71,832**	(43,877)
Accounts receivable	**(1,190,839)**	(1,230,601)
Inventories and other current assets	**(64,525)**	(57,801)
Due from brokers	**(164,852)**	(111,379)
Investments classified as trading	**(516,524)**	(436,686)
Other assets	**108,461**	42,581
Increase (decrease) in:		
Accounts payable and accrued liabilities	**7,596**	39,674
Estimated third-party payor settlements, net	**128,440**	(22,753)
Due to brokers	**(25,401)**	47,285
Other current liabilities	**(89,934)**	113,974
Self-insurance liabilities	**(53,004)**	(7,409)
Other noncurrent liabilities	**(200,824)**	(325,766)
Net cash provided by continuing operating activities	**597,989**	993,580
Net cash provided by and adjustments to reconcile change in net assets for discontinued operations	**134,956**	127,984
Net cash provided by operating activities	**732,945**	1,121,564

Ascension

Consolidated Statements of Cash Flows (continued)

(Dollars in Thousands)

	Year Ended June 30, 2016	Year Ended June 30, 2015
Investing activities		
Property, equipment, and capitalized software additions, net	**(1,139,060)**	(918,586)
Proceeds from sale of property and equipment	**13,643**	6,701
Issuance of note receivable for business combination	**(637,109)**	-
Net proceeds from sale/acquisition of other assets	**296,071**	40,516
Net cash used in investing activities	**(1,466,455)**	(871,369)
Financing activities		
Issuance of debt	**5,154,869**	753,371
Repayment of debt	**(4,403,407)**	(892,816)
Decrease in assets under bond indenture agreements	**18,303**	5,564
Transfers to sponsors and other affiliates, net	**(12,867)**	(27,745)
Restricted contributions, investment return, and other	**143,259**	129,843
Distributions of noncontrolling interest, net	**(158,638)**	(148,602)
Net cash provided by (used in) financing activities	**741,519**	(180,385)
Net increase in cash and cash equivalents	**8,009**	69,810
Cash and cash equivalents at beginning of year	**688,228**	618,418
Cash and cash equivalents at end of year	**$ 696,237**	$ 688,228

The accompanying notes are an integral part of the consolidated financial statements.

Ascension

Notes to Consolidated Financial Statements
(Dollars in Thousands)

June 30, 2016

1. Organization and Mission

Organizational Structure

Ascension Health Alliance, d/b/a Ascension (Ascension), is a Missouri nonprofit corporation formed on September 13, 2011. Ascension is the sole corporate member and parent organization of Ascension Health, a Catholic national health system consisting primarily of nonprofit corporations that own and operate local healthcare facilities, or Ministry Markets, located in 24 states and the District of Columbia.

Ascension serves as the member or shareholder of various subsidiaries as listed below:

- Alpha Fund
- Ascension Care Management
- Ascension Global Mission
- Ascension Health
- Ascension Holdings
- Ascension Information Services
- Ascension Investment Management (AIM)
- Ascension Leadership Institute
- Ascension Ministry and Mission Fund
- Ascension Ministry Service Center
- Ascension Risk Services
- Ascension Ventures (AV)
- AV Holding Company
- The Resource Group
- Smart Health Solutions

Ascension and its member organizations are hereafter referred to collectively as the System.

Sponsorship

Ascension is sponsored by Ascension Sponsor, a Public Juridic Person. The Participating Entities of Ascension Sponsor are the Daughters of Charity of St. Vincent de Paul, St. Louise Province; the Congregation of St. Joseph; the Congregation of the Sisters of St. Joseph of Carondelet; the Congregation of Alexian Brothers of the Immaculate Conception Province, Inc. – American Province; and the Sisters of the Sorrowful Mother of the Third Order of St. Francis of Assisi – US/Caribbean Province.

1. Organization and Mission (continued)

Mission

The System directs its governance and management activities toward strong, vibrant, Catholic Ministries united in service and healing, and dedicates its resources to spiritually centered care which sustains and improves the health of the individuals and communities it serves. In accordance with the System's mission of service to those persons living in poverty and other vulnerable persons, each Ministry Market accepts patients regardless of their ability to pay. The System uses four categories to identify the resources utilized for the care of persons living in poverty and community benefit programs:

- Traditional charity care includes the cost of services provided to persons who cannot afford healthcare because of inadequate resources and/or who are uninsured or underinsured.

- Unpaid cost of public programs, excluding Medicare, represents the unpaid cost of services provided to persons covered by public programs for persons living in poverty and other vulnerable persons.

- Cost of other programs for persons living in poverty and other vulnerable persons includes unreimbursed costs of programs intentionally designed to serve the persons living in poverty and other vulnerable persons of the community, including substance abusers, the homeless, victims of child abuse, and persons with acquired immune deficiency syndrome.

- Community benefit consists of the unreimbursed costs of community benefit programs and services for the general community, not solely for the persons living in poverty, including health promotion and education, health clinics and screenings, and medical research.

Discounts are provided to all uninsured and underinsured patients, including those with the means to pay. Discounts provided to those patients who did not qualify for financial assistance are not included in the cost of providing care of persons living in poverty and other community benefit programs. The cost of providing care to persons living in poverty and other community benefit programs is estimated by reducing charges forgone by a factor derived from the ratio of each entity's total operating expenses to the entity's billed charges for patient care. Certain costs such as graduate medical education and certain other activities are excluded from total operating expenses for purposes of this computation.

1. Organization and Mission (continued)

The amount of traditional charity care provided, determined on the basis of cost, was $495,863 and $500,067 for the years ended June 30, 2016 and 2015, respectively. The amount of unpaid cost of public programs, cost of other programs for persons living in poverty and other vulnerable persons, and community benefit cost is reported in the accompanying supplementary information.

2. Significant Accounting Policies

Principles of Consolidation

All corporations and other entities for which operating control is exercised by the System or one of its member corporations are consolidated, and all significant inter-entity transactions have been eliminated in consolidation. Investments in entities where the System does not have operating control are recorded under the equity or cost method of accounting. Income (loss) from unconsolidated entities is included in consolidated excess of revenues and gains over expenses and losses in the accompanying Consolidated Statements of Operations and Changes in Net Assets as follows:

	Year Ended June 30,	
	2016	**2015**
Other revenue	**$ 114,085**	$ 64,792
Nonoperating (losses) gains	**(40,649)**	5,210

Use of Estimates

Management has made estimates and assumptions that affect the reported amounts of certain assets, liabilities, revenues, and expenses. Actual results could differ from those estimates.

2. Significant Accounting Policies (continued)

Fair Value of Financial Instruments

Carrying values of financial instruments classified as current assets and current liabilities approximate fair value. The fair values of financial instruments measured at fair value are disclosed in the Fair Value Measurements note.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and interest-bearing deposits with original maturities of three months or less.

Short-Term Investments

Short-term investments consist of investments with original maturities exceeding three months and up to one year.

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost or market value using first-in, first-out (FIFO) or a methodology that closely approximates FIFO.

Long-Term Investments and Investment Return

Investments, excluding investments in unconsolidated entities, are measured at fair value, are classified as trading securities, and include pooled short-term investment funds; U.S. government, state, municipal and agency obligations; corporate and foreign fixed income securities; asset-backed securities; and equity securities. Investments also include alternative investments and other investments which are valued based on the net asset value of the investments, as further discussed in the Fair Value Measurements note. Investments also include derivatives held by the Alpha Fund, also measured at fair value, as discussed in the Pooled Investment Fund note.

2. Significant Accounting Policies (continued)

Long-term investments include assets limited as to use of approximately $1,284,000 and $1,306,000, at June 30, 2016 and 2015, respectively, comprised primarily of investments placed in trust and held by captive insurance companies for the payment of self-insured claims and investments which are limited as to use, as designated by donors.

Purchases and sales of investments are accounted for on a trade-date basis. Investment returns consist of dividends, interest, and gains and losses. The cost of substantially all securities sold is based on the average cost method. Investment returns, excluding returns of self-insurance trust funds, are reported as nonoperating gains (losses) in the Consolidated Statements of Operations and Changes in Net Assets, unless the return is restricted by donor or law. Investment returns of self-insurance trust funds are reported as a separate component of income from operations in the Consolidated Statements of Operations and Changes in Net Assets.

Property and Equipment

Property and equipment are stated at cost or, if donated, at fair market value at the date of the gift. A summary of property and equipment at June 30, 2016 and 2015, is as follows:

	Year Ended June 30,	
	2016	**2015**
Land and improvements	**$ 935,542**	$ 882,702
Buildings and equipment	**16,505,068**	15,646,664
	17,440,610	16,529,366
Less accumulated depreciation	**8,981,575**	8,646,863
	8,459,035	7,882,503
Construction in progress	**560,970**	391,427
Total property and equipment, net	**$ 9,020,005**	$ 8,273,930

Depreciation is determined on a straight-line basis over the estimated useful lives of the related assets. Depreciation expense in 2016 and 2015 was $825,681 and $772,407, respectively.

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2. Significant Accounting Policies (continued)

Several capital projects have remaining construction and related equipment purchase commitments of approximately $587,000 as of June 30, 2016.

Intangible Assets

Intangible assets primarily consist of goodwill and capitalized computer software costs, including internally developed software. Costs incurred in the development and installation of internal use software are expensed or capitalized depending on whether they are incurred in the preliminary project stage, application development stage, or post-implementation stage, and the nature of the costs. Intangible assets are included in the Consolidated Balance Sheets as presented in the table that follows. Capitalized software costs in the table below include software in progress of $244,552 and $180,427 at June 30, 2016 and 2015, respectively:

	Year Ended June 30,	
	2016	**2015**
Capitalized software costs	**$ 2,050,184**	$ 1,743,423
Less accumulated amortization	**1,123,474**	952,542
Capitalized software costs, net	**926,710**	790,881
Goodwill	**210,320**	206,563
Other, net	**31,731**	37,974
Intangible assets included in other assets	**242,051**	244,537
Total intangible assets, net	**$ 1,168,761**	$ 1,035,418

Intangible assets whose lives are indefinite, primarily goodwill, are not amortized and are evaluated for impairment at least annually or when circumstances indicate a possible impairment may exist, while intangible assets with definite lives, primarily capitalized computer software costs, are amortized over their expected useful lives. Amortization expense for these intangible assets in 2016 and 2015 was $206,860 and $177,070, respectively.

2. Significant Accounting Policies (continued)

The System is in the final phases of a significant multi-year, System-wide enterprise resource planning project, including information technology and process standardization (Symphony), which is expected to continue through fiscal year 2017. The project is facilitating a transition to a common software product for various finance, information technology, procurement, and human resources management processes, including standardization of those processes throughout the System. Capitalized costs of Symphony were approximately $329,000 and $323,000 at June 30, 2016 and 2015, respectively, and are being amortized on a straight-line basis over the expected useful life of the software. Certain costs of this project were also expensed. Accumulated amortization of Symphony was approximately $120,000 and $87,000 at June 30, 2016 and 2015, respectively. See the Impairment, Restructuring, and Nonrecurring Losses discussion below for additional information about costs associated with Symphony.

Noncontrolling Interests

The consolidated financial statements include all assets, liabilities, revenues, and expenses of entities that are controlled by the System and therefore consolidated. Noncontrolling interests in the Consolidated Balance Sheets represent the portion of net assets owned by entities outside the System, for those entities in which the System's ownership interest is less than 100%.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those assets whose use by the System has been limited by donors to a specific time period or purpose. Permanently restricted net assets consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity, which include endowment funds. Temporarily restricted net assets and earnings on permanently restricted net assets, including earnings on endowment funds, are used in accordance with the donors' wishes, primarily to purchase equipment and to provide charity care and other health and educational services. Contributions with donor-imposed restrictions that are met in the same reporting period are reported as unrestricted.

Temporarily and permanently restricted net assets consist solely of controlling interests of the System.

2. Significant Accounting Policies (continued)

Performance Indicator

The performance indicator is the excess of revenues and gains over expenses and losses. Changes in unrestricted net assets that are excluded from the performance indicator primarily include pension and other postretirement liability adjustments, transfers to or from sponsors and other affiliates, net assets released from restrictions for property acquisitions, change in unconsolidated entities' net assets, discontinued operations, and contributions received of property and equipment.

Operating and Nonoperating Activities

The System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, long-term care, and other healthcare services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to the System's primary mission are considered to be nonoperating.

Net Patient Service Revenue, Accounts Receivable, and Allowance for Doubtful Accounts

Net patient service revenue is reported at the estimated realizable amounts from patients, third-party payors, and others for services provided and includes estimated retroactive adjustments under reimbursement agreements with third-party payors. The System recognizes patient service revenue at the time services are rendered, even though the patient's ability to pay may not be completely assessed at that time. Revenue under certain third-party payor agreements is subject to audit, retroactive adjustments, and significant regulatory actions. Provisions for third-party payor settlements and adjustments are estimated in the period the related services are provided and adjusted in future periods as additional information becomes available and as final settlements are determined.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates will change by a material amount in the near term. Adjustments to revenue related to prior periods increased net patient service revenue by $102,217 and $100,950 for the years ended June 30, 2016 and 2015, respectively.

2. Significant Accounting Policies (continued)

The percentage of net patient service revenue, less provision for doubtful accounts earned by payor for the years ended June 30, 2016 and 2015, is as follows:

	Year Ended June 30,	
	2016	**2015**
Medicare - traditional and managed	**35 %**	35 %
Medicaid - traditional and managed	**12**	11
Commercial and other managed care	**49**	50
Self-Pay and other	**4**	4
	100 %	100 %

The System grants credit without collateral to its patients, who are primarily local residents and are insured under third-party payor arrangements. Significant concentrations of accounts receivable, less allowance for doubtful accounts, at June 30, 2016 and 2015, are as follows:

	Year Ended June 30,	
	2016	**2015**
Medicare - traditional and managed	**27 %**	27 %
Medicaid - traditional and managed	**9**	9
Commercial and other managed care	**42**	43
Self-Pay and other	**22**	21
	100 %	100 %

2. Significant Accounting Policies (continued)

The provision for doubtful accounts is based upon management's assessment of expected net collections considering historical experience, economic conditions, trends in healthcare coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience by payor category, including those amounts not covered by insurance. The results of this review are then used to make any modifications to the provision for doubtful accounts to establish an appropriate allowance for doubtful accounts. After satisfaction of amounts due from insurance and reasonable efforts to collect from the patient have been exhausted, the System follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the System. Accounts receivable are written off after collection efforts have been followed in accordance with the System's policies. The methodology for determining the allowance for doubtful accounts and related write-offs on uninsured patient accounts has remained consistent with the prior year.

Other Operating Revenue

Other operating revenue includes net gains on sales of assets, clinical engineering services, retail pharmacy revenue, income from unconsolidated entities, premium revenue, net assets released from restrictions for operating purposes, and other nonpatient service revenue. Net gains on sales of assets were $201,330 and $47,456 for the years ended June 30, 2016 and 2015, respectively. Assets sold during the years ended June 30, 2016 and 2015 include certain nonhospital operating entities and patient care equipment.

Impairment, Restructuring, and Nonrecurring Losses

Long-lived assets are reviewed for impairment whenever events or business conditions indicate the carrying amount of such assets may not be fully recoverable. Initial assessments of recoverability are based on estimates of undiscounted future net cash flows associated with an asset or group of assets. Where impairment is indicated, the carrying amount of these long-lived assets is reduced to fair value based on future discounted net cash flows or other estimates of fair value.

2. Significant Accounting Policies (continued)

Nonrecurring expenses associated with Symphony include project management and process re-engineering costs, amortization expense for those Health Ministries not yet on Symphony, as well as costs to develop a business intelligence data warehouse. Costs associated with product deployment are recorded as nonrecurring losses, and costs associated with product support are recorded as recurring operating expenses.

During the year ended June 30, 2016, the System recorded total impairment, restructuring, and nonrecurring losses, net of $227,832. This amount was comprised primarily of $129,494 of nonrecurring expenses associated with Symphony, one-time termination benefits and other restructuring expenses of $72,097, impairment expenses of $14,064, and other nonrecurring expenses of $12,177.

During the year ended June 30, 2015, the System recorded total impairment, restructuring, and nonrecurring losses, net of $134,022. This amount was comprised primarily of $100,541 of nonrecurring expenses associated with Symphony, one-time termination benefits and other restructuring expenses of $11,304, impairment expenses of $19,208, and other nonrecurring expenses of $2,969.

Amortization

Bond issuance costs, discounts, and premiums are amortized over the term of the bonds using a method approximating the effective interest method.

Capitalized software, including internally developed software, is amortized on a straight-line basis over the expected useful life of the software.

Income Taxes

The member healthcare entities of the System are primarily tax-exempt organizations under Internal Revenue Code Section 501(c)(3) or Section 501(c)(2), and their related income is exempt from federal income tax under Section 501(a). The System accounts for uncertainty in income tax positions by applying a recognition threshold and measurement attribute for financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. The System has determined that no material unrecognized tax benefits or liabilities exist as of June 30, 2016.

2. Significant Accounting Policies (continued)

The System had deferred tax assets of approximately $378,000 and $354,000 for federal and state income tax purposes primarily related to net operating loss carryforwards for the years ended June 30, 2016 and 2015, respectively. A valuation allowance of approximately $377,000 and $344,000 was recorded due to the uncertainty regarding use of the deferred tax assets for the years ended June 30, 2016 and 2015, respectively.

Regulatory Compliance

Various federal and state agencies have initiated investigations regarding reimbursement claimed by certain members of the System. The investigations are in various stages of discovery, and the ultimate resolution of these matters, including the liabilities, if any, cannot be readily determined; however, in the opinion of management, the results of the investigations will not have a material adverse impact on the consolidated financial statements of the System.

Reclassifications

Certain reclassifications were made to the 2015 accompanying consolidated financial statements to conform to the 2016 presentation.

Subsequent Events

The System evaluates the impact of subsequent events, which are events that occur after the Consolidated Balance Sheet date but before the consolidated financial statements are issued, for potential recognition or disclosure in the consolidated financial statements as of the Consolidated Balance Sheet date. For the year ended June 30, 2016, the System evaluated subsequent events through September 12, 2016, representing the date on which the accompanying audited consolidated financial statements were issued.

3. Organizational Changes

Business Combinations

Crittenton Hospital Medical Center – Michigan

Effective October 1, 2015, Ascension Michigan became the sole corporate member of Crittenton Hospital Medical Center (Crittenton) under the terms of an agreement among Ascension Michigan, Crittenton and Ascension Health. The fair value of the unrestricted net assets totaling $137,912 was recognized in the Consolidated Statements of Operations and Changes in Net Assets for the year ended June 30, 2016 as a nonoperating contribution from business combination.

Wheaton Franciscan Healthcare – Southeast Wisconsin, Inc.

Effective March 1, 2016, Ascension Health became the sole corporate member of Wheaton Franciscan Healthcare – Southeast Wisconsin, Inc. (Wheaton) under the terms of an agreement between Ascension Health and Wheaton Franciscan Services, Inc. The fair value of the unrestricted net assets totaling $167,049 was recognized in the Consolidated Statements of Operations and Changes in Net Assets for the year ended June 30, 2016 as a nonoperating contribution from business combination.

The fair values of Crittenton and Wheaton's net assets, by major type, that were recognized by the System during the year ended June 30, 2016 were as follows. The valuations of these net assets were substantially complete as of June 30, 2016.

	Crittenton	Wheaton	Total
Net working capital	$ 80,335	$ 312,129	$ 392,464
Long-term investments	102,890	27,511	130,401
Property and equipment	193,174	645,299	838,473
Investments in unconsolidated entities	4,491	58,174	62,665
Intangible assets, including capitalized software costs	-	48,820	48,820
Other long-term assets	795	2,567	3,362
Long-term debt	(161,205)	(641,936)	(803,141)
Other long-term liabilites assumed	(79,177)	(270,452)	(349,629)
Fair value of total net assets	$ 141,303	$ 182,112	$ 323,415

3. Organizational Changes (continued)

The fair value of net assets of $323,415 in the preceding table was recognized in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2016, as a nonoperating contribution from business combinations of $304,961, and contributions of temporarily and permanently restricted net assets of $16,091 and $2,363, respectively.

During the year ended June 30, 2016, Ascension recognized revenues of Crittenton and Wheaton combined totaling $611,100, and an excess of revenues and gains over expenses and losses totaling $15,560, of which all was attributable to controlling interest. Ascension recognized a decrease in unrestricted net assets – controlling interests, excluding the excess of revenues and gains over expenses and losses of $15,560 above, of $10,003 and a decrease in temporarily restricted net assets of Crittenton and Wheaton of $618 for the year ended June 30, 2016.

The following unaudited pro forma financial information presents the combined results of operations of Ascension, Crittenton and Wheaton for the years ended June 30, 2016 and 2015, respectively, as though the business combination transactions had occurred on July 1, 2014. This pro forma financial information is not necessarily indicative of the results of operations that would occur if these entities were consolidated into the System during those periods, nor is it necessarily indicative of future operating results.

	Year Ended June 30,	
	2016	**2015**
Total operating revenue	**$ 22,838,814**	$ 22,102,272
Excess of revenues and gains over expenses and losses attributable to controlling interest	**118,977**	838,856
(Decrease) increase in unrestricted net assets - controlling interest	**(532,879)**	266,808
Decrease in unrestricted net assets - noncontrolling interests	**(143,164)**	(83,498)
Increase in temporarily restricted net assets	**36,226**	43,487
Increase in permanently restricted net assets	**2,636**	3,900

3. Organizational Changes (continued)

Divestitures

Discontinued Operations

During the year ended June 30, 2016, Ascension, including certain of its wholly owned subsidiaries, closed on the sale of, or undertook actions to sell or transfer ownership of, certain assets and liabilities, as follows:

- In February 2015, Carondelet Health, a wholly owned subsidiary of Ascension Health, sold certain assets and liabilities associated with the operations of Carondelet Health, including St. Joseph Medical Center in Kansas City, Missouri and St. Mary's Medical Center in Blue Springs, Missouri to Prime Healthcare Services (Prime). Operations and associated assets and liabilities of Carondelet Health's long-term care facilities and of two charitable foundations remain with Ascension.

- In June 2015, Ascension entered into two separate non-binding letters of intent with a third party to pursue the potential sale of certain Ascension assets and liabilities and related operations in the states of Washington and Idaho. Completion of these proposed transactions is subject to due diligence and execution of final definitive agreements, including obtaining all necessary regulatory approvals.

- On July 1, 2015, Catholic Health, Inc. (Catholic Health) became the sole corporate member of Mount St. Mary's Hospital in Lewiston, New York under the terms of an affiliation agreement between Ascension Health and Catholic Health.

- On September 1, 2015, Carondelet Health Network, a subsidiary of Ascension Health, sold certain assets, liabilities and related operations, excluding certain non-acute entities, in Tucson, Arizona to CHN Holdings, LLC, a joint venture in which Ascension holds a noncontrolling interest.

3. Organizational Changes (continued)

Assets and liabilities associated with the aforementioned transactions were held for sale and qualified for discontinued operations as of June 30, 2016 and 2015, and are included in other current assets and other current liabilities, respectively, in the System's Consolidated Balance Sheets. Assets held for sale were $144,490 and $392,613 at June 30, 2016 and 2015, respectively, while liabilities held for sale were $30,552 and $112,923 at June 30, 2016 and 2015, respectively. Net losses of the entities, which include losses of Carondelet Health Network through the September 1, 2015 sale date and a $14,520 loss on sale, are included in the loss from discontinued operations in the Consolidated Statements of Operations and Changes in Net Assets and were $15,790 and $47,916 for the years ended June 30, 2016 and 2015, respectively. Revenues of the entities were $355,516 and $1,020,288 for the years ended June 30, 2016 and 2015, respectively, which includes revenues of Carondelet Health through the sale date.

Assets Held for Sale

In March 2016, Ministry Health Care (Ministry), a subsidiary of Ascension Health, entered into a non-binding letter of intent with Marshfield Clinic Health Systems, Inc. (Marshfield Clinic) to pursue the potential sale of substantially all the assets of Saint Joseph's Hospital of Marshfield, Inc. (Marshfield), a wholly owned subsidiary of Ministry. In addition, the letter of intent also includes Ascension's acquisition of Marshfield Clinic's 50% membership interest in The Diagnostic & Treatment Center, LLC. Completion of the proposed transactions is subject to due diligence and execution of final definitive agreements, including obtaining all necessary regulatory approvals.

Assets and liabilities associated with the aforementioned transaction are designated as assets and liabilities held for sale, and included in other current assets and other current liabilities, respectively, in the System's Consolidated Balance Sheets. Assets and liabilities held for sale were $161,058 and $11,760 at June 30, 2016, respectively. Net income of Marshfield is included in the excess of revenues and gains over expenses and losses in the Consolidated Statements of Operations and Changes in Net Assets and is $35,499 and $54,207 for the years ended June 30, 2016 and 2015, respectively. Revenues of Marshfield total $319,959 and $374,539 for the years ended June 30, 2016 and 2015, respectively.

3. Organizational Changes (continued)

Other

In addition to the transactions discussed above, effective November 1, 2014, Ministry Health Care, Inc. (Ministry), a subsidiary of Ascension Health, and Ministry's wholly owned subsidiary, Ministry Holdings, Inc., (MHI), sold a 50% membership interest in MHI to Froedtert Health, Inc. The sale resulted in a loss of control by Ministry over MHI, and as such, Ministry deconsolidated MHI as of that date. The 50% investment in MHI, which was renamed Network Health, Inc. in conjunction with the sale transaction, was reported at its fair value on the November 1, 2014 transaction date, subsequent to which this investment has been accounted for using the equity method of accounting. This transaction resulted in a gain, which is included in other operating revenue in the Consolidated Statements of Operations and Changes in Net Assets for the year ended June 30, 2015.

Effective February 1, 2015, Ascension Health and Adventist Health System entered into a joint operating agreement, which provides for an integrated health delivery system in Illinois, known as AMITA Health (AMITA). AMITA includes five hospitals of Alexian Brothers Health System (Alexian) a subsidiary of Ascension Health, and four hospitals of Adventist Midwest Health (Adventist), a subsidiary of Adventist Health System. The creation of AMITA Health did not result in a change in control of the hospitals of Alexian and Adventist. Both parties share the cash flows generated by AMITA based on an agreed upon split.

In May 2016, Ascension sold primarily all of the assets, liabilities and operations of its Medxcel, Inc. business to TMX Holdings, LLLP (TMX), a partnership in which Ascension maintains a 50% interest. As a result of the transaction, Ascension recognized a gain, which is included in other operating revenue in the Consolidated Statements of Operations and Changes in Net Assets for the year ended June 30, 2016, and the interest in TMX was recorded at its initial fair value. Subsequent to the transaction, Ascension is accounting for its interest in TMX under the equity method of accounting.

4. Pooled Investment Fund

At June 30, 2016 and 2015, a significant portion of the System's investments consists of the System's interest in the Alpha Fund, a limited liability company organized in the state of Delaware. Certain System investments, including some held by the Health Ministries and their consolidated foundations, are managed outside of the Alpha Fund.

The Alpha Fund includes the investment interests of the System and other Alpha Fund members. AIM, a wholly owned subsidiary of the System, serves as the manager and primary investment advisor of the Alpha Fund, overseeing the investment strategies offered to the Alpha Fund's members. AIM provides expertise in the areas of asset allocation, selection and monitoring of outside investment managers, and risk management. The Alpha Fund is consolidated in the System's financial statements. The portion of the Alpha Fund's net assets representing interests held by entities other than the System are reflected in noncontrolling interests in the Consolidated Balance Sheets, which amount to $1,256,666 and $1,405,401 at June 30, 2016 and 2015, respectively.

The Alpha Fund invests in a diversified portfolio of investments including alternative investments, such as real asset funds, hedge funds, private equity funds, commodity funds, and private credit funds. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods ranging from 1 to 120 days. Due to redemption restrictions, investments in certain of these funds, whose fair value was approximately $1,981,000 at June 30, 2016, cannot currently be redeemed. However, the potential for the Alpha Fund to sell its interest in these funds in a secondary market prior to the end of the fund term does exist.

4. Pooled Investment Fund (continued)

The Alpha Fund's investments in certain alternative investment funds also include contractual commitments to provide capital contributions during the investment period, which is typically five years and can extend to the end of the fund term. During these contractual periods, investment managers may require the Alpha Fund to invest in accordance with the terms of the agreement. Commitments not funded during the investment period will expire and remain unfunded. As of June 30, 2016, contractual agreements of the Alpha Fund expire between October 2016 and January 2022. The remaining unfunded capital commitments of the Alpha Fund total approximately $1,590,000 for 141 individual funds as of June 30, 2016. Due to the uncertainty surrounding whether the contractual commitments will require funding during the contractual period, future minimum payments to meet these commitments cannot be reasonably estimated. These committed amounts are expected to be primarily satisfied by the liquidation of existing investments in the Alpha Fund.

In the normal course of operations and within established Alpha Fund guidelines, the Alpha Fund may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, options, and forward contracts as well as warrants and swaps. These instruments are used primarily to adjust the portfolio duration, restructure term structure exposure, change sector exposure, and arbitrage market inefficiencies. See the Fair Value Measurements note for a discussion of how fair value for the Alpha Fund's derivatives is determined.

At June 30, 2016 and 2015, the notional value of Alpha Fund derivatives outstanding was approximately $4,540,000 and $3,615,000, respectively. The fair value of Alpha Fund derivatives in an asset position was $34,713 and $15,826 at June 30, 2016 and 2015, respectively, while the fair value of Alpha Fund derivatives in a liability position was $31,677 and $33,595 at June 30, 2016 and 2015, respectively. These derivatives are included in long-term investments in the Consolidated Balance Sheets at June 30, 2016 and 2015.

Due from brokers and due to brokers on the Consolidated Balance Sheets at June 30, 2016 and 2015, represent the Alpha Fund's positions and amounts due from or to various brokers, primarily for security transactions not yet settled, and cash held by brokers for securities sold, not yet purchased.

5. Cash and Investments

The System's cash and investments are reported in the Consolidated Balance Sheets as presented in the table that follows. Total cash and investments, net, includes both the System's membership interest in the Alpha Fund and the noncontrolling interests held by other Alpha Fund members. System unrestricted cash and investments, net, represent the System's cash and investments excluding the noncontrolling interests held by other Alpha Fund members and assets limited as to use.

	June 30,	
	2016	**2015**
Cash and cash equivalents	**$ 696,237**	$ 688,228
Short-term investments	**122,545**	146,822
Long-term investments	**15,069,123**	14,990,505
Subtotal	**15,887,905**	15,825,555
Other Alpha Fund assets and liabilities:		
In other current assets	**27,768**	28,356
In other long-term assets	**2,335**	2,491
In accounts payable and other accrued liabilities	**(9,312)**	(9,035)
In other noncurrent liabilities	**(4,569)**	(3,256)
Due from brokers, net	**208,057**	17,804
Total cash and investments, net	**16,112,184**	15,861,915
Less noncontrolling interests of Alpha Fund	**1,256,666**	1,405,401
System cash and investments, including assets limited as to use	**14,855,518**	14,456,514
Less assets limited as to use:		
Under bond indenture agreement	**20,002**	38,305
Self-insurance trust funds	**676,375**	713,174
Temporarily or permanently restricted	**595,761**	595,931
Total assets limited as to use	**1,292,138**	1,347,410
System unrestricted cash and investments, net	**$ 13,563,380**	$ 13,109,104

5. Cash and Investments (continued)

At June 30, 2016 and 2015, the composition of cash and cash equivalents, short-term investments and long-term investments, which include certain assets limited as to use, is summarized as follows.

	June 30, 2016	June 30, 2015
Cash and cash equivalents and short-term investments	**$ 935,026**	$ 942,760
Pooled short-term investment funds	**471,099**	413,223
U.S. government, state, municipal and agency obligations	**3,064,411**	2,749,101
Corporate and foreign fixed income securities	**1,728,149**	1,705,427
Asset-backed securities	**771,971**	874,440
Equity securities	**2,996,662**	3,218,447
Alternative investments and other investments:		
Private equity and real estate funds	**1,648,545**	1,436,158
Hedge funds	**2,677,275**	3,030,653
Commodities funds and other investments	**1,594,767**	1,455,346
Total alternative investments and other investments	**5,920,587**	5,922,157
Total cash and cash equivalents, short-term investments, and long-term investments	**$ 15,887,905**	$ 15,825,555

As of June 30, 2016 and 2015, the System's membership interest in the Alpha Fund totaled $11,861,266 and $11,974,700, respectively. As of June 30, 2016 and 2015, the noncontrolling interest (see Note 4) in the Alpha Fund, representing interests held by entities other than the System, totaled $1,256,666 and $1,405,401, respectively.

Investment return recognized by the System for the years ended June 30, 2016 and 2015, is summarized in the following table. Total investment return includes the System's return on certain investments held and managed outside the Alpha Fund and the investment return of the Alpha Fund. System investment return represents the System's total investment return, net of the investment return earned by the noncontrolling interests of other Alpha Fund members.

5. Cash and Investments (continued)

	Year Ended June 30, 2016	Year Ended June 30, 2015
Interest and dividends	**$ 234,677**	$ 231,114
Net losses on investments reported at fair value	**(609,308)**	(209,796)
Restricted investment return and unrealized losses, net	**(6,349)**	7,769
Total investment return	**(380,980)**	29,087
Less return earned by noncontrolling interests of Alpha Fund	**(42,756)**	(9,563)
System investment return	**$ (338,224)**	$ 38,650

6. Fair Value Measurements

The System categorizes, for disclosure purposes, assets and liabilities measured at fair value in the consolidated financial statements based upon whether the inputs used to determine their fair values are observable or unobservable. Observable inputs are inputs that are based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about pricing the asset or liability, based on the best information available in the circumstances.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an asset's or liability's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement of the asset or liability. The System's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

6. Fair Value Measurements (continued)

The System follows the three-level fair value hierarchy to categorize these assets and liabilities recognized at fair value at each reporting period, which prioritizes the inputs used to measure such fair values. Level inputs are defined as follows:

Level 1 – Quoted prices (unadjusted) that are readily available in active markets or exchanges for identical assets or liabilities on the reporting date.

Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 pricing inputs include prices quoted for similar assets and liabilities in active markets or exchanges or prices quoted for identical or similar assets and liabilities in markets that are not active. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Significant pricing inputs that are unobservable for the asset or liability, including assets or liabilities for which there is little, if any, market activity for such asset or liability. Inputs to the determination of fair value for Level 3 assets and liabilities require management judgment and estimation.

Net Asset Value – Values are based on the calculated net asset value. The calculated net asset values for underlying investments are fair value estimates determined by an external fund manager based on quoted market prices, operating results, balance sheet stability, growth, and other business and market sector factors.

There were no significant transfers between Levels 1 and 2 during the years ended June 30, 2016 and 2015.

As of June 30, 2016 and 2015, the assets and liabilities listed in the fair value hierarchy tables below use the following valuation techniques and inputs:

6. Fair Value Measurements (continued)

Cash and Cash Equivalents and Short-Term Investments

Cash and cash equivalents and certain short-term investments include certificates of deposit, whose fair value is based on cost plus accrued interest. Significant observable inputs include security cost, maturity, and relevant short-term interest rates. Other short-term investments designated as Level 2 investments primarily consist of commercial paper, whose fair value is based on the income approach. Significant observable inputs include security cost, maturity, credit rating, interest rate, and par value.

Pooled Short-term Investment Fund

The pooled short-term investment fund is a short term exchange traded money market fund primarily invested in treasury securities.

U S. Government, State, Municipal, and Agency Obligations

The fair value of investments in U.S. government, state, municipal, and agency obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark constant maturity curves and spreads.

Corporate and Foreign Fixed Income Securities

The fair value of investments in U.S. and international corporate bonds, including commingled funds that invest primarily in such bonds, and foreign government bonds is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker-dealer quotes, issuer spreads, and security specific characteristics, such as early redemption options.

Asset-backed Securities

The fair value of U.S. agency and corporate asset-backed securities is primarily determined using techniques consistent with the income approach. Significant observable inputs include prepayment speeds and spreads, benchmark yield curves, volatility measures, and quotes.

6. Fair Value Measurements (continued)

Equity Securities

The fair value of investments in U.S. and international equity securities is primarily determined using techniques consistent with the market and income approaches. The values for underlying investments are fair value estimates determined by external fund managers based on quoted market prices, operating results, balance sheet stability, growth, dividend, dividend yield, and other business and market sector fundamentals.

Alternative Investments and Other Investments

Alternative investments consist of private equity, hedge funds, private equity funds, commodity funds, and real estate partnerships. The fair value of private equity is primarily determined using techniques consistent with both the market and income approaches, based on the System's estimates and assumptions in the absence of observable market data. The market approach considers comparable company, comparable transaction, and company-specific information, including but not limited to restrictions on disposition, subsequent purchases of the same or similar securities by other investors, pending mergers or acquisitions, and current financial position and operating results. The income approach considers the projected operating performance of the portfolio company.

The fair value of hedge funds, private equity funds, commodity funds, and real estate partnerships is primarily determined using net asset values, which approximate fair value, as determined by an external fund manager based on quoted market prices, operating results, balance sheet stability, growth, and other business and market sector fundamentals.

Other investments include derivative assets and derivative liabilities of the Alpha Fund, whose fair value is primarily determined using techniques consistent with the market approach. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity, and recovery rates.

6. Fair Value Measurements (continued)

Benefit Plan Assets

The fair value of benefit plan assets is based on original investment into a guaranteed pooled fund, plus guaranteed, annuity contract-based interest rates. Significant unobservable inputs to the guaranteed rate include the fair value and average duration of the portfolio of investments underlying annuity contract, the contract value, and the annualized weighted-average yield to maturity of the underlying investment portfolio.

Interest Rate Swap Assets and Liabilities

The fair value of interest rate swaps is primarily determined using techniques consistent with the market approach. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity, and recovery rates.

Investments Sold, Not Yet Purchased

The fair value of investments sold, not yet purchased is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark, constant maturity curves, and spreads.

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2016, for all financial assets and liabilities measured at fair value on a recurring basis in the System's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2016				
Cash equivalents	$ 497,847	$ 12,173	$ -	$ 510,020
Short-term investments	46,750	20,291	287	67,328
Pooled short-term investment funds	471,099	-	-	471,099
U.S. government, state, municipal and agency obligations	-	3,064,411	-	3,064,411
Corporate and foreign fixed income securities	-	1,604,725	29,545	1,634,270
Asset-backed securities	-	629,140	142,831	771,971
Equity securities	2,671,500	130,930	3,759	2,806,189
Alternative investments and other investments:				
Private equity and real estate funds	1,409	2,400	197,886	201,695
Commodities funds and other investments	13,420	5,183	4,464	23,067
Assets at net asset value:				
Corporate and foreign fixed income securities				93,879
Equity securities				190,473
Private equity and real estate funds				1,446,850
Hedge funds				2,677,275
Commodities funds and other investments				1,454,136
Cash and other assets not at fair value				475,242
Cash and investments				$ 15,887,905
Benefit plan assets, in other noncurrent assets	$ 336,434	$ 33,055	$ 56,070	$ 425,559
Interest rate swaps, in other noncurrent assets	-	10,713	-	10,713
Investments sold, not yet purchased, in other noncurrent liabilities	-	4,569	-	4,569
Interest rate swaps, included in other noncurrent liabilities	-	236,702	-	236,702

6. Fair Value Measurements (continued)

For the year ended June 30, 2016, the changes in the fair value of the assets and liabilities measured using significant unobservable inputs (Level 3) consisted of the following.

	Short-term investments	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Commodities Funds and Other Investments	Benefit Plan Assets
Year Ended June 30, 2016							
Beginning balance	$ 301	$ 26,599	$ 89,364	$ 2,198	$ 187,338	$ (4,245)	$ 35,256
Total realized and unrealized gains (losses):							
Included in nonoperating gains (losses)	(14)	(2,661)	(3,472)	(61)	17,014	(6,445)	(3)
Included in changes in net assets	-	-	-	-	-	(47)	-
Purchases	-	19,410	82,958	611	50,400	8,701	31,245
Sales	-	(10,790)	(40,064)	(2,222)	(55,697)	-	(19,892)
Transfers into Level 3	-	3,512	16,075	3,233	1	6,500	25,508
Transfers out of Level 3	-	(6,525)	(2,030)	-	(1,170)	-	(16,044)
Ending balance	$ 287	$ 29,545	$ 142,831	$ 3,759	$ 197,886	$ 4,464	$ 56,070
The amount of total gains or losses for the period included in nonoperating gains (losses) attributable to the changes in unrealized gains or losses relating to assets still held at June 30, 2016	$ -	$ (1,625)	$ (5,621)	$ 494	$ 4,153	$ -	$ -

The basis for recognizing and valuing transfers into or out of Level 3, in the Level 3 rollforward, is as of the beginning of the period in which the transfers occur.

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2015, for all financial assets and liabilities measured at fair value on a recurring basis in the System's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2015				
Cash equivalents	$ 523,021	$ 12,050	$ -	$ 535,071
Short-term investments	63,107	42,523	301	105,931
Pooled short-term investment funds	413,223	-	-	413,223
U.S. government, state, municipal and agency obligations	-	2,749,101	-	2,749,101
Corporate and foreign fixed income securities	-	1,523,567	26,599	1,550,166
Asset-backed securities	-	785,076	89,364	874,440
Equity securities	3,040,776	41,380	2,198	3,084,354
Alternative investments and other investments:				
Private equity and real estate funds	19	5,901	187,338	193,258
Commodities funds and other investments	57,566	(6,217)	(4,245)	47,104
Assets at net asset value:				
Corporate and foreign fixed income securities				155,261
Equity securities				134,093
Private equity and real estate funds				1,242,900
Hedge funds				3,030,653
Commodities funds and other investments				1,309,726
Cash and other assets not at fair value				400,274
Cash and investments				$ 15,825,555
Benefit plan assets, in other noncurrent assets	$ 323,421	$ 1,243	$ 35,256	$ 359,920
Interest rate swaps, in other noncurrent assets	-	46,495	-	46,495
Investments sold, not yet purchased, in other noncurrent liabilities	151	3,105	-	3,256
Interest rate swaps, included in other noncurrent liabilities	-	188,051	-	188,051

6. Fair Value Measurements (continued)

For the year ended June 30, 2015, the changes in the fair value of the assets and liabilities measured using significant unobservable inputs (Level 3) consisted of the following. Level 3 investments of the Alpha Fund are included in transfers in the table below.

	Short-term investments	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Commodities Funds and Other Investments	Benefit Plan Assets
Year Ended June 30, 2015							
Beginning balance	$ 293	$ 15,611	$ 99,921	$ 51,578	$ 167,754	$ 62,686	$ 40,493
Total realized and unrealized gains (losses):							
Included in income from operations	-	(12)	1	(1,681)	-	(165)	-
Included in nonoperating gains (losses)	7	(241)	(1,411)	550	81,505	(85,737)	-
Included in changes in net assets	-	-	-	-	34	-	-
Purchases	1	18,939	62,740	749	48,858	75,174	11,580
Sales	-	(7,615)	(37,714)	(27,528)	(83,572)	(15,381)	(14,893)
Transfers into Level 3	-	2,447	10,268	-	132,964	4,648	3,518
Transfers out of Level 3	-	(2,530)	(44,441)	(21,470)	(160,205)	(45,470)	(5,442)
Ending balance	$ 301	$ 26,599	$ 89,364	$ 2,198	$ 187,338	$ (4,245)	$ 35,256
The amount of total gains or losses for the period included in nonoperating gains (losses) attributable to the changes in unrealized gains or losses relating to assets still held at June 30, 2015	$ -	$ (275)	$ (1,012)	$ 407	$ 3,058	$ (81,115)	$ -

The basis for recognizing and valuing transfers into or out of Level 3, in the Level 3 rollforward, is as of the beginning of the period in which the transfers occur.

7. Long-Term Debt

Long-term debt at June 30, 2016 and 2015 is comprised of the following and is presented in accordance with the specific master trust indenture to which the debt relates. As further discussed below, certain portions of long-term debt are secured under the Alexian Brothers Health System Master Trust Indenture; the Mercy Regional Health Center, Inc. Master Trust Indenture; The Howard Young Medical Center, Inc. Master Trust Indenture; the St. John Health System Master Trust Indenture; and the Ministry Health Care Master Trust Indenture.

	June 30, 2016	June 30, 2015
Tax-exempt hospital revenue bonds – secured under Ascension Health Alliance Senior Credit Group Master Trust Indenture:		
Variable rate demand bonds, subject to a put provision that provides for a cumulative 7-month notice and remarketing period, payable through November 2047; interest (0.68% at June 30, 2016) tied to a market index plus a spread	**$ 350,890**	$ 391,160
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2047; interest (0.40% to 0.45% at June 30, 2016) set at prevailing market rates	**254,170**	189,285
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2033; interest (0.40% to 0.45% at June 30, 2016) set at prevailing market rates	**299,650**	307,300
Indexed put bonds subject to weekly rate resets based on a taxable index, payable through November 2046; interest at 1.264% at June 30, 2016	**153,800**	153,800
Fixed rate put bonds (converted from an indexed put bond mode based on a taxable index in May 2009) payable through November 2046; interest at 4.10% at June 30, 2016	**153,690**	153,690
Fixed rate serial and term bonds payable in installments through November 2051; interest at 3.00% to 5.00%	**2,392,360**	1,168,765
Fixed rate serial and term bonds payable in installments through November 2039; interest at 5.00%	**-**	585,290
Fixed rate serial mode bonds payable through 2047 with purchase dates ranging from February 2017 through April 2022; interest at 0.95% to 5.00% through the purchase dates	**1,120,680**	1,140,045

7. Long-Term Debt (continued)

	June 30, 2016	June 30, 2015
Tax-exempt hospital revenue bonds – unsecured under Ascension Health Alliance Subordinate Master Trust Indenture:		
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2026; interest (0.40% at June 30, 2016) set at prevailing market rates	**$ 42,985**	$ 54,180
Fixed rate serial mode bonds payable through 2027 with purchase dates through May 2020; interest at 1.15% to 5.00%	**419,055**	434,675
Taxable bonds – secured under Ascension Health Alliance Senior Credit Group Master Trust Indenture:		
Taxable fixed rate term bonds payable in installments through November 2053; interest at 3.945% and 4.847%	**1,125,000**	425,000
Total hospital revenue bonds under Senior Master Trust Indenture and Subordinate Master Trust Indenture	**6,312,280**	5,003,190
Tax-exempt hospital revenue bonds – secured under Alexian Brothers Health System Master Trust Indenture:		
Fixed rate serial and term bonds payable in installments through February 2038; interest at 4.25% to 5.50%	**61,935**	153,370
Total hospital revenue bonds under the Alexian Brothers Health System Master Trust Indenture	**61,935**	153,370
Tax-exempt hospital revenue bonds – secured under Mercy Regional Health Center, Inc. Master Trust Indenture:		
Fixed rate serial and term bonds payable in installments through November 2029; interest at 4.00% to 5.00%	**21,915**	22,995
Total hospital revenue bonds under the Mercy Regional Health Center, Inc. Master Trust Indenture	**21,915**	22,995
Tax-exempt hospital revenue bonds – secured under The Howard Young Medical Center, Inc. Master Trust Indenture:		
Fixed rate serial and term bonds payable in installments through August 2030; interest at 3.00% to 5.00%	**-**	18,310
Total hospital revenue bonds under The Howard Young Medical Center, Inc. Master Trust Indenture	**-**	18,310

7. Long-Term Debt (continued)

	June 30, 2016	June 30, 2015
Tax-exempt hospital revenue bonds – secured under St. John Health System Master Trust Indenture:		
Fixed rate serial and term bonds payable in installments through February 2042; interest at 4.00% to 5.00%	**$ 385,240**	$ 395,215
Total hospital revenue bonds under the St. John Health System Master Trust Indenture	**385,240**	395,215
Tax-exempt hospital revenue bonds – secured under Ministry Health Care Master Trust Indenture:		
Fixed rate serial and term bonds payable in installments through August 2035; interest at 3.00% to 5.50%	**-**	347,230
Total hospital revenue bonds under the Ministry Health Care Master Trust Indenture	**-**	347,230
Total hospital revenue bonds – all Master Trust Indentures	**6,781,370**	5,940,310
Other debt:		
Obligations under capital leases	**24,987**	27,572
Other	**111,923**	116,586
	6,918,280	6,084,468
Unamortized premium, net	**271,774**	187,391
Less current portion	**(96,193)**	(84,985)
Less long-term debt subject to short-term remarketing arrangements	**(1,666,245)**	(1,176,790)
Long-term debt, less current portion and long-term debt subject to short-term remarketing arrangements	**$ 5,427,616**	$ 5,010,084

7. Long-Term Debt (continued)

	June 30, 2016	June 30, 2015
Ascension Health Alliance Senior Master Trust Indenture long-term debt obligations, including unamortized premium, net	**$ 4,388,376**	$ 3,403,592
Ascension Health Alliance Subordinate Master Trust Indenture long-term debt obligations, including unamortized premium, net	**434,542**	493,746
Alexian Brothers Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	**50,296**	152,220
Mercy Regional Health Center, Inc. Master Trust Indenture long-term debt obligations, including unamortized premium, net	**22,627**	24,072
The Howard Young Medical Center, Inc. Master Trust Indenture long-term debt obligations, including unamortized premium, net	**-**	18,900
St. John Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	**403,132**	415,212
Ministry Health Care Master Trust Indenture long-term debt obligations, including unamortized premium, net	**-**	367,008
Other	**128,643**	135,334
Long-term debt, less current portion, and long-term debt subject to short-term remarketing arrangements	**$ 5,427,616**	$ 5,010,084

Scheduled principal repayments of long-term debt, considering obligations subject to short-term remarketing as due according to their long-term amortization schedule, as of June 30, 2016, are as follows:

	Ascension Health Alliance MTIs	Alexian Brothers Health System MTI	Mercy Regional Health Center, Inc. MTI	St. John Health System MTI	Other Debt	Total
Year Ending June 30:						
2017	$ 65,455	$ 12,845	$ 1,125	$ 7,900	$ 8,868	$ 96,193
2018	68,530	15,355	1,175	6,810	9,140	101,010
2019	88,780	2,080	1,230	7,150	22,621	121,861
2020	91,880	2,495	1,285	7,510	21,251	124,421
2021	95,345	1,700	1,350	7,895	8,949	115,239
Thereafter	5,902,290	27,460	15,750	347,975	66,081	6,359,556
Total	$ 6,312,280	$ 61,935	$ 21,915	$ 385,240	$ 136,910	$ 6,918,280

7. Long-Term Debt (continued)

The carrying amounts of variable rate bonds and other notes payable approximate fair value. The fair values of the unsecured fixed rate serial and term bonds are obtained from independent public valuation services. The fair value of fixed rate serial and term bonds, including the component of variable rate demand bonds subject to long-term fixed interest rates, approximates carrying value at June 30, 2016 and 2015. During the years ended June 30, 2016 and 2015, interest paid was approximately $203,000 and $220,000, respectively. Capitalized interest was approximately $3,700 and $3,200 for the years ended June 30, 2016 and 2015, respectively.

Certain members of the System formed the Ascension Health Alliance Credit Group (Senior Credit Group). Each Senior Credit Group member is identified as either a senior obligated group member, a senior designated affiliate, or a senior limited designated affiliate. Senior obligated group members are jointly and severally liable under a Senior Master Trust Indenture (Senior MTI) to make all payments required with respect to obligations under the Senior MTI and may be entities not controlled directly or indirectly by the System. Senior designated affiliates and senior limited designated affiliates are not obligated to make debt service payments on the obligations under the Senior MTI. The System may cause each senior designated affiliate to transfer such amounts as are necessary to enable the obligated group to comply with the terms of the Senior MTI, including payment of the outstanding obligations. Additionally, each senior limited designated affiliate has an independent limited designated affiliate agreement and promissory note with the System with stipulated repayment terms and conditions, each subject to the governing law of the senior limited designated affiliate's state of incorporation.

Pursuant to a Supplemental Master Indenture dated February 1, 2005, senior obligated group members, which are operating entities, have pledged and assigned to the Master Trustee a security interest in all of their rights, title, and interest in their pledged revenues and proceeds thereof.

A Subordinate Credit Group, which is comprised of subordinate obligated group members, subordinate designated affiliates, and subordinate limited designated affiliates, was created under the Subordinate Master Trust Indenture (Subordinate MTI). The subordinate obligated group members are jointly and severally liable under the Subordinate MTI to make all payments required with respect to obligations under the Subordinate MTI and may be entities not controlled directly or indirectly by the System. Subordinate designated affiliates and subordinate limited designated affiliates are not obligated to make debt service payments on the obligations under the Subordinate MTI.

7. Long-Term Debt (continued)

The System may cause each subordinate designated affiliate to transfer such amounts as are necessary to enable the obligated group members to comply with the terms of the Subordinate MTI, including payment of the outstanding obligations. Additionally, each subordinate limited designated affiliate has an independent subordinate limited designated affiliate agreement and promissory note with the System, with stipulated repayment terms and conditions, each subject to the governing law of the subordinate limited designated affiliate's state of incorporation.

The unsecured variable rate demand bonds of both the Senior and Subordinate Credit Groups, while subject to long-term amortization periods, may be put to the System at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within 12 months after June 30, 2016, the principal amount of such bonds has been classified as a current liability in the accompanying Consolidated Balance Sheets. Management believes the likelihood of a material amount of bonds being put to the System to be remote. However, to address this possibility, management has taken steps to provide various sources of liquidity in the event any bonds would be put, including the line of credit, commercial paper program, and maintaining unrestricted assets as a source of self-liquidity.

On January 1, 2012, Alexian Brothers became part of the System. Subsequently, the System redeemed or refinanced a portion of Alexian Brothers' debt; however, a portion of the bonds previously issued for the benefit of Alexian Brothers remains outstanding (the Alexian Brothers' Bonds). The Alexian Brothers' Bonds continue to be secured by the Alexian Brothers Health System Master Trust Indenture (As Amended and Restated), dated October 1, 1992, between the Members of the Alexian Brothers Health System Obligated Group established under this document and the Alexian Brothers Health System Master Trustee.

On April 1, 2013, Marian Health System joined Ascension Health. Subsequently, the System redeemed or refinanced a portion of the debt of the Marian Systems; however, a portion of the bonds previously issued for the benefit of the Marian Systems remains outstanding. These bonds continue to be secured by the respective Master Trust Indentures, including the Amended and Restated Master Trust Indenture dated October 1, 1999, by and between St. John Health System and the St. John Health Master Trustee; and the Master Trust Indenture dated January 15, 2013, between Mercy Regional Health Center, Inc. and the Mercy Regional Health Center, Inc. Master Trustee.

7. Long-Term Debt (continued)

In order to terminate the respective Master Trust Indentures of Crittenton and Wheaton, and the redemption or defeasance of all associated outstanding debt, Ascension issued taxable commercial paper of approximately $161,000 and $637,000, respectively, during the year ended June 30, 2016. Following the discharge of these Master Trust Indentures, certain Crittenton and Wheaton entities were added to the Senior and Subordinate Credit Groups.

In May 2016, Ascension issued $2,046,250 of debt, consisting of $1,346,250 tax-exempt bonds through issuing authorities in Wisconsin, Alabama and Michigan, and $700,000 taxable bonds. The debt was issued to refund certain Ascension 2006 fixed rate bonds payable through 2039, to refund the commercial paper associated with the Crittenton and Wheaton transactions, to refund the remaining debt of Ministry Health Care, Inc. and Howard Young Health Care, Inc. and to reimburse the System for previous capital expenditures. Subsequent to the closing, both the Ministry Health Care Master Trust Indenture and The Howard Young Medical Center, Inc. Master Trust Indenture were terminated and certain Ministry Health Care, Inc. and Howard Young Health Care, Inc. entities were added to the Senior and Subordinate Credit Groups.

Due to aggregate financing activity during the fiscal years ended June 30, 2016 and 2015, losses on extinguishment of debt of $13,594 and $992, respectively, were recorded, which are included in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

As of June 30, 2016, the Senior Credit Group has two lines of credit totaling $1,000,000. The first line of credit totals $500,000 which may be used as a source of funding for unremarketed variable debt (including commercial paper) or for general corporate purposes. The second line of credit totals $500,000 which may be used for general corporate purposes. Both lines are committed to November 3, 2017 and as of June 30, 2016 and 2015, there were no borrowings under either line of credit.

7. Long-Term Debt (continued)

As of June 30, 2016, the Senior Credit Group has a $100,000 revolving line of credit related to its letters of credit program toward which a bank commitment of $100,000 extends to November 24, 2016. The revolving line of credit may be accessed solely in the form of Letters of Credit issued by the bank for the benefit of the members of the Credit Groups. Of this $100,000 revolving line of credit, letters of credit totaling $78,892 have been issued as of June 30, 2016. No borrowings were outstanding under the letters of credit as of June 30, 2016 and 2015.

8. Derivative Instruments

The System uses interest rate swap agreements to manage interest rate risk associated with its outstanding debt. Interest rate swaps with varying characteristics are outstanding under the Master Trust Indentures of the System, Alexian Brothers, Ministry Health Care, and St. John Health. These swaps have historically been used to effectively convert interest rates on variable rate bonds to fixed rates and rates on fixed rate bonds to variable rates. At June 30, 2016 and 2015, the notional values of outstanding interest rate swaps were as follows:

	June 30,	
	2016	**2015**
Ascension Health Alliance MTI	**$ 2,146,107**	$ 2,128,757
Alexian Brothers Health System MTI	**-**	31,220
Ministry Health Care MTI	**-**	191,800
St. John Health System MTI	**100,000**	100,000
Total	**$ 2,246,107**	$ 2,451,777

8. Derivative Instruments (continued)

The System recognizes the fair value of its interest rate swaps in the Consolidated Balance Sheets as assets, recorded in other noncurrent assets, or liabilities, recorded in other noncurrent liabilities, as appropriate. The respective fair values of interest rate swaps in an asset and liability position for the System, Alexian Brothers, Ministry Health Care and St. John Health were as follows:

	June 30, 2016		June 30, 2015	
	Asset	Liability	Asset	Liability
Ascension Health Alliance MTI	$ 10,713	$ 236,367	$ 41,516	$ 168,008
Alexian Brothers Health System MTI	-	-	-	1,170
Ministry Health Care MTI	-	-	4,708	18,873
St. John Health System MTI	-	335	271	-
Total	$ 10,713	$ 236,702	$ 46,495	$ 188,051

The System's interest rate swap agreements include collateral requirements for each counterparty under such agreements, based upon specific contractual criteria, subject to master netting arrangements. Collateral requirements are separately calculated for the System, Alexian Brothers, Ministry Health Care, and St. John Health based on the credit ratings of each. In the case of the System, the applicable credit rating is the Senior Credit Group long-term debt credit ratings (Senior Debt Credit Ratings), as obtained from each of two major credit rating agencies. Credit rating and the net liability position of total interest rate swap agreements outstanding with each counterparty determine the amount of collateral to be posted. No collateral was posted at June 30, 2016 and 2015.

The System does not account for any of its interest rate swaps as hedges, and accordingly, all changes in the fair value of interest rate swaps are recognized in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets. The System does not offset fair value amounts recognized for derivative instruments.

9. Retirement Plans

Defined-Benefit Plans

Certain System entities participate in defined-benefit pension plans (the System Plans), which are noncontributory, defined-benefit pension plans. Benefits are based on each participant's years of service and compensation. All of the System Plans' assets are invested in Trusts, which include the Master Pension Trust (the Trust) and other trusts (the Other Trusts). The System Plans' assets primarily consist of short-term investments, equity, fixed income, and alternative investments, consisting of various hedge funds, real estate funds, private equity funds, commodity funds, private credit funds, and certain other private funds. Contributions to the System Plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to participants.

Most System defined benefit plans were frozen effective December 31, 2012. Four of the System Plans remain ongoing with $25,467 of service cost recognized during the year ended June 30, 2016.

The assets of the System Plans are available to pay the benefits of eligible employees and retirees of all participating entities. In the event entities participating in the System Plans are unable to fulfill their financial obligations under the System Plans, the other participating entities are obligated to do so.

9. Retirement Plans (continued)

The following table sets forth the combined benefit obligations and assets of the System Plans at June 30, 2016 and 2015, components of net periodic benefit costs for the years then ended, and a reconciliation of the amounts recognized in the accompanying consolidated financial statements.

	Year Ended June 30,	
	2016	**2015**
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$7,786,840**	$ 7,691,959
Service cost	**25,467**	35,558
Interest cost	**352,212**	323,991
Assumption change	**583,125**	102,950
Actuarial loss	**41,378**	43,967
Acquisitions	**1,069,401**	-
Curtailment	**(12,206)**	(19,613)
Benefits paid	**(410,253)**	(391,972)
Projected benefit obligation at end of year	**9,435,964**	7,786,840
Accumulated benefit obligation at end of year	**9,386,710**	7,763,448
Change in plan assets:		
Fair value of plan assets at beginning of year	**7,305,030**	7,465,115
Actual return on plan assets	**482,083**	190,859
Employer contributions	**24,381**	41,027
Acquisitions	**798,138**	-
Benefits paid	**(410,253)**	(391,971)
Fair value of plan assets at end of year	**8,199,379**	7,305,030
Net amount recognized at end of year and funded status	**$ (1,236,585)**	$ (481,810)

The System Plans' funded status as a percentage of the projected benefit obligation at June 30, 2016 and 2015, was 86.9% and 93.8%, respectively. The System Plans' funded status as a percentage of the accumulated benefit obligation at June 30, 2016 and 2015, was 87.4% and 94.1%, respectively.

9. Retirement Plans (continued)

Included in unrestricted net assets at June 30, 2016 and 2015, are the following amounts that have not yet been recognized in net periodic pension cost for the System Plans:

	Year Ended June 30, 2016	Year Ended June 30, 2015
Unrecognized prior service credit	$ (8,293)	$ (12,071)
Unrecognized actuarial loss	1,546,707	833,066
	$ 1,538,414	$ 820,995

Changes in plan assets and benefit obligations recognized in unrestricted net assets for System Plans during 2016 and 2015 include:

	Year Ended June 30, 2016	Year Ended June 30, 2015
Current year actuarial loss	$ 749,175	$ 528,084
Amortization of actuarial loss	(35,534)	(25,956)
Amortization of prior service credit	3,778	5,277
	$ 717,419	$ 507,405

	Year Ended June 30, 2016	Year Ended June 30, 2015
Components of net periodic benefit cost		
Service cost	$ 25,467	$ 35,558
Interest cost	352,212	323,991
Expected return on plan assets	(618,961)	(591,639)
Amortization of prior service credit	(3,140)	(3,423)
Amortization of actuarial loss	34,985	27,360
Curtailment gain	(638)	(1,854)
Settlement gain	549	(1,404)
Net periodic benefit	$ (209,526)	$ (211,411)

9. Retirement Plans (continued)

The prior service credit and actuarial loss included in unrestricted net assets and expected to be recognized in net periodic pension cost during the year ending June 30, 2017, are $3,000 and $64,811, respectively.

The assumptions used to determine the benefit obligation and net periodic benefit cost for the System Plans are set forth below:

	June 30,	
	2016	**2015**
Weighted-average discount rate	**3.80%**	4.48%
Weighted-average rate of compensation increase	**4.00%**	4.00%
Weighted-average expected long-term rate of return on plan assets	**8.36%**	8.30%

The expected long-term rate of return on the System Plans' assets is based on historical and projected rates of return for current and planned asset categories in the investment portfolio. Assumed projected rates of return for each asset category were selected after analyzing historical experience and future expectations of the returns and volatility for assets of that category using benchmark rates. Based on the target asset allocation among the asset categories, the overall expected rate of return for the portfolio was developed and adjusted for historical and expected experience of active portfolio management results compared to benchmark returns and for the effect of expenses paid from plan assets.

The System Plans' assets invested in the Trust are invested in a portfolio designed to protect principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, with a reasonable and prudent level of risk. Diversification is achieved by allocating to funds and managers that correlate to one of three economic strategies: growth, deflation, and inflation. Growth strategies include U.S. equity, emerging market equity, global equity, international equity, directional hedge funds, private equity, high yield, and private credit. Deflation strategies include core fixed income, absolute return hedge funds, and cash. Inflation strategies include inflation-linked bonds, commodity-related investments, and real assets. The System Plans use multiple investment managers with complementary styles, philosophies, and approaches. In accordance with the System Plans' objectives, derivatives may also be used to gain market exposure in an efficient and timely manner.

9. Retirement Plans (continued)

In accordance with the System Plans' asset diversification targets, as presented in the table that follows, the Trust holds certain alternative investments, consisting of various hedge funds, real asset funds, private equity funds, commodity funds, private credit funds, and certain other private funds. These investments do not have observable market values. As such, each of these investments is valued at net asset value (NAV) as determined by each fund's investment manager, which approximates fair value. Management elected to use the NAV per share, or equivalent, for fair value. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods ranging from 1 to 120 days. Due to redemption restrictions, investments of certain private funds, whose fair value was approximately $1,981,000 at June 30, 2016, cannot currently be redeemed. However, the potential for the System Plans to sell their interest in real asset funds and private equity funds in a secondary market prior to the end of the fund term does exist.

The investments in these alternative investment funds may also include contractual commitments to provide capital contributions during the investment period, which is typically five years, and may extend to the end of the fund term. During these contractual periods, investment managers may require the System Plans to invest in accordance with the terms of the agreement. Commitments not funded during the investment period will expire and remain unfunded. As of June 30, 2016, investment periods expire between October 2016 and September 2018. The remaining unfunded capital commitments of the Trust total approximately $238,000 for 59 individual contracts as of June 30, 2016.

The weighted-average asset allocation for the System Plans in the Trust at the end of fiscal 2016 and 2015 and the target allocation for fiscal 2017, by asset category, are as follows:

	Target Allocation	Percentage of Plan Assets At Year-End	
Asset Category	**2017**	**2016**	**2015**
Growth	57 %	**46 %**	53 %
Deflation	28	**38**	29
Inflation	15	**16**	18
Total	100 %	**100 %**	100 %

9. Retirement Plans (continued)

The following tables summarize fair value measurements at June 30, 2016 and 2015, by asset class and by level, for the System Plans' assets and liabilities. As also discussed in the Fair Value Measurements note, the System follows the three-level fair value hierarchy to categorize plan assets and liabilities recognized at fair value, which prioritizes the inputs used to measure such fair values. The inputs and valuation techniques discussed in the Fair Value Measurements note also apply to the System Plans' assets and liabilities as presented in the following tables.

	Level 1	Level 2	Level 3	Total
June 30, 2016				
Short-term investments	$ 1,235,230	$ -	$ -	$ 1,235,230
Derivatives receivable	31,674	280,634	55,187	367,495
U.S. government, state, municipal and agency obligations	1,840	1,567,670	-	1,569,510
Corporate and foreign fixed income securities	-	617,395	7,870	625,265
Asset-backed securities	-	154,113	41,220	195,333
Equity securities	1,555,564	12,226	12,321	1,580,111
Assets at net asset value:				
Corporate and foreign fixed income securities				8,929
Equity securities				97,760
Private equity and real estate funds				908,403
Hedge funds				1,406,679
Commodities funds and other investments				349,516
Other receivables				241,603
Total				8,585,834
Derivatives payable	30,917	11,291	4,819	47,027
Other payables				339,428
Total				386,455
Fair value of plan assets				$ 8,199,379

9. Retirement Plans (continued)

	Level 1	Level 2	Level 3	Total
June 30, 2015				
Short-term investments	$ 388,255	$ -	$ -	$ 388,255
Derivatives receivable	4	35,381	5,443	40,828
U.S. government, state, municipal and agency obligations	-	1,304,665	-	1,304,665
Corporate and foreign fixed income securities	-	707,838	3,372	711,210
Asset-backed securities	-	170,791	19,610	190,401
Equity securities	1,648,055	309,259	1,345	1,958,659
Assets at net asset value:				
Corporate and foreign fixed income securities				28,531
Equity securities				57,027
Private equity and real estate funds				966,266
Hedge funds				1,462,938
Commodities funds and other investments				350,788
Other receivables				74,703
Total				7,534,271
Derivatives payable	54	132,987	14,180	147,221
Investments sold, not yet purchased	2,146	-	-	2,146
Other payables				79,874
Total				229,241
Fair value of plan assets				$ 7,305,030

9. Retirement Plans (continued)

For the years ended June 30, 2016 and 2015, the changes in the fair value of the System Plans' assets measured using significant unobservable inputs (Level 3) consisted of the following:

	Net Derivatives	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities
June 30, 2016				
Beginning balance	**$ (8,737)**	**$ 3,372**	**$ 19,610**	**$ 1,345**
Acquisitions	**-**	**-**	**-**	**8,190**
Total actual return on assets	**(3,649)**	**(1,200)**	**(73)**	**2,008**
Purchases, issuances, and settlements	**62,754**	**6,184**	**26,325**	**738**
Transfers (out of) into Level 3	**-**	**(486)**	**(4,642)**	**40**
Ending balance	**$ 50,368**	**$ 7,870**	**$ 41,220**	**$ 12,321**
Actual return on plan assets relating to plan assets still held at June 30, 2016	**$ 50,368**	**$ (1,642)**	**$ (446)**	**$ (58)**

	Net Derivatives	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities
June 30, 2015				
Beginning balance	$ 16,424	$ 1,820	$ 24,080	$ 3,045
Total actual return on assets	(9,715)	(1,311)	(515)	(306)
Purchases, issuances, and settlements	(15,446)	7,716	898	(1,747)
Transfers (out of) into Level 3	-	(4,853)	(4,853)	353
Ending balance	$ (8,737)	$ 3,372	$ 19,610	$ 1,345
Actual return on plan assets relating to plan assets still held at June 30, 2015	$ (9,140)	$ (1,269)	$ (139)	$ (553)

9. Retirement Plans (continued)

The Trust has entered into a series of swap agreements with a net notional amount of $4,374,410. The combined targeted duration of these swaps and the Trust's fixed income investments approximates the duration of the liabilities of the Trust. Currently, 75% of the dollar duration of the liability is subject to this economic hedge. The purpose of this strategy is to economically hedge the change in the net funded status for a significant portion of the liability that can occur due to changes in interest rates.

Information about the expected cash flows for the System Plans follows:

Expected employer contributions 2017	$ 30,042
Expected benefit payments:	
2017	625,090
2018	632,035
2019	596,819
2020	601,883
2021	599,422

The contribution amount above includes expected amounts paid to Trusts. The benefit payment amounts above reflect the total benefits expected to be paid from Trusts.

9. Retirement Plans (continued)

Other Postretirement Benefit Plans

In addition to the retirement plan described above, certain Health Ministries sponsor postretirement benefit plans that provide healthcare benefits to qualified retirees who meet certain eligibility requirements. The total benefit obligation of these plans at June 30, 2016 and 2015 is $36,044 and $44,274, respectively. The net asset included in pension and other postretirement liabilities in the accompanying Consolidated Balance Sheets at June 30, 2016 and 2015 is $7,954 and $2,040, respectively. The change in the plans' assets and benefit obligations recognized in unrestricted net assets during the year ended June 30, 2016 and 2015, was a decrease of $3,731 and $3,633, respectively.

Defined-Contribution Plans

System entities participate in contributory and noncontributory defined-contribution plans covering all eligible associates. There are three primary types of contributions to these plans: employer automatic contributions, employee contributions, and employer matching contributions. Benefits for employer automatic contributions are determined as a percentage of a participant's salary and, for certain entities, increases over specified periods of employee service. These benefits are funded annually, and participants become fully vested over a period of time. Benefits for employer matching contributions are determined as a percentage of an eligible participant's contributions each payroll period. These benefits are funded each payroll period, and participants become fully vested in these employer contributions immediately. Expenses for the defined-contribution plans were $326,881 and $284,866 during 2016 and 2015, respectively.

10. Self-Insurance Programs

Certain System hospitals and other entities participate in pooled risk programs to insure professional and general liability risks and workers' compensation risks to the extent of certain self-insured limits. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. The System provides its self-insurance through various trust funds and captive insurance companies. Actuarially determined amounts, discounted at 6% for the System, are contributed to the trust funds and the captive insurance companies to provide for the estimated cost of claims. The loss reserves recorded for estimated self-insured professional, general liability, and workers' compensation claims include estimates of the ultimate costs for both reported claims and claims incurred but not reported, which are discounted at 6% in 2016 and 2015 for the System. Those entities not participating in the self-insured programs are insured under separate policies.

Professional and General Liability Programs

Professional and general liability coverage is provided on a claims-made or occurrence basis through a wholly owned onshore trust and through Ascension Health Insurance (AHIL), a direct subsidiary of Ascension Risk Services.

The wholly owned onshore revocable trust has a self-insured retention up to $10,000 per occurrence with no aggregate. Excess coverage is provided through AHIL with limits up to $205,000. AHIL retains $5,000 per incident and in the aggregate for professional liability. AHIL also retains a 20% quota share of the first $25,000 of umbrella excess. The remaining excess coverage is reinsured by commercial carriers.

Sunflower Assurance, Inc. (Sunflower) was acquired when Via Christi Health joined the System. Prior to acquisition, Sunflower provided excess coverage with limits up to $75,000 above the primary coverage for Via Christi Health and retained 10% of the first reinsurance layer of $10,000 on a quota share basis. The remaining excess coverage was reinsured by commercial carriers. As of October 1, 2013, Via Christi Health's primary and excess medical professional and general liability and employed physician programs were integrated into the System trust and AHIL. After January 1, 2014, the employer stop loss and employee life insurance coverage provided by Sunflower to Via Christi Health were not renewed and are in run off.

10. Self-Insurance Programs (continued)

Effective July 1, 2014, the reinsurance of Ascension's independent physician professional liability program with ProAssurance Corporation (ProAssurance), the System's partner insurance company, was transferred from AHIL to Sunflower.

Employed physicians and certain entities in the states of Indiana, Kansas, Pennsylvania, and Wisconsin are provided coverage by ProAssurance on a fronted basis and are reinsured through AHIL. These entities and physicians are provided professional liability coverage with limits in compliance with participation in the Patient Compensation Funds. The Patient Compensation Funds apply to claims in excess of the primary self-insured limit, except the Fund in Kansas, which only covers claims up to the first $1,000 and then the trust and AHIL cover amounts above $1,000.

Beginning July 1, 2014, Sunflower offered physician professional liability coverage through insurance or reinsurance arrangements to nonemployed physicians practicing at the System's various facilities, primarily in Michigan, Indiana, Texas, Florida, Illinois and Alabama. Coverage is offered to physicians with limits ranging from $100 per claim to $1,000 per claim with various aggregate limits. Beginning July 1, 2014, AHIL offered similar coverage to employed physicians in the states of Indiana, Kansas, Pennsylvania and Wisconsin.

Included in operating expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets is professional and general liability expense of $122,683 and $105,037 for the years ended June 30, 2016 and 2015, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are professional and general liability loss reserves of $552,656 and $566,134 at June 30, 2016 and 2015, respectively.

Workers' Compensation

Workers' compensation coverage is provided on an occurrence basis through a grantor trust. The self-insured trust provides coverage up to $1,500 per occurrence with no aggregate. The trust provides a mechanism for funding the workers' compensation obligations of its members. Prior to October 1, 2013, workers' compensation coverage for Via Christi Health, Ministry, and St. John Health System, a subsidiary of Ascension Health, (collectively the former Marian Health System) was self-insured or commercially insured up to various limits and excess insurance against catastrophic loss was obtained through commercial insurers.

10. Self-Insurance Programs (continued)

Included in employee benefits in the accompanying Consolidated Statements of Operations and Changes in Net Assets is workers' compensation expense of $41,777 and $44,746 for the years ended June 30, 2016 and 2015, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are workers' compensation loss reserves of $138,221 and $137,239 at June 30, 2016 and 2015, respectively.

11. Lease Commitments

Certain System entities are lessees under operating lease agreements for the use of space in buildings owned by third parties, including medical office buildings (MOBs) and medical and information technology equipment. In addition, certain System entities have subleased space within buildings where the entity has a current operating lease commitment. Certain System entities are also lessors under operating lease agreements, primarily ground leases related to third-party-owned MOBs on land owned by the System entity.

The System's future minimum noncancelable payments associated with operating leases with terms of one year or more where a System entity is the lessee, as well as future minimum noncancelable receipts associated with operating leases where a System entity is the sublessor or lessor, are presented in the table that follows. Future minimum payments and receipts relate to noncancelable leases with terms of one year or more.

	Future Payments Where the System is Lessee	Future Receipts Where the System is Sublessor/ Lessor	Net Future Payments (Receipts)
Year ending June 30:			
2017	$ 164,000	$ 41,813	$ 122,187
2018	145,992	35,371	110,621
2019	105,889	28,041	77,848
2020	76,478	22,119	54,359
2021	54,584	18,621	35,963
Thereafter	178,354	284,019	(105,665)
Total	$ 725,297	$ 429,984	$ 295,313

11. Lease Commitments (continued)

Rental expense under operating leases amounted to $391,054 and $383,752 in 2016 and 2015, respectively.

12. Contingencies and Commitments

The System is involved in litigation and regulatory investigations arising in the ordinary course of business. Regulatory investigations also occur from time to time. In the opinion of management, after consultation with legal counsel, these matters are expected to be resolved without material adverse effect on the System's Consolidated Balance Sheet.

In September 2010, Ascension Health received a letter from the U.S. Department of Justice (the DOJ) in connection with its nationwide review to determine whether, in certain cases, implantable cardioverter defibrillators (ICD) were provided to certain Medicare beneficiaries in accordance with national coverage criteria. The DOJ's investigation spans a time frame beginning in 2003. Effective June 26, 2015, the DOJ and Ascension Health entered into a Settlement Agreement, thereby settling all issues alleged as part of the investigation. The release in the Settlement Agreement extends through March 31, 2015 and includes all of Ascension Health's individual hospitals subject to the investigation.

In March 2013, Ascension and certain of its subsidiaries were named as defendants to litigation surrounding the Church Plan status of various System pension plans. On May 9, 2014, the United States District Court, Eastern District of Michigan, Southern Division, issued a Decision and Order Granting Defendants' Motion to Dismiss in favor of Ascension and the other defendants. On June 11, 2014, the plaintiff in the case filed a Notice of Appeal. On March 17, 2015, upon motion of the parties, the Sixth Circuit remanded the case to the District Court to consider approving a proposed settlement of the lawsuit by the parties. On September 17, 2015, the District Court issued its Order approving the proposed settlement, and the settlement became final on November 16, 2015.

12. Contingencies and Commitments (continued)

The System enters into agreements with non-employed physicians that include minimum revenue guarantees. The terms of the guarantees vary. The carrying amounts of the liability for the System's obligation under these guarantees were $21,152 and $31,380 at June 30, 2016 and 2015, respectively, and are included in other current and noncurrent liabilities in the accompanying Consolidated Balance Sheets. The maximum amount of future payments that the System could be required to make under these guarantees is approximately $65,589.

The System entered into Master Service Agreements for information technology services provided by third parties. The maximum amount of future payments that the System could be required to make under these agreements is approximately $142,004.

Guarantees and other commitments represent contingent commitments issued by Ascension Health Alliance Senior and Subordinate Credit Groups, generally to guarantee the performance of an affiliate to a third party in borrowing arrangements such as commercial paper issuances, bond financing, and other transactions. The terms of guarantees are equal to the terms of the related debt, which can be as long as 25 years. The following represents the remaining guarantees and other commitments of the Senior and Subordinate Credit Groups at June 30, 2016:

Hospital de la Concepción 2000 Series A debt guarantee	$	27,165
St. Vincent de Paul Series 2000 A debt guarantee		28,300
Other guarantees and commitments		26,798

Supplementary Information

Building a better working world

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Report of Independent Auditors on Supplementary Information

The Board of Directors
Ascension Health Alliance d/b/a Ascension

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying Schedule of Net Cost of Providing Care of Persons Living in Poverty and Other Community Benefit Programs, the Credit Group Consolidated Balance Sheets, the Credit Group Consolidated Statement of Operations and Changes in Net Assets, the Schedule of Credit Group Cash and Investments, and the Schedule of Credit Group Statistical Information are presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information, except for that portion marked "unaudited," has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information, except for that portion marked "unaudited" on which we express no opinion, is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Ernst + Young LLP

September 12, 2016

A member firm of Ernst & Young Global Limited

Ascension

Schedule of Net Cost of Providing Care of Persons Living in Poverty and Other Community Benefit Programs

(Dollars in Thousands)

Years Ended June 30, 2016 and 2015

The net cost of providing care to persons living in poverty and other community benefit programs is as follows:

	Year Ended June 30, 2016	Year Ended June 30, 2015
Traditional charity care provided	**$ 495,863**	$ 500,067
Unpaid cost of public programs for persons living in poverty	**804,361**	857,283
Other programs for persons living in poverty and other vulnerable persons	**151,177**	142,843
Community benefit programs	**365,800**	410,169
Care of persons living in poverty and other community benefit programs	**$ 1,817,201**	$ 1,910,362

Ascension

Credit Group[1] Financial Statements
Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2016	June 30, 2015
Assets		
Current assets:		
Cash and cash equivalents	**$ 676,338**	$ 369,707
Short-term investments	**120,139**	107,148
Accounts receivable, less allowance for doubtful accounts ($1,203,752 and $1,086,946 at June 30, 2016 and 2015, respectively)	**2,457,775**	2,019,830
Inventories	**313,373**	266,412
Due from brokers	**313,717**	148,865
Estimated third-party payor settlements	**180,655**	219,754
Other	**1,047,280**	1,021,679
Total current assets	**5,109,277**	4,153,395
Long-term investments	**14,995,607**	14,825,293
Property and equipment, net	**7,713,956**	6,196,874
Other assets:		
Investment in unconsolidated entities	**959,823**	554,999
Capitalized software costs, net	**874,921**	707,888
Due from affiliates	**445,066**	629,727
Other	**869,473**	840,578
Total other assets	**3,149,283**	2,733,192
Total assets	**$ 30,968,123**	$ 27,908,754

Continued on next page.

[1] The Credit Group Financial Statements are comprised of the System (see Note 1) excluding the assets, liabilities and net assets of Alexian Brothers Health System (ABHS), including senior care facilities previously a part of ABHS and still a member of the Alexian Brothers Health System Master Trust Indenture (Alexian Brothers), and St. John Health System, Inc. (St. John). Ministry Health Care, Inc. (Ministry) became a member of the Credit Group in June 2016, but Ministry is excluded from the Credit Group for the year ended June 30, 2015. The Credit Group Financial Statements also include the System's noncontrolling interest (see Note 2) of the Alpha Fund (see Notes 4 and 5), which represents $1,256,666, or approximately 8.8%, and $1,405,401, or approximately 10.0%, of the Alpha Fund's net assets as of June 30, 2016 and 2015, respectively. See Note 5 for further discussion of noncontrolling interests of the Alpha Fund.

Ascension

Credit Group[1] Financial Statements
Consolidated Balance Sheets (continued)
(Dollars in Thousands)

	June 30, 2016	June 30, 2015
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 74,088**	$ 55,018
Long-term debt subject to short-term remarketing arrangements	**1,666,245**	1,176,790
Accounts payable and accrued liabilities	**2,321,853**	1,929,677
Estimated third-party payor settlements	**403,974**	303,952
Due to brokers	**105,660**	131,061
Current portion of self-insurance liabilities	**208,023**	228,470
Other	**244,790**	318,696
Total current liabilities	**5,024,633**	4,143,664
Noncurrent liabilities:		
Long-term debt (senior and subordinated)	**4,946,705**	4,013,590
Self-insurance liabilities	**483,404**	483,041
Pension and other postretirement liabilities	**1,211,038**	435,919
Other [2]	**1,896,020**	2,361,699
Total noncurrent liabilities	**8,537,167**	7,294,249
Total liabilities	**13,561,800**	11,437,913
Net assets:		
Unrestricted		
Controlling interest	**15,348,952**	14,401,351
Noncontrolling interests [3]	**1,430,052**	1,570,641
Unrestricted net assets	**16,779,004**	15,971,992
Temporarily restricted	**440,555**	373,721
Permanently restricted	**186,764**	125,128
Total net assets	**17,406,323**	16,470,841
Total liabilities and net assets	**$ 30,968,123**	$ 27,908,754

[2] Includes $735,440 at June 30, 2016 representing the amounts due to Alexian Brothers and St. John from Ascension attributable to interests in investments held by Ascension and $1,444,171 at June 30, 2015 representing the amounts due to Alexian Brothers, St. John and Ministry from Ascension attributable to interests in investments held by Ascension.

[3] Includes $1,256,666 and $1,405,401 at June 30, 2016 and 2015, respectively, attributable to the Alpha Fund (see Notes 4 and 5).

Ascension

Credit Group[1] Financial Statements
Consolidated Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

	Year Ended June 30, 2016 [5]	2015
Operating revenue:		
Net patient service revenue	**$18,973,765**	$ 16,151,787
Less provision for doubtful accounts	**991,536**	937,646
Net patient service revenue, less provision for doubtful accounts	**17,982,229**	15,214,141
Other revenue	**1,782,810**	1,496,945
Total operating revenue	**19,765,039**	16,711,086
Operating expenses:		
Salaries and wages	**8,123,907**	6,929,569
Employee benefits	**1,587,726**	1,391,593
Purchased services	**1,308,812**	982,118
Professional fees	**1,259,951**	1,089,779
Supplies	**2,776,848**	2,381,789
Insurance	**174,040**	158,954
Interest	**169,591**	152,851
Depreciation and amortization	**913,493**	749,206
Other	**2,520,736**	2,153,158
Total operating expenses before impairment, restructuring and nonrecurring losses, net	**18,835,104**	15,989,017
Income from operations before self-insurance trust fund investment return and impairment, restructuring and nonrecurring losses, net	**929,935**	722,069
Self-insurance trust fund investment return	**(16,334)**	(15,137)
Impairment, restructuring and nonrecurring losses, net	**(193,831)**	(126,927)
Income from operations	**719,770**	580,005
Nonoperating gains (losses):		
Investment return [4]	**(335,296)**	43,227
Loss on extinguishment of debt	**(5,849)**	(992)
Losses on interest rate swaps	**(85,884)**	(24,495)
(Loss) income from unconsolidated entities	**(41,188)**	4,689
Contributions from business combinations	**304,961**	-
Other	**(74,498)**	(64,786)
Total nonoperating losses, net	**(237,754)**	(42,357)
Excess of revenues and gains over expenses and losses	**482,016**	537,648
Less noncontrolling interests	**16,365**	75,805
Excess of revenues and gains over expenses and losses attributable to controlling interest	**465,651**	461,843

Continued on next page.

[4] Includes the investment return of ($411,690) and ($34,180) for the years ended June 30, 2016 and 2015, respectively, attributable to the Alpha Fund. Of the Alpha Fund's investment return, ($42,756) and ($9,563) for the years ended June 30, 2016 and 2015, respectively, is included in the noncontrolling interests.

[5] As Ministry became a member of the Credit Group in June 2016, Ministry's financial results for the fiscal year ended June 30, 2015 are excluded from the Credit Group Consolidated Statement of Operations and Changes in Net Assets for that period, yet included for the fiscal year ended June 30, 2016 as if the change had occurred as of July 1, 2015.

Ascension

Credit Group[1] Financial Statements
Consolidated Statement of Operations and Changes in Net Assets (continued)
(Dollars in Thousands)

	Year Ended June 30, 2016 [5]	2015
Unrestricted net assets, controlling interest:		
Excess of revenues and gains over expenses and losses	**$ 465,651**	$ 461,843
Transfers to sponsors and other affiliates, net	**(31,169)**	(5,352)
Net assets released from restrictions for property acquisitions	**44,297**	35,308
Pension and other postretirement liability adjustments	**(706,169)**	(459,508)
Change in unconsolidated entities' net assets	**(6,976)**	(2,730)
Addition to Credit Group [1,5]	**1,198,250**	-
Other	**(53)**	(2,194)
Increase in unrestricted net assets, controlling interest, before loss from discontinued operations	**963,831**	27,367
Loss from discontinued operations	**(16,230)**	(44,058)
Increase (decrease) in unrestricted net assets, controlling interest	**947,601**	(16,691)
Unrestricted net assets, noncontrolling interest:		
Excess (deficit) of revenues and gains over expenses and losses	**16,365**	75,805
Distributions of capital	**(254,788)**	(195,760)
Contributions of capital	**96,150**	45,578
Membership interest changes, net	**-**	(5,824)
Addition to Credit Group [1,5]	**2,578**	-
Other	**(894)**	(4,250)
Decrease in unrestricted net assets, noncontrolling interest [6]	**(140,589)**	(84,451)
Temporarily restricted net assets, controlling interest:		
Contributions and grants	**117,875**	94,832
Investment return	**(5,157)**	4,892
Net assets released from restrictions	**(78,575)**	(76,560)
Contributions from business combinations	**16,091**	-
Addition to Credit Group [1,5]	**20,782**	-
Other	**(4,182)**	1,453
Increase in temporarily restricted net assets, controlling interest	**66,834**	24,617
Permanently restricted net assets, controlling interest:		
Contributions	**5,298**	5,759
Investment return	**(1,706)**	(27)
Contributions from business combinations	**2,363**	-
Addition to Credit Group [1,5]	**56,924**	-
Other	**(1,243)**	(4,412)
Increase in permanently restricted net assets, controlling interest	**61,636**	1,320
Increase (decrease) in net assets	**935,482**	(75,205)
Net assets, beginning of period	**16,470,841**	16,546,046
Net assets, end of period	**$17,406,323**	$ 16,470,841

[6] Includes net distributions of $105,978, comprised of distributions of $174,413 and contributions of $68,435 for the year ended June 30, 2016 and net distributions of $75,117, comprised of distributions of $107,382 and contributions of $32,265 for the year ended June 30, 2015, attributable to the Alpha Fund.

Ascension

Schedule of Credit Group Cash and Investments

(Dollars in Thousands)

The Credit Group's cash and investments at June 30, 2016 and 2015, are presented in the table that follows. Total cash and investments, net, includes both the Credit Group's membership interest in the Alpha Fund as well as the noncontrolling interests held by other Alpha Fund members. Credit Group unrestricted cash and investments, net, represent the Credit Group's cash and investments excluding the noncontrolling interests held by other Alpha Fund members and assets limited as to use.

	June 30,	
	2016	**2015**
Cash and cash equivalents	**$ 676,338**	$ 369,707
Short-term investments	**120,139**	107,148
Long-term investments	**14,995,607**	14,825,293
Subtotal	**15,792,084**	15,302,148
Other Alpha Fund assets and liabilities:		
In other current assets	**27,768**	28,356
In other long-term assets	**2,335**	2,491
In accounts payable and accrued liabilities	**(9,312)**	(9,035)
In other noncurrent liabilities	**(4,569)**	(3,256)
Due from brokers, net	**208,057**	17,804
Total cash and investments, net	**16,016,363**	15,338,508
Less noncontrolling interests of Alpha Fund	**1,256,666**	1,405,401
Less interest in investments held by Ascension on behalf of:		
Alexian Brothers	**453,093**	373,833
St. John Health System	**282,347**	400,789
Ministry Health System	**-**	669,549
Credit Group cash and investments, net including assets limited as to use	**14,024,257**	12,488,936
Less assets limited as to use:		
Under bond indenture agreements	**2,910**	2,910
Self insurance trust funds	**675,762**	705,134
Temporarily or permanently restricted	**566,308**	472,628
Credit Group unrestricted cash and investments, net	**$ 12,779,277**	$ 11,308,264

Ascension

Schedule of Credit Group Statistical Information (unaudited)

(Dollars in Thousands)

	Year Ended June 30, 2016	Year Ended June 30, 2015
Total Available Beds	**18,683**	15,841
Total Patient Days	**4,179,141**	3,833,805
Total Discharges	**693,075**	624,350
Average Length of Stay	**6.03**	6.14
Total Outpatient Visits	**24,104,285**	20,190,989

The percentage of net patient service revenue, less provision for doubtful accounts, earned by payor for the years ended June 30, 2016 and 2015, are as follows:

	Year Ended June 30, 2016	Year Ended June 30, 2015
Medicare - traditional and managed	**36 %**	37 %
Medicaid - traditional and managed	**13**	11
Commercial and other managed care	**50**	50
Self-Pay and other	**1**	2
	100 %	100 %

Significant concentrations of accounts receivable, less allowance for doubtful accounts, at June 30, 2016 and 2015, are as follows:

	June 30, 2016	June 30, 2015
Medicare - traditional and managed	**28 %**	27 %
Medicaid - traditional and managed	**9**	9
Commercial and other managed care	**43**	43
Self-Pay and other	**20**	21
	100 %	100 %

Tab 11

Attachment Section B-G

Self Pay or Uninsured Care Policy

Financial Assistance Policy

http://www.sthealth.com/locations/saint-thomas-highlands-hospital/patients-and-visitors/admitting-and-registration

Admitting and Registration

Patient Registration/Admitting

Saint Thomas Highlands Hospital's Patient Registration Department welcomes you to our facility and will work to ensure your admission process will be a smooth and easy process. Our services also include Same Day Pre-Registration and Scheduling.

Pre-Admitting

From your provided insurance information, our department verifies and secures authorization for any surgical procedure(s) that your insurance company requires. If any problems occur while obtaining authorization, you will be notified prior to procedure. The Pre-Admitting Department hours of operation are Monday – Friday, 6:00 a.m. – 5:00 p.m. and may be reached at (931) 738-9211.

Scheduling

Procedures to occur in Same Day Surgery and/or Imaging Department of Saint Thomas Highlands Hospital can be scheduled by calling **(931) 738-9211**.
Patients registering at Saint Thomas Highlands Hospital should have all of their pertinent information available for registration.

This should include:

- Social Security Card
- All active insurance cards
- Picture ID
- Living Will, if available
- Durable Power of Attorney, if available

If a valid insurance card is presented at the time of service, we will accept your insurance and bill the charges to your insurance carrier, regardless of the amount. However, you are responsible to pay any deductible and/or co-payment amounts as specified under the schedule of benefits of your insurance coverage. Payment of these amounts will be requested at the time of service.

You may determine the co-payment or deductible amounts you are responsible for by contacting the claims service phone number of your insurance company or the personnel (human resources) director at your place of employment.

Self Pay or Uninsured Patients

If you are not covered under a healthcare plan, you will receive the same care as insured patients. The quality of care our patients receive is not determined by their ability to pay. You will be asked to pay the full amount of your charges or cash deposit at the time of discharge. If you cannot make a cash deposit, we will ask you to speak with a financial counselor to discuss a plan for paying your bill.

http://www.sthealth.com/locations/saint-thomas-highlands-hospital/patients-and-visitors/admitting-and-registration

Outpatient Services

We consider that a 45-day period after billing is more than a reasonable time for your insurance carrier to pay your bill. If we do not receive payment from your insurance within 45 days, you will be billed for the services rendered and contacted by a representative of our office to intervene and request payment from your insurance company. If payment is not received within an acceptable timeframe, you will be held responsible for the balance in full. Please note your contract is with your insurance company and you and not with the hospital.

In the event your insurance carrier submits payment after you have paid, the overpayment will be applied to any balance(s) outstanding, with the excess refunded to you.

http://www.sthealth.com/locations/saint-thomas-highlands-hospital/patients-and-visitors/hospital-bill-pay

Hospital Bill Pay

We offer a convenient way to view your statement or make payments on your hospital bill by credit card. Simply click on the following link and you will be re-directed to a secure website. This method is secure and will allow you to pay your bill in full or in part, based upon the arrangements you have made with the hospital business office.

Click here to view or pay your hospital bill online.

As with any provider of healthcare, such as your doctor or drugstore, we request you pay your up-front deductibles and co-pays at the time of service. The cost of operating a hospital is very high, as we have significant payroll and overhead obligations. We are glad to work with you in any way we can to help you with understanding or paying your bill. If you cannot pay your bill at the time of service, we are glad to work out a payment plan for you. You can call the hospital business office at anytime between 9:00 a.m. and 4:00 p.m., Monday through Friday, excluding holidays.

FINANCIAL ASSISTANCE PROGRAM

Financial assistance is available to you if you do not have insurance and you do not qualify for state or federal assistance.

Our **FINANCIAL ASSISTANCE PROGRAM** is available as follows:

- If you are under-insured (you do have some form of insurance coverage for health care services but such coverage is insufficient to pay your current bill). An example of this would be an insurance policy that does not cover maternity benefits.
- If you are uninsured (you do not have health insurance and are not eligible for Medicare, Medicaid or public assistance).

A **FINANCIAL ASSISTANCE APPLICATION** must be completed by you in order to assess your eligibility for this program. In addition, we will verify that you do not have insurance or your insurance does not cover your stay at our hospital.

If you receive financial assistance from our Financial Assistance Program, we will ask you to sign an agreement to pay the reduced portion of your bill in monthly installments. We will be glad to work with you on the amount of the monthly payments.

The **FINANCIAL ASSISTANCE APPLICATION** requires income verification which includes at least two (2) documents from the following list.

- Most recent State or Federal Income Tax Return

http://www.sthealth.com/locations/saint-thomas-highlands-hospital/patients-and-visitors/hospital-bill-pay

- Employer Pay Stubs for the last two months
- Written documentation from income sources
- Copies of all bank statements for the last three months
- Current credit report (which we can obtain based on your authorization)

Please contact the hospital business office at **(931) 738-9211** for more information on our Financial Assistance Program. You can apply for this program prior to your date of service and up to 4 months after your date of service. Prior to calling the business office, it would be helpful if you had gathered at least two of the documents noted above.

Tab 12

Attachment Section B-C2

Medical Director Qualifications

Medical Director Agreement Renewal

JUN 14 '17 PM 3:48

Lanny Michael Leftwich, Jr. M.D.

Board Certified Psychiatrist

1936 Forest Circle, Cookeville, TN 38506
931-644-2460

- CURRENT EMPLOYMENT

May 2007-Present	**Bradford Health Systems** - Medical Director of Substance Rehab Program
June 2005-Present	**Valor Healthcare/Corporate Health & Wellness** - VA Contract Staff Psychiatrist Humana/→ (contract has changed to each of the above contracting agents)

- PAST EMPLOYMENT

2011 - Feb 2014	Oakpoint Geropsych Hospital - Interim Medical Director @ various times PRN
Feb 2008-Sept 2009	**Generations Mental Health Ctr** - Medical Director of Community MH Clinic
June 2005-Sept 2007	**Psychiatric Assoc of the Cumberlands, PLLC** - Founder and Medical Director of Private Psychiatric Firm
Oct 2002-June 2005	**Centerstone Behavioral Health** - Staff Psychiatrist
May 2001-Oct 2002	**Cherokee Health Services** - Staff Psychiatrist
July 1997-May 2001	**Palmetto Health Alliance** - Psychiatry Resident
	Bryan Psychiatric Hospital - Physician Moonlighting
	Hall Psychiatric Institute - Physician Moonlighting
1991-1993	**Cookeville General Hospital** - Phlebotomist
1990-1991	**Deloitte & Touche** - Tax Staff (Certified Public Accountant)

- EDUCATION

Residency	University of South Carolina - completed 2001
Medical	University of Tennessee, Memphis, TN Doctor of Medicine, May 1997
Undergraduate	Tennessee Technological University, Cookeville, TN Bachelor of Science in Accounting, July 1986-May 1990 (Certified Public Accountant - 1991)

- HONORS AND EXTRACURRICULAR ACTIVITIES

Post Medical	Finance Committee - local Church Enrollment Mgmt Committee - local school system
Medical	Residency Selection Committee Professionalism Committee Peer Counselor to first year medical students American Psychiatric Association Member

RENEWAL OF AGREEMENT OR CONTRACT
(Capella 110) (Rev. 3/13/06)

This **RENEWAL**, dated 26th day of March, 2015, is attached to and incorporated into that **Professional Services Agreement** (hereinafter "Original Agreement") dated the **30th** day of **April, 2014**, by **White County Community Hospital, LLC d/b/a Highlands Medical Center** (the "Facility") and **Lanny Leftwich, M.D.** ("Physician").

WHEREAS, the parties hereto mutually desire to extend the term of the Original Agreement on terms and conditions set forth herein;

NOW, THEREFORE, it is agreed as follows:

1. The Original Agreement is hereby readopted and reaffirmed and its terms and conditions are incorporated herein by reference (check and complete one box, as appropriate):

   1.1 ☒ No other term, condition or requirement of the Original Agreement is hereby modified or amended except as provided in paragraph 2 below.

   1.2 The Original Agreement is amended in the following manner:

   _____

   _____

   _____

2. The term of the Original Agreement is hereby extended for an additional period commencing upon the expiration date of the Original Agreement and ENDING on **April 30th, 2018**.

3. Interim final rules published March 26, 2004, in Federal Register Vol. 69, No. 59, 42 CFR'411.357 (d)(1)(ii) implementing 42 USC '1395nn *et seq.*, require entities with which physicians or their family members have financial arrangements to cross-reference all such agreements for ease of audit purposes.

   3.1 ☒ NO CHANGES. There are no changes to the prior cross-reference addendum;

   3.2 UPDATED LIST. The following list constitutes all agreements existing as of the date of this Renewal Agreement between the Facility and the Physician or the Physician's family members:

Name of Contract Party	Relation to Physician Source of Referrals	Description of Contract	Start of Term	End of Term

4. Physician agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA") and any current and future regulations promulgated thereunder including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Part 142 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements." Physician agrees not to use or further disclose any Protected Health Information (as

defined in 45 C.F.R. Section 164.501) or Individually Identifiable Health Information (as defined in 42 U.S.C. Section 1320d), other than as permitted by HIPAA Requirements and the terms of this Agreement.

Physician will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations.

5. Neither this Renewal Agreement nor any amendment or modification hereto shall be effective or legally binding upon Facility, or any officer, director, employee or agent thereof, unless and until it has been reviewed and approved in writing by a Senior Vice President of Facility's owner and by Facility's Legal Counsel.

6. **CERTIFICATE.** By signature hereto, the Facility CEO hereby certifies that the Original Agreement as amended covers all services to be rendered, that the compensation, including any bonuses, is at fair market for identifiable services and not determined in a manner based upon volume or value of referrals, that production bonuses, if any, exclude ancillary services and that there are no side agreements.

PHYSICIAN:

Lanny Leftwich, M.D.

By: _____

Name: Lanny Leftwich

Title: Medical Director

Date: 3/26/15

FACILITY:

White County Community Hospital, LLC d/b/a Highlands Medical Center

By: _____

Name: Bill Little

Title: Chief Executive Officer

Date: 3-26-15

Tab 13

Attachment Section B-C2

Quality Management Plan

Utilization Management – Continuum of Care Plan

Saint Thomas Health

STRATEGIC QUALITY MANAGEMENT PLAN
FISCAL YEAR 2017

INTRODUCTION

Rooted in the loving ministry of Jesus as healer, we commit ourselves to servicing all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care that sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

Saint Thomas Health (STH) is committed to the delivery of outstanding, patient-centered healthcare with a focus on service to the poor and vulnerable. That commitment is the key characteristic of care delivery and arises from safe and clinically effective care, efficiently and compassionately delivered for each patient and family. Equally important to STH is the optimization of provider experience. This emphasis is reflected in collaborative administrative and clinical engagement in governing healthcare delivery with a focus on efficient clinical workflows which enhance provider efficiency, effectiveness, and resource stewardship.

The Quality Strategy is based on the concept that predictable, scalable, and sustainable provision of quality care across the continuum can only be delivered by highly reliable healthcare processes, applied across all components of a clinically integrated system of care. This requires:

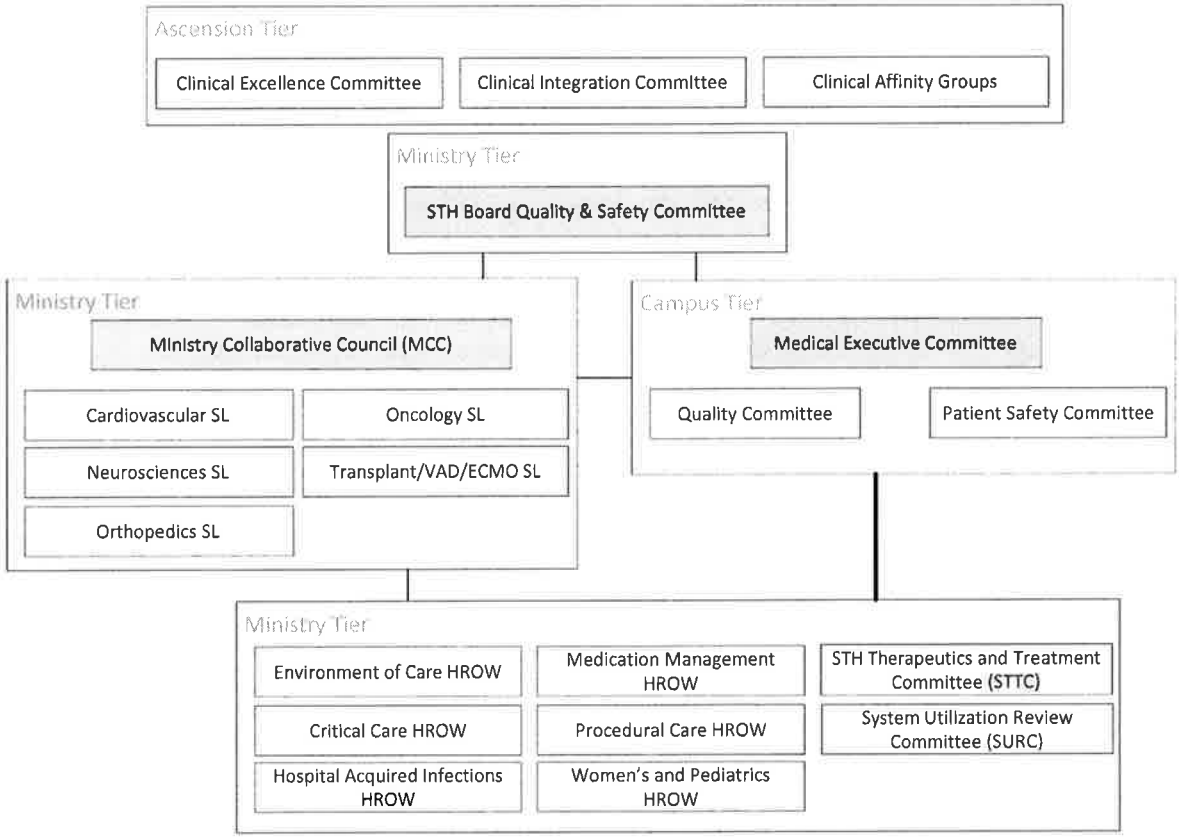
- Commitment to person-centered care
- Broad cultural understanding of, and commitment to, high reliability principals
- Development and application of evidence-based medicine (EBM)
- Design of standardized clinical care workflows that leverage health information technology (HIT) in a manner that enhances provider efficiency while broadly enabling, and where appropriate automating, uniform EBM applications across populations
- Use of HIT that enhances patient and consumer engagement
- Data management strategies that facilitate rapid-cycle clinical and operational process improvement
- Accountability for understanding and applying structured methodology for continuous clinical process evaluation and improvement
- Clinical and administrative partnerships focused on exceptional patient care and supporting the associates providing that care

STRUCTURE AND RESPONSIBILITY

The STH quality infrastructure is focused on multidisciplinary clinical engagement that spans the entire ministry and continuum of care. The goals of the STH Quality include:

- Establishing a ministry-wide structure that integrates into existing campus based processes
- Increasing physician engagement and ownership of Quality governance, definition of EBM standards, and reduction in care variability
- Increasing alignment between STH Quality and Ascension Health Quality priorities
- Providing system level oversight with respect to STH performance against quality targets
- Narrowing the scope of Quality initiatives to those identified as high impact/high priority
- Accelerating speed to delivery of Quality improvement
- Development of Service Line Quality to support growth and expansion
- Collaborating with Joint Ventured and affiliated entities to assure quality throughout the continuum of care

The STH Quality Infrastructure is shown below.



Board of Directors—The Board of Directors reviews and evaluates patient care activities to assess, preserve, and improve the overall performance, safety and efficiency of patient care

and services in the Hospital. While maintaining overall responsibility, the Board delegates operational authority to the MCC, MECs, Medical Staff, and Senior Leadership. In exercising its supervising responsibility, the Board:

- Provides resources/support systems for quality management functions related to patient care, safety, and risk mitigation.
- Receives reports on the findings, actions, and results of quality management activities.
- Approves actions taken.
- Recommends further actions and/or follow up.

The Ministry-level groups have established communication channels between their campus level and Ascension level analogs, enhancing collaboration across all levels of the corporate quality infrastructure. The Ministry-level Quality infrastructure tiers consists of:

- Ministry Collaborative Council (MCC)
- High Reliability Organization Workgroups (HROW)
    - Medication Management HROW
    - Procedural Care HROW
    - Environment of Care HROW
    - Hospital Acquired Infections HROW
    - Critical Care HROW
    - Women's and Pediatrics HROW
- Service Lines
- STH Therapeutics Council (STTC)
- System Utilization Review Committee (SURC)

Each of these groups has either clinical/administrative dyad leadership or administrative/physician subject matter expert leadership. The groups are composed of cross-system physician, nursing, Quality, Performance Improvement, IT and operational/finance representatives, supporting multi-disciplinary contribution to the establishment of consensus system quality standards. Additionally the MCC has non-clinical community representation. The Ministry tier groups have an over-arching function to assure standardized practice and operational performance throughout the ministry. Brief descriptions of each group and their major functions are provided below:

- MCC – The MCC is a multi-disciplinary group comprised of MEC member physician leaders from each campus and senior administrative leadership. The MCC has dyad physician/administrative leadership and serves as the Quality Council for STH. MCC responsibilities include:
    - Monitoring of overall STH performance relative to locally and nationally defined quality metrics
    - Aligning STH clinical and quality resources with Ascension Health quality improvement priorities
    - Evaluation and prioritization of STH resource allocation across the scope of STH quality initiatives

- Provide executive sponsorship for HROWs
- Provide assistance, as necessary, in reaching policy and procedure consensus within the HROWs

- HROWs – The HROWs are a suite of workgroups that serve as subcommittees for the MCC, each focused on a subset of high priority Ascension Health Quality initiatives. These workgroups are each facilitated by one of the campus CMOs, CNOs or Ministry CQO and led collaboratively with physician subject matter experts from all campuses. The HROWs are the primary site for the development and refinement of specific quality improvement initiatives. HROW responsibilities include:
  - Development of consensus around clinical evidence used to deliver EBM
  - Development of system policies guiding clinical application of EBM at the point of care
  - Design and review of health information technologies that expose and support EBM guidelines within the clinical workflow
  - Recommending clinical outcomes metrics and EBM protocol compliance metrics used to gauge success of quality improvement initiatives
  - Ensure communication to MCC, STTC, Campus MECs and Campus Quality Committees

- Service Lines – Supporting the STH Strategic plan to develop specific service lines into Centers of Excellence, the following lines have been identified for quality development and other service lines may be added as the need is identified:
  - Cardiovascular
  - Neurosciences
  - Oncology
  - Orthopedics
  - Transplant/VAD/ECMO

  Each service line will be led by a clinical and administrative dyad and will be supported by Quality, Performance Improvement, and Performance Analytics. Individual service lines responsibilities include:
  - Identification of and participation in performance improvement initiatives
  - EBM protocol development specific to that service line
  - Design and review of health information technologies that expose and support EBM guidelines within the clinical workflow
  - Analysis of causative factors for serious safety events and near misses occurring within the service line
  - Ensure communication to Quality and Patient Safety Committee of the STH Board, MCC, and Campus MECs

- STTC – The STTC is a multi-disciplinary group comprised of physician subject matter experts and administrative leadership from all campuses. The STTC has dyad physician/administrative leadership and serves as the Pharmacy and Therapeutics Council for STH. STTC responsibilities include:

- Ensures STH alignment with Ascension National Quality initiatives/goals as conveyed by Ascension National Quality leadership groups (AH Clinical Excellence Committee, AH Therapeutics Affinity Group)
- Sponsor implementation of system standards for pharmacy and medication management processes that impact quality and patient safety; formulation of supporting system-wide policies
- Provide oversight and direction of Health Information technologies that intersect pharmacy and clinical medication management processes and impact quality of care and patient safety
- Provide oversight of STH performance against pharmacy and clinical medication management outcome metric targets
- Communicate with the STH Quality and Patient Safety Committee of the STH Board, MCC, HROW, MECs, and Campus Quality Committees

- System Utilization Review Committee (SURC) — The SURC is a multi-disciplinary group comprised of physician representation delegated by the MECs, Care Management, Revenue Cycle Management, and Finance. SURC responsibilities include:
  - Ensure the quality, appropriateness, and efficiency of care and resources furnished by the health system, facilities, and their medical staffs
  - Promote and support effective and efficient utilization of the facilities and services provided through an on-going monitoring program
  - Identify and review problematic patterns of over-, under-, and inefficient utilization of resources.
  - Evaluate disease specific care paths to reduce readmissions and identify disparities of care that could impact readmissions
  - Develop and incorporate practical solutions to resolve these identified inefficient and/or unnecessary practice patterns.
  - Communicate with the STH Quality and Patient Safety committee of the STH Board, MCC and MECs

At the Campus tier, the responsibility of oversight of quality and patient safety is delegated by the STH Board to the MECs. The Medical Staffs participate in developing indicators to systematically evaluate care. The MECs review results of ongoing monitoring and evaluation of patient care. Each campus has a Quality Committee and Patient Safety Committee. The major function of each multidisciplinary group is listed below:

- Quality Council
  - Overseeing the design of systematic, coordinated, and continuous quality initiatives
  - Fostering an organization-wide commitment to performance improvement, patient safety, and risk management
  - Establishing performance improvement priorities in each department within the facility
  - Assessing the effectiveness of quality initiatives
  - Allocating resources for quality management
  - Assuring that staff are trained in quality management theory and methods

    - Analyzing quality management effectiveness
- Patient Safety Committee
    - Focuses on processes and systems with minimization of individual blame/retribution for involvement in a medical/health care error
    - Holds campus accountable for eliminating or reducing the impact of the safety error in incidences of recurrence
    - Reviews events to identify serious safety events, safety events, and near misses
    - Organizational learning about medical/health care errors to develop and maintain a culture of safety across the campus
    - Sharing of that knowledge to effect behavioral changes in itself and other health care organizations
    - Review and action development for product/equipment recall
    - Review and action development for TJC Safety Alerts

It is essential and part of this Quality Management Plan that the Ministry, campuses, MECs, Quality and Patient Safety Team, Performance Team, and Risk Management are integrated to assure the bi-directional flow of information to appropriate areas within each hospital, between campuses, and throughout the entire Ministry.

HIGH RELIABILITY/CONTINUOUS PROCESS IMPROVMENT

Continuous clinical process improvement (CPI) is the driver of highly reliable health care delivery. STH has utilized CPI methodologies (Lean/A3/PDCA) to pursue clinical and business process redesign. CPI methodologies are formally integrated into all quality initiatives. All departments and associates participate in performance improvement. A coordinated and integrated approach is utilized to attain an effective, efficient performance improvement system. CPI represents a systematic approach to improvement. It gives teams a practical model and set of tools for analysis and redesign of work processes.

Implementation of process management is carried out through the following steps:

- Identifying the priority process(s) for improvement
- Defining the boundaries of the identified process(s)
- Clarifying the process(s) and identifying causes of variability
- Collecting and analyzing data (targeted study/on-going monitoring)
- Identifying ways to redesign the process, controlling variability, and measuring process performance
- Communicating and implementing improvement activities, and
- Evaluating the effectiveness of actions taken based on results.

The Chief Medical Officer Council will oversee the setting of priorities for performance improvement activities that cross multiple facilities. The council will evaluate each opportunity and direct appropriate actions. Quality Management activities may be re-prioritized by the CMO Council based on results, needs and resources.

DATA COLLECTION, MONITORING, AND EVALUATION

- Data Collection – STH participates in multiple nationally recognized databases and registries. This participation allows STH to benchmark against organizations of similar size and case mix index and promotes continual growth and improvement.

  Each campus measures its performance, key functions, and processes through the establishment of a systematic process for data collection. Important functions and processes of care are selected on the basis of which most significantly impact patient care in review of opportunity sources and other entities. These may be included, but not limited to the following:
  - Problem Prone/High Risk/Volume Processes
  - Utilization Review and Risk Management Findings
  - Results of ongoing activities designed to control infections
  - Safety of care environment
  - Importance to patient/customer
  - Impact on the dimensions of performance which might include, but not limited to diagnosis, treatments, processes, and other activities directly affecting patient care

- Ongoing Systems Analysis – Utilizing tracer methodology, a collaborative team systematically evaluates processes designed to deliver safe, quality care. Hospital patients and systems are traced to evaluate compliance with established requirements, to validate the effectiveness of current processes, and to maintain an effective program for identifying opportunities for improvement.

- Ongoing Systems Analysis is performed monthly rotating between campuses and hospital departments to ensure a comprehensive Ministry-wide assessment. Findings are reported to leadership for development of process improvement. Follow-up tracers are completed at a later date to ensure compliance with the stated goal.

- Root Cause Analysis (RCA) –Root Cause Analysis is a process for identifying the basis or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. Staffing effectiveness is evaluated within the process of the Root Cause Analysis. The RCA method involves studying a process to learn in greater detail how it is performed, how it can malfunction, and how errors occur. In the event that a significant undesirable performance or variation is detected or suspected, Root Cause Analysis is initiated. Root Cause Analysis is performed, at a minimum, for any reportable serious adverse event.

- Failure Mode and Effects Analysis (FMEA) – At least every 18 months, STH selects at least one high risk process for proactive assessment. Selection of the process is based in part on information published periodically by the Joint Commission about frequently occurring types of sentinel events and processes that pose high risk to patients. Processes that have the greatest potential for affecting patient safety are the primary focus for risk assessments. Processes are designed with a focus on quality and reliability to achieve

desired outcomes and protect patients.

The FMEA process identifies undesirable variation in processes reviewed and identifies the possible effects on patients (seriousness of the effect). Redesign of processes and systems protect and prevent the effects of the failure mode. The redesigned process will be tested and implemented with effectiveness evaluated. Strategies for maintaining the effectiveness of the redesign (over time) will be established.

RISK MITIGATION

The Risk Management Department is charged with the responsibility for implementation and coordination of the risk mitigation. The Risk Management Department works collaboratively with Quality and Patient Safety and Performance Improvement to limit risk throughout the Ministry. Risk Management has the ability to cross lines of accountability and to influence and/or change behavior of individuals within each hospital.

Risk Management responsibilities include, but are not limited to:

- Reviewing all occurrences, events, and investigative reports; investigation of serious incidents; trending of data; recommendation of corrective action needed; and continued monitoring to evaluate the effectiveness of actions taken.
- Reporting specific occurrences in accordance with federal, state and other regulatory requirements.
- Reporting trended data to the governing body, appropriate facility committees, appropriate departments, and involved individuals.
- Participating in review of ethical issues.
- Identifying and correcting unsafe conditions and practices across all departments of the Ministry.
- Working with insurance carriers for the purpose of reporting potential claims (including but not limited to professional liability, general liability, property, and auto damage) and participating in the management of claims in accordance with current Ascension Health guidelines.
- Management of associate safety

REPORTING OF INFORMATION RELATING TO MEDICAL/HEALTH CARE ERRORS

STH utilized the Event Reporting System to collect and review safety events occurring in the Ministry. The system is utilized to assist in risk identification, risk analysis, and risk reduction. An ongoing evaluation and analysis of the reported events is conducted and appropriate actions initiated when opportunities for improvement are identified.

All associates are educated regarding the need for reporting events and near misses and the use of the Event Reporting System.

External reporting of unanticipated adverse outcomes will be directed within the guidelines and standards of appropriate regulatory agencies (i.e., TJC, TDH, etc.).

CONFIDENTIALITY

STH has established a Patient Safety Organization (PSO). The data, reports, and committee minutes generated by quality improvement activities, peer review, and risk management are confidential, statutorily privileged, and will be made accessible only to those individuals who participate in the process and to those agencies responsible for ascertaining the existence of ongoing and effective performance improvement and risk mitigation programs.

Committee members are made aware that any and all data reviewed by them is held in strict confidence. Any breach of this confidence may result in disciplinary action.

The proceedings and records of the hospital and medical staff committees are not subject to discovery or admissible as evidence in a court of law.

RETENTION OF RECORDS

Quality Management data will be retained for a minimum of three (3) years.

Current Status: *Active*

PolicyStat ID: *2771114*

Saint Thomas Health

Effective:	*11/2001*
Last Reviewed:	*02/2016*
Last Revised:	*02/2016*
Next Review:	*01/2017*
Owner:	*Teresa Maxwell: Mgr, Care Management*
Section/Dept:	*Provision of Care, Treatment, and Services*
References:	
Applicability:	*Saint Thomas_Highlands Hospital*

Utilization Management/ Continuum of Care Plan

SCOPE:

Saint Thomas Highlands Hospital, in accordance with the requirements of the Health and Human Services Conditions of Participation, Centers for Medicare and Medicaid Services (CMS) guidelines, and Standards of The Joint Commission, delineates its Plan for Utilization/Case Management. The plan contains references to both utilization management and case management. Utilization/Case Management applies to the staff and committee responsible for the Utilization/Case Management program and reflects the broader scope of efforts to effectively manage resource utilization. Utilization/case management reflects to the actual process of reviewing patient care. This plan has been developed and approved by the Quality Improvement Council, the Medical Executive Committee, and the Board of Trustees.

The Board of Trustees has the ultimate responsibility for review of the quality, appropriateness and medical necessity of admissions, continued stays, and supportive services. It delegates specific functions to the Medical Staff to develop and implement a comprehensive Utilization/Case Management Plan. The Medical Staff and Board of Trustees approval of the plan verifies acknowledgement of this responsibility. The Utilization/Case Management Plan is under the direction of the Clinical Utilization Committee. The Committee shall review the plan annually for its scope and objectives.

PURPOSE:

The purpose of the Utilization/Case Management plan includes:

1. To assess and improve the delivery of quality care to all patients, regardless of payment source, in an efficient and cost-effective manner.
2. To delineate the methods for conducting reviews of appropriateness and medical necessity of admissions, continued stays, supportive services, and discharge planning.
3. To assist in the promotion and maintenance of high quality care through analysis, review, and evaluation of clinical practices within the Hospital.
4. To assure continuity of patient care and address over/under utilization and scheduling of resources.
5. The appropriateness, clinical necessity, and timeliness of support services provided directly by the hospital or through referral contracts through concurrent review.

POLICY:

CLINICAL UTILIZATION COMMITTEE

A. **Organization:**
The committee will be composed of two (2) or more physicians of the active staff representing the admitting services of the medical staff and assisted by other professional personnel. The Physician Advisor will be a member of the committee.

Representatives from Administration, Health Information Management, Case Management, Performance Improvement, Infection Control, Pharmacy, and Nursing shall attend committee meetings. When the committee makes a physician recommendation the decision of practice considerations will be referred to the Medical Executive Committee for action where collaboration can occur between the medical staff leaders.

Upon invitation from the Chairman other representatives of the hospital or medical staff may attend meetings. The Chairman and other designated members of the Committee shall serve as Physician Advisor if there is not an appointed advisor available.

B. **Responsibilities:**
Responsibilities of the Committee include:

1. To develop, maintain, and execute an effective Utilization/Case Management
2. Plan; review and revise the plan as necessary, and assure the functions required by the plan are continuously performed and documented in a proper and timely manner.
3. To provide efficient utilization of beds and supportive services through concurrent and retrospective reviews of the necessity for inpatient admissions, appropriate duration of stays, and timely appropriate use of diagnostic/therapeutic services.
4. To effect the development of a plan whereby patients receive needed care delivered in an efficient cost-effective manner. This process assures quality of care in conformity with criteria of optimal use as determined by the medical staff. Any quality concerns identified in the review process are referred to Quality Improvement Council.
5. To effect the development, maintenance, and execution of the functional elements of the Peer Review Organization Program (PRO) to include: admission request and certification, preadmission request/testing, length of stay review. Discharge planning and retrospective evaluation of performance measured to clinically valid criteria.
6. To review patterns/profiles generated by the peer review organization and hospital, to identify opportunities to improve provision of care, and to initiate appropriate actions.
7. To collaborate and establish criteria, standards, and norms for pre-admission/admission review, and continued stay review.

C. **Meetings:**
The committee shall meet at least quarterly or more frequently as needed.

CONFIDENTIALITY

Confidentiality shall be maintained based on full respect of the patient's right to privacy and in keeping with the hospital policy and the PRO Confidentiality Statement. All employees of Saint Thomas Highlands Hospital or

outside agencies that are involved in the review process will be made aware of the responsibility to maintain confidentiality. The records and reports utilized and/or generated by the committee members are regarded as confidential and both patient and provider privacy will be protected in reports by using coded identification. This committee is part of the performance improvement/quality assurance process for Saint Thomas Highlands Hospital and all records, minutes, and reviews are protected under the medical staff peer review process for quality improvement. The Quality Department shall be responsible for maintaining all such reports. All data shall be considered the property of Saint Thomas Highlands Hospital.

CONFLICT OF INTEREST

A person may not review a case or make final utilization determination if he/she has or is perceived to have a conflict of interest such as having participated in development or executing that patient's treatment plan or is a member of the patient's family. Physician Advisors may not participate in decisions on cases where the Physician Advisor is the attending or consulting physician or where the Physician Advisor's partner, associate, or relative is involved in the care of the patient. The Physician Advisor should not participate in any case in which his/her objectivity may be impaired. No member of the Clinical Utilization Committee may have a financial interest in Saint Thomas Highlands Hospital. It is the responsibility of the member or prospective member to notify the committee of any such interest.

PLAN OF CARE

The attending physician, along with the ancillary personnel, will establish a written plan of care for each patient. This is to be completed within 24 hours of admission by the attending physician or other health care personnel or before authorization for payment.

This care plan will include the following:

1. Diagnosis, symptoms, complaints, and complications indicating reason for admission.
2. A description of the functional level of the individual.
3. Orders for medications, therapy, restorative, and rehabilitative services.
4. Activities
5. Social services and discharge planning.
6. Plans for continuing care as appropriate.

Orders and activities must be developed in accordance with the physician's instructions. Orders and activities will be reviewed and revised as appropriate by all personnel involved in the care of the patient.

METHODS OF REVIEW/REVIEW PROCESS

A. **Who Shall Perform Reviews:**

   1. The reviews falling under this Utilization/Case Management plan for patients in the acute care medical-surgical setting shall be conducted concurrently and/or retrospectively by the Director of Case Management, Case Managers, the Physician Advisor, Executive Health Resources (EHR) and/ or by the Clinical Utilization Committee.
   2. Commercial insurers who request access to medical records for review purposes must present signed consent forms in the Health Information Management Department if the patient has been discharged. If the patient is still in-house, the Case Management Department will verify that the patient's insurance company as designated on their face sheet matches the name of the insurance company that the reviewer is representing.

B. **Selection of Patients to be Reviewed:**
Categories of patients subject to review will be evaluated for medical necessity and appropriateness of continued stay in the acute medical-surgical units of the hospital, and critical care. Patients to be reviewed concurrently include:

1. All inpatients, observation patients, and patients requiring discharge planning assistance from the emergency department and ambulatory Surgery setting regardless of payor source.
2. Any patient where an identified concern is brought to the attention of Utilization/Case Management personnel from any healthcare provider/representatives.
3. Patients requiring procedures that are not available at Saint Thomas Highlands Hospital, needing arrangements with another facility for the procedure.
4. Patients under a targeted DRG, diagnosis, procedure, or focused physician reviews, as designated by the Quality Improvement Council for review.
5. Patients on a sample bases will be reviewed for the medical necessity of admissions, duration of stays, and professional services furnished. The review need only to include for cases that they reasonably assume to be outlier cases based on extended length of stay or extraordinary high costs.

C. **Pre-Certification:**
In accordance with CMS regulation and other third party payers, pre-admission certification is carried out on all scheduled admissions through the Admission/Business office, prior to or at the time of admission. Utilization/Case Management personnel will assist, as needed, in the pre-certificate process.

D. **Admission Review:**
The case manager, using appropriate criteria, conducts initial review within 24 case management business hours or one (1) working day of admission. The criteria utilized by the PRO are utilized by Saint Thomas Highlands Hospital. The admission is screened for medical necessity and appropriateness for acute level of care. The admission may be justified by either meeting both intensity of service and severity of illness criteria or by physician order where the physician documents the medical need for inpatient admission status using two midnights as a baseline. The patient may also be admitted to inpatient status if the stay is authorized as such according to individual commercial insurance/managed care guidelines. If the criteria are met, admission is approved. If the admission cannot be certified using criteria the attending physician is contacted by the case manager for additional information. If the case manager still cannot determine medical necessity the case is then referred to the physician advisor and/or Executive Health Resources (EHR) for review. He/she is asked to make a peer determination as to whether hospitalization is medically necessary within 24 hours. (When there is a delay with support services, verbal contact with the appropriate department is made to expedite appropriate utilization.)

If after reviewing the record and discussing the case with the attending physician, the physician advisor determines that inpatient hospitalization is not required, he/she shall deny the admission.

1. Written notification including statement of party's or parties' right to appeal and method to file, shall be sent to the patient (or his/her representative), the attending physician, the CEO, the Clinical Utilization Committee Chairman, the Business Office, the PRO or its specified designee, and the Director of Case Management on the same day the decision is made.
2. When possible, verbal notification will precede written notification. Notification is issued in the form of an Admission Hospital Notice of Non-Coverage letter.
3. The Case Manager shall complete the Admission Hospital Notice of Non-Coverage letter and the letter shall be signed by the Clinical Utilization Committee Chairman or designee for each admission

that is not certified. The letter shall contain sufficient detail to enable the parties to adequately prepare for reconsideration proceedings if so required. The letter shall also inform the involved persons of their rights to seek reconsideration of the determination. The right to reconsideration shall exist even if the patient has left the hospital before filing a request for reconsideration. The notice shall specify the time period for reconsideration and the procedures for requesting reconsideration. The notice shall specify the time period for reconsideration and the procedures for requesting reconsideration.

At time of admission, the case manager will initiate an individual utilization review worksheet. If the admission criteria are met, the admission is approved. All admission and subsequent patient reviews will be documented on this form until the patient is discharged from hospital.

During admission review on acute medical-surgical unit/units, the case manager will meet with the patient and/or family to initiate an assessment of the patient's discharge planning needs.

Diagnosis/physician concerns, etc. for inappropriate admissions will be presented to the Clinical Utilization Committee by the Director of Case Management or designee. Appropriate supporting data shall be obtained through retrospective profile monitoring. If such areas are identified, methods for their correction or prevention will be considered by members of the Clinical Utilization Committee, including selection of diagnosis and/or physicians for focused review.

E. **Concurrent Review:**

Once the admission is approved, continued stay reviews will be performed by the case managers not less than:

1. Every 48 case management business hours from the previous review date until the time of patient discharge.
2. Additionally, when problems/trends are identified that warrant a more focused review or as required/ requested by regulatory agencies and individual commercial insurance standards.
3. The CMS Geometric Length of Stay (GMLOS) by DRG as published in the Federal Register will be used as a guideline for length of stay comparisons. This may vary depending on the age/disability group of patient.

Patient charts shall be reviewed for the level of service provided and need for continued hospitalization. Each day of the hospital stay will be reviewed using the appropriate criteria as specified in this plan, If the discharge screens are not met the hospital day will be considered justified. When the discharge screening criteria are met there is indication that the patient is stable and can safely be discharged form an acute level of care. If it becomes apparent that further hospitalization is not justified, the reviewer shall contact the attending physician. If the attending physician agrees, he/she shall discharge the patient. If there are undocumented factors which justifies continued stay, the attending physician shall provide documentation and the stay shall be justified. If the attending physician concurs that further hospitalization is not justified but the patient objects to the discharge, the case manager shall issue a hospital- issued notice of non-coverage continued stay denial letter to the patient (or his/her representative). This letter shall be signed by the Chairman of the Clinical Utilization Committee or designee and a copy sent to the attending physician, CEO, the business office, the CFO, the PRO or its specified designee, and the Director of Case Management on the same day the decision is made.

If the discharge screens are met but the attending physician does not agree a referral to the Physician Advisor is made. If the physician advisor considers the continued stay to be inappropriate and attending physicians is not in agreement, the case is automatically referred to the Clinical Utilization Committee. Before making a determination that an admission or continued stay is not medically necessary, the Clinical Utilization Committee must consult the practitioner or practitioners responsible for the care of the patient and afford the practitioner or practitioners the opportunity to present their views. A continued stay denial will not be issued without the agreement of two physicians on the committee. If after review by the second physician a determination is made that denial is appropriate the case manager will notify the patient or family attending physician hospital administration, business office and PRO. Written notification shall include appeal rights. In cases where the physician advisor determines that a Medicaid denial is appropriate he/she will contact the attending physician.

Notice of Adverse Determination: In no case does any part of a denial process mandate that the patient must leave the hospital. It only means necessity for hospitalization will cease the day the notice is issued.

F. **Review of Individual Days of Care:**

Delays in Care, Inefficient Scheduling of Resources:
Utilization related concerns including delays in supportive services are identified through both the case management's pattern analysis and the quality assessment and improvement process.

During the continued stay review process monitoring will occur for avoidable days (i.e. problems with delays/unavailability of hospital services, delays in test results, social or placement problems, missed orders, delays attributed to physician convenience, preference, etc. that lead to unnecessary days of hospitalization). This information will be documented on the case management worksheet and entered into the computer program. Avoidable days will be analyzed by the case management director for patterns or trends. This information will be reported quarterly to the Clinical Utilization Committee and hospital departments in the Avoidable Day Report for appropriate measures to improve the process.

Under Utilization of Services:
Under utilization of services will be screened by the case managers during the concurrent review process.

Patient records will be screened for patient care services that are needed and not ordered and/or provided for. The reviewers will monitor follow-up on abnormal test results and appropriate unit placement. When concerns are identified the case manager will notify the Physician Advisor for immediate intervention.

Re-admissions within 31 days will be reviewed for inappropriate discharged on first admission or complications as a result of the original discharge plan. The case managers will receive a list daily of admissions that were discharged within the preceding 31 days. As patterns/trends are identified they will be reported to the Clinical Utilization Committee.

The case managers will assure discharge plans are met prior to patient discharge. If plans are not met and a discharge order is written the attending physician is contacted. If necessary, the Physician Advisor will assist with intervention. The director of case management will compare data to peer norms to identify any pattern of under utilization by physician or DRG.

Appropriateness of Services:

At the Clinical Utilization Committee meetings, appropriateness review of designated high volume radiology, cardiopulmonary, laboratory, and physical therapy services will be reported. Each department director will report the findings of their review activities to the committee, with concerns, and recommendations for improvement.

Any in-patient order for routine outpatient procedures, such as MRI's, mammograms, bone scans, etc. will be shared with the case managers. These orders are reviewed to approved criteria, where applicable for the procedure. Disputed case considerations will be referred to the Physician Advisor for test considerations and discussion with the ordering physician for clarification of necessity. This information will be reported to the Clinical Utilization Committee on a quarterly basis for their review.

Data Collection, Analysis, and Reporting

The case manager will be responsible for the collection of data to support concurrent review, patient care evaluation studies and profile analysis. The patient record and case management worksheet will include information needed for the committee to perform utilization review:

1. Identification of the patient.
2. The name of the patient's physician.
3. Date of admission.
4. The plan of care required.
5. Initial and subsequent continued stay review dates.
6. Procedures and dates.
7. Justification of emergency admission if applicable.
8. Discharge planning.
9. Discharge diagnosis.
10. Discharge status.
11. Physician Advisor activity.
12. Other supporting material request by the committee

Data shall be gathered manually for admission certification and extended stay reviews on a daily basis via the case management worksheet. Review worksheets shall serve as the data collection tool. Data from the review form will be entered into the Case Management Program for reporting purposes. Reports will be taken to the Clinical Utilization Committee for review, recommendations, and actions. These and other computer-generated reports are evaluated quarterly to detect patterns of inappropriate utilization and evaluate changes in practice patterns. Quarterly summary reports of collected data will be given to the Clinical Utilization Committee for evaluation and action with confidentiality to patient and practitioner specific information.

Medicaid Certification and Re-Certification:

The need for inpatient services for Medicaid patients must be certified within 24 case management business hours of admission. If an individual applies for assistance while in the hospital the certification must be completed before the Medicaid agency will authorize payment. Medicaid patients are reviewed the same as all other reviewed patients.

Re-certification must be made as requested by Medicaid. The certification is placed on the face sheet attached to the case management worksheet.

DISCHARGE PLANNING/SOCIAL SERVICES

Acute Medical-Surgical Unit/Units:

The process of discharge planning begins prior to or at admission for all acute care medical-surgical patients. The case manager screens all patients to assess their potential post-hospitalization needs. They work with attending physicians, patients, and families to assure continuity of care after discharge. Saint Thomas Highlands Hospital maintains an open referral system. The initiation of discharge planning is not delayed until the physician writes an order. Screening and discharge referrals also occur from other health care professionals such as nursing and other ancillary services.

The case manager assesses discharge-planning needs within one working day of the patient's admission and initiates discharge planning if nursing home or rehabilitation placement, durable medical equipment, home health care, hospice, or transportation is needed. Discharge planning activities include provisions for or referral to services required to improve or maintain health status after discharge.

During the process of concurrent review the case manager will reassess discharge-planning needs as necessitated by changes in patient/family condition. The case manager assists those patients in need of additional resources. These include, but are not limited to, financial assistance, emotional support, counseling, and Medicaid and guardianship programs. All discharge planning activities will be clearly documented in the patient's medical record.

CONDUCT OF RECONSIDERATION

The PRO will perform the Conduct of Reconsideration. (Peer Review Organization). Exchange of information will occur between the hospital and the PRO and intermediary.

The hospital shall furnish the PRO/intermediary with written notice of any adverse initial determination made by the hospital regarding items and services furnished any Medicare beneficiary. The written notice shall be in the form of a copy of the letter to the patient advising that Hospital benefits will cease after a specified date. The written notice shall be furnished to the PRO within 24 hours of the decision and to the Intermediary at the time the claim is submitted for processing.

COMMITTEE REPORTS AND RECORDS

The Clinical Utilization Committee shall maintain the minutes and records of each committee meeting and will include the actions taken regarding the admission or continued stay of any patient reviewed, and the reasons for such actions. The committee will report on identified trends associated with over-utilization, under-utilization, and inefficient scheduling of its resources. Copies of such reports and records shall be made available to the committee members, the Hospital CEO, and the Medical Executive Committee. The Clinical Utilization Committee shall make a summary report to the Quality Improvement Council, Medical Executive Committee and Board of Trustees.

The Director of Case Management shall be responsible for maintaining individual and aggregate data with respect to the reviews of acute care patients. He/she shall be responsible for distribution of the reports to appropriate individuals. The Utilization Review process is conducted as part of the Quality Improvement program of the Medical Staff and Hospital. The Case Management Department will maintain copies of all worksheets and other data. All utilization review findings shall be considered confidential.

DEVELOPING A CORRECTIVE PLAN LINKING THE RESULTS TO CONTINUING MEDICAL EDUCATION

When medical staff quality improvement opportunities are identified through concurrent review, recommendations for action shall be the responsibility for the medical staff and shall be documented as part of the continuing education function.

RELATIONSHIP TO THIRD PARTY PAYERS

The hospital is responsible through the case management function are for the process of receiving and presenting claims to third parties, including the fiscal intermediary the basis upon which payment is allowed by the intermediary the conditions under which the intermediary denies claims and the claims appeal data about a case shall be open to review by fiscal intermediaries, state agencies, and the PRO. Information and data shall be protected to assure confidentiality.

HOSPITAL ADMINISTRATION

The hospital administration shall provide assistance to assure the proper functioning of he Case Management Program and that information is properly assembled, forms available, and provision of secretarial assistance, meeting space, and being the liaison with all departments. Administration is responsible for considering and acting upon decisions and recommendations of the case management function with respect to hospital policy, procedures, and staffing.

PHYSICIAN ADVISOR AND REVIEW PERSONNEL

A designated Physician Advisor will be available for at least two hours Monday through Friday, to communicate with the case managers regarding questionable admission and concurrent review cases. This communication will usually be in person at least once each working day and via telephone at other times as necessary. The case managers will seek specific assistance and advice form the physician advisor in the following situations:

1. Whenever the case manager has reason to believe that an admission, continued stay, or ancillary service is not medically necessary based on criteria.
2. Whenever the case manager is unable to make a decision as to whether there is medical necessity for acute care.
3. Whenever there is a question of quality of care being rendered.
4. To assist in the implementation of discharge planning when delayed by either the patient, family, and/or attending physician.
5. To intervene with the attending physician when under-utilization concerns are identified as well as delays in services.

The Physician Advisor has authority to initiate denial of an admission or extension of length of stay (pending PRO review and concurrence when required).

In most instances the Physician Advisor shall render a decision within twenty-four (24) hours as to the approval or denial of an admission or continued stay. The Director of Case Management under the direction of the CFO shall oversee review activities. Case Management review shall be conducted by personnel qualified to follow directives of the Clinical Utilization Committee and to apply PRO criteria and regulations. Sufficient qualified reviewers will be assigned to meet the requirements of reviews.

COLLABORATION WITH RISK MANAGEMENT

During the conduct of concurrent review the case managers or other designated utilization review personnel will screen patient records for risk management concerns (i.e. falls, potential liability, infections, possible safety

issues, etc.). If any concerns are identified through the review process, they will be documented on the review worksheet. When identified, the risk manager will be notified who will investigate and take appropriate action with the hospital administrator and/or the medical staff.

COLLABORATION WITH PERFORMANCE IMPROVEMENT AND/OR THE MEDICAL STAFF

Utilization/Case Management is one of the components of a hospital performance improvement program. During the course of concurrent and retrospective review, the case managers will screen patient records for quality concerns, including those specific events designated by the management review, they will be documented on the worksheet. Case management and quality improvement functions will be integrated as follows:

All quality concerns are referred to the Chief Quality Officer for review by the appropriate medical staff review committee.

If a potential quality issue is identified during the review process and is considered to be of immediate need for correction it will be immediately referred to the physician advisor. He/she will review the patient's medical record and call the attending physician or the hospital Department manager for discussion of the issue. If the attending physician or hospital department manager is unwilling to correct the problem to the satisfaction of the physician advisor, the chairperson of the attending physician's department or administration will be immediately notified; Administration and the risk manager may also be notified.

If a potential quality issue is identified, however, and correction has already occurred, the case will be referred to the Chief Quality Officer for referral to the appropriate Medical Staff Committee or Department Manager. Problem DRG's will have Quality Improvement Teams assigned to evaluate the problem, determine the cause and recommend corrective action. If the Chief Quality Officer or Clinical Utilization Committee identifies a utilization-related problem, this should be relayed to the Quality Improvement Council. For more information on the relationship, refer to the Quality Improvement Plan.

REVISION AND REVIEW

The Utilization/Case Management Plan shall be reviewed annually by the Clinical Utilization Committee and revised as necessary. The Quality Improvement Council, Medical Executive committee of the Medical Staff and the Board of Trustees of the hospital will approve any revision.

PROCEDURE:

Not applicable.

REFERENCES:

The Joint Commission CAMH
CMS Conditions of Participation

All revision dates: 02/2016, 02/2015, 01/2013, 06/2012, 02/2012, 02/2011, 01/2010, 01/2009, 11/2007, 03/2005

Attachments:

No Attachments

Tab 14

Attachment Section B-D1

Hospital License

Board for Licensing Health Care Facilities

State of Tennessee

0000000127

No. of Beds 0060

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SAINT THOMAS HIGHLANDS HOSPITAL, LLC *to conduct and maintain a*

Hospital SAINT THOMAS HIGHLANDS HOSPITAL, LLC

Located at 401 SEWELL ROAD, SPARTA

County of WHITE *, Tennessee.*

This license shall expire MAY 05 *,* 2018 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 18TH *day of* APRIL *,* 2017 *.*

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner, MD
COMMISSIONER

DCF011

Tab 15

Attachment Section B-D1

Award Letter: The Joint Commission

Accreditation Report: The Joint Commission

Re-Visit Report: The Joint Commission

The Joint Commission

March 1, 2017

Robert A. Wachtel
CEO
Saint Thomas Highlands Hospital, LLC
401 Sewell Road
Sparta, TN 38583

Joint Commission ID #: 7909
Program: Hospital Accreditation
Accreditation Activity: Unannounced Full Event
Accreditation Activity Completed: 02/24/2017

Dear Mr. Wachtel:

The Joint Commission thanks Saint Thomas Highlands Hospital, LLC for participating in the accreditation process.

Your organization received Requirement(s) for Improvement during its recent survey. These Requirement(s) for Improvement and follow-up activities have been summarized in the Accreditation Report that is posted on your secure extranet site, The Joint Commission Connect.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

Official Accreditation Report

Saint Thomas Highlands Hospital, LLC
401 Sewell Road
Sparta, TN 38583

Organization Identification Number: 7909

Unannounced Full Event: 2/21/2017 - 2/24/2017

Report Contents

Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process (*Please note, if your survey event resulted in a Preliminary Denial of Accreditation status, other follow-up events may apply*). The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	02/21/2017-02/24/2017

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare Deficiency Follow-up Survey will occur. Please address and correct any Condition Level Deficiencies immediately, as the follow-up event addressing these deficiencies will occur within 45 days of the last survey date identified above. The follow-up event is in addition to the written Evidence of Standards Compliance response.
- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice, and has the potential to impact only one or a very limited number of patients, visitors, staff
- Pattern: multiple occurrences of the deficiency, or a single occurrence that has the potential to impact more than a limited number of patients, visitors, staff
- Widespread: deficiency is pervasive in the facility, or represents systemic failure, or has the potential to impact most/all patients, visitors, staff

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days *(Please note, if your survey event resulted in a Preliminary Denial of Accreditation status, other follow-up events may apply)*. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey
MODERATE/PATTERN, MODERATE/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey
MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
LOW/LIMITED	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate that ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

The Joint Commission

SAFER Matrix

Hospital Accreditation Program

Likelihood to Harm a Patient/Visitor/Staff	Limited	Pattern	Widespread
ITL			
High		IC.02.02.01 EP 2	EC.02.06.01 EP 1
Moderate	MM.05.01.11 EP 2 MS.06.01.05 EP 2 NPSG.03.04.01 EP 5 PC.02.01.03 EP 1 PC.02.01.03 EP 7	EC.02.03.01 EP 1 MM.04.01.01 EP 13	
Low	LS.02.01.10 EP 7 LS.02.01.10 EP 10 LS.02.01.30 EP 11 LS.02.01.30 EP 18 LS.02.01.35 EP 4 LS.02.01.35 EP 6 PC.02.02.03 EP 11	EC.02.03.03 EP 3	

Scope

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. *(Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your organization may need to submit a Plan Of Correction in 10 days or an ESC in 45 days.)* The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

CoP: §482.25 **Tag:** A-0489 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(a)(3)	A-0494	HAP - MM.05.01.11/EP2	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Condition

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.06.01/EP1	Condition
§482.41(b)	A-0709	HAP - EC.02.03.01/EP1	Standard
§482.41(b)(1)(ii)	A-0710	HAP - LS.02.01.30/EP11	Standard
§482.41(b)(1)(i)	A-0710	HAP - EC.02.03.03/EP3, LS.02.01.10/EP7, EP10, LS.02.01.30/EP18, LS.02.01.35/EP4, EP6	Standard

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CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP - IC.02.02.01/EP2

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

Requirements for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.01

Standard Text: The hospital manages fire risks.

Element(s) of Performance:

1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion.

Likelihood to Cause Harm: Moderate
Scope : Pattern

Observation(s):

EP 1
§482.41(b) - (A-0709) - §482.41(b) Standard: Life Safety from Fire

The hospital must ensure that the life safety from fire requirements are met.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service. The kitchen range hood filters contained a lot of grease and other material.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.03

Standard Text: The hospital conducts fire drills.

Element(s) of Performance:

3. When quarterly fire drills are required, at least 50% are unannounced. Fire drills are held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions.
Note 1: When drills are conducted between 9:00 P.M. and 6:00 A.M., the hospital may use alternative methods to notify staff instead of activating audible alarms.
Note 2: For additional guidance, see NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3.

Likelihood to Cause Harm: **Low**
Scope : **Pattern**

Observation(s):

EP 3
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.
This Standard is NOT MET as evidenced by:

Observed in Document Review at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service.
In 5 of 12 fire drill checks, three of the first quarter 2016 fire drills were on Fridays and within two hours, two of the second quarter fire drills were on Tuesday and at 10:00 PM.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01

Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Likelihood to Cause Harm: **High**
Scope : **WideSpread**

Observation(s):

EP 1
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Condition is NOT MET as evidenced by:

Observed in Building Tour at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service.
In 6 of 6 ligature point checks, there was a flexible water line from the wall to the toilet that could be used as an anchor point in all of the behavioral health patient rooms.

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service.
In 2 of 5 patients rooms in geri psych, the surveyor identified a ligature risk existed in the shower with a shower hook. The organization did not identify this in the risk assessment that was provided to the surveyor.

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service.
In 3 of 5 geri psych patient rooms, the surveyor identified ligature risks in the bathroom, identified as grab bars in the shower that were open. This was not identified in the risk assessment that was given to the surveyor.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Likelihood to Cause Harm: High
Scope : Pattern

Observation(s):

EP 2
§482.51 - (A-0940) - §482.51 Condition of Participation: Condition of Participation: Surgical Services
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service. In 10 of 37 Steris Machine documentation strips, in endoscopy the surveyor identified that the steris documentation failed to indicate if the indicator was positive or negative.

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service. During a patient tracer activity in surgery the surveyor identified that a handle to a screw driver in a double peel pack had the inner wrap crinkled.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

7. Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5)

Likelihood to Cause Harm: Low
Scope : Limited

10. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5)

Likelihood to Cause Harm: Low
Scope : Limited

Observation(s):

EP 7
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service. The fire-rated door on the fire-rated wall between Radiology and Nuclear medicine did not close and latch when tested. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure.

EP 10
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service. There was an open four inch sleeve through the fire-rated wall, over the doors in the employee entrance corridor, This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

11. Corridor doors are constructed to resist the passage of smoke, fitted with positive latching hardware, hinged so that they swing, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). Undercuts are no larger than one inch. Roller latches are prohibited. (For full text, refer to NFPA 101-2012: 18/19.3.6.3.1; 19.3.6.3.4; 18.3.6.3.5; 18/19.3.6.4; 18/19.3.6.5; 19.3.6.3.10; 18/19.3.6.3.11)

Likelihood to Cause Harm: Low
Scope : Limited

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7)
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.

Likelihood to Cause Harm: Low
Scope : Limited

Observation(s):

EP 11
§482.41(b)(1)(ii) - (A-0710) - (ii) Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.
This Standard is NOT MET as evidenced by:

Observed In Building Tour at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service.
The suite doors in the OR suite near same day surgery were not equipped with positive latching hardware
The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved: EP 8: Increased Surveillance.

EP 18
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service. There was a 3/4 inch opening, over the doors, in the 1 hour fire/smoke wall near the surgical suite. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2)

Likelihood to Cause Harm: Low
Scope : Limited

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13 -2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3)

Likelihood to Cause Harm: Low
Scope : Limited

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service. There was cable zip-tied to the automatic sprinkler system in the boiler room. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure.

EP 6
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service. There were items stored within 18 inches of the sprinkler deflectors in the OR storage room near the employee bathroom. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.06.01.05

Standard Text: The decision to grant or deny a privilege(s), and/or to renew an existing privilege (s), is an objective, evidence-based process.

Element(s) of Performance:

2. The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:
- Current licensure and/or certification, as appropriate, verified with the primary source
- The applicant's specific relevant training, verified with the primary source
- Evidence of physical ability to perform the requested privilege
- Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
- Peer and/or faculty recommendation
- When renewing privileges, review of the practitioner's performance within the hospital

Likelihood to Cause Harm: Moderate
Scope : Limited

Observation(s):

EP 2

Observed in Credentialing and Privileging at (401 Sewell Road, Sparta, TN) site.
During review of a physician file the surveyor identified that the license was renewed in 2015 and a primary source verification was not done at the time of the renewal.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.04.01.01

Standard Text: Medication orders are clear and accurate.

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

Likelihood to Cause Harm: **Moderate**
Scope : **Pattern**

Observation(s):

EP 13

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site.
In 2 of 6 patient records reviewed, the surveyor identified that the organization did not implement its medication policies. For example the following was identified in the medical record: Morphine PRN, Hydrocodone PRN.
Range orders, Morphine 2-8 mg. every 2-3 hours PRN severe pain.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.11

Standard Text: The hospital safely dispenses medications.

Element(s) of Performance:

2. The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice.
Note 1: Dispensing practices and recordkeeping include antidiversion strategies.
Note 2: This element of performance is also applicable to sample medications.

Likelihood to Cause Harm: Moderate
Scope : Limited

Observation(s):

EP 2
§482.25(a)(3) - (A-0494) - (3) Current and accurate records must be kept of the receipt and disposition of all scheduled drugs.
This Standard is NOT MET as evidenced by:

Observed in Medication Management Tracer at (401 Sewell Road, Sparta, TN) site for the Hospital deemed service.
During the medication management tracer the surveyor identified that the medical surgical unit did not do a narcotic count for the morning shift. This finding was verified by leadership.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.03.04.01

Standard Text: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.

Element(s) of Performance:

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.
Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

Likelihood to Cause Harm: **Moderate**
Scope : **Limited**

Observation(s):

EP 5

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site.
During tracer activity in the ED the surveyor observed a nurse draw up Succinylcholine in a syringe gave it to the doctor to administer and the syringe was not labeled.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.03

Standard Text: The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. *
Note: Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:
- Responsible for the care of the patient
- Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements
- Acting within his or her scope of practice under state law
- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services
Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Likelihood to Cause Harm: **Moderate**
Scope : **Limited**

7. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).

Likelihood to Cause Harm: **Moderate**
Scope : **Limited**

Observation(s):

EP 1

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site.
During a patient tracer in physical therapy the surveyor identified that the organization did not have orders to evaluate and treat the patient . The only order in the medical record was for a physical therapy referral, the patient was receiving TENS and traction.

EP 7

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site.
During a patient tracer the surveyor identified that the organization did not follow the plan of care. For example: the following order was not done: Toradol 30 mg. IV on arrival to PACU.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.02.03

Standard Text: The hospital makes food and nutrition products available to its patients.

Element(s) of Performance:

11. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.

Likelihood to Cause Harm: Low
Scope : Limited

Observation(s):

EP 11

Observed in Individual Tracer at (401 Sewell Road, Sparta, TN) site.
During a patient tracer in surgery the surveyor identified that a refrigerator that contained food for patients was not monitored for three consecutive days.

The Joint Commission

Official Accreditation Report

Saint Thomas Highlands Hospital, LLC
401 Sewell Road
Sparta, TN 38583

Organization Identification Number: 7909

Unannounced Medicare Deficiency Survey: 4/4/2017 - 4/4/2017

Report Contents

Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process (*Please note, if your survey event resulted in a Preliminary Denial of Accreditation status, other follow-up events may apply*). The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	04/04/2017-04/04/2017

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice, and has the potential to impact only one or a very limited number of patients, visitors, staff
- Pattern: multiple occurrences of the deficiency, or a single occurrence that has the potential to impact more than a limited number of patients, visitors, staff
- Widespread: deficiency is pervasive in the facility, or represents systemic failure, or has the potential to impact most/all patients, visitors, staff

SAFER Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey
MODERATE/PATTERN, MODERATE/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey
MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
LOW/LIMITED	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate that ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

The Joint Commission
SAFER Matrix

As a result of the accreditation activity conducted, there were no Requirements for Improvement identified; therefore, the SAFER matrix is not applicable and will not appear within the report.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. *(Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your organization may need to submit a Plan Of Correction in 10 days or an ESC in 45 days.)* The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

As a result of the accreditation activity conducted, there were no Requirements for Improvement identified.

Tab 16

Attachment Section B-D2

Plan of Correction

June 14, 2017

Mr. Robert Wachtel, Administrator
Saint Thomas Highlands Hospital
401 Sewell Dr
Sparta TN 38583

RE: 44-0192

Dear Mr. Wachtel:

The East Tennessee Region of Health Care Facilities conducted a complaint investigation on April 19 - May 1, 2017. A desk review was conducted, based on that review; we are accepting your plan of correction and are assuming that your facility is in compliance with all participation requirements as of June 14, 2017.

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-594-9396 or by fax: 865-594-5739.

Sincerely,

Tamra Turberville/cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT: cw

TN00039426, TN00039629, TN00039755, TN00039886

May 03, 2017

Mr. Robert Wachtel, Administrator
Saint Thomas Highlands Hospital
401 Sewell Dr
Sparta TN 38583

Provider Number: 44-0192

Dear Mr.Wachtel:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Saint Thomas Highlands Hospital on **April 19 - May 1, 2017**. You are requested to submit a Plan of Correction by **May 13, 2017** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to June 15, 2017.

Please submit the Plan of Correction (POC), by May 13, 2017:

State of Tennessee Department of Health
Health Care Facilities
7175 Strawberry Plains Pike, Ste 103
Knoxville TN 37914

Your POC must contain the following:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice.

- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

Department of
Health

Mr. Robert Wachtel
May 03, 2017
Page 2

- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction Form.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If you have any questions, please contact this office at (865) 594-9396 or by facsimile at (865) 594-2168.

Sincerely,

Tamra Turberville RN

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT: cw

Enclosure: CMS-2567

TN00039426, TN00039629, TN00039755, TN00039886

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	440192		C 05/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THOMAS HIGHLANDS HOSPITAL	401 SEWELL DR SPARTA, TN 38583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS During investigations of complaint #39886, #39755, #39629, and #39426 completed on 5/1/17 at Saint Thomas Highlands Hospital, deficiencies were cited related to complaint #39426 under 42 CFR Part 482, Requirements for Acute Care Hospitals.	A 000		
A 021	482.11(a) COMPLIANCE WITH LAWS The hospital must be in compliance with applicable Federal laws related to the health and safety of patients. This STANDARD Is not met as evidenced by: Based on review of facility policy, medical record reviews, and interviews, the facility failed to report allegations of abuse for two patients (#5 and #9) of 11 patients reviewed. The findings included: Review of facility policy Abuse and Neglect of Patients, dated 11/2015, revealed "...Other agencies and organizations may also have obligations to investigate allegations of abuse or neglect. These included various hospital accreditation agencies, as well as local, state, and federal governmental agencies...The Hospital will cooperate and coordinate with these or other agencies as requested and as required by laws and regulations..." Medical record review revealed Patient #5 was admitted to the facility's geriatric behavioral unit on 7/9/16 with diagnosis of Chronic Obstructive Pulmonary Disease with Acute Exacerbation (a	A 021		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	440192		C 05/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THOMAS HIGHLANDS HOSPITAL	401 SEWELL DR SPARTA, TN 38583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 021	Continued From page 1 desease of the lung which has worsened suddenly), Alzheimer's Dementia (a disease of the brain), and Chronic Hypertension (elevated blood pressure). Continued review revealed the patient was discharged to a skilled nursing facility on 7/25/16. Medical record review of a Case Management Assessment note dated 7/13/16 at 9:46 AM revealed "...Pt's son admitted to SW [Social Worker] that he hit the pt [patient] across the face to keep her from pulling out IV [intravenous line] recently..." Interview with Registered Nurse (RN) #2 on 4/24/17 at 10:10 AM, in the Chief Nursing Officer's (CNO) office, revealed she received a telephone call on 7/11/16 from Patient #5's granddaughter and she stated Patient #5 was slapped by the patient's son while in the Emergency Department (ED). Continued interview revealed the incident was not witnessed by any of the ED staff nor was it reported to the facility by the patient. Further interview revealed the incident was reported to Adult Protective Services (APS) and the local police. Continued interview revealed the allegation was not reported to federal or state agencies. Interview with Licensed Medical Social Worker (LMSW) #1 on 4/24/17 at 9L43 AM, in the CNO's office, revealed she remembered the case incident. Continued interview revealed she interviewed the patient's son after the patient's granddaughter reported the alleged abuse and the patient's son admitted he hit the patient (his mother). Further interview revealed the incident was not witnessed by staff and was not reported by the patient to any of the staff. Continued	A 021		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	440192		C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THOMAS HIGHLANDS HOSPITAL	401 SEWELL DR SPARTA, TN 38583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 021	Continued From page 2 interview confirmed the incident was reported to APS and the local police, but the facility failed to report the incident to federal or state agencies. Interview with the CNO on 4/19/17 at 2:30 PM, in her office, confirmed the facility reported the incident to APS and the local police, but failed to report the allegation to federal and state agencies and the failed to comply with applicable laws. Medical record review revealed Patient #9 was admitted to the hospital on 8/19/16 to the Senior Care Unit with diagnosis of Major Neurocognitive Impairment with Psychosis and Behavioral Disturbances. Further review revealed the patient was discharged home in stable condition with her family on 8/31/16. Interview with Social Worker (SW) #2 on 4/24/17 at 9:10 AM, in the CNO's office, revealed Nurse Aide (NA) #2 reported to SW #2 an incident of verbal abuse by NA #1 to Patient #9. Continued interview revealed NA #2 was in the process of termination from employment at the facility for poor job performance when she made the allegation against NA #1, and NA #1 and NA #2 had developed an enmity relationship. Further interview confirmed the allegation of abuse was not reported to federal and state agencies. Interview with RN/Charge Nurse #1 on 4/24/17 at 9:45 AM, in the CNO's office, confirmed the facility failed to report the incident to applicable authorities. Interview with the CNO on 4/24/17 at 11:30 PM, in her office, confirmed the allegation of abuse incident was not reported to federal and state agencies and the facility failed to follow applicable	A 021		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 021	Continued From page 3 laws.	A 021		
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on review of facility policy, review of facility documentation, and interview, the facility failed to protect the rights of 1patient (#11) of 11 patients reviewed. The findings included: Review of facility policy Patient Rights and Responsibilities, dated 4/2013, revealed "...You have the right to private and confidential treatment/personal care, communications..." Review of a facility document "Conversations with [named Nurse Aid]" completed by Registered Nurse (RN) #1, not dated, revealed "...Week of August 15 [2016]...allegation that [Nurse Aid #1] had videotaped a patient screaming in the ICU. [Nurse Aide #1] was called in and said she had audio taped it and this was verified by [RN #3]. There was no video..." Telephone interview with Nurse Aide (NA) #1 on 4/24/17 at 12:05 PM confirmed revealed NA #1 made an audio recording of a confused patient who was screaming. Interview with RN #1 on 4/24/17 at 9:45 AM, in	A 143		

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A 143	Continued From page 4 the CNO's office, revealed NA #2 told her NA #1 recorded a video of a confused patient who was screaming. Continued interview revealed RN #1 interviewed NA #1 and NA #1 admitted to the incident. Further interview confirmed the facility failed to follow facility policy and failed to ensure a patient's right to personal privacy.	A 143		

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	TNP531127		C 05/01/2017

NAME OF PROVIDER OR SUPPLIER: SAINT THOMAS HIGHLANDS HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 401 SEWELL DR, SPARTA, TN 38583

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H1110	1200-08-01-.11 (8) Records and Reports (8) The hospital shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211. This Rule is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to report allegations of abuse for 2 patients (#5 and #9) of 11 patients reviewed. The findings included: Review of facility policy, Abuse and Neglect of Patients, effective date 11/2015, revealed "...Other agencies and organizations may also have obligations to investigate allegations of abuse or neglect. These included various hospital accreditation agencies, as well as local, state, and federal governmental agencies...The Hospital will cooperate and coordinate with these or other agencies as requested and as required by laws and regulations..." Medical record revealed Patient #5 was admitted to the facility's geriatric behavioral health unit on 7/9/16 with diagnosis of Chronic Obstructive Pulmonary Disease with Acute Exacerbation (disease of the lung which worsened suddenly), Alzheimer's Dementia (disease of the brain), and Chronic Hypertension (elevated blood pressure). Continued review revealed the patient was discharged to a skilled nursing facility on 7/25/16.	H1110		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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H1110	Continued From page 1 Medical record review of a Case Management Assessment note dated 7/13/16 at 9:46 AM revealed "...Pt's [patient's] son admitted to SW [Social Worker] that he hit the pt [patient] across the face to keep her from pulling out IV [intravenous] [line] recently..." Interview with Registered Nurse (RN) #2 on 4/24/17 at 10:10 AM, in the Chief Nursing Officer's (CNO) office, revealed she received a telephone call on 7/11/16 from Patient #5's granddaughter, which stated the patient was slapped by the patient's son while the patient was in the Emergency Department (ED). Continued interview revealed the incident was not witnessed by any of the ED staff and the incident was not reported to hospital staff prior to the granddaughter's report. Further interview confirmed the incident was reported to Adult Protective Service (APS) and the local police, but was not reported to the Tennessee Department of Health. Interview with Licensed Medical Social Worker (LMSW) #1 on 4/24/17 at 9:43 AM, in the CNO's office, revealed she remembered the incident. Continued interview revealed she interviewed the patient's son after the patient's granddaughter reported the alleged abuse and the patient's son admitted he hit the patient (his mother). Further interview revealed the incident was not witnessed by staff and the patient did not report the incident to the facility. Continued interview confirmed the incident was reported to APS and to the police, but the facility failed to report the incident to the Tennesssee Department of Health. Interview with the CNO on 4/19/17 at 2:30 PM, in her office, confirmed the facility failed to report the abuse incident to the Tennessee Department	H1110		

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H1110	Continued From page 2 of Health. Medical record review revealed Patient #9 was admitted to the hospital on 8/19/16 to the Senior Care Unit with diagnosis of Major Neurocognitive Impairment with Psychosis and Behavioral Disturbances. Further review revealed the patient was discharged home in stable condition with her family on 8/31/16. Interview with Social Worker (SW) #2 on 4/24/17 at 9:10 AM, in the CNO's office, revealed Nurse Aide (NA) #2 reported to SW #2 an incident of verbal abuse by NA #1 to Patient #9. Continued interview revealed NA #2 was in the process of termination from employment at the facility for poor job performance when she made the allegation against NA #1, and NA #1 and NA #2 had developed an enmity relationship. Further interview confirmed the allegation of abuse was not reported to the Tennessee Department of Health. Interview with RN #1 on 4/24/17 at 9:45 AM, in the CNO's office, confirmed the alleged incident was not reported to the Tennessee Department of Health. Interview with the CNO on 4/24/17 at 11:30 PM, in her office, confirmed the facility failed to follow facility policy and failed to report the alleged incident to the Tennessee Department of Health.	H1110		

May 03, 2017

Mr. Robert Wachtel, Administrator
Saint Thomas Highlands Hospital
401 Sewell Dr
Sparta TN 38583

Provider Number: 44-0192

Dear Mr.Wachtel:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Saint Thomas Highlands Hospital on **April 19 - May 1, 2017.** You are requested to submit a Plan of Correction by **May 13, 2017** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to June 15, 2017.

Please submit the Plan of Correction (POC), by May 13, 2017:

State of Tennessee Department of Health
Health Care Facilities
7175 Strawberry Plains Pike, Ste 103
Knoxville TN 37914

Your POC must contain the following:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice.

- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

Mr. Robert Wachtel
May 03, 2017
Page 2

- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction Form.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If you have any questions, please contact this office at (865) 594-9396 or by facsimile at (865) 594-2168.

Sincerely,

Tamra Turberville RN

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT: cw

Enclosure: CMS-2567

TN00039426, TN00039629, TN00039755, TN00039886

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 000	INITIAL COMMENTS During investigations of complaint #39886, #39755, #39629, and #39426 completed on 5/1/17 at Saint Thomas Highlands Hospital, deficiencies were cited related to complaint #39426 under 42 CFR Part 482, Requirements for Acute Care Hospitals.	A 000		
A 021	482.11(a) COMPLIANCE WITH LAWS The hospital must be in compliance with applicable Federal laws related to the health and safety of patients. This STANDARD is not met as evidenced by: Based on review of facility policy, medical record reviews, and interviews, the facility failed to report allegations of abuse for two patients (#6 and #9) of 11 patients reviewed. The findings included: Review of facility policy Abuse and Neglect of Patients, dated 11/2015, revealed "...Other agencies and organizations may also have obligations to investigate allegations of abuse or neglect. These included various hospital accreditation agencies, as well as local, state, and federal governmental agencies...The Hospital will cooperate and coordinate with these or other agencies as requested and as required by laws and regulations..." Medical record review revealed Patient #6 was admitted to the facility's geriatric behavioral unit on 7/9/16 with diagnosis of Chronic Obstructive Pulmonary Disease with Acute Exacerbation (a	A 021	POC to address Failure to Comply with Laws 1)Every patient has the potential to be a victim of abuse if the facility's staffs are not knowledgeable about the prevention. All management and leadership at Saint Thomas Highlands has been re-educated on the importance of reporting any all allegations of abuse to both Federal and State Agencies in compliance with Federal and State statues. Re-education has been provided on the necessity to report any all allegations of abuse to the Saint Thomas Health Risk Director and Regional Risk Manager. Reporting to all entities will be immediate upon knowledge of the suspected abuse, whether or not the allegation is substantiated. 2)All Staff will be re-educated on prevention and reporting of abuse thru the mandatory assignment of an on-line education module in Ascension Health's myLearning. This assignment will include a review of Saint Thomas Health's policy Abuse and Neglect of Patients, including details on the chain of command' process expected when reporting suspected abuse incidents. The myLearning education begins May 15, 2017 and ends June 14, 2017. Staff risk suspension if this education is not completed timely. Any Staff who work PRN or are currently on FML must complete the education before their next scheduled shift. 3)Saint Thomas Health's policy *Abuse and Neglect of Patients* will be reviewed in Medical Surgical, Case Mgt., ED and Senior Care mandatory staff meetings during the month of May. 4)Ongoing, new staff will be educated during orientation after hire.	June 14, 2017 June 14, 2017 June 14, 2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

President CEO

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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A 021	Continued From page 1 desease of the lung which has worsened suddenly), Alzheimer's Dementia (a disease of the brain), and Chronic Hypertension (elevated blood pressure). Continued review revealed the patient was discharged to a skilled nursing facility on 7/26/16. Medical record review of a Case Management Assessment note dated 7/13/16 at 9:46 AM revealed "...Pt's son admitted to SW [Social Worker] that he hit the pt [patient] across the face to keep her from pulling out IV [intravenous line] recently..." Interview with Registered Nurse (RN) #2 on 4/24/17 at 10:10 AM, in the Chief Nursing Officer's (CNO) office, revealed she received a telephone call on 7/11/16 from Patient #5's granddaughter and she stated Patient #5 was slapped by the patient's son while in the Emergency Department (ED). Continued interview revealed the incident was not witnessed by any of the ED staff nor was it reported to the facility by the patient. Further interview revealed the incident was reported to Adult Protective Services (APS) and the local police. Continued interview revealed the allegation was not reported to federal or state agencies. Interview with Licensed Medical Social Worker (LMSW) #1 on 4/24/17 at 9L43 AM, in the CNO's office, revealed she remembered the case incident. Continued interview revealed she interviewed the patient's son after the patient's granddaughter reported the alleged abuse and the patient's son admitted he hit the patient (his mother). Further interview revealed the incident was not witnessed by staff and was not reported by the patient to any of the staff. Continued	A 021	5)Monitoring of compliance with reporting of suspected abuse will be tracked by Saint Thomas Highland's Director of Clinical Operations, thru an ongoing weekly review of events entered into Ascension Health's ERS (incident reporting system). 6)ERS event reporting metrics will be reported by STH's Regional Risk Manager to the Saint Thomas Highland's Quality Council on an ongoing monthly basis.	June 14, 2017

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A 021	Continued From page 3 laws.	A 021	POC to address Failure to Comply with Patient's Right to Privacy 1)Every patient has the potential to have their privacy rights violated if the facility's staffs are not knowledgeable about the prevention. All management and leadership at Saint Thomas Highlands have been re-educated on the importance of ensuring patient's rights, especially to the right of privacy.	
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on review of facility policy, review of facility documentation, and interview, the facility failed to protect the rights of 1patient (#11) of 11 patients reviewed. The findings included: Review of facility policy Patient Rights and Responsibilities, dated 4/2013, revealed "...You have the right to private and confidential treatment/personal care, communications..." Review of a facility document "Conversations with [named Nurse Aid]" completed by Registered Nurse (RN) #1, not dated, revealed "...Week of August 15 [2016]...allegation that [Nurse Aid #1] had videotaped a patient screaming in the ICU. [Nurse Aide #1] was called in and said she had audio taped it and this was verified by [RN #3]. There was no video..." Telephone Interview with Nurse Aide (NA) #1 on 4/24/17 at 12:05 PM confirmed revealed NA #1 made an audio recording of a confused patient who was screaming. Interview with RN #1 on 4/24/17 at 9:45 AM, in	A 143	2)All Staff will be re-educated thru the mandatory assignment of an on-line education module in Ascension Health's myLearning. This assignment will include a review of Saint Thomas Health's policy *Patient Rights and Responsibilities*, which speaks to the patient's right to private and confidential treatment personal communications All staff will also be re-educated on Saint Thomas Health's policy -*Cell Phones and Other Electronic Communication Devices, HR II-04*. Saint Thomas Health prohibits the use of camera phones, cameras or tape recorders in the workplace as a preventive step necessary to secure patient and associate privacy and business information. The myLearning education begins May 15, 2017 and ends June 14, 2017. Staff risk suspension if this education is not completed timely. Any Staff who work PRN or are currently on FML must complete the education before their next scheduled shift. 3)SaintThomasHealth'spolicies-*PatientRightsand ResponsibilitiesandCellPhonesandOther Electronic CommunicationDevices,HRII-04*,willbe reviewedin Medical Surgical,EDandSeniorCare mandatorystaff meetingsduringthemonthofinMay. 4)Newstaffwillbeeducatedduringorientationafter hire andannuallythereafter. 5)Monitoringofcompliancewithreportingof suspected abusewillbetrackedbySaintThomas Highland's DirectorofClinicalOperations,thruweekly Leadership Roundson5patientsperweekand ongoingweekly reviewofeventsenteredinto AscensionHealth'sERS (incidentreportingsystem). 6)MetricsfromLeadershiproundsandERSevent reportingwillbereportedbySTH'sRegionalRisk ManagertotheSaintThomasHighland'sQuality Council on an ongoing monthly basis. reporting system.	June 14, 2017 June 14, 2017 June 14, 2017 June 14, 2017

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A 143	Continued From page 4 the CNO's office, revealed NA#2 told her NA#1 recorded a video of a confused patient who was screaming. Continued interview revealed RN #1 interviewed NA#1 and NA#1 admitted to the incident. Further interview confirmed the facility failed to follow facility policy and failed to ensure a patient's right to personal privacy.	A 143		0

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STREET ADDRESS, CITY, STATE, ZIP CODE: 401 SEWELL DR, SPARTA, TN 38583

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H1110	1200-08-01-.11 (8) Records and Reports (8) The hospital shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211. This Rule is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to report allegations of abuse for 2 patients (#5 and #9) of 11 patients reviewed. The findings included: Review of facility policy, Abuse and Neglect of Patients, effective date 11/2015, revealed "...Other agencies and organizations may also have obligations to investigate allegations of abuse or neglect. These included various hospital accreditation agencies, as well as local, state, and federal governmental agencies...The Hospital will cooperate and coordinate with these or other agencies as requested and as required by laws and regulations..." Medical record revealed Patient #5 was admitted to the facility's geriatric behavioral health unit on 7/9/16 with diagnosis of Chronic Obstructive Pulmonary Disease with Acute Exacerbation (disease of the lung which worsened suddenly), Alzheimer's Dementia (disease of the brain), and Chronic Hypertension (elevated blood pressure). Continued review revealed the patient was discharged to a skilled nursing facility on 7/25/16.	H1110	POC to address 1)Every patient has the potential to be a victim of abuse if the facility's staffs are not knowledgeable about the prevention. All management and leadership at Saint Thomas Highlands has been re-educated on the importance of reporting any all allegations of abuse to both Federal and State Agencies in compliance with Federal and State statues. Re-education has been provided on the necessity to report any all allegations of abuse to the Saint Thomas Health Risk Director and Regional Risk Manager. Reporting to all entities will be immediate upon knowledge of the suspected abuse, whether or not the allegation is substantiated. 2)All Staff will be re-educated on prevention and reporting of abuse thru the mandatory assignment of an on-line education module in Ascension Health's myLearning. This assignment will include a review of Saint Thomas Health's policy Abuse and Neglect of Patients, including details on the chain of command' process expected when reporting suspected abuse incidents. The myLearning education begins May 15, 2017 and ends June 14, 2017. Staff risk suspension if this education is not completed timely. Any Staff who work PRN or are currently on FML must complete the education before their next scheduled shift. 3)Saint Thomas Health's policy Abuse and Neglect of Patients will be reviewed in Medical Surgical, Case Mgt., ED and Senior Care mandatory staff meetings during the month of May 4)Ongoing, new staff will be educated during orientation after hire. 5)Monitoring of compliance with reporting of suspected abuse will be tracked by Saint Thomas Highland's Director of Clinical Operations, thru weekly Leadership Rounds on 5 patients per week and ongoing weekly review of events entered into Ascension Health's ERS (incident reporting system). 6)ERS event reporting metrics will be reported by STH's Regional Risk Manager to the Saint Thomas Highland's Quality Council on an ongoing monthly basis.	June 14, 2017 June 14, 2017 June 14, 2017 June 14, 2017

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE President | (X6) DATE

PRINTED: 05/03/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 05/01/2017

NAME OF PROVIDER OR SUPPLIER: SAINT THOMAS HIGHLANDS HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 401 SEWELL DR, SPARTA, TN 38583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1110	Continued From page 1 Medical record review of a Case Management Assessment note dated 7/13/16 at 9:46 AM revealed "...Pt's [patient's] son admitted to SW [Social Worker] that he hit the pt [patient] across the face to keep her from pulling out IV [intravenous] [line] recently..." Interview with Registered Nurse (RN) #2 on 4/24/17 at 10:10 AM, in the Chief Nursing Officer's (CNO) office, revealed she received a telephone call on 7/11/16 from Patient #5's granddaughter, which stated the patient was slapped by the patient's son while the patient was in the Emergency Department (ED). Continued interview revealed the incident was not witnessed by any of the ED staff and the incident was not reported to hospital staff prior to the granddaughter's report. Further interview confirmed the incident was reported to Adult Protective Service (APS) and the local police, but was not reported to the Tennessee Department of Health. Interview with Licensed Medical Social Worker (LMSW) #1 on 4/24/17 at 9:43 AM, in the CNO's office, revealed she remembered the incident. Continued interview revealed she interviewed the patient's son after the patient's granddaughter reported the alleged abuse and the patient's son admitted he hit the patient (his mother). Further interview revealed the incident was not witnessed by staff and the patient did not report the incident to the facility. Continued interview confirmed the incident was reported to APS and to the police, but the facility failed to report the incident to the Tennesssee Department of Health. Interview with the CNO on 4/19/17 at 2:30 PM, in her office, confirmed the facility failed to report the abuse incident to the Tennessee Department	H1110		

PRINTED: 05/03/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	TNP531127		C 05/01/2017

NAME OF PROVIDER OR SUPPLIER: SAINT THOMAS HIGHLANDS HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 401 SEWELL DR, SPARTA, TN 38583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1110	Continued From page 2 of Health. Medical record review revealed Patient #9 was admitted to the hospital on 8/19/16 to the Senior Care Unit with diagnosis of Major Neurocognitive Impairment with Psychosis and Behavioral Disturbances. Further review revealed the patient was discharged home in stable condition with her family on 8/31/16. Interview with Social Worker (SW) #2 on 4/24/17 at 9:10 AM, in the CNO's office, revealed Nurse Aide (NA) #2 reported to SW #2 an incident of verbal abuse by NA #1 to Patient #9. Continued interview revealed NA #2 was in the process of termination from employment at the facility for poor job performance when she made the allegation against NA #1, and NA #1 and NA #2 had developed an enmity relationship. Further interview confirmed the allegation of abuse was not reported to the Tennessee Department of Health. Interview with RN #1 on 4/24/17 at 9:45 AM, in the CNO's office, confirmed the alleged incident was not reported to the Tennessee Department of Health. Interview with the CNO on 4/24/17 at 11:30 PM, in her office, confirmed the facility failed to follow facility policy and failed to report the alleged incident to the Tennessee Department of Health.	H1110		

Tab 17

Proof of Publication

HSDA Letter of Intent

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the The Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson, White & Surrounding (County), Tennessee, on or before 06/09 (Month / day), 2017 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Saint Thomas Highlands Hospital, LLC (Name of Applicant) Hospital Provider (Facility Type-Existing)

owned by: Saint Thomas Regional Hospitals with an ownership type of Limited Liability Company and to be managed by: Saint Thomas Highlands Hospital, LLC intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the expansion of its existing geropsychiatric unit from ten (10) beds to fourteen (14) beds at 401 Sewell Road in Sparta, TN, 38583 (White County). At the time this project is licensed and opens for patients, Saint Thomas Highlands Hospital will de-license four (4) medical-surgical beds. The project involves the renovation of 900 square feet of existing hospital space. No major medical equipment is involved. Total project costs are estimated to be $358,226.

The anticipated date of filing the application is: June 14, 2017

The contact person for this project is Blake Estes (Contact Name) Executive Director (Title)

who may be reached at: Saint Thomas Health (Company Name) 102 Woodmont Blvd., Suite 800 (Address)

Nashville	TN	37205	615 / 222-7235
(City)	(State)	(Zip Code)	(Area Code / Phone Number)

(Signature) 6/8/17 (Date) Blake.Estes@sth.org (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Tab 18

Proof of Publication

Evidence of Publication

Continued to next column

Continued to next column

Public Notices

Public Notices

0002192045

NOTICE OF DISSOLUTION:

Pursuant to Tennessee Code Annotated § 48-249-611(c), notice is hereby given that Pohlid, PLLC, a Tennessee limited liability company (the "Company"), has been dissolved and is in the process of winding up and liquidating its business and affairs. All persons with claims against the Company must send their claims to the Company in writing at P.O. Box 1034, Brentwood, TN 37024. The following information must be included in each claim: (1) the name, address, and telephone number of the claimant; (2) if the claimant is an entity, the name of the individual with claimant having knowledge of the claim; (3) a description and basis of the claim; (4) the amount of the claim; (5) the date the claim arose; and (6) any documentation substantiating the claim. A claim against the Company will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this notice. The Company does not admit any claims and reserves the right to deny and reject and any claims submitted.

0002197034

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Saint Thomas Highlands Hospital, LLC, an existing hospital provider, owned by: Saint Thomas Regional Hospitals, with an ownership type of limited liability company and to be managed by: Saint Thomas Highlands Hospital, LLC intends to file an application for a Certificate of Need for the expansion of its existing geropsychiatric unit from ten (10) beds to fourteen (14) beds at 401 Sewell Road in Sparta, TN, 38583 (White County). At the time this project is licensed and opens for patients, Saint Thomas Highlands Hospital will delicense four (4) medical-surgical beds. The project involves the renovation of 900 square feet of existing hospital space. No major medical equipment is involved. Total project costs are estimated to be $358,226.

The anticipated date of filing the application is June 14, 2017.

The contact person for this project is Blake Estes, Executive Director, Planning and Strategy, Saint Thomas Health, who may be reached at Saint Thomas Health, 102 Woodmont Blvd., Suite 800, Nashville, TN 37205, 615-222-7235.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

August 1, 2017

Blake Estes
Executive Director
102 Woodmont Blvd, Suite 800
Nashville, TN 37205

RE: Certificate of Need Application -- Saint Thomas Highlands Hospital, LLC - CN1706-020
The expansion of an existing geriatric inpatient psychiatric unit from 10 beds to 14 beds located at 401 Sewell Road, Sparta (White County), TN 38583. T**he estimated project costs is $358,226.**

Dear Mr. Estes:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on August 1, 2017. The first 60 days of the cycle are assigned to the Tennessee Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Tennessee Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on October 25, 2017.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning, and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: August 1, 2017

RE: Certificate of Need Application
Saint Thomas Highlands Hospital, LLC - CN1706-020

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on August 1, 2017 and end on October 1, 2017.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Blake Estes
cc: Marthagem Whitlock, TDMHSAS

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

JUN 9 '17 AM 10:47

LETTER OF INTENT

The Publication of Intent is to be published in the The Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson, White & Surrounding (County), Tennessee, on or before 06/09 (Month / day), 2017 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Saint Thomas Highlands Hospital, LLC (Name of Applicant) Hospital Provider (Facility Type-Existing)

owned by: Saint Thomas Regional Hospitals with an ownership type of Limited Liability Company and to be managed by: Saint Thomas Highlands Hospital, LLC intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the expansion of its existing geropsychiatric unit from ten (10) beds to fourteen (14) beds at 401 Sewell Road in Sparta, TN, 38583 (White County). At the time this project is licensed and opens for patients, Saint Thomas Highlands Hospital will de-license four (4) medical-surgical beds. The project involves the renovation of 900 square feet of existing hospital space. No major medical equipment is involved. Total project costs are estimated to be $358,226.

The anticipated date of filing the application is: June 14, 2017

The contact person for this project is Blake Estes (Contact Name) Executive Director (Title)

who may be reached at: Saint Thomas Health (Company Name) 102 Woodmont Blvd., Suite 800 (Address)

Nashville (City)	TN (State)	37205 (Zip Code)	615 / 222-7235 (Area Code / Phone Number)

(Signature) 6/8/17 (Date) Blake.Estes@sth.org (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Supplemental #1

Saint Thomas Highlands Hospital, LLC

CN1706-020

THE STRATEGY HOUSE
Healthcare Advisors

JUN 28 '17 AM 10:52

SUPPLEMENTAL #1
June 28, 2017
10:52 am

71 Vickery Street
Roswell, Georgia 30075
Telephone 770-394-8465
Facsimile 770-394-5470
www.thestrategyhouse.net

June 27, 2017

Via Hand Delivery

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243

RE: Certificate of Need Application CN1706-020
Saint Thomas Highlands Hospital, LLC

Dear Mr. Earhart:

Thank you for your letter of June 21, 2017 acknowledging the receipt of our June 14, 2017 application for a Certificate of Need for the expansion of an existing geriatric inpatient psychiatric unit at Saint Thomas Highlands Hospital from 10 beds to 14 beds.

The following responses are provided for clarification or additional discussion. As requested, **this information has been submitted in triplicate by 12:00 p.m., Wednesday, June 28, 2017.**

---

1. **Section A: Project Details Item 6B Plot Plan**

   The plot plan is noted. However, please provide a revised plot plan that includes the location of the proposed renovation.

   RESPONSE: The location of the proposed renovation is contained in the circled area of the revised plot plan. Please refer to **Attachment 1**.

2. **Section A: Project Details Item 6B (2) Floor Plan**

   The floor plan indicates there will be three private rooms renovated. However, the rest of the application indicates there will be two semi-private rooms added. Please clarify.

   RESPONSE: Three patient rooms (108, 122 and 123) are located in the left section of the floor plan. These three rooms are not part of the project and are just beyond the existing geropsychiatric rooms (116, 118, 119, 120 and 121) in the right section of the floor plan.

There are two shaded patient rooms in the center of the floor plan, immediately above and below the "Corridor 142" designation. These two rooms will be part of the project.

The entry doors to the geropsychiatric unit will be moved from the right to the left on the floor plan to accommodate the two additional shaded patient rooms.

If approved, how many semi-private rooms and private rooms will be located in the geriatric psychiatric unit?

RESPONSE: Upon approval, Highlands will operate seven semi-private geropsychiatric rooms. The program will not have any private geropsychiatric rooms.

It appears there will be two nurse's stations in the floor plan. Please clarify if both stations will be staffed.

RESPONSE: The nurse's station on the left side of the floor plan is not part of the geropsychiatric program. There is one nurse's station on the right side of the floor plan for the geropsychiatric program.

Please clarify if it is typical to place an employee lounge next to a patient's room.

RESPONSE: The lounge with the staff toilet is not part of the geropsychiatric program. Having a staff lounge in proximity to patient rooms keeps staff accessible to patients whenever needs might arise.

Why is there an employee lounge and an employee break room in the floor plan.

RESPONSE: These particular areas are adjacent to the geropsychiatric program though not part of the program itself.

The floor plan does not include quiet areas, time-out rooms, or a seclusion room. Please clarify.

RESPONSE: Highlands focuses on patient de-escalation techniques to avoid seclusion and restraints. Staff training from the Crisis Prevention Institute (CPI), an international training organization, emphasizes the following alternatives for anxious patients:

- Walk with patients
- Sing to them
- Rub their backs
- Remove them from the dayroom if too stimulating
- Sit with nursing staff
- Allow them to call family
- Visit the locked patio with staff supervision
- Toilet them, provide nourishment, allow them to rest in their room if preferred

SUPPLEMENTAL #1
June 28, 2017
10:52 am

All these techniques attempt to re-focus the patient. Highlands will even provide PRNs if indicated.

A seclusion room is actually contained on the geropsychiatric floor but it had been labeled as storage. A revised floor plan is provided in **Attachment 2**.

Please clarify if the proposed renovations will accommodate a geriatric population with ambulatory and other physical challenges according to ADA guidelines.

RESPONSE: Yes, the proposed renovations will accommodate a geriatric population with ambulatory and other physical challenges according to ADA guidelines.

3. **Section B, Need, Item 2a. Additional Factors/Involuntary Admissions. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   It is noted the applicant will not accept emergency involuntary admissions. Where are these admissions referred?

   RESPONSE: If a true involuntary admission, the patient is referred to Saint Thomas Stones River Hospital, TriStar Skyline Madison or TrustPoint Hospital. If the physician will do a health care surrogate, the patient can be admitted to Highhlands.

4. **Section B, Need, Item 2b. Additional Factors TennCare/Indigent. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   The applicant notes STHH Senior Care Program currently serves and will continue to serve the TennCare and indigent populations. However, there is no charity care in the Historical or Projected Data Charts of the applicant. Please clarify.

   RESPONSE: Due to the ages of the patients served in the geropsychiatric service, the vast majority of reimbursement is from Medicare and, to a much lesser degree, TennCare. Charity care is an immaterial amount overall. Please note, however, that this program will continue to follow the Saint Thomas Health indigent and charity care guidelines.

5. **Section B, Need, Item 2.d Continuum of Care. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   The applicant notes patients are referred to other providers, as necessary, for other services in the continuum of care. Please complete the following chart that will indicate the applicant's service area 65+ Geriatric Psychiatric Continuum of Care.

   RESPONSE: Information is provided in the chart below. Also, Highlands maintains a geropsychiatric outpatient clinic in addition to its ten-bed inpatient service. If an adult patient, especially aged 55-64, outpatients may be referred to (primarily) Generations Gaithers in McMinnville, Volunteer Behavioral Health in Murfreesboro,

Personal Growth and Learning Center in Cookeville or Mental Health Co-Op in Cookeville. Other times, the initial referral source will place the patient.

Provider Name	Intensive Outpatient Program	Partial Hospitalization Program	Inpatient Hospitalization
Senior Perspectives (Crossville)	X	X	
Ten Broeck (Cookeville)	X	X	
Riverside Center at Stones River Hospital (Woodbury)			X

6. **Section B, Need, Item 2.j Crisis Stabilization Unit. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   It is noted the service area has a crisis stabilization unit at Volunteer Behavioral Health in Cookeville. Please clarify if the Cookeville CSU accepts geriatric patients.

   RESPONSE: The Cookeville CSU can accept geriatric patients but only if they are independent and ambulatory.

7. **Section B, Need, Item 3 Incidence and Prevalence. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   The applicant notes Van Buren County has a small admission rate for both 2013 and 2015. What is considered "small"?

   RESPONSE: "Small" is statistically nonreportable by TDMHSAS.

8. **Section B, Need, Item 9 Relationship to Existing Similar Services (Psychiatric Inpatient Services-Service Specific Criteria-)**

   Please indicate the staffed bed occupancy of the applicant's geriatric inpatient psychiatric unit in 2016.

   RESPONSE: The staffed (and licensed) bed occupancy of the applicant's geriatric inpatient psychiatric unit in 2016 was 84.1% based on ten beds.

9. **Section B, Need, Item 9 Licensure and Quality Considerations (Psychiatric Inpatient Services-Service Specific Criteria-)**

   Please indicate how the applicant provides culturally competent services.

SUPPLEMENTAL #1
June 28, 2017
10:52 am

RESPONSE: Upon admission, the staff at Highlands asks the patient his or her preferences with respect to religion, blood transfusions, food preferences, etc. Staff also has access to translation services if needed. Staff asks if patients would prefer pastoral services and the pastor will visit throughout the week. Staff has made flash cards for communication purposes with respect to aphasia and heritage. Recently, two female patients from Europe were provided tea and sandwiches daily at their customary tea time. Whatever the need, Highlands will attempt to accommodate it.

It is noted the applicant does not utilize patient seclusion or restraints. Please explain why the applicant's inpatient geriatric psychiatric unit patients do not require a seclusion or restraint room. If needed, how are patients physically safely managed?

RESPONSE: Highlands focuses on patient de-escalation techniques to avoid seclusion and restraints. Staff training from the Crisis Prevention Institute (CPI), an international training organization, emphasizes the following alternatives for anxious patients:

- Walk with patients
- Sing to them
- Rub their backs
- Remove them from the dayroom if too stimulating
- Sit with nursing staff
- Allow them to call family
- Visit the locked patio with staff supervision
- Toilet them, provide nourishment, allow them to rest in their room if preferred

All these techniques attempt to re-focus the patient. Highlands will even provide PRNs if indicated.

10. Section B, Need, Item 11 Community Linkage Plan. (Psychiatric Inpatient Services-Service Specific Criteria-)

Please provide the applicant's proposed primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

RESPONSE: As indicated in the CON application executive summary, approximately 65% of the geropsychiatric patients at Highlands are diagnosed with dementia or Alzheimer's. These diseases are, unfortunately, a part of the natural aging process. Highlands focuses on early intervention to mitigate these conditions as soon as possible. The Senior Care program provides a 24-hour confidential phone assessment service for patients and families.

If possible, please provide letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of the application that details specific instances of unmet need for geriatric psychiatric inpatient services. Please provide measurable instances of unmet need rather than providing broad statements.

RESPONSE: As indicated in the CON application, the Highlands geropsychiatric program operated at 100% utilization 31% of the time and at 90% utilization another 43 % of the time. These measurable data points demonstrate that patients are being turned away. Patient needs are not being met. Highlands will provide additional documentation and testimonials at the Agency meeting when the application will be reviewed.

11. Section B, Need, Renovation and Expansion 3 (a) and 3 (b)

Please address the criteria and standards: Construction, Renovation, and Replacement of Health Care Institutions, items 3 (a) and 3 (b).

RESPONSE: The acceptable existing demand for the proposed project is documented by the very high occupancy of the existing ten-bed unit – over 90% for three-quarters of the time recently and 84.1% for 2016.

At less than $400,000, this project does not qualify as major renovation. The addition of two semi-private patient rooms to the five existing semi-private patient rooms cannot be accomplished without moving the access/control doors to the geropsychiatric unit and other minor renovations.

12. Section B. Need, Item C

The applicant refers to the 2016 JAR for the table on page 26. The 2016 JAR has not been published by the Department of Health. Please clarify.

RESPONSE: The applicant has completed and submitted the 2016 JAR, including the patient origin information. Though not yet published, it is still based on valid, recent and internal historical information for Highlands.

13. Section B. Need, Item 5

Your response to this item is noted. Please complete the following chart for the applicant's inpatient geriatric psychiatric unit.

RESPONSE: The following information comports with the 2014 – 2016 Joint Annual Reports.

Geriatric Psychiatric	2014	2015	2016	% change from 14-16
Licensed Beds	10	10	10	
Staffed Beds	10	10	10	
Admissions	220	277	271	
Patient Days	2,821	3,080	3,069	+8.8%
ADC	7.7	8.4	8.4	
ALOS	12.8	11.1	11.3	
%Staffed Occupancy	77.3%	84.4%	84.1%	
% Licensed Occupancy	77.3%	84.4%	84.1%	+8.8% or 6.8 pct pts

14. Section B, Need, Item 6

Please complete the following tables for Year One and Year Two:

RESPONSE: Approximately 93% of the geropsychiatric unit patient volume is for patients aged 65+ while the remaining 7% is for patients aged 55 – 64. All beds (ten existing plus four proposed) are projected to be utilized equally. There will be a slight drop in utilization in the first year as the four beds come on line, allowing for a conservative ramp up in volume.

Projected Inpatient Utilization

Variable	2018	2019	2018	2019
Ages 65+ Psych Licensed Beds	Existing 10 beds	Existing 10 Beds	Proposed 4 Beds	Proposed 4 beds
Ages 65+ Psych. Admissions	208	271	83	108
Ages 65+ Psych. Pat. Days	2,348	3,064	940	1,228
Ages 65+ Psych ALOS	11.3	11.3	11.3	11.3
Ages 65+ Psych ADC	6.4	8.4	2.6	3.4
Ages 65+ % Lic. Occ.	64.3%	84.0%	65.0%	85.0%

15. Section B. Economic Feasibility Item A.5 Architect's Letter

The architect's letter is noted. However, please revise the letter to include an attestation the physical environment will conform to applicable federal standards, licensing agencies' requirements including AIA Guidelines and Design and Construction of Hospital and Health Care facilities in current use by the licensing authority.

RESPONSE: Please see **Attachment 3**.

16. Section B. Economic Feasibility Item B Funding Letter

Please provide the referenced funding letter.

RESPONSE: Please see **Attachment 4** for the Saint Thomas Health funding letter along with the internal financial statements for Saint Thomas West Hospital. As explained in the letter, Saint Thomas Health utilizes a centralized cash management system with the funds reported under the name of Saint Thomas West Hospital.

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17. Section B. Economic Feasibility Item C (Historical Data Chart)

Please provide a Historical Data Chart for the total facility.

RESPONSE: Please see **Attachment 5**. The facility was acquired by Saint Thomas Health on August 1, 2015. The fiscal year end of the prior owner was different from that of the current owner.

- 2014 data covers the 12-month calendar year
- 2015 data covers the 7 months through July
- 2016 data covers the 11 months ending in June

Also note that, due to the ownership change, individual line item amounts have been assigned to the application line items appearing to be the most appropriate category.

The applicant refers to the Projected Data Chart rather than the Historical Data Chart on the bottom of page 37. Please correct and submit a replacement page 37 (R-37).

RESPONSE: Please see **Attachment 6** for a corrected page.

The total operating expenses total of $1,638,878 for Year 2015 appears incorrect. Please correct and submit a revised Historical Data Chart.

RESPONSE: The correct value should be $1,038,878 rather than $1,638,878. Please see the attachment above for a corrected page.

18. Section B. Economic Feasibility, Item D, Projected Data Chart

As prescribed in the application, please provide a Projected Data Chart for the total facility.

RESPONSE: Please see **Attachment 7** for the total facility. Project-specific data was provided previously.

19. Section B, Economic Feasibility, Item E (1) Project's Average Gross Charge, Average deduction from Operating Revenue, and Average Net Charge

It is unclear how the applicant calculated the gross charge, deduction from revenue, and average net charge for the previous and current year. None of the calculations match the historical data chart. Please clarify.

RESPONSE: The table in question has been reproduced below. Years have been added to the column headings for further clarity. The current year, 2017, has not been reported on the Historical Data Chart. Two numbers in the Previous Year column

had a slight rounding "error" of three or four dollars. Corrections have been made here.

	Previous Year *(2016)*	Current Year *(2017)*	Year One *(2018)*	Year Two *(2019)*	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	3,430	3,413	3,413	3,413	0%
Deduction from Revenue *(Total Deductions/Utilization Data)*	***1,120***	1,139	1,161	1,184	4%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	***2,310***	2,274	2,252	2,229	-2%

20. Section B, Economic Feasibility, Item E. (3)

Please compare the proposed charges of the project to current Medicare allowable fee schedule by common procedure terminology (CPT) codes.

RESPONSE: DRGs are a more appropriate measure for this project, specifically:

- DRG 884 – Organic disturbances and mental retardation ($11,059)
- DRG 885 – Psychoses ($8,973)

Average Medicare "payments" were provided by the American Hospital Directory (ahd.com). This compares to a year one projected gross charge of $38,567.

21. Section B, Economic Feasibility, Item G. Payor Mix

The applicant is Projecting Gross Operating Revenue of $1,222,419 in Year One. However, the applicant's past Joint Annual Reports did not indicate TennCare as a funding source. Please clarify.

RESPONSE: Given the facility's change in ownership on August 1, 2015, projections are deemed more reliable. Regardless, the vast majority of the patient reimbursement is expected to come from government payment sources.

22. Section B. Orderly Development, Item C.2

The medical director's qualifications are noted. However, the Tennessee Department of Health's licensure verification web-site indicates the medical director currently has staff privileges in 4 South Carolina Hospitals. Please clarify.

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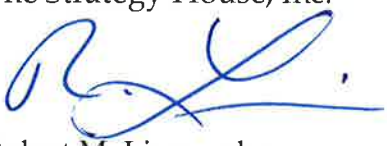
RESPONSE: As indicated in the Highlands medical director's CV, Dr. Leftwich completed his residency training in South Carolina. The licensure verification data may contain information from this time period.

A notarized affidavit accompanies these responses and is found at **Attachment 8**. On behalf of Saint Thomas Highlands Hospital, we look forward to having this application deemed complete to start the formal review process.

Sincerely,

The Strategy House, Inc.



Robert M. Limyansky
Partner

attachments

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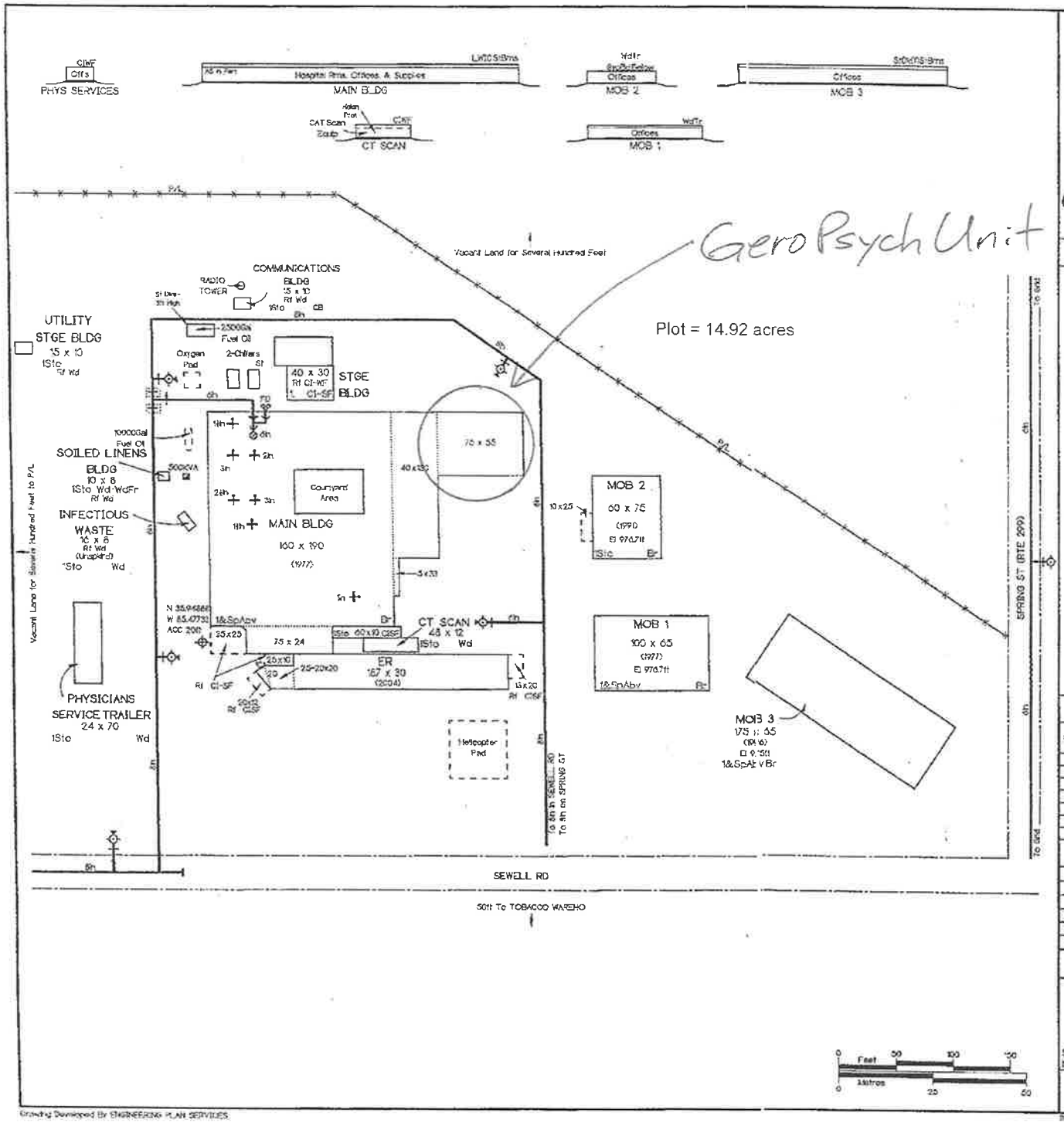
June 28, 2017
10:52 am

Attachments

1. Plot Plan
2. Floor Plan
3. Architect's Cost Letter
4. Funding Letter with Documentation
5. Historical Data Chart – Total Facility
6. Corrected Pages (R-37, R-38)
7. Projected Data Chart – Total Facility
8. Affidavit

Attachment 1



FM Global

LEGEND

Dry or frost proof hydrant with the department number connection (number of hose outlets) hydrant number or hose outlets

DAVID - DOES THIS APPEAR CORRECT TO YOU? PLEASE SHOW JOHN M 12/5

All sprinkler bed settings are nonconductive to the steel frame unless otherwise noted.

SPRINKLER SYSTEM DATA

RISER LOCATION	Type Riser	Working (psi)	Water Supply	O.S. (in)	HYDRAULICALLY DESIGNED SYSTEM DATA: Density Sensitive Sections	Design area of sp or sprinkler	DEMAND NOW: Flow (gpm)	Press (psi)
MAIN	HYD	90	25	1/2	0.10	1500	556	51

CHOSEN-RADCSHYD.DLSER

REVISIONS

DR	CH	DATE	CHANGES MADE
GLS	LTD	Oct-6-03	For Baseline Risk Evaluation of C.C.McGaughey, Jr.
MET		10-21-99	For F-Reg Insp of W.A. Hayes 10-6-99
DFF		12-6-96	For 5-Yrs Insp of W.A. Hayes 11-13-96 Reviews 870-1074

COMMUNITY HEALTH SYSTEMS, INC.
"WHITE COUNTY COMMUNITY HOSPITAL"
Sparta, Tennessee

Sketch from W.A. Hayes
November 13, 1996

Scale: 1in = 60ft.
By David P. Finnerain

FACTORY MUTUAL INSURANCE COMPANY
Engineering Plan Services
101 BOSTON-PROVIDENCE TURNPIKE, NORWOOD, MASS. 02062

INDEX 84794.99

1/1

Drawing Developed by ENGINEERING PLAN SERVICES

INDEX BY VID

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SUPPLEMENTAL #1

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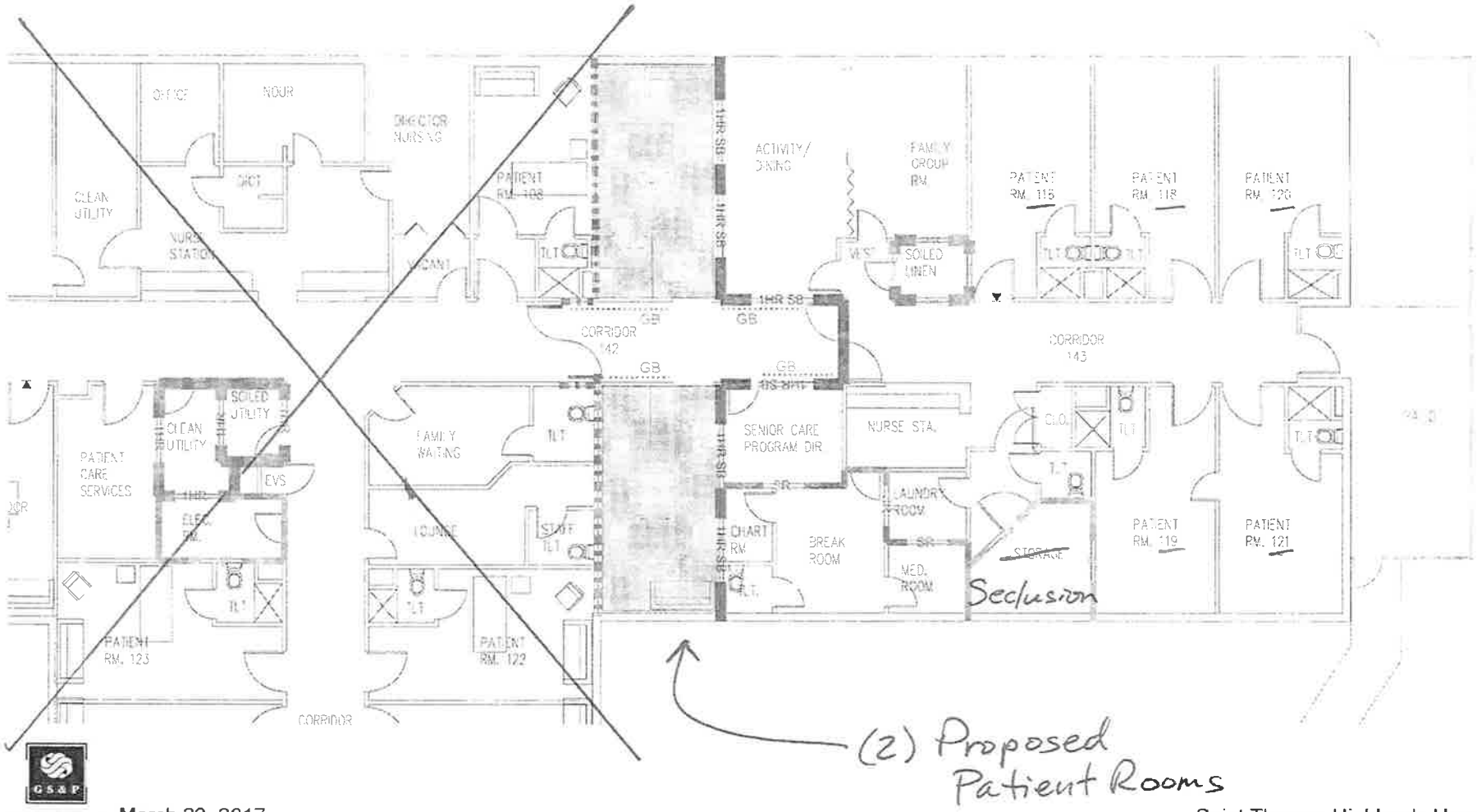
Attachment 2

Existing GeroPsych Unit



(2) Proposed Patient Rooms

GS&P
GRESHAM SMITH AND PARTNERS

March 22, 2017
GS&P #19252.44

Saint Thomas Highlands Hospital
Geri-Psych Unit Renovation

SUPPLEMENTAL #1
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SUPPLEMENTAL #1

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Attachment 3

SUPPLEMENTAL #1

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GRESHAM
SMITH AND
PARTNERS

June 26, 2017

Andy Wachtel, FACHE
President and Chief Executive Officer
St Thomas Highlands
Sparta, TN 38583

RE: Verification of costs for St Thomas Highlands Hospital Renovations for Gero-Psych Unit Renovation

Dear Mr. Wachtel:

As I understand the initial scope and schedule, Highlands Hospital of Sparta, TN is planning on renovating their existing behavioral health patient unit to accommodate two (2) additional Geropsychiatric patient rooms. Additional scope has been identified to relocate the unit such as updates to a smoke-compartment assembly with penetrations, relocate of control doors and corridor renovations in addition to the patient rooms themselves for a total approximate 900 square feet. Although this initial scope is preliminary I have toured the facility along with the Owner and other General Contractor consultants and have reviewed their cost estimates for the work.

In my opinion the current construction estimate of $204,701 ($227 / SF) along with the total estimated project estimate of $336,000 including fees, equipment construction and other professional services for the above project description are reasonable, based on similar projects. Additionally, the physical environment of the renovated limits of construction will be designed to meet applicable federal standards and licensing agency's requirements including the AIA/FGI Guidelines for Design and Construction of Health Care Facilities.

Please do not hesitate to contact me if you have any questions.

Sincerely,

David Magner, AIA NCARB
TN Registration #103012

SUPPLEMENTAL #1

June 28, 2017

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Attachment 4

SUPPLEMENTAL #1
June 28, 2017
10:52 am

June 27, 2017

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application – Saint Thomas Highlands Hospital

Dear Ms. Hill:
Saint Thomas Health has a centralized cash management program for managing and investing operating funds for all Saint Thomas Health hospitals, including Saint Thomas Highlands Hospital. This letter is to confirm that Saint Thomas Health has available more than sufficient resources to fund the CON cost of $358,226 required to implement Highlands Hospital's project to expand its inpatient geropsychiatric beds.
Thank you for attention to this matter.

Sincerely,

Justin McElroy
Vice President, Finance
Saint Thomas Health

102 Woodmont Blvd., Suite 800
Woodmont Centre
Nashville, TN 37205
SaintThomasHealth.com

Saint Thomas West Hospital
Balance Sheet
at Nine Months Ending of Fiscal Year 2017
(Dollars in Thousands)

	March 31, 2017
ASSETS	
CURRENT ASSETS:	
Cash and Cash Equivalents	$10,809
Gross Patient Accounts Receivable	184,214
Less Allowances	-130,581
Patient Accounts Receivable, Net	$53,633
Estimated Settlements from Third-Party Payors	8,973
Total Intercompany Receivables	804,762
Total Inventory	9,887
Total Other Current Assets	2,276
Total Current Assets	**$890,340**
PROPERTY AND EQUIPMENT	
Land and Improvements	$10,098
Buildings	321,977
Equipment	156,602
Construction in Progress	1,479
Less Accumulated Depreciation	-352,782
Total Property and Equipment, Net	**$137,374**
Other Assets:	
Investments in Unconsolidated Entities	6,986
Other	13,151
Total Other Assets	**$20,137**
Total Assets	**$1,047,851**

	March 31, 2017
LIABILITIES AND NET ASSETS	
CURRENT LIABILITIES	
Current Portion of Long-Term Debt	$1,286
Accounts Payable	11,131
AR Credit Balances, Net	1,031
Accrued Liabilities	7,320
Estimated Settlements to Third-Party Payors	3,754
Current Portion of Self-Insurance Liability	1,507
Total Other Current Liabilities	815,999
Total Current Liabilities	**$842,028**
NONCURENT LIABILITIES	
Long-Term Debt	
Centralized Debt Management System	97,004
Net Long-Term Debt	**$97,004**
Other Long-Term Liabilities	
Self-Insurance Liabilitiy	$669
Pension and Other Post Retirement Benefits	0
Other	245
Total Noncurrent Liabilities	**$97,918**
Total Liabilities	**$939,946**
NET ASSETS	
Unrestricted Net Assets	$81,511
Current Year Net Income	$26,394
Total Liabilities and Net Assets	$1,047,851

SUPPLEMENTAL #1
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SUPPLEMENTAL #1

June 28, 2017
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Saint Thomas West Hospital
Statement of Operations
For Nine Months Ending March 31, 2017 of 2017 Fiscal Year

GROSS PATIENT SERVICE REVENUE:	
Total Inpatient Routine Revenue	$169,661,546
Inpatient Ancillary Revenue	775,599,824
Outpatient Revenue	484,515,858
Total Gross Patient Service Revenue	**$1,429,777,228**
REVENUE DEDUCTIONS:	
Charity Care	$41,958,923
Medicare Deductions	712,947,284
Medicaid Deductions	63,866,565
Blue Cross Deductions	166,503,252
HMO/PPO Deductions	76,466,264
Other Revenue and Contract Deductions	55,674,255
Total Revenue Deductions	**$1,117,416,544**
Net Patient Service Revenue	**$312,360,684**
OTHER REVENUE:	
Other Revenue	$16,490,941
Gain on Sale of Assets	2,250
Income from Unconsolidated Entities	1,587,790
Total Other Revenue	**$18,080,981**
Total Operating Revenue	**$330,441,666**
OPERATING EXPENSES:	
Salaries and Wages	$71,541,996
Employee Benefits	14,655,975
Purchasd Services	97,891,992
Professional Fees	6,133,801
Supplies	72,140,449
Insurance	1,854,568
Interest	2,541,743
Income Tax	
Depreciation	13,784,161
Amortization	246,489
Other Operating Expenses	22,265,397
Total Operating Expenses	**$303,056,571**
Income (Loss) From Recurring Operations	**27,385,094**
Recurring Op Inc before Non-Recurring Items	
Total Impair Write-Down, Restruct, Non-Recurr	0
Income (Loss) from Operations	**$27,385,094**
NONOPERATING GAINS (LOSSES):	
Other Non-Operating Activity	-991,305
Total Non-Operating Gains (Losses), Net	**-$991,305**
Income (Loss) Before Other NonOper Items	**$26,393,789**
Net Income (Loss)	**$26,393,789**

SUPPLEMENTAL #1

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Attachment 5

☐ Total Facility
☐ Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month). **RESPONSE: See Supplemental 1 notes for dates**

		Year 2014	Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	5,642	5,316	5,088
B.	Revenue from Services to Patients			
	1. Inpatient Services	$39,502,670	$22,666,516	$30,299,146
	2. Outpatient Services	$72,897,755	$47,472,848	$76,188,045
	3. Emergency Services	Included in OP	Included in OP	Included in OP
	4. Other Operating Revenue (Specify)_____	$256,769	$170,518	$436,010
	Gross Operating Revenue	$112,639,194	$70,309,882	$106,923,201
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$86,426,926	$54,640,846	$82,299,601
	2. Provision for Charity Care	$373,461	$214,748	$1,747,582
	3. Provisions for Bad Debt	$3,645,613	$1,772,100	$1,748,886
	Total Deductions	$90,446,000	$56,627,694	$85,796,069
NET OPERATING REVENUE		$22,193,194	$13,682,188	$21,127,132
D.	Operating Expenses			
	1. Salaries and Wages	$9,714,905	$5,905,247	$9,515,205
	a. Direct Patient Care			
	b. Non-Patient Care			
	2. Physician's Salaries and Wages			
	3. Supplies	$3,449,527	$2,279,306	$3,516,594
	4. Rent	$312,440	$193,003	$270,019
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
	5. Management Fees:	$413,237	$275,729	
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
	6. Other Operating Expenses	$4,324,352	$2,472,023	$4,910,255
	Total Operating Expenses	$18,214,461	$11,125,308	$18,212,073
E.	**Earnings Before Interest, Taxes and Depreciation**	$3,978,733	$2,556,880	$2,915,059
F.	Non-Operating Expenses			
	1. Taxes	$61,887	$275,523	
	2. Depreciation	$1,253,350	$688,819	$792,868
	3. Interest	$20,364	$140,674	
	4. Other Non-Operating Expenses	$164,352	$(34,508)	$261,212
	Total Non-Operating Expenses	$1,499,953	$1,070,508	$1,054,080
NET INCOME (LOSS)		$2,478,780	$1,486,372	$1,860,979

Chart Continues Onto Next Page

NET INCOME (LOSS)	$2,478,780	$1,486,372	$1,860,979
G. Other Deductions			
1. Annual Principal Debt Repayment	$_____	$_____	$_____
2. Annual Capital Expenditure	_____	_____	_____
Total Other Deductions	$_____	$_____	$_____
NET BALANCE	$2,478,780	$1,486,372	$1,860,979
DEPRECIATION	$1,253,350	$688,819	$792,868
FREE CASH FLOW (Net Balance + Depreciation)	$3,732,130	$2,175,191	$2,653,847

■ Total Facility

☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2014	Year 2015	Year 2016
1. Professional Services Contract	$673,865	$391,783	$932,964
2. Contract Labor	$1,614,772	$898,039	$2,245,724
3. Imaging Interpretation Fees	_____	_____	_____
4. Dues	_____	_____	_____
5. Benefits	_____	_____	_____
6. T & E	_____	_____	_____
7. Minor Equipment	_____	_____	_____
Total Other Expenses	**$2,288,637**	**$1,289,822**	**$3,178,688**

SUPPLEMENTAL #1

June 28, 2017
10:52 am

Attachment 6

B. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-2.)***

__ 1) Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ 2) Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ 3) General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ 4) Grants – Notification of intent form for grant application or notice of grant award;

X 5) Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

__ 6) Other – Identify and document funding from all other sources.

RESPONSE: The relatively minimal project costs will be paid from existing cash reserves at Saint Thomas Health. Please see **Tab 9 – Attachment Section B-B5**.

C. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

RESPONSE: Please refer to the completed ***historical*** data chart for the existing STHH Senior Care geropsychiatric inpatient unit on the following pages.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month). **RESPONSE: Data for Highlands inpatient psych unit only.**

		Year 2014	Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	2,821	3,080	3,175
B.	Revenue from Services to Patients			
	1. Inpatient Services	$9,335,966	$10,775,843	$10,891,668
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify)			
	Gross Operating Revenue	$9,335,966	$10,775,843	$10,891,668
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$2,517,199	$2,907,291	$3,545,781
	2. Provision for Charity Care			
	3. Provisions for Bad Debt	35,675	53,126	11,765
	Total Deductions	$2,552,874	$2,960,417	$3,557,546
NET OPERATING REVENUE		$6,783,092	$7,815,426	$7,334,122
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Direct Patient Care	669,332	620,066	724,807
	b. Non-Patient Care	78,000	78,000	80,000
	2. Physician's Salaries and Wages	105,000	105,000	105,000
	3. Supplies	19,570	12,486	12,934
	4. Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
	5. Management Fees:			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
	6. Other Operating Expenses	221,282	223,326	240,669
	Total Operating Expenses	$1,093,184	***$1,038,878***	$1,163,410
E.	**Earnings Before Interest, Taxes and Depreciation**	$5,689,908	$6,776,548	$6,170,712
F.	Non-Operating Expenses			
	1. Taxes	$	$	$
	2. Depreciation	588	588	588
	3. Interest			
	4. Other Non-Operating Expenses			
	Total Non-Operating Expenses	$ 588	$ 588	$ 588
NET INCOME (LOSS)		$5,689,320	$6,775,960	$6,170,124

Chart Continues Onto Next Page

SUPPLEMENTAL #1

June 28, 2017
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Attachment 7

SUPPLEMENTAL #1
June 28, 2017
10:52 am

☐ Total Facility
☐ Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

	Year 2018	Year 2019
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	6,306	7,373
B. Revenue from Services to Patients		
1. Inpatient Services	$38,499,526	$39,077,019
2. Outpatient Services	$81,433,733	$82,665,389
3. Emergency Services		
4. Other Operating Revenue (Specify)_____	$ 962,367	$976,803
Gross Operating Revenue	$120,905,626	$122,719,211
C Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$91,302,786	$92,672,328
2. Provision for Charity Care	$4,129,652	$4,191,597
3. Provisions for Bad Debt	$1,818.259	$1,845,533
Total Deductions	$97,250,697	$ 98,709,458
NET OPERATING REVENUE	$23,654,929	$24,009,753
D. Operating Expenses		
1. Salaries and Wages	$9,412,305	$9,600,551
a. Direct Patient Care		
b. Non-Patient Care		
2. Physician's Salaries and Wages		
3. Supplies	$3,722,487	$3,796,937
4. Rent		
a. Paid to Affiliates	$143,468	$146,337
b. Paid to Non-Affiliates		
5. Management Fees:		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
6. Other Operating Expenses	$7,667,398	$7,820,746
Total Operating Expenses	$ 20,945,658	$21,364,571
E. **Earnings Before Interest, Taxes and Depreciation**	$2,709,271	$2,645,182
F. Non-Operating Expenses		
1. Taxes	$	$
2. Depreciation	$1,323,859	$1,350,336
3. Interest		
4. Other Non-Operating Expenses	$40,000	$40,800
Total Non-Operating Expenses	$1,363,859	$1,391,136
NET INCOME (LOSS)	$1,345,412	$1,254,046

Chart Continues Onto Next Page

NET INCOME (LOSS)	$1,345,412	$1,254,046
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$_____	$_____
2. Annual Capital Expenditure	_____	_____
Total Other Deductions	$_____	$_____
NET BALANCE	$1,345,412	$1,254,046
DEPRECIATION	$1,323,859	$1,350,336
FREE CASH FLOW (Net Balance + Depreciation)	$2,669,271	$2,604,382

■ Total Facility

☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Professional Services Contract	$1,065,215	$1,086,519
2. Contract Labor	$4,583,883	$4,675,561
3. Imaging Interpretation Fees	_____	_____
4. Dues	_____	_____
5. Benefits	_____	_____
6. T & E	_____	_____
7. Minor Equipment	_____	_____
Total Other Expenses	**$5,649,098**	**$5,762,080**
	–	–

Attachment 8

JUN 28 '17 AM 10:52

SUPPLEMENTAL #1
June 28, 2017
10:52 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Saint Thomas Highlands Hospital

I, Blake Estes, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Executive Director, Planning
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27 day of June, 2017 witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires 1/9, 2018

HF-0043

Revised 7/02

DIANE FRANKLIN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.

Supplemental #2

Saint Thomas Highlands Hospital, LLC

CN1706-020

JUL 10 '17 PM 3:53

SUPPLEMENTAL #2
July 10, 2017
3:53 pm

71 Vickery Street
Atlanta, Georgia 30075
Telephone 770-394-8465
Facsimile 770-394-5470
www.thestrategyhouse.net

July 10, 2017

Via Hand Delivery

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243

RE: Certificate of Need Application CN1706-020
Saint Thomas Highlands Hospital, LLC

Dear Mr. Earhart:

Thank you for your letter of June 29, 2017 requesting information for the Certificate of Need for the expansion of an existing geriatric inpatient psychiatric unit at Saint Thomas Highlands Hospital from 10 beds to 14 beds.

This information is being submitted in triplicate, as requested.

---

1. **Section A: Project Details Item 6B (2) Floor Plan**

   It is noted there are two shaded patient rooms in the center of the floor plan. However, the floor plan does not provide an outline of what is contained in the two rooms. Please provide a legible floor plan of the two rooms the applicant proposes that are part of the proposed project.

   RESPONSE: A revised floor plan illustrates the configuration of the two patient rooms. Please refer to **Attachment 1**.

2. **Section B, Need, Item 2a. Additional Factors/Involuntary Admissions. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   It is noted the applicant will refer true emergency involuntary admissions to other inpatient providers. However, it is unclear how designating a health care surrogate

and admitting a patient to Highlands Hospitals is part of the emergency involuntary process. Please clarify.

RESPONSE: The process described is an alternative to a formal involuntary commitment that still results in a patient being admitted to Highlands. By way of explanation, a healthcare surrogate is a person appointed to make medical decisions for a patient when that patient is unable or unwilling to offer consent. The surrogate, rather than the patient, can then consent to having the patient admitted to Highlands. Thus, the patient is still admitted to Highlands under this surrogate process.

3. **Section B. Economic Feasibility Item C (Historical Data Chart)**

The Historical Data Chart for the total facility is noted in Attachment #5 in Supplemental #1. However, the 2014 Gross Operating Revenue amount of $112,639,194 is incorrect. Please revise and submit a corrected page 38.

RESPONSE: The $112,639,194 is correct. Line B.2, however, was reported as $72,897,755 and should have been $72,879,755. The transposition error has been corrected. Please refer to **Attachment 2**.

The breakout on page 39 of "other expenses" in the amount of $2,288,637 in 2014, $1,289,822 in 2015, and $3,178,688 in Supplemental #1 is noted. However, the figures do not match the amounts in D.6 in the Historical Data Chart of $4,324,352 in 2014, $2,472,023, and $4,910,255. If necessary, please provide a revised page 39.

RESPONSE: Additional line item details in the "other expense" category are provided. Please refer to **Attachment 2**.

4. **Section B. Economic Feasibility, Item D, Projected Data Chart**

The Projected Data Chart for the total facility is noted in Attachment #6 of Supplemental #1. However, the 2018 Gross Operating Revenue amount of $120,905,626 is incorrect. Please revise and submit a corrected page 41.

RESPONSE: The $120,905,626 is correct. Line B.2, however, was reported as $81,433,733 and should have been $81,443,733. The digit error has been corrected. Please refer to **Attachment 3**.

The breakout on page 42 of "other expenses" in the amount of $5,649,098 for 2018 and $5,762,080 for 2019 in Supplemental #1 is noted. However, the figures

do not match the amounts in D.6 in the Projected Data Chart of $7,667,398 for 2018 and $7,820,746 in 2019.

RESPONSE: Additional line item details in the "other expense" category are provided. Please refer to **Attachment 3**.

A notarized affidavit accompanies these responses and is found at **Attachment 4**. On behalf of Saint Thomas Highlands Hospital, we look forward to having this application deemed complete to start the formal review process.

Sincerely,

The Strategy House, Inc.

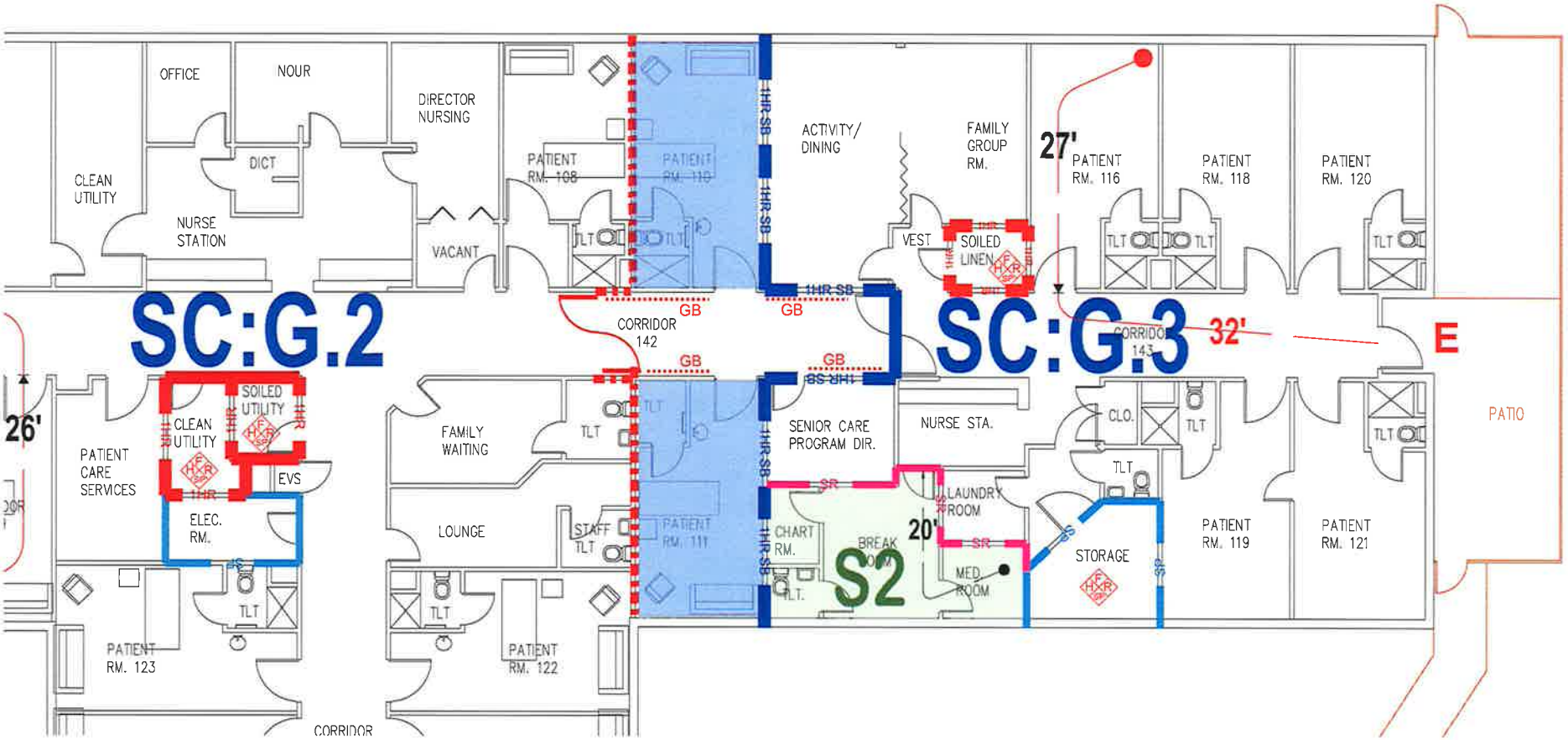
Robert M. Limyansky
Partner

attachments

SUPPLEMENTAL #2

July 10, 2017
3:53 pm

Attachment 1



GRESHAM SMITH AND PARTNERS

March 22, 2017
GS&P #19252.44

Saint Thomas Highlands Hospital
Geri-Psych Unit Renovation

SUPPLEMENTAL #2

July 10, 2017
3:53 pm

Attachment 2

SUPPLEMENTAL #2

July 10, 2017
3:53 pm

☐ Total Facility
☐ Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month). **RESPONSE: See Supplemental 1 notes for dates**

		Year 2014	Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	5,642	5,316	5,088
B.	Revenue from Services to Patients			
	1. Inpatient Services	$39,502,670	$22,666,516	$30,299,146
	2. Outpatient Services	$72,879,755	$47,472,848	$76,188,045
	3. Emergency Services	Included in OP	Included in OP	Included in OP
	4. Other Operating Revenue (Specify)_____	$256,769	$170,518	$436,010
	Gross Operating Revenue	$112,639,194	$70,309,882	$106,923,201
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$86,426,926	$54,640,846	$82,299,601
	2. Provision for Charity Care	$373,461	$214,748	$1,747,582
	3. Provisions for Bad Debt	$3,645,613	$1,772,100	$1,748,886
	Total Deductions	$90,446,000	$56,627,694	$85,796,069
NET OPERATING REVENUE		$22,193,194	$13,682,188	$21,127,132
D.	Operating Expenses			
	1. Salaries and Wages	$9,714,905	$5,905,247	$9,515,205
	a. Direct Patient Care			
	b. Non-Patient Care			
	2. Physician's Salaries and Wages			
	3. Supplies	$3,449,527	$2,279,306	$3,516,594
	4. Rent	$312,440	$193,003	$270,019
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
	5. Management Fees:	$413,237	$275,729	
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
	6. Other Operating Expenses	$4,324,352	$2,472,023	$4,910,255
	Total Operating Expenses	$18,214,461	$11,125,308	$18,212,073
E.	**Earnings Before Interest, Taxes and Depreciation**	$3,978,733	$2,556,880	$2,915,059
F.	Non-Operating Expenses			
	1. Taxes	$61,887	$275,523	
	2. Depreciation	$1,253,350	$688,819	$792,868
	3. Interest	$20,364	$140,674	
	4. Other Non-Operating Expenses	$164,352	$(34,508)	$261,212
	Total Non-Operating Expenses	$1,499,953	$1,070.508	$1,054,080
NET INCOME (LOSS)		$2,478,780	$1,486,372	$1,860,979

Chart Continues Onto Next Page

SUPPLEMENTAL #2

July 10, 2017

3:53 pm

NET INCOME (LOSS)	$2,478,780	$1,486,372	$1,860,979
G. Other Deductions			
1. Annual Principal Debt Repayment	$_____	$_____	$_____
2. Annual Capital Expenditure	_____	_____	_____
Total Other Deductions	$_____	$_____	$_____
NET BALANCE	$2,478,780	$1,486,372	$1,860,979
DEPRECIATION	$1,253,350	$688,819	$792,868
FREE CASH FLOW (Net Balance + Depreciation)	$3,732,130	$2,175,191	$2,653,847

■ Total Facility

☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2014	Year 2015	Year 2016
1. Professional Services Contract	$673,865	$391,783	$932,964
2. Contract Labor	$1,614,772	$898,039	$2,245,724
3. Repairs & Maintenance	$563,438	$379,458	$216,973
4. Rents & Leases	$312,440	$193,003	$270,019
5. Utilities	$292,649	$173,798	$275,189
6. _____	_____	_____	_____
7. Miscellaneous	$867,188	$435,942	$969,386
Total Other Expenses	$4,324,352	$2,472,023	$4,910,255

SUPPLEMENTAL #2

July 10, 2017
3:53 pm

Attachment 3

■ Total Facility
□ Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

	Year 2018	Year 2019
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	6,306	7,373
B. Revenue from Services to Patients		
1. Inpatient Services	$38,499,526	$39,077,019
2. Outpatient Services	$81,443,733	$82,665,389
3. Emergency Services		
4. Other Operating Revenue (Specify)	$ 962,367	$976,803
Gross Operating Revenue	$120,905,626	$122,719,211
C Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$91,302,786	$92,672,328
2. Provision for Charity Care	$4,129,652	$4,191,597
3. Provisions for Bad Debt	$1,818,259	$1,845,533
Total Deductions	$97,250,697	$ 98,709,458
NET OPERATING REVENUE	$23,654,929	$24,009,753
D. Operating Expenses		
1. Salaries and Wages	$9,412,305	$9,600,551
a. Direct Patient Care		
b. Non-Patient Care		
2. Physician's Salaries and Wages		
3. Supplies	$3,722,487	$3,796,937
4. Rent		
a. Paid to Affiliates	$143,468	$146,337
b. Paid to Non-Affiliates		
5. Management Fees:		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
6. Other Operating Expenses	$7,667,398	$7,820,746
Total Operating Expenses	$ 20,945,658	$21,364,571
E. **Earnings Before Interest, Taxes and Depreciation**	$2,709,271	$2,645,182
F. Non-Operating Expenses		
1. Taxes	$	$
2. Depreciation	$1,323,859	$1,350,336
3. Interest		
4. Other Non-Operating Expenses	$40,000	$40,800
Total Non-Operating Expenses	$1,363,859	$1,391,136
NET INCOME (LOSS)	$1,345,412	$1,254,046

Chart Continues Onto Next Page

SUPPLEMENTAL #2

July 10, 2017
3:53 pm

NET INCOME (LOSS)	$1,345,412	$1,254,046
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$_____	$_____
2. Annual Capital Expenditure	_____	_____
Total Other Deductions	$_____	$_____
NET BALANCE	$1,345,412	$1,254,046
DEPRECIATION	$1,323,859	$1,350,336
FREE CASH FLOW (Net Balance + Depreciation)	$2,669,271	$2,604,382

■ Total Facility

☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Professional Services Contract	$1,065,215	$1,086,519
2. Contract Labor	$4,583,883	$4,675,561
3. Repairs & Maintenance	$337,366	$344,113
4. Rents & Leases	$345,033	$351,934
5. Utilities	$429,374	$437,962
6. _____	_____	_____
7. Miscellaneous	$906,527	$924,657
Total Other Expenses	**$7,667,398**	**$7,820,746**

SUPPLEMENTAL #2

July 10, 2017
3:53 pm

Attachment 4

SUPPLEMENTAL #2
July 10, 2017
3:53 pm

JUL 10 '17 PM 2:57

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SAINT THOMAS HIGHLANDS HOSPITAL

I, STEVEN BLAKE ESTES, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

EXECUTIVE DIRECTOR, PLANNING
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 7 day of July, 2017, witness my hand at office in the County of DAVIDSON, State of Tennessee.

Diane Franklin
NOTARY PUBLIC

My commission expires 01/09/, 2018.

DIANE FRANKLIN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.

HF-0043

Revised 7/02