Original Application

Saint Thomas Rutherford Hospital

CN1707-021

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 17 PM 12:13

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

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

Saint Thomas Rutherford Hospital
Name

1700 Medical Center Parkway — Rutherford
Street or Route — County

Murfreesboro — Tennessee — 37129
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: Rutherford County is the fastest growing county in Tennessee. Despite the rapid population growth in the service area, STRH is projecting relatively modest gains in bed utilization – less than 1% per year overall – due to inpatient and observation bed hold conditions. Even at this rate, without additional beds, STRH will be runing 97.9% occupancy by 2019. Therefore, the major impact of this project is to reduce bed occupancy to a more manageable 80%, including outpatient and observation patients, thus averting many bed holds.

The existing medical-surgical beds at Saint Thomas Rutherford Hospital ("STRH") have been operating at nearly 90% utilization, resulting in inpatient/observation bed holds. This is a result of multiple factors: (1) increasing inpatient utilization from Rutherford County, (2) increasing inpatient in-migration from throughout the region, (3) increasing observation patient utilization and (4) increasing observation patient utilization exceeding 24 hours. Seventy-two (72) additional medical-surgical and extended observation beds are required to meet current and projected patient demand.

This is the first service expansion CON application filed by STRH since the replacement hospital opened in 2010 and is consistent with Saint Thomas' long standing goal to maximize existing resources to the fullest extent possible before increasing service capacity. Separate from this CON project, STRH will also be expanding its emergency and surgical services departments.

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

2) Ownership structure;

RESPONSE: STRH is 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: The proposed STRH service area is very similar to the existing STRH service area, recognizing the continuation of two patient referral trends: (1) increasing inpatient utilization from Rutherford County and (2) increasing inpatient in-migration from throughout the region.

STRH will continue to serve a five-county primary (Rutherford) and secondary (Bedford, Cannon, Coffee, Warren) service area. The rapid growth in Rutherford

County, the primary service area county, is the most distinguishing characteristic of the population served. Rutherford County leads the state of Tennessee (number one ranking of 95 counties) in projected population growth from 2017 to 2021 – 36,154 persons. As the ranking implies, this number exceeds the growth projected for even Davidson or Shelby counties. In terms of percentage population growth, Rutherford County is second in the state – 11.2%.

In 2017, the total service area had an estimated population of 485,746. Official sources indicate that the service area population will grow by approximately 8.5%, or 41,310 persons, by 2021. This is significantly higher growth than the 4.4% projected for Tennessee.

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

4) Existing similar service providers;

RESPONSE: Besides STRH, TriStar StoneCrest Medical Center is the only other medical-surgical hospital in the primary service area (Rutherford County). Each of the secondary service area counties also has a medical-surgical hospital. However, as the data indicates, STRH is approximately three times larger than the second largest service area medical-surgical hospital. This is true across a range of metrics – beds, admissions, patient days, average daily census. The other service area medical-surgical hospitals are simply not an alternative to the proposed project in terms of the level of care provided at STRH.

5) Project cost;

RESPONSE: The cost to construct 52,000 square feet of new space is $22,199,000. Total project costs are $47,478,943. Constructing two floors atop an existing patient bed tower (originally designed for vertical expansion) was deemed the least costly, most effective and most efficient alternative to address the very high utilization of hospital beds at STRH.

6) Funding;

RESPONSE: Funding for the project will come from Saint Thomas Health's corporate parent, Ascension.

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, STRH was financially feasible before the proposed bed addition and is expected to remain financially feasible with the proposed bed addition.

8) Staffing.

RESPONSE: The STRH is currently and appropriately staffed for a census of 277 patients. A census of 285 patients is projected for Year 2 and will require approximately 31 more clinical FTEs over the existing 1,029 clinical FTEs. Additional staff will be recruited using the existing resources of both STRH 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: The utilization statistics below are from STRH's internal financial reporting data, which tracks both inpatients and outpatients. The hospital's existing 286 licensed beds are essentially occupied on any given day by 190 inpatients and another 60 outpatients (observation, surgical/procedural 23-hour stays, etc.). What appears to be 60%-70% bed utilization quickly becomes nearly 90% bed utilization.

STRH Bed Utilization Components, FY2016 & FY2017
Midnight Census, Sunday - Saturday

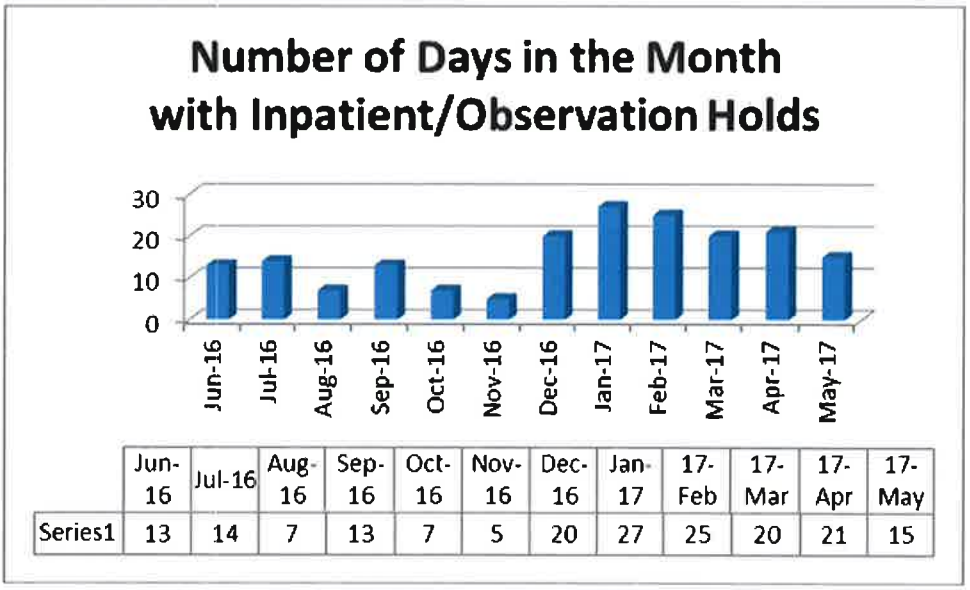
	Actual Daily Inpatient Census	Outpatients in a Bed	Actual Daily Total Census
FY2016	63,674	24,772	88,446
ADC	174	68	242
Occupancy %	60.8%	23.7%	84.5%
FY2017 (10 months)	63,118	20,178	83,296
ADC	188	60	249
Occupancy %	65.9%	21.1%	86.9%
Last 12 months	68,706	22,180	90,886
ADC	188	61	249
Occupancy %	65.8%	21.2%	87.1%

The situation for patients, families and admitting physicians becomes even more dire when weekday peaks are considered. As a result, STRH is unable to place a patient in a bed about half the days in a month, resulting in "holds" being placed on existing inpatient and observation beds.

Stated another way, observation patient volume (excluding other outpatients) continues to increase at STRH. Within this increase, shorter stay observation patients (eight hours or

less) are declining as a percentage of the total. The increase in observation stays of 24+ hours has increased significantly during this same time period.

As the Agency is aware, there is a push among both government and commercial payors to implement so-called "two midnight" rules and other methods to reduce payment as inpatient hospital stays. On any given day, STRH will have more than 60 patients in a hospital bed, many still undergoing a "status" determination for inpatient or outpatient reimbursement purposes. This can go on for more than 36 hours, rendering traditional ER holding areas inappropriate. For example, AIA Facility Guidelines Institute design standards allow cubicles to be used instead of private rooms, sharing one toilet among six patients and one shower among twelve patients. This is not an appropriate setting for placing a patient who will stay 24, 36 or more hours, regardless of their reimbursement (IP/OP) status.



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	17-Feb	17-Mar	17-Apr	17-May
Series1	13	14	7	13	7	5	20	27	25	20	21	15

Rutherford County is the fastest growing county in Tennessee. Despite the rapid population growth in the service area, STRH is projecting relatively modest gains in bed utilization – less than 1% per year overall – due to inpatient and observation bed hold conditions. Even at this rate, without additional beds, STRH will be runing 97.9% occupancy by 2019. Therefore, the major impact of this project is to reduce bed occupancy to a more manageable 80%, including outpatient and observation patients, thus averting many bed holds.

2) Economic Feasibility;

RESPONSE: As indicated in the Historical Data Chart and the Projected Data Chart, STRH was financially feasible before the proposed bed addition and is expected to remain financially feasible with the proposed bed addition.

STRH 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.

3) Appropriate Quality Standards; and

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

4) Orderly Development to adequate and effective health care.

RESPONSE: Under the 10% bed expansion provision of Public Chapter 1043, STRH could have added 28 beds without prior CON review and approval. Instead, STRH is seeking approval to add two floors of 36 beds each. Constructing these two floors atop an existing patient bed tower with a footprint for 36 beds per floor (originally designed for vertical expansion) was deemed the least costly, most effective and most efficient alternative to address the very high utilization of hospital beds at STRH.

Again, Rutherford County is the fastest growing county in Tennessee. Despite the rapid population growth in the service area, STRH is projecting relatively modest gains in bed utilization – less than 1% per year overall – due to inpatient and observation bed hold conditions. Even at this rate, without additional beds, STRH will be runing 97.9% occupancy by 2019. Therefore, the major impact of this project is to reduce bed occupancy to a more manageable 80%, including outpatient and observation patients, thus averting many bed holds.

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 Rutherford Hospital — Name
615-396-4100 — Phone Number

1700 Medical Center Parkway — Street or Route
Rutherford — County

Murfreesboro — City
TN — State
37129 — 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	
D.	Corporation (For Profit)		I.	Other (Specify)	
E.	Corporation (Not-for-Profit)	X			

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-4B-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 4, 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 5, 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 6, 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 community's focus on existing infrastructure limitations and the need to improve roadways is strong evidence of the robust growth in the service area, especially in Rutherford County. Areas of Rutherford County that are experiencing unprecedented growth and the need for infrastructure and roadway development include Smyrna and other areas of Murfreesboro. Further evidence of area growth are references in newspaper articles about roadway development to new public schools that are being constructed in Rutherford County, including a middle school that is scheduled to open in August 2017, an elementary school in August 2018 and a Rockvale High School in 2019. Please see **Tab 7, Attachment Section A-6B-3** for articles discussing the traffic and growth challenges in the area.

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

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

Check appropriate lines(s).

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

A. New Institution ____
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)_____ ____
F. Change in Bed Complement X
[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]
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 440053

Medicaid Provider Number Hospital 440053

Certification Type General Hospital

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	198	198	72			270
2) Surgical	"	"	"			"
3) ICU/CCU	32	32				32
4) Obstetrical	27	27				27
5) NICU	16	16				16
6) Pediatric	13	13				13
7) Adult Psychiatric						
8) Geriatric Psychiatric						
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	286	286	72			358

**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 medical-surgical beds at STRH have been operating at nearly 90% utilization, resulting in inpatient/observation bed holds. This is a result of multiple factors: (1) increasing inpatient utilization from Rutherford County, (2) increasing inpatient in-migration from throughout the region, (3) increasing observation patient utilization and (4) increasing observation patient utilization exceeding 24 hours. Seventy-two (72) additional medical-surgical and extended observation beds are required to meet current and projected patient demand. This is the first service expansion CON application filed by STRH since the replacement hospital opened in 2010 and is 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. Gordon Ferguson, President and CEO of Saint Thomas Rutherford Hospital and President of Saint Thomas Regional Hospitals, 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
36-Bed Inpatient Licensed Bed Unit				6th Floor		26,000	26,000
36-Bed Inpatient Licensed Bed Unit				7th Floor		26,000	26,000
Unit/Department GSF Sub-Total						52,000	52,000
Other GSF Total							
Total GSF						52,000	52,000
*Total Cost						$22,188,000	$22,188,000
**Cost Per Square Foot						$427	$427
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)* **Response:** Costs necessary for utilities, construction 90' above ground, construction above a working hospital, temporary vertical circulation for workers, supplies and construction waste					☐ 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 – Acute Care Bed Need Services and Construction, Renovation, Expansion and Replacement of Health Care Institutions. See responses, below.

1) Acute Care Bed Need Services

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year:

   Using the latest utilization and patient origin data from the Joint Annual Report of Hospitals and the most current population projection series from the Department of Health, perform the following:

   Step 1

   Determine the current Average Daily Census (ADC) in each county.

   $$ADC = \frac{\text{Patient Days}}{365 \text{ (366 in leap year)}}$$

   Step 2

   To determine the service area population (SAP) in both the current and projected year:

a. Begin with a list of all the hospital discharges in the state, separated by county, and showing the discharges both by the county where the patient actually lives (resident discharges), and the county in which the patient received medical treatment.

b. For the county in which the hospital is (or would be) located (service county), determine which other counties have patients who are treated in your county (resident counties). Treat all of the discharges from another state as if that whole state were a single resident county. The total discharges of residents from another state should be calculated from state population estimates and the latest National Center for Health Statistics southeastern discharge rates.

c. For each resident county, determine what percent of their total resident discharges are discharged from a hospital in your service county (if less than one percent, disregard).

d. For each resident county, apply the percentage determined above to the county's population (both projected and current). Add together the resulting numbers for all the resident counties and add that sum to the projected and current population of your service county. This will give you the service area population (SAP).

Step 3

Determine projected Average Daily Census as:

$$\text{Projected ADC} = \text{Current ADC} \times \frac{\text{Projected SAP}}{\text{Current SAP}}$$

Step 4

Calculate Projected Bed Need for each county as:

$$\text{Projected Need} = \text{Projected ADC} + 2.33 \times \sqrt{\text{Projected ADC}}$$

However, if projected occupancy:

$$\text{Projected Occupancy:} \quad \frac{\text{Projected ADC}}{\text{Projected Need}} \times 100$$

is greater than 80 percent, then calculate projected need :

$$\text{Projected Need} = \frac{\text{Projected ADC}}{.8}$$

RESPONSE: The latest official projections for 2017 and 2021 are based upon 2015 JARs. See **TAB 9, Attachment Section B-A1**, which also includes prior projections.

Following these guidelines, STRH and the Rutherford County hospitals served patients from 21 counties in 2015.

In terms of the population, Rutherford County leads the state of Tennessee (number one ranking of 95 counties) in projected population growth from 2017 to 2021 – 36,154 persons.[1] As the ranking implies, this number exceeds the growth projected for even Davidson or Shelby counties. In terms of percentage population growth, Rutherford County is second in the state – 11.2%.

This official acute care bed need projection methodology is currently under review for revision by the Agency. Across the entire state, only two counties have any projected need for licensed beds – Polk and Washington. Despite the extraordinary historical and projected population growth in Rutherford County, a surplus of 66 beds is projected for 2021.

In the past, this same need projection methodology has produced very erratic results for Rutherford County. Just three years ago (based on 2012 JARs), Rutherford County had an average daily census of 220 and a current year need projection of 275 beds. The current projections (based on 2015 JARs), report an average daily census of 297 patients and a current year need projection of 371 beds.

Stated differently, the Rutherford County actual official hospital average daily census increased by 77 patients (297 – 220). The current year hospital bed need projection increased by 96 beds (371-275). From this perspective alone, the STRH request for 72 additional licensed acute care beds, projected four years out, is not unreasonable. With additional documentation, STRH will demonstrate that its request for 72 additional licensed acute care beds is necessary to maintain quality and cost-effective hospital services in Rutherford County and the larger tertiary referral area.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

   a. All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

      RESPONSE: This guideline has not been met. However, as explained below, STRH qualifies for special consideration.

      In addition, the existing medical-surgical beds at STRH have been operating at nearly 90% utilization, resulting in inpatient/observation bed holds. This is a result of multiple factors: (1) increasing inpatient utilization from Rutherford County, (2) increasing inpatient in-migration from throughout the region, (3) increasing observation patient utilization and (4) increasing observation patient utilization exceeding 24 hours.

[1] Davidson County is number two, followed by Williamson County at number three.

b. All outstanding CON projects for new acute care beds in the proposed service area are licensed.

RESPONSE: This guideline has been met. No acute care beds are under development. It is our understanding that other types of beds have been approved and are being developed. In addition, as explained below, STRH qualifies for special consideration.

c. The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

RESPONSE: STRH is seeking approval under this guideline. STRH seeks 72 additional licensed acute care beds. The need justification and projections are presented in Part F of this section.

- Specialty health service units. As the Agency is aware, there is a push among both government and commercial payors to implement so-called "two midnight" rules and other methods to reduce payment as inpatient hospital stays. On any given day, STRH will have more than 60 patients in a hospital bed, many still undergoing a "status" determination for inpatient or outpatient reimbursement purposes. This can go on for more than 36 hours, rendering traditional ER holding areas inappropriate.

  The 72 licensed beds requested by STRH are part of a specialty inpatient unit intended to meet the needs of both traditional inpatients and these extended stay outpatient status and observation status patients who require monitoring, staffing and facilities comparable to a traditional inpatient.

- Tertiary care hospital. The population in and around Rutherford County has boomed and continues to boom (first in growth in Tennessee). So too has the number of specialty physicians in the community and the types of hospital services provided at STRH.

  STRH qualifies as a tertiary care hospital, based upon the following advanced service offerings.

  - Thoracic Surgery
  - Interventional Cardiology, Electrophysiology, and Heart Failure Medicine, Nuclear Cardiology subspecialties
  - Vascular and Interventional Radiology
  - Medical Residency training program for Emergency Medicine and Family Medicine
  - Interventional Gastroenterology
  - GYN Oncology
  - Neurology / Neurosurgery

- Maternal-Fetal Medicine
- Neonatology
- Vascular Surgery
- Infectious Disease
- Radiation Oncology
- Palliative Medicine

- Regional referral hospital. These advanced service offerings have led to more patients from a wider geographic area seeking care at STRH. As illustrated in the table below, Rutherford County patients at STRH increased by 1,507 from 2014 to 2016. Yet, the percentage of STRH patients from Rutherford County declined from 70.0% to 66.1%.

  Patients from the four secondary service area counties increased by 970 from 2014 to 2016. And, the percentage of STRH patients from its secondary service area increased from 21.3% to 22.8%.

  Patients from STRH's tertiary service area counties increased by 719 from 2014 to 2016. And, the percentage of STRH patients from its tertiary service area increased from 8.7% to 11.1%.

STRH Patient Origin Trends – Joint Annual Reports

	2014	2015	2016		2014	2015	2016
County	Patients	Patients	Patients		Dist.	Dist.	Dist.
Total	15,642	15,873	18,838		100.0%	100.0%	100.0%
Rutherford	10,952	10,955	12,459		70.0%	69.0%	66.1%
Bedford	1,058	1,072	1,379		6.8%	6.8%	7.3%
Coffee	831	984	1,239		5.3%	6.2%	6.6%
Warren	656	636	862		4.2%	4.0%	4.6%
Cannon	782	772	817		5.0%	4.9%	4.3%
SSA	3,327	3,464	4,297		21.3%	21.8%	22.8%
Other	1,363	1,454	2,082		8.7%	9.2%	11.1%

In addition, STRH is the referral hub for the Saint Thomas Health Regional Hospitals network.

- Saint Thomas DeKalb Hospital
- Saint Thomas Highlands Hospital
- Saint Thomas River Park Hospital
- Saint Thomas Stones River Hospital

These hospitals are part of a regionalization strategy, culminating with the purchase of four hospitals from Capella Healthcare in 2015.

Organizationally, the hospitals above report up to the President and CEO of Saint Thomas Rutherford Hospital.

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 Acute Care Bed Need Services are addressed immediately above. The STRH bed expansion project meets the requirements for special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

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 proposed beds will be added to the existing STRH facility.

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.

      RESPONSE: As described more fully throughout this application, the existing medical-surgical beds at STRH have been operating at nearly 90% utilization, resulting in inpatient/observation bed holds. This is a result of multiple factors: (1) increasing inpatient utilization from Rutherford County, (2) increasing inpatient in-migration from throughout the region, (3) increasing observation patient utilization and (4) increasing observation patient utilization exceeding 24 hours.

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

      RESPONSE: All licensed beds at STRH are currently set up and staffed. Expansion is the only option for adding the proposed beds.

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: STRH is the referral hub for the Saint Thomas Health Regional Hospitals network.

- Saint Thomas DeKalb Hospital
- Saint Thomas Highlands Hospital
- Saint Thomas River Park Hospital
- Saint Thomas Stones River Hospital

These hospitals are part of a regionalization strategy, culminating with the purchase of four hospitals from Capella Healthcare in 2015. Organizationally, the hospitals above report up to the President and CEO of Saint Thomas Rutherford Hospital.

This project represents the right-sizing of assets at STRH. No previously approved projects are related to this proposed bed addition. In fact, this is the first service expansion CON application filed by STRH since the replacement hospital opened in 2010. This project is consistent with Saint Thomas' long standing goal to maximize existing resources to the fullest extent possible before increasing service capacity.

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 Rutherford Hospital – All Inpatients
Actual, 2016 JAR

Service Area Counties	Historical Utilization-County Residents	% of Total Patients
Rutherford	12,459	66.1%
Bedford	1,379	7.3%
Coffee	1,239	6.6%
Warren	862	4.6%
Cannon	817	4.3%
Subtotal	16,756	88.9%
Other	2,082	11.1%
Total	18,838	100.0%

Source: 2016 JAR

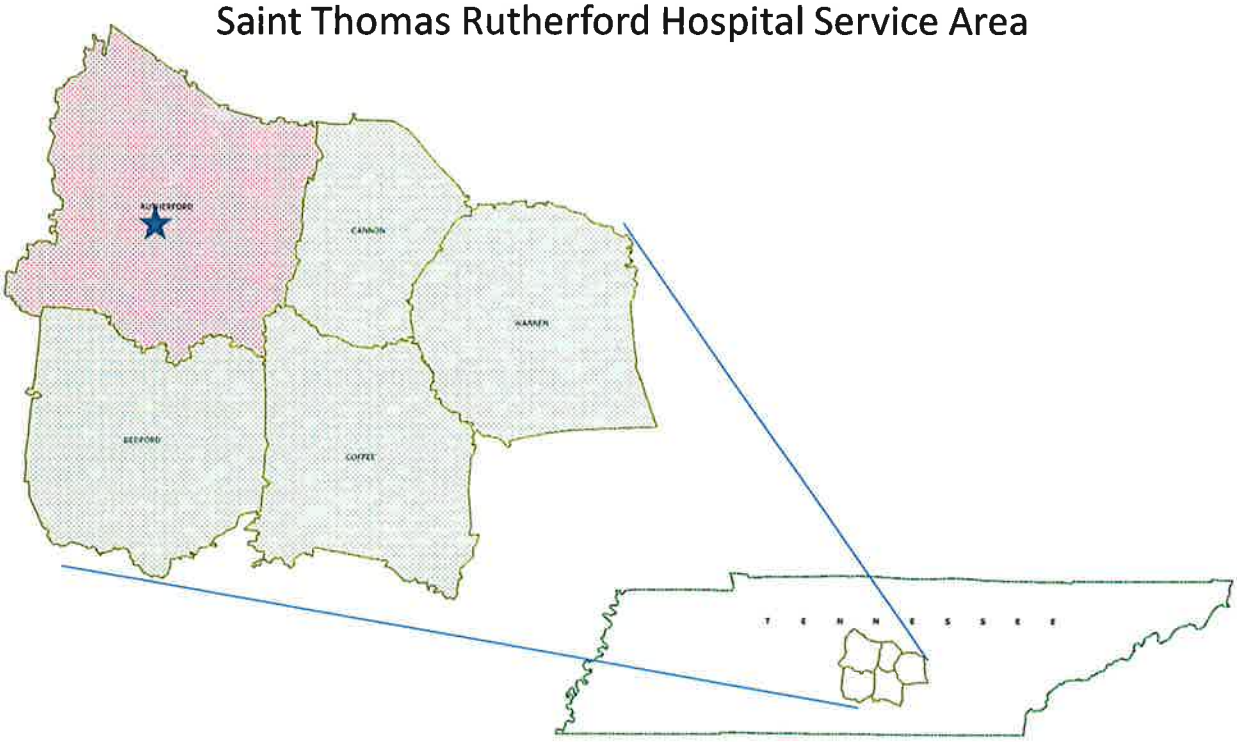
Saint Thomas Rutherford Hospital – All Inpatients
Projected, Year 2

Service Area Counties	Projected Utilization-County Residents	% of Total Patients
Rutherford	13,197	63.5%
Bedford	1,559	7.5%
Coffee	1,455	7.0%
Warren	1,039	5.0%
Cannon	935	4.5%
Subtotal	18,185	87.5%
Other	2,598	12.5%
Total	20,782	100.0%

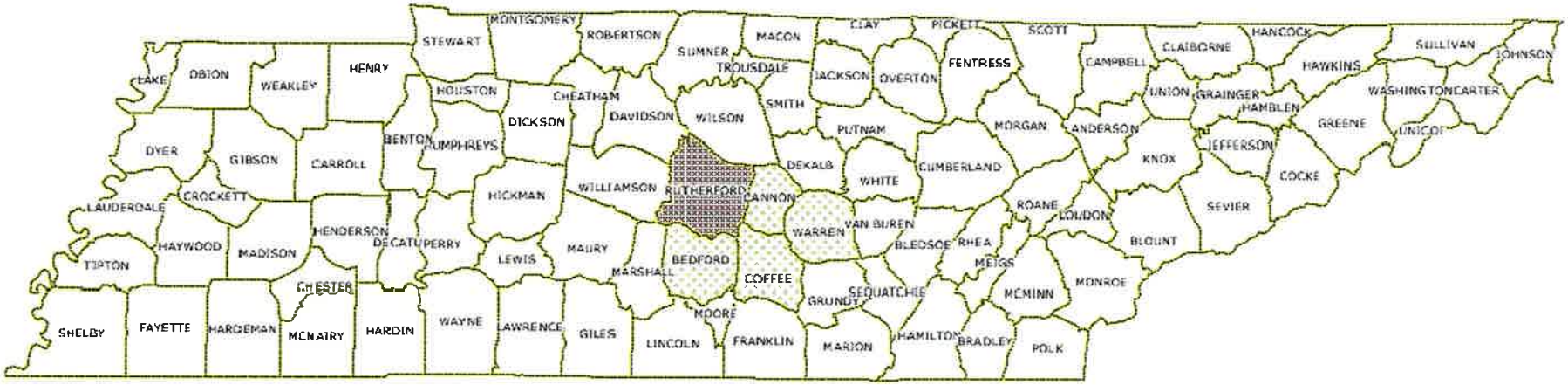
RESPONSE: The proposed STRH service area is very similar to the existing STRH service area, recognizing the continuation of two patient referral trends: (1) increasing inpatient utilization from Rutherford County and (2) increasing inpatient in-migration from throughout the region.

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 STRH.

Saint Thomas Rutherford Hospital Service Area



County Level Map



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

RESPONSE: STRH will continue to serve a five-county primary and secondary service area. The rapid growth in Rutherford County, the primary service area county, is the most distinguishing characteristic of the population served. Rutherford County leads the state of Tennessee (number one ranking of 95 counties) in projected population growth from 2017 to 2021 – 36,154 persons.[2] As the ranking implies, this number exceeds the growth projected for even Davidson or Shelby counties. In terms of percentage population growth, Rutherford County is second in the state – 11.2%.

In 2017, the total service area had an estimated population of 485,746. Official sources indicate that the service area population will grow by approximately 8.5%% or 41,310 persons by 2021. This is significantly higher growth than the 4.4% projected for Tennessee.

Compared to the overall Tennessee median household income ("MHI") of $45,219, the service area MHIs are significantly lower ($35,376 - $41,984) in all but Rutherford County ($56,219). Three of the five service area counties (Warren, Coffee, Cannon) have a higher percentage of residents in poverty than Tennessee's 17.6%. While 18.7% of the service area's total population is enrolled in TennCare compared to 21.1% for Tennessee, the rate is at or above the state average in all but Rutherford County.

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 Population

** 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.*

[2] Davidson County is number two, followed by Williamson County at number three.

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.

Though seniors (age 65+) are high users of healthcare services, this project will benefit all population age cohorts. Therefore, there is not a separate target population for this project.

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 Population
Bedford	50,301	52,517	4.4%	all	all	4.4%	100%	36.6	$41 984	N/A	17.1%	12,696	25.2%
Cannon	14,562	15,035	3.2%	all	all	3.2%	100%	38.3	$41,533	N/A	18.4%	3,069	21.1%
Coffee	56,423	58,331	3.4%	all	all	3.4%	100%	39.7	$41,590	N/A	18.6%	13,616	24.1%
Rutherford	323,441	359,595	11.2%	all	all	11.2%	100%	32.9	$56,219	N/A	12.4%	49,992	15.5%
Warren	41,019	41,578	1.4%	all	all	1.4%	100%	39.5	$35,376	N/A	21.2%	11,316	27.6%
Service Area Total	485,746	527,056	8.5%	all	all	8.5%	100%	NA	NA	N/A	N/A	90,689	18.7%
State of TN Total	6,886,441	7,188,358	4.4%	all	all	4.4%	100%	37.6	$45,219	N/A	17.6%	1,454,231	21.1%

Source:TN DOH Health Statistics, Bureau of the Census - 2015, and Bureau of TennCare - May 2017

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: STRH 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.

In Tennessee, Ascension's Saint Thomas Health operates nine hospitals in addition to a comprehensive network of affiliated joint ventures, medical practices, clinics and rehabilitation facilities that cover a 68-county area and employ more than 8,000 associates. Across the state, Saint Thomas Health provided more than $78 million in community benefit and care of persons living in poverty in fiscal year 2016. Serving Tennessee for 15 years, Ascension is a faith-based healthcare organization committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. Ascension is the largest non-profit health system in the U.S. and the world's largest Catholic health system, operating 2,500 sites of care – including 141 hospitals and more than 30 senior living facilities – in 24 states and the District of Columbia.

In terms of the service area population, Rutherford County leads the state of Tennessee (number one ranking of 95 counties) in projected population growth from 2017 to 2021 – 36,154 persons.[3] As the ranking implies, this number exceeds the growth projected for even Davidson or Shelby counties. In terms of percentage population growth, Rutherford County is second in the state – 11.2%. These statistics indicate that there will be a need for the beds proposed by STRH.

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 following information was compiled from the TDH standard Report for Hospitals, 2013-2015. Besides STRH, TriStar StoneCrest Medical Center is the only other medical-surgical hospital in the primary service area (Rutherford County). Each of the secondary service area counties also has a medical-surgical hospital.

However, as the data below indicates, STRH is approximately three times larger than the second largest service area medical-surgical hospital. This is true across a range of metrics – beds, admissions, patient days, average daily census. The other service area medical-surgical hospitals are simply not an alternative to the proposed project in terms of the level of care provided at STRH.

[3] Davidson County is number two, followed by Williamson County at number three.

Rutherford County - TriStar StoneCrest Medical Center

	2013	2014	2015	% change from 2013-2015
Licensed Beds	109	109	109	
Staffed Beds	109	109	109	
Admissions	5,124	5,277	5,208	
Patient Days	16,254	17,480	18,252	+12.3%
ADC	45	48	50	
ALOS	3.2	3.3	3.5	
%Staffed Occupancy	40.9%	43.9%	45.9%	
% Licensed Occupancy	40.9%	43.9%	45.9%	+12.2% or 5.0 pct pts

Bedford County – Heritage Medical Center

	2013	2014	2015	% change from 2013-2015
Licensed Beds	60	60	60	
Staffed Beds	60	52	52	
Admissions	1,930	1,793	1,594	
Patient Days	5,723	6,220	6,002	+4.9%
ADC	16	17	16	
ALOS	3.0	3.5	3.8	
%Staffed Occupancy	26.1%	32.8%	31.6%	
% Licensed Occupancy	26.1%	28.4%	27.4%	+5.0% or 1.3 pct pts

Cannon County – Saint Thomas Stones River Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	60	60	60	
Staffed Beds	50	50	50	
Admissions	696	794	840	
Patient Days	4,525	4,816	5,469	+20.9%
ADC	12	13	15	
ALOS	6.5	6.1	6.5	
%Staffed Occupancy	24.8%	26.4%	30.0%	
% Licensed Occupancy	20.7%	22.0%	25.0%	+20.8% or 4.3 pct pts

Coffee County – Harton Regional Medical Center

	2013	2014	2015	% change from 2013-2015
Licensed Beds	135	135	135	
Staffed Beds	107	107	115	
Admissions	4,815	4,834	4,742	
Patient Days	19,549	20,521	20,532	+5.0%
ADC	54	56	56	
ALOS	4.1	4.2	4.3	
%Staffed Occupancy	50.1%	52.5%	48.9%	
% Licensed Occupancy	39.7%	41.6%	41.7%	+5.0% or 2.0 pct pts

Coffee County – United Regional Medical Center (incl. Med Ctr of Manchester)

	2013	2014	2015	% change from 2013-2015
Licensed Beds	79	79	49	
Staffed Beds	51	51	36	
Admissions	2,160	1,914	1,136	
Patient Days	7,536	6,065	3,768	-50.0% (consolidated in 2015)
ADC	20	16	10	
ALOS	3.5	3.2	3.3	
%Staffed Occupancy	39.2%	31.4%	28.7%	
% Licensed Occupancy	25.3%	20.3%	21.1%	-16.6% or -4.2 pct pts

Warren County – Saint Thomas River Park Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	125	125	125	
Staffed Beds	125	125	125	
Admissions	3,207	2,935	2,875	
Patient Days	11,395	11,341	11,996	+5.3%
ADC	31	31	33	
ALOS	3.6	3.9	4.2	
%Staffed Occupancy	25.0%	24.9%	26.3%	
% Licensed Occupancy	25.0%	24.9%	26.3%	+5.2% or 1.3 pct pts

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: From the data reported below, it appears at least initially that inpatient bed utilization at STRH has remained relatively constant over the past three reporting years.

Rutherford County – Saint Thomas Rutherford Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	286	286	286	
Staffed Beds	268	268	268	
Admissions	16,176	15,642	15,873	
Patient Days	63,503	58,744	63,688	+0.3%
ADC	174	161	174	
ALOS	3.9	3.8	4.0	
%Staffed Occupancy	64.9%	60.1%	64.9%	
% Licensed Occupancy	60.8%	56.3%	61.0%	+0.3% or +0.2 pct pts

However, this is too simplistic a view of the true bed utilization at STRH. Even by expanding staffed beds to fully licensed capacity, STRH's true bed utilization has approached 90% utilization the past two years.

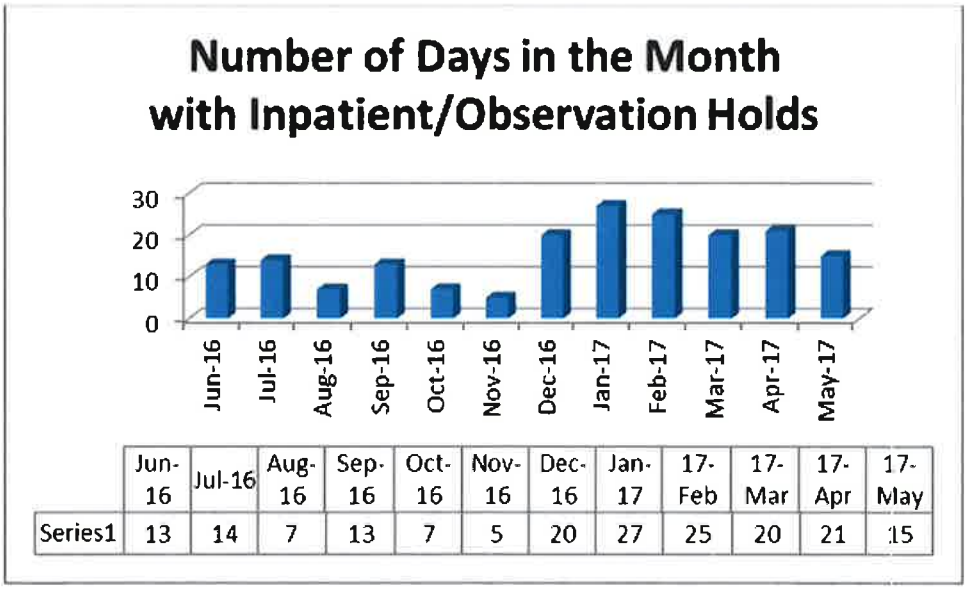
As the Agency is aware, there is a push among both government and commercial payors to implement so-called "two midnight" rules and other methods to reduce payment as inpatient hospital stays. On any given day, STRH will have more than 60 patients in a hospital bed, many still undergoing a "status" determination for inpatient or outpatient reimbursement purposes. This can go on for more than 36 hours, rendering traditional ER holding areas inappropriate.

The utilization statistics below are from STRH's internal financial reporting data, which tracks both inpatients and outpatients. The hospital's existing 286 licensed beds are essentially occupied on any given day by 190 inpatients and another 60 outpatients (observation, surgical/procedural 23-hour stays, etc.). What appears to be 60%-70% bed utilization quickly becomes nearly 90% bed utilization.

STRH Bed Utilization Components, FY2016 & FY2017
Midnight Census, Sunday - Saturday

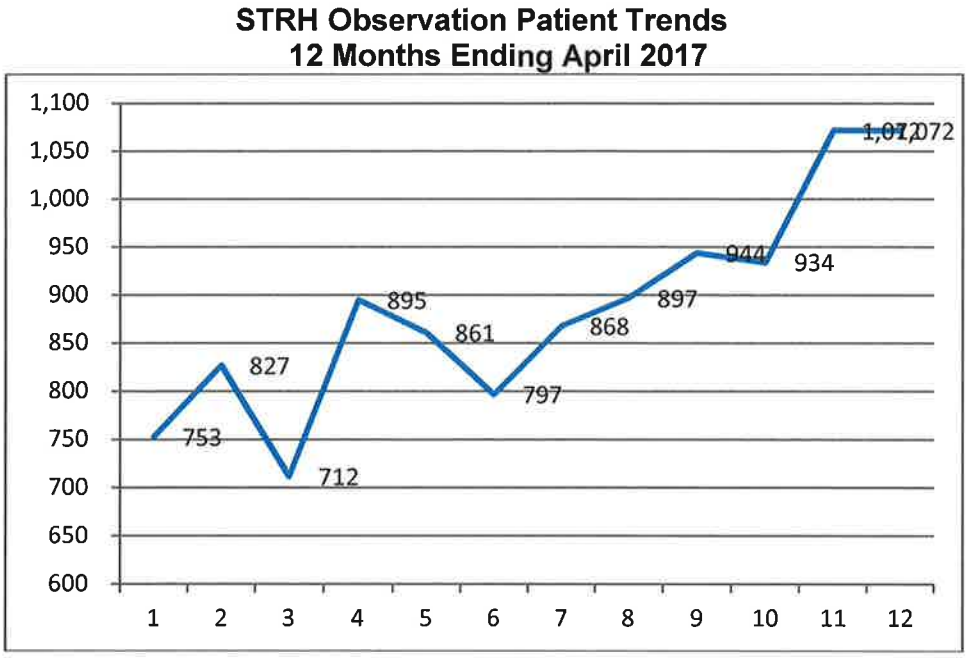
	Actual Daily Inpatient Census	Outpatients in a Bed	Actual Daily Total Census
FY2016	63,674	24,772	88,446
ADC	174	68	242
Occupancy %	60.8%	23.7%	84.5%
FY2017 (10 months)	63,118	20,178	83,296
ADC	188	60	249
Occupancy %	65.9%	21.1%	86.9%
Last 12 months	68,706	22,180	90,886
ADC	188	61	249
Occupancy %	65.8%	21.2%	87.1%

The situation for patients, families and admitting physicians becomes even more dire when weekday peaks are considered. As a result, STRH is unable to place a patient in a bed about half the days in a month, resulting in "holds" being placed on existing inpatient and observation beds.

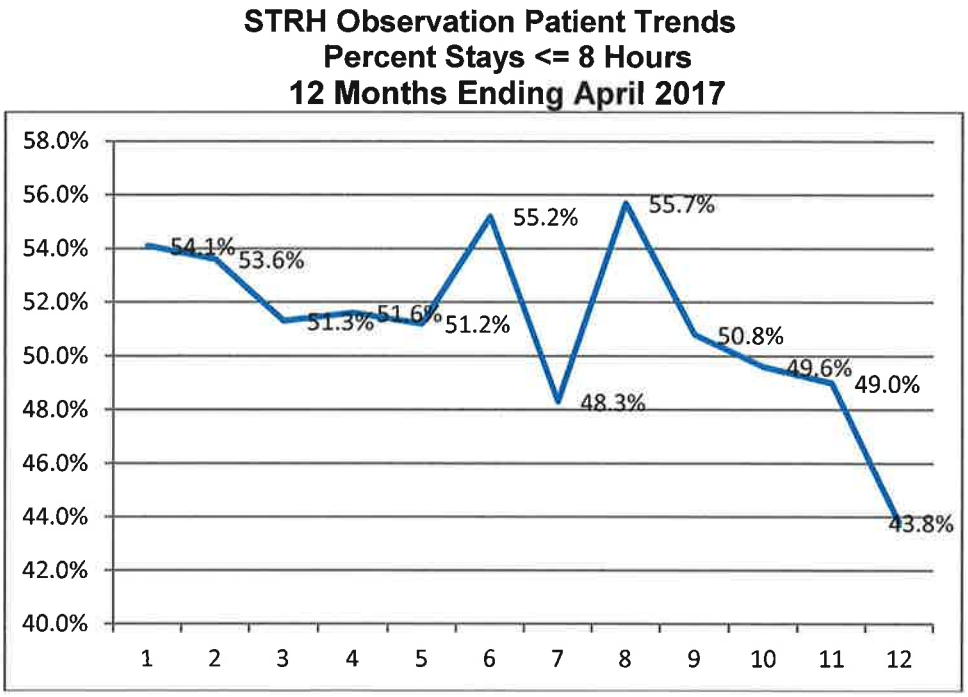


	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	17-Feb	17-Mar	17-Apr	17-May
Series1	13	14	7	13	7	5	20	27	25	20	21	15

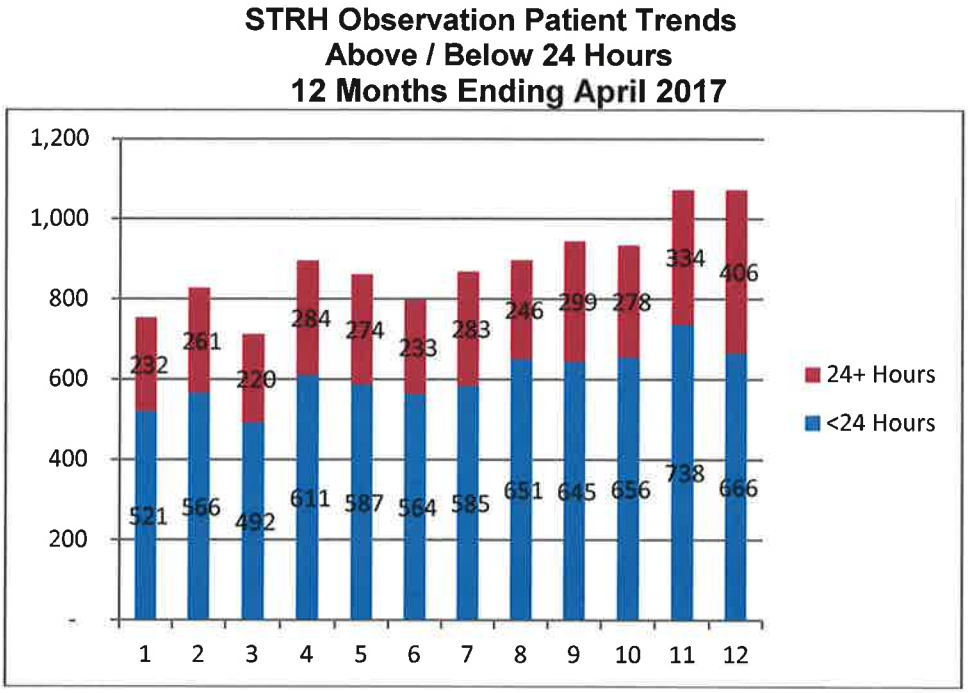
Stated another way, observation patient volume (excluding other outpatients) continues to increase at STRH.



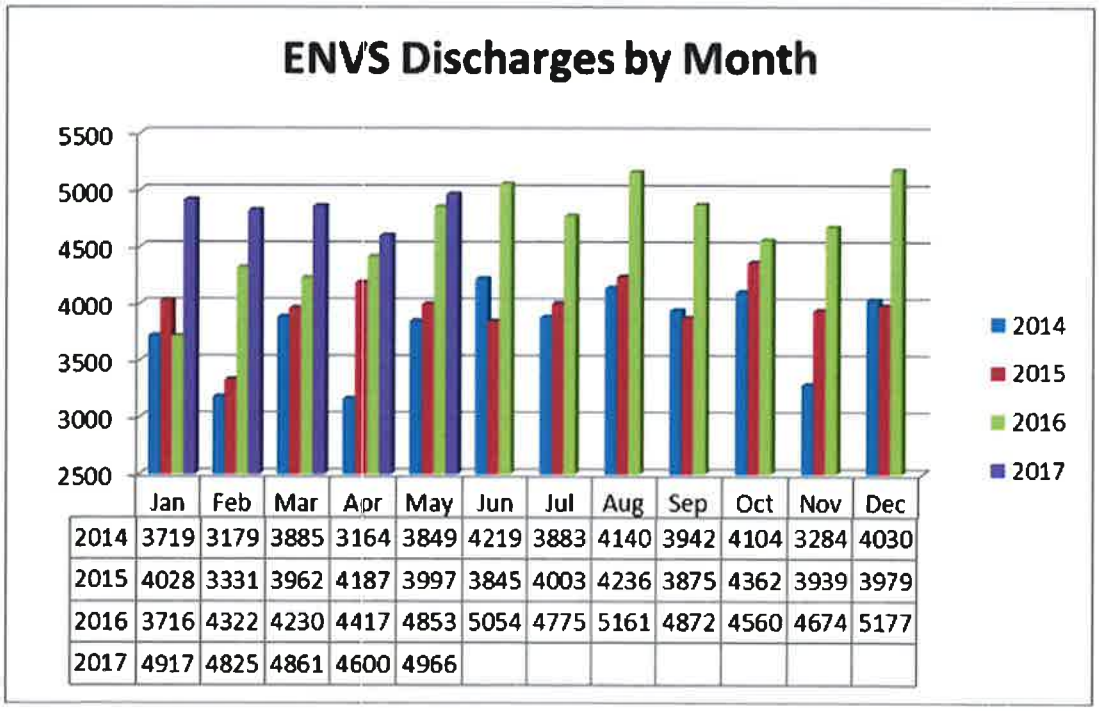
Within this increase, shorter stay observation patients (eight hours or less) are declining as a percentage of the total.



The increase in observation stays of 24+ hours has increased significantly during this same time period.



STH maintains a "transfer center" to optimize bed utilization. While this has decreased the turnaround time for making beds available, it has not eliminated the bed shortage. The following data reports the number of times that a bed is turned over for a new patient by STRH's environmental services department. In 2014, a high turnover month had about 4,000 discharges. In 2017, this number has increased to almost 5,000 discharges in most months.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014	3719	3179	3885	3164	3849	4219	3883	4140	3942	4104	3284	4030
2015	4028	3331	3962	4187	3997	3845	4003	4236	3875	4362	3939	3979
2016	3716	4322	4230	4417	4853	5054	4775	5161	4872	4560	4674	5177
2017	4917	4825	4861	4600	4966							

With one of the busiest emergency departments in the state, STRH records more than 90,000 patient visits per year. Through a partnership with the University of Tennessee College of Medicine, STRH's emergency department is the home for the UT Emergency Medicine Residency Program. STRH is addressing short duration ED observation patient volumes outside the scope of this CON application.

Both growth in population and traffic congestion are major drivers in ED utilization and overall services at STRH. The largest physician group in the community, Murfreesboro Medical Clinic, is constantly adding providers to its staff and supports this bed expansion project. The Clinic sees over 30,000 patients per month. More significantly, the Clinic averages more than 1,429 new patients per month. This is one component driving incresed bed utilization at STRH.

Another component is the recently opened Saint Thomas Medical Partners – New Salem, a full-service care site designed to meet medical needs close to home. Saint Thomas is consistently exploring less costly outpatient alternatives to care, even if it results in less revenue for the health system.

Rutherford County is the fastest growing county in Tennessee. Despite the rapid population growth in the service area, STRH is projecting relatively modest gains in bed utilization – less than 1% per year overall – due to inpatient and observation bed hold conditions. Even at this rate, without additional beds, STRH will be runing 97.9% occupancy by 2019. Therefore, the major impact of this project is to reduce bed occupancy to a more manageable 80%, including outpatient and observation patients, thus averting many bed holds.

Rutherford County – Saint Thomas Rutherford Hospital

	2016 Actual	2017 Interim	2018 Interim	2019 Interim	2020 Year 1	2021 Year 2
Licensed Beds	286	286	286	286	358	358
Staffed Beds	286	286	286	286	358	358
Admissions	18,931	19,320	19,709	20,098	20,487	20,782
Patient Days	78,502	79,108	79,714	80,320	80,924	82,089
ADC	215	217	218	220	222	225
ALOS	4.1	4.1	4.0	4.0	4.0	4.0
%Staffed Occupancy	80.2%	76.1%	76.5%	77.2%	62.0%	62.8%
% Licensed Occupancy	80.2%	76.1%	76.5%	77.2%	62.0%	62.8%
Outpatients in Beds	60	60	60	60	60	60
Adjusted ADC	275	277	278	280	282	285
% Licensed Occupancy	96.2%	96.9%	97.2%	97.9%	78.8%	79.6%

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. At an estimated project cost of $47,383,943 (Project Cost Form, line D), the calculated filing fee would be $272,458. Therefore, the maximum filing fee threshold has been reached. Enclosed please find a filing fee check in the amount of $95,000 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: Reported equipment costs are consistent with these guidelines.

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 licensed architect's construction cost verification letter in **Tab 10 – Attachment Section B-A5**.

PROJECT COST CHART

JUL 14 '17 PM12:16

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	$3,718,658
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$1,175,000
3.	Acquisition of Site	
4.	Preparation of Site	$2,000,000
5.	Total Construction Costs	$22,188,000
6.	Contingency Fund	$4,979,984
7.	Fixed Equipment (Not included in Construction Contract)	$5,862,468
8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	$2,854,184
9.	Other (Specify) Furnishings, Furniture	$4,605,649
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)	$47,383,943
E.	CON Filing Fee	$95,000
F.	Total Estimated Project Cost (D+E) **TOTAL**	$47,478,943

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 project costs will be paid from existing cash reserves at Ascension, the parent of Saint Thomas Health. Please see **Tab 11 – 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 STRH facility on the following pages.

■ 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 CY Jan reported (Month).

	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.	57,127	66,567	78,502
B. Revenue from Services to Patients			
1. Inpatient Services	$ 463,131,361	$ 550,171,044	$ 658,073,091
2. Outpatient Services	306,484,464	341,935,627	342,868,123
3. Emergency Services	179,833,849	192,610,130	214,926,111
4. Other Operating Revenue *(Provider Tax, JV Imaging, USPI)*	12,711,815	13,212,264	13,138,168
Gross Operating Revenue	$ 962,161,489	$1,097,929,065	$1,229,005,493
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$ 639,973,486	$ 739,881,294	$ 829,540,194
2. Provision for Charity Care	48,738,222	52,925,661	75,100,095
3. Provisions for Bad Debt	16,440,606	19,829,756	20,276,736
Total Deductions	$ 705,152,314	$ 812,636,711	$ 924,917,025
NET OPERATING REVENUE	$ 257,009,175	$ 285,292,354	$ 304,088,468
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	$ 64,941,293	71,988,473	77,953,112
b. Non-Patient Care	2,705,887	2,999,520	3,248,046
2. Physician's Salaries and Wages	5,963,118	6,829,013	8,591,535
3. Supplies	34,177,396	38,918,207	40,859,772
4. Rent			
a. Paid to Affiliates			
b. Paid to Non-Affiliates	3,607,725	3,298,565	3,314,231
5. Management Fees:			
a. Paid to Affiliates	36,159,231	43,726,719	51,082,626
b. Paid to Non-Affiliates			
6. Other Operating Expenses	48,205,725	49,349,241	47,122,863
Total Operating Expenses	$195,760,375	$217,109,738	$232,172,185
E. **Earnings Before Interest, Taxes and Depreciation**	$ 61,248,800	$ 68,182,616	$ 71,916,283
F. Non-Operating Expenses			
1. Taxes	$	$	$
2. Depreciation	21,004,272	20,385,133	16,988,133
3. Interest	1,934,343	1,928,631	1,969,776
4. Other Non-Operating Expenses			
Total Non-Operating Expenses	$ 22,938,615	$ 22,313,764	$ 18,957,909
NET INCOME (LOSS)	$ 38,310,185	$ 45,868,852	$ 52,958,374

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ 38,310,185	$ 45,868,852	$ 52,958,374
G. Other Deductions			
1. Annual Principal Debt Repayment	$_____	$_____	$_____
2. Annual Capital Expenditure	_____	_____	_____
Total Other Deductions	$_____	$_____	$_____
NET BALANCE	$ 38,310,185	$ 45,868,852	$ 52,958,374
DEPRECIATION	21,004,272	20,385,133	16,988,133
FREE CASH FLOW (Net Balance + Depreciation)	$ 59,314,457	$ 66,253,985	$ 69,946,507

■ Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2014	Year 2015	Year 2016
1. Purchased Services	$ 21,273,122	$ 23,319,233	$ 26,147,847
2. Provider Tax Expense	18,498,669	16,658,601	10,526,695
3. All Other	8,433,934	9,371,407	10,448,321
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	**$48,205,725**	**$49,349,241**	**$47,122,863**

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 existing STRH facility 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 CY Jan reported (Month).

	Year 2020	Year 2021
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	80,924	82,089
B. Revenue from Services to Patients		
1. Inpatient Services	$808,078,000	$860,555,000
2. Outpatient Services	276,060,800	293,856,000
3. Emergency Services	414,091,200	440,784,000
4. Other Operating Revenue (Specify)_____	13,245,000	13,510,000
Gross Operating Revenue	$1,511,475,000	$1,608,705,000
C Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$1,055,559,600	$1,132,732,800
2. Provision for Charity Care	93,827,520	100,687,360
3. Provisions for Bad Debt	23,456,880	25,171,840
Total Deductions	$1,172,844,000	$1,258,592,000
NET OPERATING REVENUE	$338,681,000	$ 350,113,000
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	84,144,960	87,250,560
b. Non-Patient Care	3,506,040	3,635,440
2. Physician's Salaries and Wages	11,014,300	11,385,440
3. Supplies	48,235,000	51,076,000
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates	3,407,000	3,414,000
5. Management Fees:		
a. Paid to Affiliates	59,606,000	61,710,000
b. Paid to Non-Affiliates		
6. Other Operating Expenses	50,573,700	52,166,560
Total Operating Expenses	$ 260,487,000	$ 270,638,000
E. **Earnings Before Interest, Taxes and Depreciation**	$ 78,144,000	$ 79,475,000
F. Non-Operating Expenses		
1. Taxes	$	$
2. Depreciation	17,349,000	17,865,000
3. Interest	2,802,000	3,026,000
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	$ 20,151,000	$ 20,891,000
NET INCOME (LOSS)	$ 57,993,000	$ 58,584,000

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ 57,993,000	$ 58,584,000
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$_____	$_____
2. Annual Capital Expenditure	_____	_____
Total Other Deductions	$_____	$_____
NET BALANCE	$ 57,993,000	$ 58,584,000
DEPRECIATION	17,349,000	17,865,000
FREE CASH FLOW (Net Balance + Depreciation)	$ 73,342,000	$ 76,449,000

■ Total Facility
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2020	Year 2021
1. Purchased Services	$ 28,170,000	$ 28,986,000
2. Provider Tax Expense	12,983,000	13,358,000
3. All Other	9,420,700	9,822,560
4.		
5.		
6.		
7.		
Total Other Expenses	**$ 50,573,700**	**$ 52,166,560**

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)*	32,547	34,762	39,443	41,409	19.1%
Deduction from Revenue *(Total Deductions/Utilization Data)*	24,090	26,161	30,607	32,397	23.8%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	8,457	8,601	8,837	9,012	4.8%

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: Data in the table above actually cover a six-year period, beginning in 2016 and ending in 2021. As indicated in the table above, the charges for services (discharges) at STRH will not be impacted significantly by the proposed project. Gross charges increase at 4.9% per year while net charges increase at a mere 1.3% per year.

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 only medical-surgical hospital in the service area remotely comparable to STRH in terms of size and services is TriStar StoneCrest Medical Center. A comparison of the 2015 JAR data indicate an average gross charge per admission of $31,001 at STRH compared to $37,367 at StoneCrest.

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, STRH was financially feasible before the proposed bed addition and is expected to remain financially feasible with the proposed bed addition.

Funding for the project will come from Ascension, the parent of Saint Thomas Health. The substantial resources of this organization is documented in the attachments. See **Tab 12 – 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	14.9%	16.1%	17.4%	17.1%	16.7%

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 STRH and Saint Thomas Health is appropriately capitalized to undertake the proposed bed 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 hospital. Furthermore, STRH will follow the same financial assistance policies that are currently in place. Please refer to **Tab 13 – Attachment Section B-G** for a copy of the STRH financial assistance policies.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$ 699,673,410	46.7%
TennCare/Medicaid	154,317,690	10.3%
Commercial/Other Managed Care	462,953,070	30.9%
Self-Pay	136,338,930	9.1%
Other (Other gov't, Workers Comp)	44,946,900	3.0%
Total	$1,498,230,000	100.0%
Charity Care	93,827,520	6.3%

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 STRH before and after the proposed bed addition.

Position Classification	Existing FTEs (enter year) 2017	Projected FTEs Year 1 2020	Average Wage (Contractual Rate) 2020	Area Wide/Statewide Average Wage 2016
A. Direct Patient Care Positions				
RNs				
LPNs				
Tech				
Rec Therapists				
Social Worker				
Total Direct Patient Care Positions	1,029	1,060	$ 31.69	
B. Non-Patient Care Positions				
Management				
Total Non-Patient Care Positions	43	44	$ 31.69	
Total Employees *(A+B)*	1,072	1,104	$ 31.69	
C. Contractual Staff				
Total Staff *(A+B+C)*	1,072	1,104	$ 31.69	

RESPONSE: STRH 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: Constructing two floors atop an existing patient bed tower (originally designed for vertical expansion) was deemed the least costly, most effective and most efficient alternative to address the very high utilization of hospital beds at STRH.

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

RESPONSE: STRH is currently staffing 285 of its 286 licensed beds. There are no alternatives 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: STRH 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: Besides STRH, TriStar StoneCrest Medical Center is the only other medical-surgical hospital in the primary service area (Rutherford County). Each of the secondary service area counties also has a medical-surgical hospital. However, as the data indicates, STRH is approximately three times larger than the second largest service area medical-surgical hospital. This is true across a range of metrics – beds, admissions, patient days, average daily census. The other service area medical-surgical hospitals are simply not an alternative to the proposed project in terms of the level of care provided at STRH.

STRH's existing 286 licensed beds are essentially occupied on any given day by 190 inpatients and another 60 outpatients (observation, surgical/procedural 23-hour stays, etc.). What appears to be 60%-70% bed utilization quickly becomes nearly 90% bed utilization.

The situation for patients, families and admitting physicians becomes even more dire when weekday peaks are considered. As a result, STRH is unable to place a patient in a bed about half the days in a month, resulting in "holds" being placed on existing inpatient and observation beds.

Stated another way, observation patient volume (excluding other outpatients) continues to increase at STRH. Within this increase, shorter stay observation patients (eight hours or less) are declining as a percentage of the total. The increase in observation stays of 24+ hours has increased significantly during this same time period.

With one of the busiest emergency departments in the state, STRH records more than 90,000 patient visits per year. Through a partnership with the University of Tennessee College of Medicine, STRH's emergency department is the home for the UT Emergency Medicine Residency Program. STRH is addressing short duration ED observation patient volumes outside the scope of this CON application.

Both growth in population and traffic congestion are major drivers in ED utilization and overall services at STRH. The largest physician group in the community, Murfreesboro Medical Clinic, is constantly adding providers to its staff and supports this bed expansion project. The Clinic sees over 30,000 patients per month. More significantly, the Clinic averages more than 1,429 new patients per month. This is one component driving incresed bed utilization at STRH.

Another component is the recently opened Saint Thomas Medical Partners – New Salem, a full-service care site designed to meet medical needs close to home. Saint Thomas is consistently exploring less costly outpatient alternatives to care, even if it results in less revenue for the health system.

Rutherford County is the fastest growing county in Tennessee. Despite the rapid population growth in the service area, STRH is projecting relatively modest gains in bed utilization – less than 1% per year overall – due to inpatient and observation bed hold conditions. Even at this rate, without additional beds, STRH will be runing 97.9% occupancy by 2019. Therefore, the major impact of this project is to reduce bed occupancy to a more

manageable 80%, including outpatient and observation patients, thus averting many bed holds.

2) Negative Effects

RESPONSE: Besides STRH, TriStar StoneCrest Medical Center is the only other medical-surgical hospital in the primary service area (Rutherford County). Each of the secondary service area counties also has a medical-surgical hospital. However, as the data indicates, STRH is approximately three times larger than the second largest service area medical-surgical hospital. This is true across a range of metrics – beds, admissions, patient days, average daily census. The other service area medical-surgical hospitals are simply not an alternative to the proposed project in terms of the level of care provided at STRH.

Rutherford County is the fastest growing county in Tennessee. Despite the rapid population growth in the service area, STRH is projecting relatively modest gains in bed utilization – less than 1% per year overall – due to inpatient and observation bed hold conditions. Even at this rate, without additional beds, STRH will be runing 97.9% occupancy by 2019. Therefore, the major impact of this project is to reduce bed occupancy to a more manageable 80%, including outpatient and observation patients, thus averting many bed holds.

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 STRH is currently and appropriately staffed for a census of 277 patients. A census of 285 patients is projected for Year 2 and will require approximately 31 more clinical FTEs over the existing 1,029 clinical FTEs. Additional staff will be recruited using the existing resources of both STRH 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: STRH already maintains a large medical-surgical hospital and understands the licensure and certification requirements for medical and clinical staff.

Please see **Tab 14 – 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: STRH maintains residency programs in family medicine and emergency medicine in conjunction with the University of Tennessee College of Medicine. Other

programs are included in the attachments. Please see **Tab 15 – Attachment Section B-C3**.

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 Commission

RESPONSE: STRH already maintains a large medical-surgical hospital and understands the licensure and certification requirements applicable to the project.

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: STRH is fully licensed and accredited.

Please see **Tab 16 – Attachment Section B-D1** for a copy of STRH's hospital license.

Please see **Tab 17 – Attachment Section B-D1** for a copy of STRH'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: Not applicable. STRH has no outstanding deficiencies.

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. STRH 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, STRH, 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, STRH 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: As described more fully throughout this application, the existing medical-surgical beds at STRH have been operating at nearly 90% utilization, resulting in inpatient/observation bed holds. This is a result of multiple factors: (1) increasing inpatient utilization from Rutherford County, (2) increasing inpatient in-migration from throughout the region, (3) increasing observation patient utilization and (4) increasing observation patient utilization exceeding 24 hours. Seventy-two (72) additional medical-surgical and extended observation beds are required to meet current and projected patient demand.

Besides STRH, TriStar StoneCrest Medical Center is the only other medical-surgical hospital in the primary service area (Rutherford County). Each of the secondary service area counties also has a medical-surgical hospital. However, as the data indicates, STRH is approximately three times larger than the second largest service area medical-surgical hospital. This is true across a range of metrics – beds, admissions, patient days, average daily census. The other service area medical-surgical hospitals are simply not an alternative to the proposed project in terms of the level of care provided at STRH.

STRH's existing 286 licensed beds are essentially occupied on any given day by 190 inpatients and another 60 outpatients (observation, surgical/procedural 23-hour stays, etc.). What appears to be 60%-70% bed utilization quickly becomes nearly 90% bed utilization.

The situation for patients, families and admitting physicians becomes even more dire when weekday peaks are considered. As a result, STRH is unable to place a patient in a bed about half the days in a month, resulting in "holds" being placed on existing inpatient and observation beds.

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

RESPONSE: With one of the busiest emergency departments in the state, STRH records more than 90,000 patient visits per year. Through a partnership with the University of Tennessee College of Medicine, STRH's emergency department is the home for the UT Emergency Medicine Residency Program. STRH is addressing short duration ED observation patient volumes outside the scope of this CON application.

Both growth in population and traffic congestion are major drivers in ED utilization and overall services at STRH. The largest physician group in the community, Murfreesboro Medical Clinic, is constantly adding providers to its staff and supports this bed expansion project. The Clinic sees over 30,000 patients per month. More significantly, the Clinic averages more than 1,429 new patients per month. This is one component driving incresed bed utilization at STRH.

Another component is the recently opened Saint Thomas Medical Partners – New Salem, a full-service care site designed to meet medical needs close to home. Saint Thomas is consistently exploring less costly outpatient alternatives to care, even if it results in less revenue for the health system.

Rutherford County is the fastest growing county in Tennessee. Despite the rapid population growth in the service area, STRH is projecting relatively modest gains in bed utilization – less than 1% per year overall – due to inpatient and observation bed hold conditions. Even at this rate, without additional beds, STRH will be runing 97.9% occupancy by 2019. Therefore, the major impact of this project is to reduce bed occupancy to a more manageable 80%, including outpatient and observation patients, thus averting many bed holds.

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

RESPONSE: This is the first service expansion CON application filed by STRH since the replacement hospital opened in 2010 and is consistent with Saint Thomas' long standing goal to maximize existing resources to the fullest extent possible before increasing service capacity.

Constructing two floors atop an existing patient bed tower (originally designed for vertical expansion) was deemed the least costly, most effective and most efficient alternative to address the very high utilization of hospital beds at STRH.

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

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

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

RESPONSE: The STRH is currently and appropriately staffed for a census of 277 patients. A census of 285 patients is projected for Year 2 and will require approximately 31 more clinical FTEs over the existing 1,029 clinical FTEs. Additional staff will be recruited using the existing resources of both STRH 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 18 and 19 – 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	30	12/2017
4. Construction contract signed	21	01/2018
5. Building permit secured	30	02/2018
6. Site preparation completed	N/A	
7. Building construction commenced	1	02/2018
8. Construction 40% complete	220	09/2018
9. Construction 80% complete	440	12/2019
10. Construction 100% complete (approved for occupancy	551	06/2020
11. *Issuance of License	10	06/2020
12. *Issuance of Service	10	07/2020
13. Final Architectural Certification of Payment	30	08/2020
14. Final Project Report Form submitted (Form HR0055)	30	09/2020

***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

JUL 14 '17 PM 12:17

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Rutherford

Gordon B Ferguson, 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.

Gordon B Ferguson, President & CEO
SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of July (Month), 2017 (Year) a Notary Public in and for the County/State of Rutherford / Tennessee.

DEBRA A DENTON
STATE OF TENNESSEE NOTARY PUBLIC
RUTHERFORD COUNTY

NOTARY PUBLIC

My commission expires 5/19 (Month/Day), 2020 (Year).

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Section A

Tab 1 - Corporate Organization Documents
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Tab 1

TAB 1, Attachment Section A-4B-1

Bylaws

Certificate of Existence

SECOND AMENDED AND RESTATED BYLAWS OF SAINT THOMAS RUTHERFORD HOSPITAL (FORMERLY KNOWN AS MIDDLE TENNESSEE MEDICAL CENTER, INC.)

ARTICLE I

CORPORATION

Section 1.1 Definitions. As used in the Governing Documents of the Corporation, the following words and phrases shall have the following meanings:

1.1-a "Approve" shall mean and include the authority to review and either adopt, accept, appoint, amend, modify, disapprove or send back for further consideration an action recommended or approved by another entity in the System. Where the term "approve" is used, that approval is required by all identified entities before the proposed action will be considered the legally valid, authorized action of the proposing entity.

1.1-b "Ascension Health Alliance" shall mean Ascension Health Alliance, a Missouri nonprofit corporation.

1.1-c "Ascension Health" shall mean Ascension Health, a Missouri nonprofit corporation.

1.1-d "Ascension Health President/CEO" shall mean the person holding the position of President/CEO of Ascension Health or his or her designee.

1.1-e "Board" or "Board of Trustees" shall mean the Board of Trustees of the Corporation.

1.1-f "Canonical Requirements" shall mean the actions and decisions governed by canon law.

1.1-g "Consultation" shall mean to confer and deliberate together.

1.1-h "Control" or "Controlled" shall mean:

(i) the authority to act as majority member, shareholder or partner of an organization;

(ii) the authority to appoint, elect or approve at least a majority of the individual members, shareholders, or partners of an organization; or

(iii) the authority to appoint, elect or approve at least a majority of the governing body of an organization.

1.1-i "Credit Group Member" shall mean all credit group members and designated affiliates as those terms are defined in Ascension Health Alliance's Master Trust Indenture, as amended or replaced, from time to time.

1.1-j "Financial Expert" shall mean the person who has the attributes set forth in Title 17 of the United States Code of Federal Regulations Section 228.407, pursuant to Title 15 Section 7625 of the United States Code under the act commonly known as the "Sarbanes Oxley Act," as amended from time to time.

1.1-k "Governing Documents" shall mean the articles of incorporation or charter, articles of organization, bylaws, partnership agreements, operating agreements or comparable documents as may be applicable depending on the form of the entity's legal organization.

1.1-l "Health Ministry" shall mean the organization in a regional or local area through which Ascension Health carries out its mission and in which Ascension Health serves as the sole or controlling member.

1.1-m "Member" shall mean Saint Thomas Health.

1.1-n "Participating Entities" shall mean the Participating Entities of the Sponsor, as they may exist from time to time.

1.1-o "Ratify" shall mean and include the authority to accept or reject, without imposing an alternative, an action recommended by another entity in the System. Where the term "ratify" is used, that ratification is required by all identified entities before the proposed action will be considered the legally valid, authorized action of the proposing entity.

1.1-p "Recommend" shall mean to initiate an action for consideration and approval or ratification by another entity or person in the System.

1.1-q "Sponsor" shall mean Ascension Health Ministries, a public juridic person.

1.1-r "State" shall mean the State of Tennessee.

1.1-s "Subsidiary Organization" shall mean any legal entity directly or indirectly controlled by the Corporation.

1.1-t System" shall mean Ascension Health Alliance and all organizations directly or indirectly controlled by Ascension Health Alliance.

1.1-u "System Policy" or "System Policies" shall mean all policies and procedures issued by Ascension Health Alliance from time to time that is intended to apply to the System or any part of the System.

Section 1.2 Name. The name of the corporation shall be Saint Thomas Rutherford Hospital, a State nonprofit corporation (the "Corporation").

Section 1.3 Philosophy. The philosophy of the Corporation is that of the Sponsor as articulated and promoted through statements of mission, vision and values of the Corporation in accordance with the official teachings of the Roman Catholic Church and the *Ethical and Religious Directives for Catholic Health Care Services* as approved, from time to time, by the United States Conference of Catholic Bishops and as implemented by the local ordinary.

Section 1.4 Statement of Role and Purposes. The Corporation will have a role statement that specifies the purposes it will serve and the manner in which the philosophy, mission and core values of the Member, Ascension Health and Ascension Health Alliance will be carried out in the community served by the Corporation. The Corporation is organized exclusively for charitable, religious, educational and scientific purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law) (the "Code"), including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Code. The Corporation's purposes shall be consistent with and supportive of the corporate purposes of the Member, Ascension Health and Ascension Health Alliance and the Corporation's purposes shall include the following:

1.4-a Serve as an integral part of the Roman Catholic Church and carry out its mission in support of or in furtherance of the charitable purposes of the organizations described in this Article.

1.4-b Further the philosophy and mission of Ascension Health of healing and service to the sick and poor, and promote, support and engage in any of the religious, charitable, scientific and educational ministries which are now, or may hereafter be established by Ascension Health, or sponsored by the Sponsor and which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

1.4-c Raise funds for any or all of the organizations described in this Article from the public and from all other sources available; receive and maintain such funds and expend principal and income therefrom in support of or in furtherance of the charitable purposes of such organizations.

1.4-d Acquire, own, use, lease as lessor or lessee, convey and otherwise deal in and with real and personal property and any interest therein, all in support of or in furtherance of the charitable purposes of organizations described in this Article.

1.4-e Contract with other organizations (for profit and nonprofit), with individuals and with governmental agencies in support of or in furtherance of the charitable purposes of the organizations described in this Article.

1.4-f Establish, develop, sponsor, promote and/or conduct educational programs, religious programs, scientific research, treatment facilities, rehabilitation centers, housing centers, management services, human service programs and other charitable activities, all in promotion and support of the interests and purposes of the organizations described in this Article.

1.4-g Own or operate facilities or own other assets for public use and welfare in furtherance of the charitable purposes of the organizations described in this Article.

1.4-h Engage in any lawful activities within the purposes for which a corporation may be organized under the Tennessee Nonprofit Corporation Act (the "Act"), as it may be amended from time to time, which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

1.4-i Serve as the controlling entity of Subsidiary Organizations that conduct health related and other activities, and limit the powers, duties and responsibilities of the governing bodies of such Subsidiary Organizations, all in accordance with requirements as established by the Member and Ascension Health.

1.4-j Support institutions sponsored by the Sponsor, both within and without the State, and cooperate with other Ascension Health institutions.

1.4-k Promote cooperation and exchange of knowledge and experience among the various apostolates of the Sponsor within the health care mission.

1.4-l Otherwise operate in support of or in furtherance of the charitable purposes of the organizations described in this Article, and do so exclusively for religious, charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Code and in the course of such operation:

(i) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its members, trustees, officers, or other private persons unless allowed by Section 501(c)(3) of the Code and the Act except that the Corporation shall be authorized and empowered to pay

reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(ii) No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office.

(iii) Notwithstanding any other provisions of the Corporation's Governing Documents, the Corporation shall only operate for charitable purposes, the Corporation shall not carry on any other activities not permitted to be carried on: (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

1.4m Operate a hospital and other health care providers and services in furtherance of the charitable purposes described above.

ARTICLE II

MEMBER

Section 2.1 Number and Eligibility. There shall be one member of the Corporation, and such member shall be Saint Thomas Health.

Section 2.2 Appointment of Officer, Trustee, or Other to Act on Behalf of Member. The Member may appoint an officer(s), Trustee(s), or anyone else to act on its behalf in the capacity of the Member of the Corporation.

ARTICLE III

MEETINGS OF MEMBER

Section 3.1 Member Meetings. Meetings of the Member shall be held at such time, date and place, both within or without the State, as shall be specified by the Member and shall be conducted in a manner as provided in the Bylaws of the Member.

ARTICLE IV

BOARD OF TRUSTEES

Section 4.1 Powers and Responsibilities. The business, property, affairs and funds of the Corporation shall be managed, supervised and controlled by its Board of Trustees

who shall exercise all of the powers of the Corporation not otherwise reserved to the Member, Ascension Health, Ascension Health Alliance or to the Sponsor, but subject to the limitations contained in the Corporation's Governing Documents and subject to applicable law. The powers of the Board, which shall be exercised in accordance with and subject to System Policies, shall include, but not be limited to, the following:

4.1-a Approve the mission and vision statements for the Corporation in Consultation with the Ascension Health President/CEO and approve the mission and vision statements for its respective Subsidiary Organizations and assure compliance with the philosophy, mission, vision, expectations and core values of Ascension Health.

4.1-b Approve the formation or acquisition of legal entities, in Consultation with Ascension Health President/CEO.

4.1-c Approve requirements of, and adopt or approve changes to, the Governing Documents of the Corporation and its Subsidiary Organizations, if the changes are consistent with the System Policies.

4.1-d Recommend the appointment of members of the Board of Trustees of the Corporation, recommend the appointment of the Board Chair of the Corporation, and evaluate the Corporation's Board and Board Chair.

4.1-e Appoint, upon the recommendation of the governing board of the applicable Subsidiary Organization, or remove, with or without cause, the board chair and members of the governing board of such Subsidiary Organization of the Corporation. Removal does not require a recommendation of such Subsidiary Organization's governing board.

4.1-f Appoint or remove the President/CEO of the Corporation with concurrent approval of the Member's President/CEO, and establish annual performance objectives, evaluate performance and determine compensation of the President/CEO of the Corporation with concurrent approval by the Member's President/CEO.

4.1-g Approve the incurrence of debt of the Corporation and its Subsidiary Organizations in accordance with System Policies.

4.1-h Approve the Integrated Strategic, Operational & Financial Plan, annual scorecard targets and initiatives for the Corporation, subject to ratification by the Ascension Health President/CEO.

4.1-i Subject to Canonical Requirements, approve and recommend for approval by the Ascension Health Board of Trustees and the Ascension Health Alliance Board of

Directors, the sale, transfer or substantial change in the use of all or substantially all of the assets of the Corporation or Subsidiary Organization that is a Credit Group Member, and divestiture, dissolution, closure, merger, consolidation, change in corporate membership or ownership, or corporate reorganization of the Corporation or Subsidiary Organization that is a Credit Group Member.

4.1-j Subject to Canonical Requirements, approve the transfer of assets and the reallocation of debt among the Corporation and the other Health Ministries in accordance with System Policies.

Section 4.2 Powers Reserved to Member. The following powers are reserved to the Member:

4.2-a Approve the formation or acquisition of legal entities for which the Corporation will serve as the sole or controlling entity.

4.2-b Approve the mission and vision statements for the Corporation.

4.2-c Approve changes to the Governing Documents of the Corporation, if the changes are consistent with System Policies.

4.2-d Appoint or remove, with or without cause, the Chair of the Board of the Corporation.

4.2-e Appoint, upon the recommendation of the Board of Trustees of the Corporation, or remove, with or without cause, the members of the Board of Trustees of the Corporation. Removal does not require a recommendation of the Board of Trustees of the Corporation.

4.2-f Approve the incurrence of debt of the Corporation in accordance with System Policies.

4.2-g Subject to the approval of Ascension Health and Ascension Health Alliance and the Board where required by the Act, approve the sale, transfer or substantial change in use of all or substantially all of the assets of the Corporation, and divestiture, dissolution, closure, merger, consolidation, change in corporate membership or ownership, or corporate reorganization of the Corporation.

4.2-h Subject to Canonical Requirements, approve the formation of a Subsidiary Organization, and the sale, transfer or substantial change in use of all or substantially all of the assets of a Subsidiary Organization of the Corporation, or the divestiture, dissolution, closure, merger, consolidation or change in corporate membership or ownership of a Subsidiary Organization that is not a Credit Group Member.

4.2-i Approve the transfer or encumbrance of the assets of the Corporation in accordance with System Policies.

4.2-j Approve the operating budget and capital plan for the Corporation.

Section 4.3 Number, Eligibility and Qualifications. The Board of Trustees shall consist of seventeen (17) members or such greater number designated by the Member. To ensure that the medical staff of the hospital operated by the Corporation has adequate representation, the Board shall permit at least one (1) member of the medical staff elected by the medical staff to serve on the Board either with or without vote, as decided by the Member. To be eligible for Board membership, a Trustee candidate shall satisfy the selection criteria and personal characteristics as may be established by the Member or Ascension Health from time to time.

Section 4.4 Vacancies. Vacancies in the Board of Trustees shall be filled by the Member upon the recommendation of the Board of Trustees of the Corporation.

Section 4.5 Appointment and Term. Board members shall be appointed, upon the recommendation of the Board of the Corporation, by the Member. Board members shall be appointed for staggered terms. Unless otherwise specified by the Member, Board appointments and reappointments shall commence as of July 1 of the fiscal year such appointment or reappointment was made and shall expire on June 30 after a full three (3) year term. If the Member specifies a commencement date other than July 1, the first year of such three (3) year term for such Board member shall commence on the date specified by the Member and shall expire on the next June 30. No Board member shall serve more than three (3) consecutive three (3) year terms or, in any event, more than nine (9) consecutive years. After a period of one (1) year of not serving on the Board, such person shall be eligible again to serve on the Board of Trustees.

Section 4.6 Power to Appoint Officers. The Member shall appoint the Chair of the Board. The Board of Trustees of the Corporation shall appoint a Vice-Chair, a Secretary and a Treasurer. The President/CEO of the Corporation shall be appointed in accordance with Section 8.1. One person may serve both as Secretary and Treasurer if the Board of Trustees so desires.

Section 4.7 Power to Appoint Other Officers and Agents. The Board of Trustees shall have the power to appoint such other officers and agents as the Board may deem necessary for transaction of the affairs of the Corporation.

Section 4.8 Removal of Officers and Agents. Any officer or agent, other than the Chair and President/CEO of the Corporation, may be removed by the Board of Trustees whenever, in the judgment of the Board, the best interests of the Corporation will be served thereby. The Chair may be removed with or without cause by the Member, and the President/CEO of the Corporation may be removed in the manner described in Section 8.3.

Section 4.9 Removal of Trustees. Any Trustee may be removed, with or without cause, at any regular or special meeting of the Member. Notice of the intention to act on such matters shall be given in the notice calling such meeting. Removal does not require a recommendation of the Corporation's Board.

Section 4.10 Resignation of Trustees. A Trustee of the Board may resign at any time by filing a written resignation with the Secretary. A resignation is effective when the notice is filed unless the notice specifies a later effective date. If a resignation is made effective at a later date, the Member, upon the recommendation of the Corporation's Board of Trustees, may fill the pending vacancy before the effective date if the Member provides that the successor does not take office until the effective date.

Section 4.11 Power to Require Bonds. The Board of Trustees may require any officer or agent to file with the Corporation a satisfactory bond conditioned for faithful performance of said officer's or agent's duties.

Section 4.12 Attendance. All Trustees must attend at least two-thirds (2/3rds) of the regular meetings of the Board. Failure to do so shall constitute a reason for removal or non-appointment.

Section 4.13 Conflicts of Interest. Each member of the Board of Trustees shall certify to the Corporation that no conflict of interest exists which would impair that member's ability to serve on the Board of Trustees and shall comply with the Corporation's Conflicts of Interest Policy.

Section 4.14 Board and Board Chair Evaluation. The Board of Trustees will complete a periodic evaluation of its performance and the performance of the Board Chair. These evaluations will assess the performance of the Board and the Board Chair in fulfilling their responsibilities as a governing body and officer and the goals of the board of trustees of the Member. The evaluation will be conducted in accordance with System Policies and shall be submitted to the board of trustees of the Member for acceptance.

Section 4.15 Compensation and Reimbursement. Any member of the Board of Trustees may receive compensation from the Corporation for services rendered to, or for expenses incurred in serving, the Corporation as a Trustee of the Corporation, or in a capacity other than as a Trustee of the Corporation while conducting activities on behalf of the System.

ARTICLE V

MEETINGS OF BOARD OF TRUSTEES

Section 5.1 Annual Meeting. The annual meeting of the Board of Trustees shall be held at such time and place as the Board shall determine.

Section 5.2 Regular Meetings. Regular meetings of the Board of Trustees shall be held at such times and places as the Board of Trustees shall from time to time determine, however, it shall meet at least quarterly. Said meetings may be held within or without the State.

Section 5.3 Meetings by Telecommunications Device. Members of the Board of Trustees may participate in a meeting by means of conference telephone or similar communications equipment if all persons participating in the meeting can hear each other simultaneously. Participation in such meeting in such manner shall constitute presence in person.

Section 5.4 Action by Written Consent. Any action required or permitted to be taken at any meeting of the Board of Trustees may be taken without a meeting, if all members of the Board of Trustees, at the time in office, consent thereto in writing and the writing or writings are filed with the minutes of the proceedings of the Board of Trustees. Action taken pursuant to this Section is effective when the last Trustee signs the consent unless the consent contains a prior or subsequent effective date.

Section 5.5 Special Meetings. Special meetings of the Board of Trustees may be called by the Chair, one-third (1/3) of the members of the Board, the Member, or the President/CEO of the Corporation, at any time by means of such written notice by first class mail, courier service, telephone, telegraph, facsimile, electronic mail, or such other communication reasonably designed to provide prompt notice of the time, place and purpose thereof to each Trustee at least forty-eight (48) hours before the date of the meeting, as the Chair in his or her discretion shall deem sufficient. Any action taken at any such meeting shall not be invalidated for want of notice if such notice shall be waived as hereinafter provided.

Section 5.6 Notices and Mailings. Written notice of all regular meetings of the Board of Trustees shall be given to each Trustee at least five (5) days before the date of the meeting, which notice may, but need not, state generally the nature of the business to be taken up at the meeting. All written notices required to be given by any provisions of these Bylaws shall state the authority pursuant to which they are issued (as "by order of the Chair" or "by order of the Board of Trustees" as the case may be) and shall bear the written, stamped, typewritten or printed signature of the Secretary or, if so empowered, an Assistant Secretary. If mailed, such notice shall be considered to be delivered when deposited in the United States' mail in a sealed, properly addressed envelope, first class postage prepaid. If sent by courier, such notice shall be considered to be delivered on the date of confirmed delivery. If sent by facsimile, such notice shall be considered to be delivered when the sender receives confirmation of successful transmission. If sent by electronic mail, such notice shall be considered to be delivered when it leaves the primary domain and passes through the gateway.

Section 5.7 Waiver of Notice. Notice of the time, place and purpose of any meeting of the Board of Trustees, may be waived by telegram, cablegram, facsimile, electronic mail, or other writing, either before or after such meeting has been held. Attendance at any meeting, except for

the sole purpose of objecting to the holding of such meeting, shall constitute a waiver of notice of said meeting.

Section 5.8 Quorum. A majority of the Board of Trustees present in person shall constitute a quorum for the transaction of business. Trustees may not establish a quorum by proxy.

Section 5.9 Manner of Acting. The act of the majority of the Trustees present in person at a meeting at which a quorum is present shall be the act of the Board of Trustees unless the act of a greater number is required by law or the Corporation's Governing Documents. No Trustee may act by proxy on any matter.

ARTICLE VI

OFFICERS

Section 6.1 Chair. The Chair shall preside over all meetings of the Board of Trustees.

Section 6.2 Vice-Chair. The Vice-Chair shall perform the duties and exercise the powers of the Chair during the absence or disability of the Chair. He or she shall perform such other duties as may be delegated by the Board of Trustees.

Section 6.3 President/CEO. The President/CEO shall have all the duties and authorities assigned to that position and will be governed by the provisions of Article VIII of these Bylaws.

Section 6.4 Secretary. The Secretary shall preserve in the books of the Corporation accurate minutes of the proceedings of such meetings. He or she shall have authority to affix the Seal of the Corporation to all instruments where its use is required by statute, by law or by resolution. He or she shall perform such other duties as may be delegated by the Board of Trustees.

Section 6.5 Treasurer. The Treasurer shall have the powers and duties usually associated with such office subject to limitation or extension by the Board of Trustees.

Section 6.6 Term. The Officers of the Corporation, except the Chair and President/CEO, shall each remain in office for a term which ordinarily shall be for one (1) year. The Chair shall serve a term which shall be for two (2) years and is eligible to serve one (1) additional two (2) year term. A Chair whose term has reached the two (2) consecutive two (2) year term limit may not be reconsidered for such position. The conditions of employment for the President/CEO of the Corporation are governed by Article VIII.

ARTICLE VII

COMMITTEES

Section 7.1 Standing Committees. The standing committees ordinarily will include the Executive Committee and such other standing committees as the Board of Trustees may authorize.

Section 7.2 Appointment. Unless otherwise specified in the Governing Documents of the Corporation, members of the standing committees and the chairs thereof shall be appointed by the Board of Trustees.

Section 7.3 Attendance. Failure to attend a minimum of one-half (1/2) of the regular assigned committee meetings shall constitute a basis for removal or non-appointment to the committee.

Section 7.4 Special Committees. Special committees may be appointed by the Board of Trustees for such purposes as circumstances may warrant. Every such committee shall limit its activity to the accomplishment of the purpose for which created and shall have no power to act except as is specifically conferred upon it by action of the Board of Trustees. Upon completion of the duties for which any such committee was appointed, such committee shall stand discharged. The Chair of the Board of Trustees shall appoint the members and a chair of each special committee.

Section 7.5 Records. Each committee and subcommittee shall maintain a written record of its procedures and activities, including minutes of its meetings, and shall submit a written report of such procedures and activities at least annually to the Board of Trustees.

Section 7.6 Manner of Acting. The act of the majority of the committee members present in person at a meeting at which a quorum is present shall be the act of the committee. No committee member may act by proxy on any matter.

Section 7.7 Meetings by Telecommunications Device. Members of any committee appointed by the Board may participate in a meeting by means of conference telephone or similar communications equipment if all persons participating in the meeting can hear each other simultaneously. Participation in such meeting in such manner shall constitute presence in person.

Section 7.8 Action by Written Consent. Any action required or permitted to be taken at a meeting of any committee may be taken without a meeting if all members of such committee, at the time in office, consent thereto in writing and the writing or writings are filed with the minutes of the proceedings of the committee. Action taken pursuant to this Section is effective when the last committee member signs the consent unless the consent contains a prior or subsequent effective date.

Section 7.9 Quorum. A quorum of any committee is defined as fifty percent (50%) of its membership.

Section 7.10 Committee Evaluation. Each committee will complete a periodic evaluation of its performance. This evaluation will assess the performance of the committee in fulfilling its roles and expectations as approved by the Board of Trustees.

Section 7.11 Executive Committee.

7.11-a Composition. The Executive Committee, if created by the Board of Trustees, shall consist of the officers of the Board of Trustees, the President and three (3) other members who shall be appointed by the Board of Trustees. The chair of the Executive Committee shall be the Chair of the Board of Trustees.

7.11-b Meetings. The Executive Committee shall meet at such time as shall be determined by the chair of the Executive Committee. When action is taken by the Executive Committee, it will be reported to the Board of Trustees at its next meeting.

7.11-c Duties. The Executive Committee shall have power to transact all regular business of the Corporation during the period between meetings of the Board of Trustees subject to any prior limitation imposed by the Board of Trustees or the Act.

Section 7.12 Audit Committee.

7.12-a Composition. The Audit Committee, if created by the Board of Trustees, shall consist of at least five (5) members, including at least one (1) Financial Expert. Members of the Audit Committee and the Chair of the Audit Committee shall be appointed by the Board. The Chair of the Audit Committee shall be a member of the Board of Trustees. At least one (1) other member of the Audit Committee shall be a member of the Board.

7.12-b Qualifications. All members of the Audit Committee shall be financially literate. A majority of the members of the Audit Committee shall consist of members who are independent of the Corporation, its management, and Ascension Health. Members of the Audit Committee shall be considered independent if they have no relationship that may interfere with the exercise of their independence from the Corporation, its management, and Ascension Health. Serving on the Board of Trustees of the Corporation in itself does not constitute lack of independence.

7.12-c Staff. The Chief Financial Officer and the Internal Auditor of the Corporation shall serve as staff to the Audit Committee. The Chief Legal Officer and Corporate Responsibility Officer may also serve as staff to the Audit Committee.

Collectively, the staff of the Audit Committee shall be responsible for delivering Audit Committee meeting minutes to the Audit Committee and delivering an Audit Committee Report to the Board of Trustees.

7.12-d Meetings. The Audit Committee shall meet a minimum of three (3) times per year. Members of the Audit Committee must attend at least half of the meetings per year.

7.12-e Duties. The Audit Committee shall be responsible for:

(i) examining the adequacy and effectiveness of the internal control systems and financial information used by the Board of Trustees and Finance Committee, as applicable, or by external agencies to evaluate the Corporation's fiscal affairs;

(ii) determining what the Corporation is doing to provide reliable financial statements and financial controls, including at a minimum, reviewing each quarterly control checklist and internal letter of representation and the annual Finance Code of Ethics;

(iii) evaluating audit performance;

(iv) ensuring that the Corporation develops and maintains an effective corporate compliance program; and

(v) reporting on the matters in this Section 7.12-e to the Board of Trustees with such recommendations as are appropriate.

Section 7.13 Compensation and Reimbursement. Any member of a committee may receive compensation from the Corporation for services rendered to, or for expenses incurred in serving, the Corporation as a committee member of the Corporation, or in a capacity other than as a committee member of the Corporation while conducting activities on behalf of the System.

ARTICLE VIII

ADMINISTRATION

Section 8.1 President/CEO. The Board of Trustees shall appoint and remove the President/CEO of the Corporation with concurrent approval of the Member's President/CEO. The Board of Trustees shall establish annual performance objectives, evaluate performance and determine compensation of the President/CEO of the Corporation with concurrent approval of the Member's President/CEO.

Section 8.2 Authority and Duties. The President/CEO of the Corporation is accountable to the Board of Trustees of the Corporation and to the President/CEO of the Member. The President/CEO of the Corporation, in keeping with sound principles of management is responsible to:

8.2-a provide leadership in carrying out the philosophy and mission of the Corporation, Ascension Health and the Member;

8.2-b provide leadership in strategic planning and organization;

8.2-c provide leadership in financial planning and budgeting;

8.2-d direct the operations of the Corporation in a manner consistent with policies established by the Board of the Corporation, System Policies and Ascension Health's philosophy, mission and core values;

8.2-e direct and facilitate organizational communications; and

8.2-f provide leadership in evaluating the performance of the Corporation.

Section 8.3 Discharge, Suspension, Disciplinary Action. Subject to the terms of any applicable contract, the Board of Trustees has the authority to effect formal disciplinary action, suspension or discharge of the President/CEO of the Corporation with concurrent approval of the Member's President/CEO.

ARTICLE IX

COMMUNITY GROUPS

Section 9.1 Community. The Board recognizes the vital role the community plays in the existence, the effectiveness and the relevance of the Corporation. It may, therefore, appoint persons from the community to appropriate roles as may, from time to time, be desirable and/or necessary in the best interests of the Corporation. The organization, bylaws and functions of all groups are subject to Board review and approval.

ARTICLE X

EXECUTION OF INSTRUMENTS

Section 10.1 Checks, Drafts and Other Orders. All checks, drafts and other orders for payment of money shall be signed in the name of the Corporation by the President/CEO of the Corporation or such officer or agent as selected by the Board of Trustees.

Section 10.2 Contracts, Conveyances and Other Legal Documents. When the execution of any contract, conveyance or other instrument has been authorized without specification of the executing officers, the President/CEO of the Corporation may execute the same in the name of and on behalf of the Corporation and may affix the corporate seal thereto. The Board of Trustees shall have power to designate the officers and agents who shall have authority to execute any instrument on behalf of the Corporation.

ARTICLE XI

DISSOLUTION

Section 11.1 Disposition of Assets. Upon the dissolution of the Corporation, the disposition of all the assets of the Corporation shall be in a manner as provided by the Board of Trustees (subject to the prior approval of the Member, Ascension Health and Ascension Health Alliance) and in accordance with the following:

11.1-a The paying of or the making of provision of the payment of all of the liabilities, direct or indirect, contingent or otherwise, including without limitation, all liabilities evidenced in all outstanding loan agreements, credit agreements, master indentures and other similar documents.

11.1-b Subject to compliance with the dissolution principles of the Member, all assets remaining after the payment of all of the liabilities of the Corporation shall be distributed to Ascension Health or such other exempt organization(s) under Section 501(c)(3) of the Code as shall be determined by Ascension Health Alliance.

11.1-c Any other assets not so disposed of shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organization or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

ARTICLE XII

INDEMNIFICATION

Section 12.1 Mandatory Indemnification of Trustees and Officers.

12.1-a To the maximum extent permitted by the provisions of Sections 48-58-501, *et seq.*, of the Act, as amended from time to time (provided, however, that if an

amendment to the Act in any way limits or restricts the indemnification rights permitted by law as of the date hereof, such amendment shall apply only to the extent mandated by law and only to activities of persons subject to indemnification under this Section which occur subsequent to the effective date of such amendment), the Corporation shall indemnify and advance expenses to any person who is or was a trustee or officer of the Corporation, or to such person's heirs, executors, administrators and legal representatives, for the defense of any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative, or investigative, and whether formal or informal (any such action, suit or proceeding being hereinafter referred to as the "Proceeding"), to which such person was, is or is threatened to be made, a named defendant or respondent, which indemnification and advancement of expenses shall include counsel fees actually incurred as a result of the Proceeding or any appeal thereof, reasonable expenses actually incurred with respect to the Proceeding, and all fines, judgments, penalties and amounts paid in settlement thereof (including the imposition of a tax under Section 4958(a)(2) of the Code), subject to the following conditions:

(i) The Proceeding was instituted by reason of the fact that such person is or was (a) a trustee of the Corporation or (b) an officer of the Corporation; and

(ii) The trustee or officer conducted himself or herself in good faith, and he or she reasonably believed (i) in the case of conduct in his or her official capacity with the Corporation, that his or her conduct was in its best interest; (ii) in all other cases, that his or her conduct was at least not opposed to the best interests of the Corporation; and (iii) in the case of any criminal proceeding, that he or she had no reasonable cause to believe his or her conduct was unlawful. The termination of a proceeding by judgment, order, settlement, conviction, or upon a plea of *nolo contendere* or its equivalent is not, of itself, determinative that the trustee or officer did not meet the standard of conduct herein described.

12.1-b The Corporation shall indemnify a trustee or officer of the Corporation who is wholly successful, on the merits or otherwise, or who is immune from suit under the provisions of Section 48-58-601 of the Act, as amended from time to time, in the defense of any Proceeding to which the trustee or officer was a party because the trustee or officer is or was a trustee or officer of the Corporation against reasonable expenses incurred by the trustee or officer in connection with the Proceeding.

Section 12.2 Permissive Indemnification of Employees and Agents. The Corporation may, to the maximum extent permitted by the provisions of Section 48-58-501, *et seq.*, of the Act, as amended from time to time (provided, however, that if an amendment to the Act in any

way limits or restricts the indemnification rights permitted by law as of the date hereof, such amendment shall apply only to the extent mandated by law and only to activities of persons subject to indemnification under this Section which occur subsequent to the effective date of such amendment), indemnify and advance expenses in a Proceeding to (a) any person who is or was an agent authorized by the Corporation to act on behalf of the Corporation, or (b) each person who serves or has served at the request of the Corporation as a trustee, officer, employee or committee member of another corporation, partnership, joint venture, limited liability company, trust or enterprise, or in either case to such person's heirs, executors, administrators and legal representatives, to the same extent as set forth in Section 12.1-a above, provided that the Proceeding was instituted by reason of the fact that such person is or was an employee or agent of the Corporation and met the standards of conduct set forth in subsection 12.1-a(ii) above. The Corporation may also indemnify and advance expenses in a Proceeding to any person who is or was an employee or agent of the Corporation to the extent, consistent with public policy, as may be provided by the Governing Documents of the Corporation, by contract, or by general or specific action of the Board of Trustees.

Section 12.3 Non-Limiting Application. The provisions of this Article shall not limit the power of the Corporation to pay or reimburse expenses incurred by a trustee, officer, employee, or agent of the Corporation in connection with such person's appearing as a witness in a Proceeding at a time when he or she has not been made a named defendant or respondent to the Proceeding.

Section 12.4 Prohibited Indemnification. Notwithstanding any other provision of this Article XII, the Corporation shall not indemnify or advance expenses to or on behalf of any trustee, officer, employee, or agent of the Corporation, or such person's heirs, executors, administrators or legal representatives:

12.4-a If a judgment or other final adjudication adverse to such person establishes his or her liability for any breach of the duty of loyalty to the Corporation, for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, or under Section 48-58-304 of the Act;

12.4-b In connection with a Proceeding by or in the right of the Corporation in which such person was adjudged liable to the Corporation;

12.4-c In connection with any other Proceeding charging improper personal benefit to such person, whether or not involving action in his or her official capacity, in which he or she was adjudged liable on the basis that personal benefit was improperly received by him or her; or

12.4-d If the indemnification would constitute an excess benefit within the meaning of Section 4958 of the Code.

Section 12.5 Insurance. The Corporation may purchase and maintain insurance on behalf of any person indemnified under this Article and shall further have the power to purchase and maintain insurance on behalf of any person who is or was serving at the request of the Corporation as a trustee, officer, partner, employee or agent of another corporation, partnership, joint venture, limited liability company, trust or other enterprise insuring against any liability under the conditions described in this Article subject to the power of the Corporation to indemnify such person under applicable law.

ARTICLE XIII

MISCELLANEOUS

Section 13.1 Books and Records. The Corporation shall keep correct and complete books and records of accounts, and other records of the activities of the Corporation as may be appropriate or required by law, and shall also keep minutes of the proceedings of its Member, the Board of Trustees and committees having authority from the Board of Trustees. All books and records of the Corporation may be inspected by the Member or its agent or attorney for any proper purpose at any reasonable time.

Section 13.2 Fiscal Year. The fiscal year of the Corporation shall begin at the beginning of July 1 and end at the close of June 30, next succeeding period.

Section 13.3 Bylaws Review. The Bylaws shall be reviewed annually and revised as deemed necessary.

Section 13.4 Fiscal Agency. The Corporation designates Ascension Health Alliance as its fiscal agent to conduct certain of its business activities, including performing any acts or contracting for any activities with respect to fiscal matters. These activities include, without limitation, the investment or loan of the funds of the Corporation as well as the funds of others, and the borrowing of funds from any source. The Corporation agrees that Ascension Health Alliance as Fiscal Agent shall have the authority to: (i) bind the Corporation as a joint and several borrower/obligor as to any funds which may be borrowed on a system-wide basis, and (ii) appoint third-parties to manage the funds of the Corporation invested by Ascension Health Alliance and delegate to third-parties the authority to invest certain funds of the Corporation and to hold such investments as nominee for the Corporation. Ascension Health Alliance is authorized to enter into such indemnification, hold harmless, subordination, or waiver agreements that Ascension Health Alliance may, in its judgment, deem appropriate. This agency includes the authority to amend or waive any provision of any agreement with any bank or other financial institution for purposes of borrowing.

ARTICLE XIV

CORPORATION SERVING AS CONTROLLING ENTITY OF SUBSIDIARY ORGANIZATIONS

Section 14.1 Governing Documents of Subsidiary Organizations. The Governing Documents of any of the Corporation's Subsidiary Organizations shall contain a section within the documents which provides for certain rights and powers to be reserved to the Corporation as the controlling entity.

Section 14.2 Specific Reserved Rights and Powers. All action by a Subsidiary Organization shall be by its governing board, subject to the following matters which require the approval of the Corporation, as the Subsidiary Organization's controlling entity:

14.2-a Approve the mission and vision statements for the Subsidiary Organization.

14.2-b Approve changes to the Governing Documents of a Subsidiary Organization, if the changes are consistent with System Policies.

14.2-c Appoint, upon the recommendation of the governing board of the Subsidiary Organization, or remove, with or without cause, the members of the governing board of the Subsidiary Organization. Removal does not require a recommendation of the Subsidiary Organization governing board.

14.2-d Approve the incurrence of debt of the Subsidiary Organization in accordance with System Policies.

14.2-e Subject to the approval of Ascension Health and Ascension Health Alliance, approve the sale, transfer or substantial change in use of all or substantially all of the assets of a Subsidiary Organization that is a Credit Group Member, and divestiture, dissolution, closure, merger, consolidation, change in corporate membership or ownership, or corporate reorganization of a Subsidiary Organization that is a Credit Group Member.

14.2-f Subject to Canonical Requirements, approve the formation of a Subsidiary Organization, and the sale, transfer or substantial change in use of all or substantially all of the assets of a Subsidiary Organization of the Corporation, or the divestiture, dissolution, closure, merger, consolidation or change in corporate membership or ownership of a Subsidiary Organization that is not a Credit Group Member.

14.2-g Approve the transfer or encumbrance of the assets of a Subsidiary Organization in accordance with System Policies.

14.2-h Approve the operating budget and capital plan for the Subsidiary Organization.

ARTICLE XV

MEDICAL STAFF

Section 15.1 Medical Staff. There shall be established within each hospital operated by the Corporation a medical staff which shall consist of all the physicians privileged to attend patients within the hospital. The Board of Trustees, in its discretion, shall delegate to the medical staff overall responsibility for the quality of professional services provided in the hospital by individuals with clinical privileges and shall ensure that the medical staff accepts and discharges this responsibility, subject to the Board of Trustees' ultimate authority.

Section 15.2. Medical Staff Bylaws. For the medical staff of each hospital operated by the Corporation, there shall be bylaws and rules and regulations for such medical staff setting forth its organization, consistent with applicable law and accreditation requirements. The medical staff bylaws, rules and regulations shall be reviewed periodically by the medical staff, and any recommendations for change shall be subject to the approval of the Board of Trustees. The medical staff may recommend changes to the bylaws or the rules and regulations, but only those approved by the board of Trustees shall become effective.

ARTICLE XVI

AMENDMENTS TO GOVERNING DOCUMENTS AND EFFECTIVE DATE

Section 16.1 Amendments. The power to approve changes to the Governing Documents of the Corporation that are consistent with System Policies shall be vested in the Member. The power to approve changes to the Governing Documents of the Corporation that are inconsistent with System Policies shall be subject to the approval of the Ascension Health Board. The Governing Documents of the Corporation may contain any provision for the regulation and management of the affairs of the Corporation not inconsistent with the other Governing Documents of the Corporation and/or applicable law of the State.

Section 16.2 Effective Date. These Bylaws shall be effective on the 13th day of December, 2013.

APPROVED AND ADOPTED by the Ascension Health Board on the 13th day of December, 2013.

SAINT THOMAS RUTHERFORD HOSPITAL

By: Gordon B Ferguson
Printed: Gordon B. Ferguson
Title: President & CEO

Tre Hargett
Secretary of State

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

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

July 13, 2017

Request Type: Certificate of Existence/Authorization
Request #: 0244170

Issuance Date: 07/13/2017
Copies Requested: 1

Document Receipt

Receipt # : 003477351	Filing Fee:	$20.00
Payment-Credit Card - State Payment Center - CC #: 3706706419		$20.00

Regarding:	Saint Thomas Rutherford Hospital		
Filing Type:	Nonprofit Corporation - Domestic	Control # :	83398
Formation/Qualification Date:	03/16/1926	Date Formed:	03/16/1926
Status:	Active	Formation Locale:	TENNESSEE
Duration Term:	Perpetual	Inactive Date:	
Business County:	RUTHERFORD COUNTY		

CERTIFICATE OF EXISTENCE

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 Rutherford Hospital

* is a Corporation duly incorporated 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
Secretary of State

Processed By: Cert Web User

Verification #: 023278328

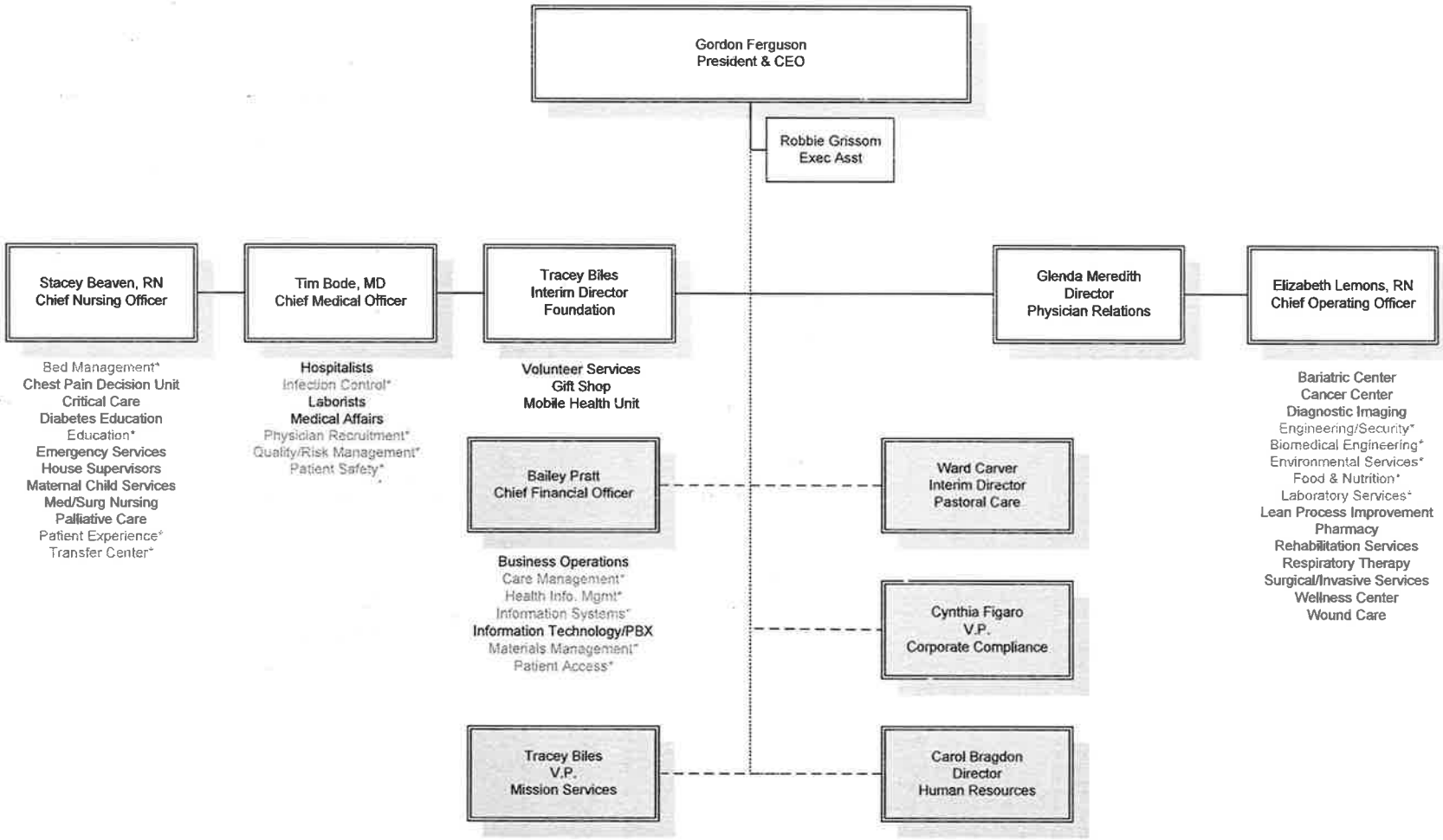
Tab 2

TAB 2, Attachment Section A-4B-2

Saint Thomas Rutherford Hospital

Saint Thomas Health

Saint Thomas Health - Rutherford



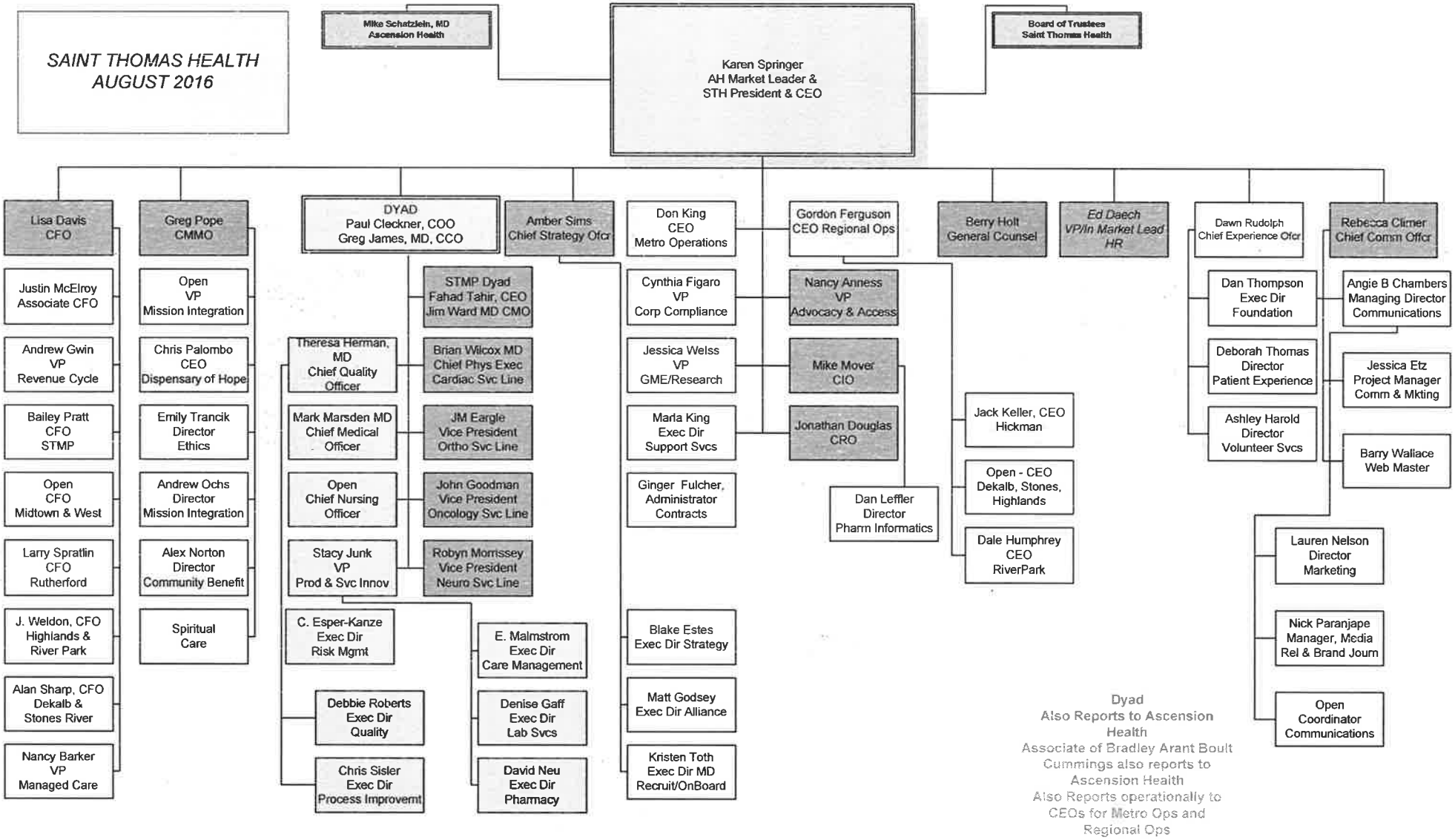
*Direct Report to System or Contracted Service.

Saint Thomas
RUTHERFORD HOSPITAL

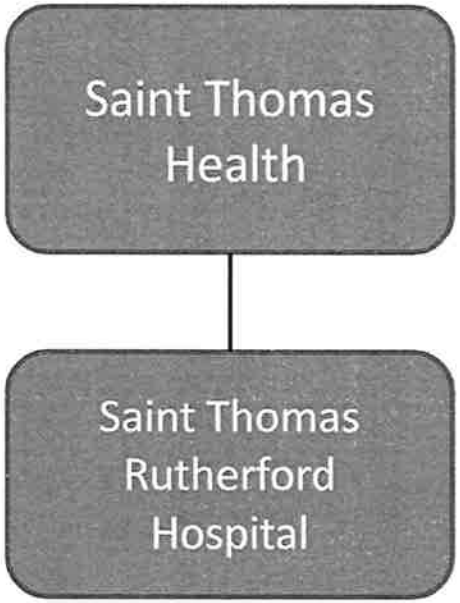
As of 3.27.17

Approved: _____

Date: _____


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 Welss
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 Anness
VP
Advocacy & Access
Mike Mover
CIO
Jonathan Douglas
CRO
Dan Leffler
Director
Pharm Informatics
Jack Keller, CEO
Hickman
Open - CEO
Dekalb, Stones,
Highlands
Dale Humphrey
CEO
RiverPark
Berry Holt
General Counsel
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 Health – Rutherford Hospital Organizational Structure



Tab 3

TAB 3, Attachment Section

Tab 4

TAB 4, Attachment Section A-6A

Site Entitlement

Name and Address of New Owner:
MIDDLE TENNESSEE MEDICAL CENTER
400 North Highland Avenue
Murfreesboro, TN 37130

SEND TAX BILL TO:
- Same -

This Instrument Prepared By:
Jerry E. Farmer
Office of the City Attorney
P. O. Box 1044
Murfreesboro, TN 37133-1044

92	Part of 18
91	Part of 3
92	17
92	27

WARRANTY DEED

FOR AND IN CONSIDERATION of the sum of TEN AND NO/100 DOLLARS ($10.00), and other good and valuable consideration, receipt of which is hereby acknowledged, the undersigned, **CITY OF MURFREESBORO, a municipal corporation existing in the State of Tennessee** (hereinafter referred to, whether singularly or collectively, as "Grantor") has this day bargained and sold and does hereby transfer and convey unto **MIDDLE TENNESSEE MEDICAL CENTER, INC., a Tennessee not-for-profit corporation,** its successors and assigns forever, that certain tract or parcel of real estate located in Rutherford County, Tennessee, and being more particularly described as follows, to-wit:

Land lying in the 13th Civil District of Rutherford County, Murfreesboro, Tennessee, generally being situated in the south east corner of the intersection of Thompson Lane and Manson Pike, Being shown on Tax Map 92 as Parcel 18, owned by the City of Murfreesboro of record in Deed Book 633, Page 717, in the register's office for Rutherford County (R.O.R.C., TN.), shown as Tract I on a boundary survey by Wiser Company LLC, drawing reference #02-03-601, and being more particularly described as follows:

BEGINNING at an iron pin set in the easterly right of way of Thompson Lane and the southerly right of way of Manson Pike, iron pin can be located S 04°32'39" E, 76.01' from the centerline intersection of said roads;

Thence, with said southerly right of way of Manson Pike for the next 9 (nine) calls, S 73°45'09 E, 38.28' to an iron pin set;

Thence, S 62°27'56" E, 100.80' to an iron pin set in the north west corner of a pump station owned by the City of Murfreesboro of record in Deed Book 599, Page 135, (R.O.R.C., TN.);

Thence, S 27°32'04" W, 30.00' to an iron pin set in the south west corner of said pumpstation;

Thence, S 62°27'56" E, 83.61' to an iron pin set in the south east corner of said pumpstation;

Thence, N 02°19'42" E, 28.51' to an iron pin set in the north west corner of said pump station;

Thence, S 62°57'34" E, 127.81' to an iron pin set;

Thence, S 83°20' 18" E, 15.33' to an iron pin set;

Thence, S 58°53'31" E, 1887.51' to a concrete monument set;

Thence, leaving said right of way, with a curve to the right having a central angle of 41°33'22", a radius of 379.00', an arc length 274.89', a chord bearing of S 38°06'51"E, with a chord length of 268.90' to a concrete monument set in the westerly right of way of the proposed Medical Center Parkway;

Thence, S 17° 20' 08" E, 16.87' to a concrete monument set;

Thence, with a curve to the right, having a central angle of 85°07'32", a radius of 50.00', an arc length 74.29', a chord bearing of S 25°13'38" W, with a chord length of 67.64' to a concrete monument set in the northerly right of way of the proposed Medical Center Parkway;

Thence, with a curve to the left, having a central angle of 12°24'33", a radius of 891.50', an arc length 193.08', a chord bearing of S 61°35'08" W, with a chord length of 192.71' to a concrete monument set in said right of way;

Thence, S 55°22'51" W, 1293.89' to a concrete monument set;

Thence, with a curve to the right, having a central angle of 39°53'39", a radius of 746.50', an arc length 519.78', a chord bearing of S 75°19'41" W, with a chord length of 509.34' to a concrete monument set;

Thence, N 84°43'32" W, 354.66' to a concrete monument set;

Thence, N 04°57'42" E, 8.46' to an iron pin found, said pin being the south east corner of the Thompson Lane Partners, LLC. Property shown in Deed Book 617, Page 10, (R.O.R.C., TN.);

Thence, with said easterly line, N 04°54'03" E, 301.92' to an iron pin found, said pin being the north east corner of said property, and the south east corner of the Walter Hunt Property shown in Deed Book 617, Page 633, (R.O.R.C., TN.);

Thence, with Hunts easterly line, N 04°56'59" E, 163.96' to an iron pin found, said pin being the north east corner of said property, and the south east corner of the Group Three Investments, L.L.C. Property shown in Deed Book 594, Page 644, (R.O.R.C., TN.);

Thence, with said easterly line, N 04°43'59" E, 419.83' to an iron pin found, said pin being the north east corner of said property, and the south east corner of the Nancy E. Harrell Property shown in Deed Book 660, Page 427, (R.O.R.C., TN.);

Thence, with Harrell's easterly line, N 04°15'04" E, 200.12' to an iron pin found, said pin being north east corner of said property, and the south east corner of the John Luck, Jr. Property shown in Deed Book 610, Page 137, (R.O.R.C., TN.);

Thence, with Luck's easterly line for next 2 (two) calls, N 05°23'42" E, 280.94' to an iron pin found;

Thence, N 05°42'13" E, 137.47' to an iron pin found, said pin being the north east corner of said Luck's Property;

Thence, N 84°36'56" W, 520.05' to an iron pin found in the easterly right of way of Thompson Lane, and being the north westerly corner of Luck's Property;

Thence, with said right of way of Thompson Lane, with a curve to the right, having a central angle of 22°08'42", a radius of 983.35' an arc length 380.07', a chord bearing of N 20°14'26" E, with a chord length of 377.71' to an iron pin set;

Thence, with said right of way, N 31°18'46" E, 504.44' to the POINT OF BEGINNING and containing 2,985,544.5 Sq. Ft. or 68.54 ac. more or less.

PROVIDED, that the property described above shall be subject to an easement for sanitary sewer and repurified water in favor of the City of Murfreesboro, said easement being described as follows:

The 50 foot wide, sanitary sewer and repurified water easement lying in the 13th Civil District of Rutherford County, Murfreesboro, Tennessee, being shown on Tract I on a boundary survey by Wiser Company LLC, drawing reference #02-03-601, and being more particularly described as follows:

BEGINNING at a point in the southerly right of way of proposed Manson Pike located S 57°50'46" E, 1643.67 feet from the centerline intersection of Thompson Lane and Manson Pike;

Thence, leaving said right of way S 11°36'38" E, 68.05' to a point;

Thence, S 58°53'31" E, 203.35' to a point;

Thence, S 31°6'31" W, 1028.62' to a point;

Thence, S 36°8'31" E, 209.44' to a point in the northerly right-of-way of the proposed Medical Center Parkway Phase III;

Thence, following said right of way N 55°22'51" E, 50.02' to a point;

Thence, leaving said right of way, N 36°8'31" W, 177.52' to a point;

Thence, N 31°6'31" E, 1045.37' to a point in the southerly right of way of proposed Manson Pike;

Thence, following said right of way N 58°53'32" W, 299.52' to the POINT OF BEGINNING and containing 74,095.49 Sq. Ft. or 1.70 ac. more or less.

This conveyance is made subject to all restrictions, easements, zoning and planning ordinances, health department regulations, and matters of record that may affect the premises, including, but not limited to, that certain Declaration of Covenants and Restrictions of record in Deed Book _____ , Page _____ , R.O.R.C.T.

Grantor's source of title being instruments of record at **Deed Book 634, Page 342, Deed Book 633, Page 653, Deed Book 633, Pages 702, 707, 710, 713 and 717, and Deed Book 633, Page 742,** Register's Office of Rutherford County, Tennessee.

TO HAVE AND HOLD said real estate, together with all appurtenances, estate and title thereunto belonging, unto the said grantee, its successors and assigns forever.

The Grantor covenants with the said **MIDDLE TENNESSEE MEDICAL CENTER, INC.** that Grantor is lawfully seized and possessed of said real estate, has a good right to convey the same, and that it is unencumbered.

The Grantor further covenants and binds itself, its heirs, successors, and assigns, forever, to warrant and defend the title to said **MIDDLE TENNESSEE MEDICAL CENTER, INC.,** its successors and assigns, against the lawful claims of all persons, whomsoever.

This conveyance is made pursuant to the terms of that certain Contract between the parties dated December 21, 2001, as amended, the terms of which (including any amendments thereto) shall not merge herein, but shall survive the closing.

Wherever used in this instrument, the singular number shall include the plural, the plural shall include the singular, and the use of any gender shall be applicable to all genders.

WITNESS OUR HANDS this the 17 day of January, 2003.

CITY OF MURFREESBORO

By: Tommy Bragg, Mayor
TOMMY BRAGG, MAYOR

ATTEST:

James B. Penner
JAMES B. PENNER, CITY RECORDER

STATE OF TENNESSEE)
: SS
COUNTY OF RUTHERFORD)

Before me, the undersigned authority, a Notary Public in and for said County and State, personally appeared **TOMMY BRAGG**, and **JAMES B. PENNER**, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon their oaths acknowledged themselves to be respectively the Mayor and City Recorder of the City of Murfreesboro, a municipal corporation, and that they as such Mayor and City Recorder, being authorized to do so, executed the within instrument (**Warranty Deed**) for the purposes therein contained, by signing thereto the name of said Corporation, and by attesting said instrument, by themselves as such Mayor and City Recorder, respectively.

WITNESS MY HAND, at office, this 17 day of January, 2003.

Judy San Angelo
NOTARY PUBLIC

JUDY SAN ANGELO
Notary Public At Large
RUTHERFORD COUNTY, TN

My Commission Expires: 3/20/05 (seal)

STATE OF TENNESSEE

RUTHERFORD COUNTY

I swear or affirm that the actual consideration for this transfer, or the value of the property, whichever is greater, is $5,483,200.00.

Sworn to and subscribed before me this 17th day of Jan., 2003.

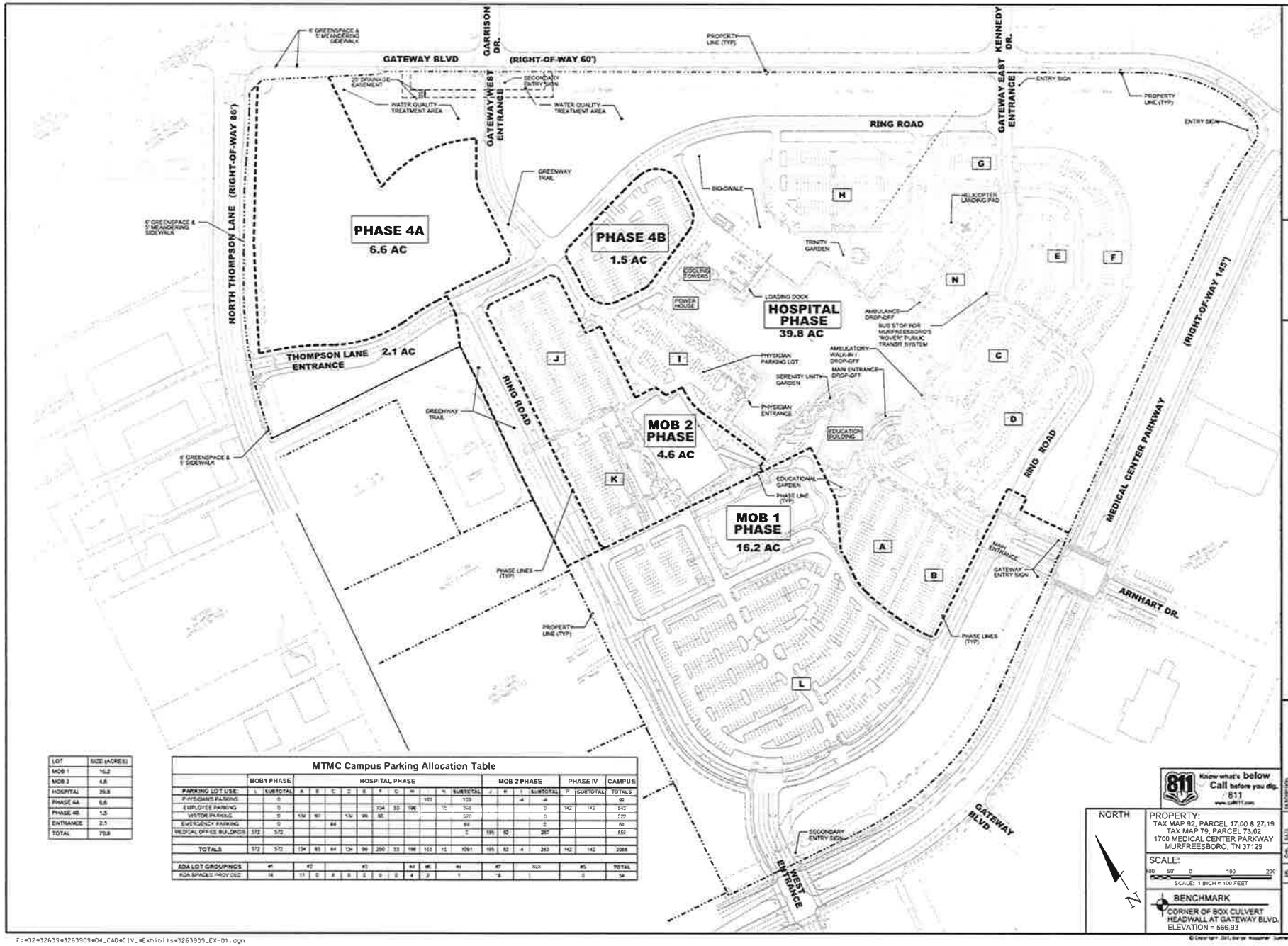
Notary Public

My commission expires 5-5-06. (seal)

Tab 5

Attachment Section A-6B-1

Plot Plan



LOT	SIZE (ACRES)
MOB 1	16.2
MOB 2	4.6
HOSPITAL	39.8
PHASE 4A	6.6
PHASE 4B	1.5
ENTRANCE	2.1
TOTAL	70.8

MTMC Campus Parking Allocation Table

	MOB1 PHASE		HOSPITAL PHASE												MOB 2 PHASE				PHASE IV		CAMPUS
PARKING LOT USE:	L	SUBTOTAL	A	B	C	D	E	F	G	H			SUBTOTAL	J	K	I	SUBTOTAL	P	SUBTOTAL	TOTALS
PHYSICIANS PARKING		0									103		103			4	4			98
EMPLOYEE PARKING		0						134	33	198		12	377				0	142	142	542
VISITOR PARKING		0	134	93		134	99	66					526				0			721
EMERGENCY PARKING		0			84								84				0			84
MEDICAL OFFICE BUILDINGS	572	572											0	195	92		287			859
TOTALS	572	572	134	93	84	134	99	200	33	198	103	12	1091	195	92	4	291	142	142	2286

ADA LOT GROUPINGS	#1		#2			#3				#4	#5	#6		#7		NOA		#8	TOTAL
ADA SPACES PROVIDED	14		11	0	8	8	0	0	0	4	2		1	4		1		0	54

BWSC
BARGE WAGGONER SUMNER & CANNON, INC.

PROPERTY EXHIBIT

PHASE IV - INFRASTRUCTURE IMPROVEMENTS
MIDDLE TENNESSEE MEDICAL CENTER
CITY OF MURFREESBORO, RUTHERFORD COUNTY, TENNESSEE

Know what's below
Call before you dig.
811
www.call811.com

NORTH

PROPERTY:
TAX MAP 92, PARCEL 17.00 & 27.19
TAX MAP 79, PARCEL 73.02
1700 MEDICAL CENTER PARKWAY
MURFREESBORO, TN 37129

SCALE:
50 0 100 200
SCALE: 1 INCH = 100 FEET

BENCHMARK
CORNER OF BOX CULVERT
HEADWALL AT GATEWAY BLVD.
ELEVATION = 566.93

DR.	BY	CHK.	BY	DATE	DESCRIPTION
				2/14/2017	ISSUED FOR REVIEW

EX-01

FILE NO. 32639-09

© Copyright 2011, Barge Waggoner Sumner & Cannon, Inc. All Rights Reserved

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4/20/2017
08:41:53 AM
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ASAron
BwsCful1.pen Horizscales: unlimited

Tab 6

Attachment Section A-6B-2

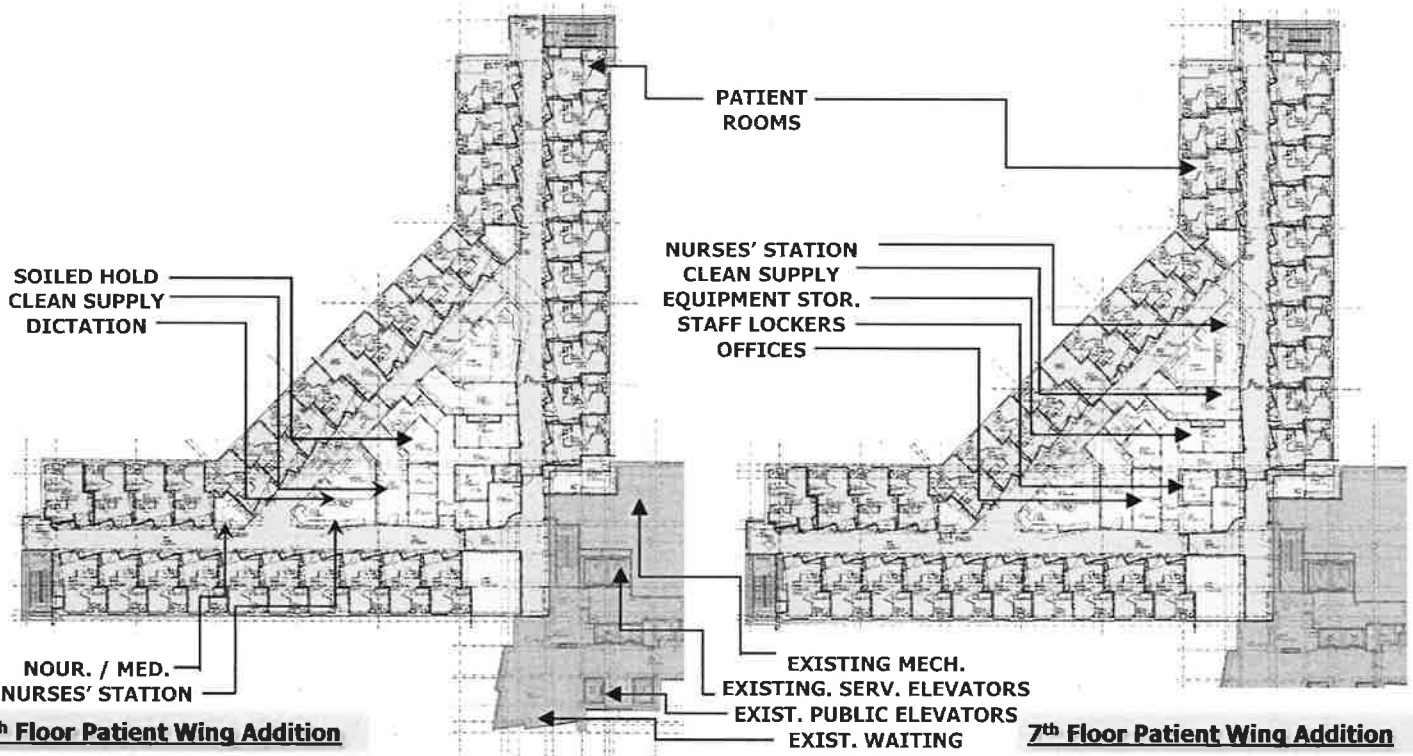
Floor Plan

Saint Thomas RUTHERFORD HOSPITAL

Saint Thomas Rutherford Hospital

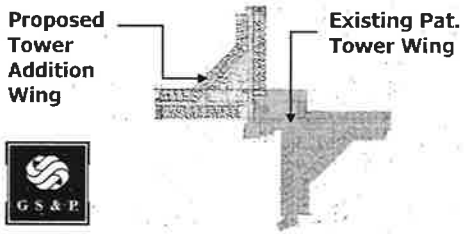
1700 Medical Center Parkway, Murfreesboro, TN 37129

Bed-Tower Addition



6th Floor Patient Wing Addition

7th Floor Patient Wing Addition



Floor Plan Diagram

N

Site Diagrams

GS&P

GRESHAM SMITH AND PARTNERS

Project Summary:

St. Thomas Rutherford Hospital, Murfreesboro, Tennessee presents a need for additional acute-care patient beds. These additional beds are proposed to be constructed atop the existing West-wing patient tower that was originally design for a vertical expansion.

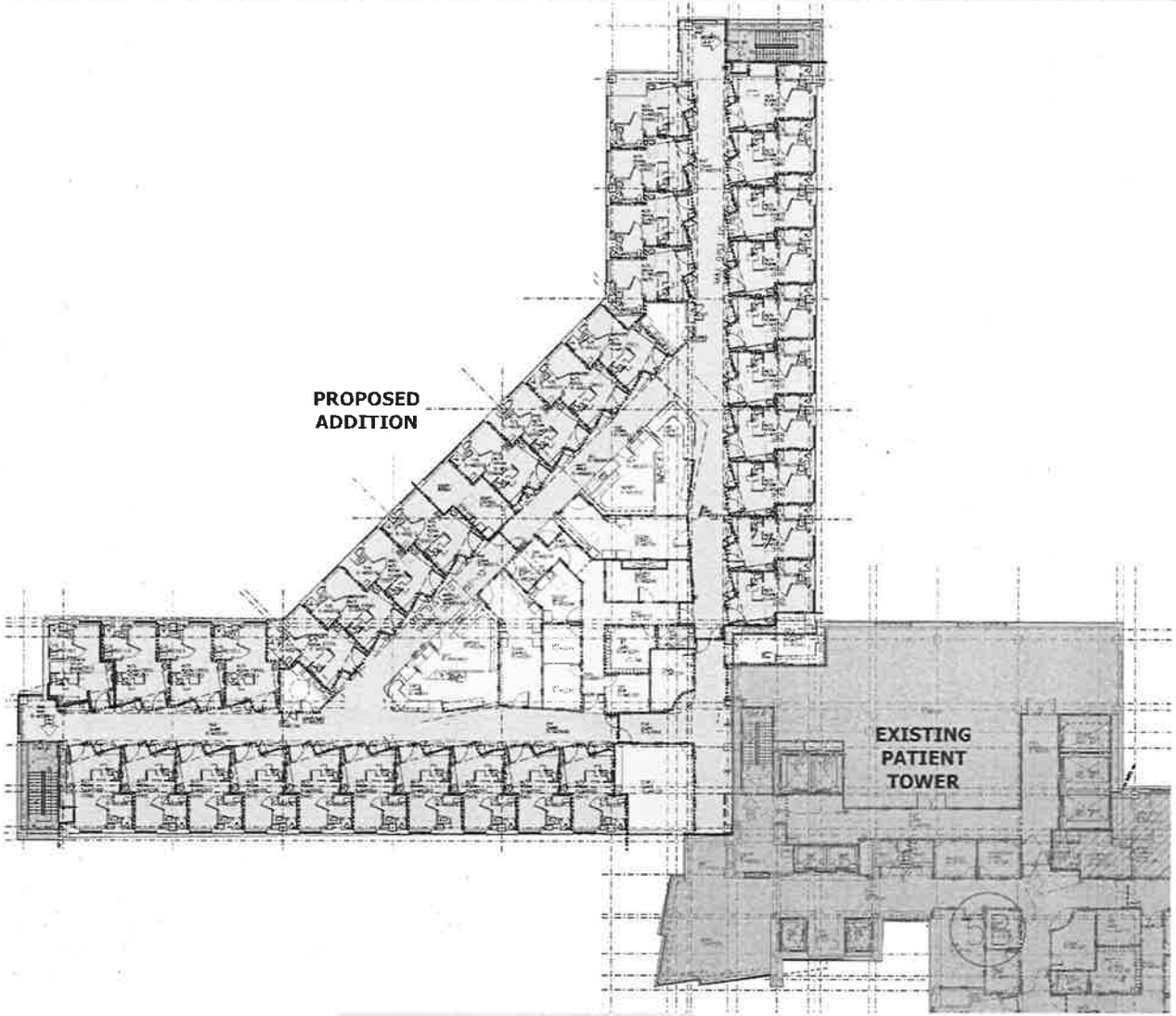
As a result, a building addition will occur to add two (2) additional floors. Each additional floors (6th and 7th floors) will add 36 beds each for a total of 72 patient beds.

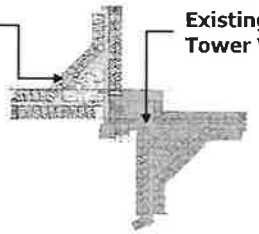
Existing patient tower includes service, patient and public elevators, lobby and waiting area as well as some mechanical support areas. These shared support spaces which were originally planned for the addition.

Each patient unit will include required FGI Design for Healthcare Facilities spaces and requirements.

Square Footage Summary:

Patient Tower Addition:	
6th Floor West	26,000 GSF
7th Floor West	26,000 GSF
Total Addition	52,000 GSF

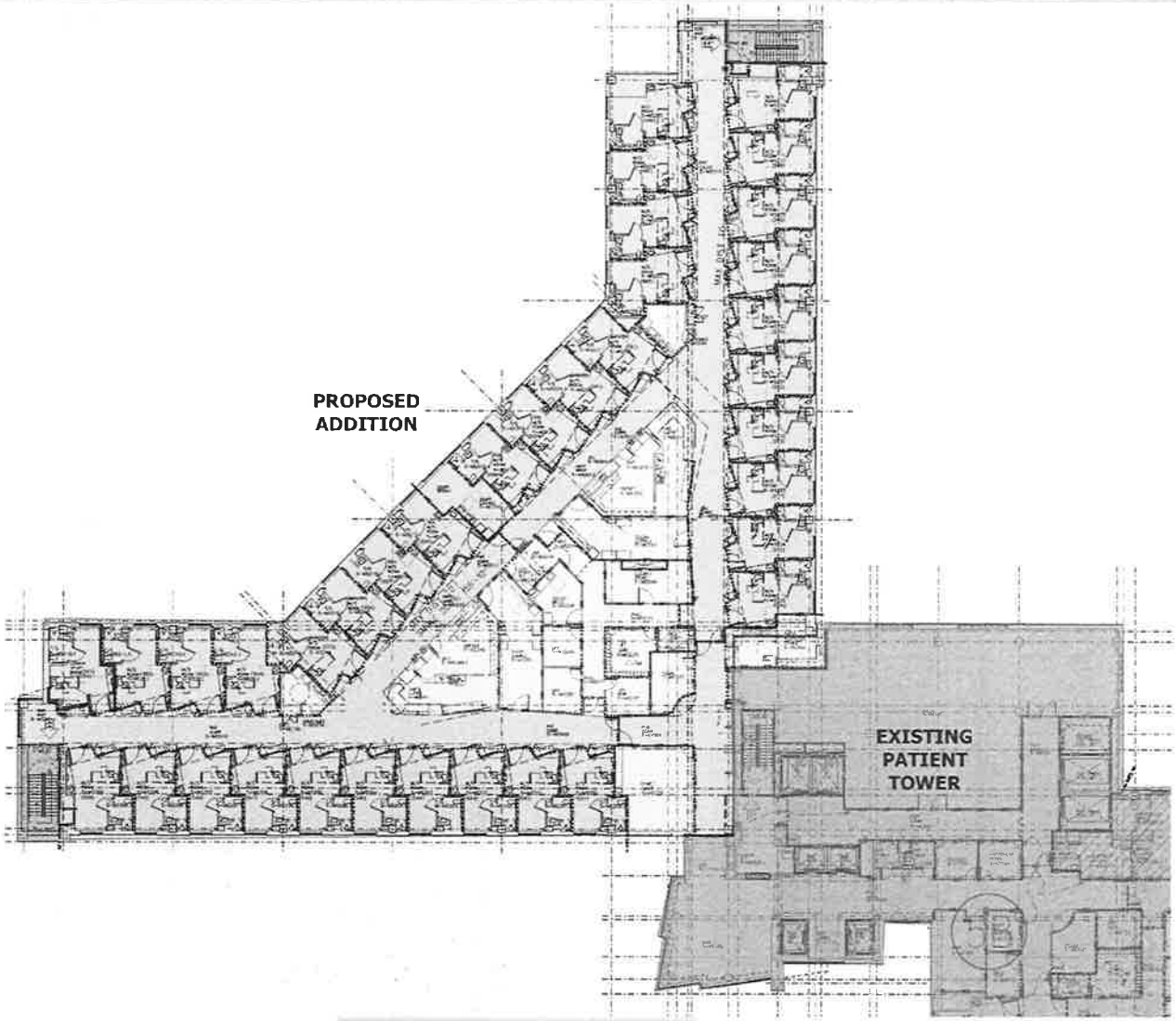




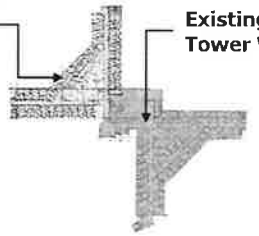
GS&P
GRESHAM SMITH AND PARTNERS

Floor Plan Diagram

Enlarged 6th Floor Schematic

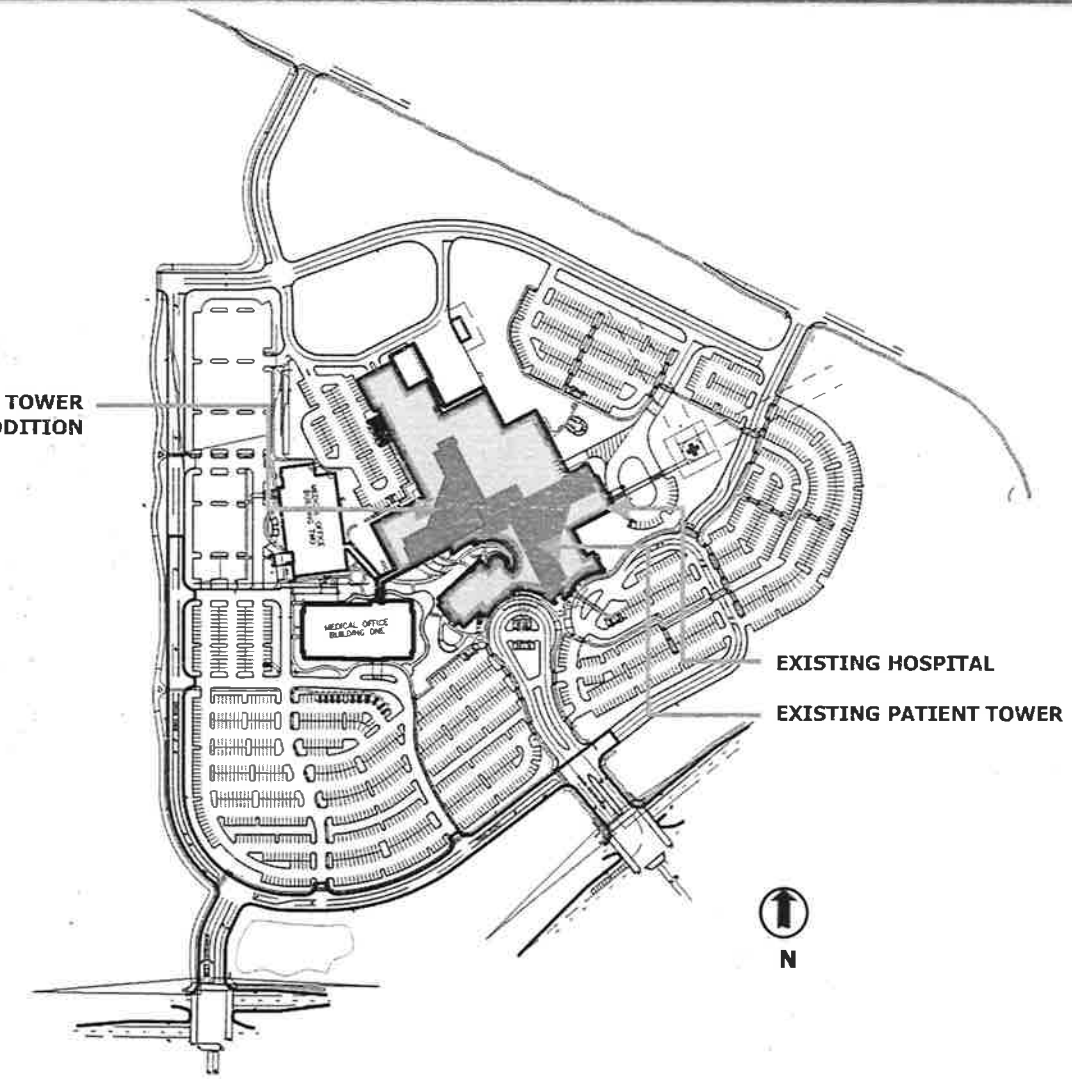


Enlarged 7th Floor Schematic

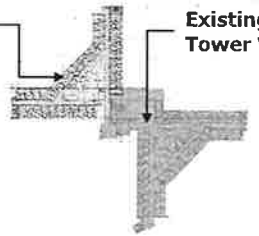


Floor Plan Diagram

GS&P
GRESHAM SMITH AND PARTNERS



Existing Site Plan



Floor Plan Diagram

GRESHAM SMITH AND PARTNERS

Tab 7

Attachment Section A-6B-3

Traffic-Related Articles

New Salem Highway widening to start 2018

Scott Broden , sbroden@dnj.com 6:23 a.m. CDT April 2, 2016

(Photo: John A. Gillis/DNJ)

MURFREESBORO — The widening project of New Salem Highway from Old Fort Parkway to Cason Lane will start in 2018, the state announced Thursday.

The New Salem Highway plan is included on the $2 billion list of 79 projects for 42 counties and 15 statewide infrastructure upgrades recommended to take place through 2019, according to a news release about the three-year Tennessee Department of Transportation schedule announced by Gov. Bill Haslam and Transportation Commissioner John Schroer.

The list also mentions a two-tenths of a mile widening of Franklin Road, which is part of state Route 96, to begin in 2017 from Veterans Parkway to east of Overall Creek.

Murfreesboro City Councilman Ron Washington wishes the list also included the widening of Thompson Lane, which is part of state Route 268, from Broad Street to Memorial Boulevard in an area that includes three Siegel schools.

"Any transportation road funding you have to be pleased with," Washington said. "However, that schedule does not meet my expectation because Thompson Lane in my opinion is a major priority. Thompson Lane is something that must be done."

Washington said the road funding should have covered even more of the widening of New Salem Highway, which is a part of state Route 99, to Veterans Parkway on the far southwest side of the city.

"Any funding you get nowadays is a blessing, so you have to be pleased, but Thompson Lane and New Salem Highway from Old Fort Parkway to Veterans Parkway are two highly congested roads that need construction," Washington said.

Ketron supports 2017 gas tax hike; others not so much
(http://www.dnj.com/story/news/local/2015/12/16/ketron-supports-2017-gas-tax-hike-others-not-so-much/77416782/)

Republican state Sen. Jim Tracy of Shelbyville agreed that the Thompson Lane project is needed and would have liked to have seen the list of funded projects also include the widening of West Jefferson Pike, which is part of state Route 266, from Nissan Drive in Smyrna to state Route 840.

"Jefferson Pike widening is at the top of the list I'm going to work on," said Tracy, who serves as the chairman of the Senate Transportation and Safety Committee.

(Photo: HELEN COMER/DNJ)

Tracy said he's pleased about the funding plans for New Salem Highway. He also wishes the list mentioned a proposed Interstate 24 interchange on Rocky Fork Road in Smyrna and the improvement of an existing interchange at Epps Mill Road on the southeast side of Rutherford County.

"With the growth going on in Rutherford County, we've to got numerous projects out there," Tracy said. "I was happy they got what they got. I'd always like more."

The senator said he's asked TDOT to conduct a new study of needed road projects and the revenues required to cover them before examining possible ways to increase revenues.

The existing state gas tax of 21.4 cents per gallon hasn't increased since around 1989, and road revenues have been unable to keep up with construction costs, said Tracy, who also wants the state to repay $260 million to the road fund that was used to balance budgets.

Smyrna Town Council wants road taxes 'enhanced'
(http://www.dnj.com/story/news/2016/02/15/council-wants-road-taxes-enhanced/80313162/)

A mile of road in 2006 cost about $35,000 to build, and that's climbed to about $100,000 today, Tracy said.

The average motorist drives about 15,000 miles per year and pays $160 in gas taxes, said Tracy, noting his monthly cell phone bill is more than that.

Councilman Washington said the federal gas tax of 18.4 cents is also overdue being raised by lawmakers.

"They need to get that gas tax around 30 cents on the federal level," said Washington, who'd also like to see the local annual wheel tax raised by $3 per vehicle to go toward road projects. "The transportation funding is still an issue with no movement in sight with long-term funding. That's the issue that Congress failed to address. Somewhere immediately down the road, Congress must address long-term transportation funding for the whole country, and not just for Rutherford County."

Contact Scott Broden at 615-278-5158. Follow him on Twitter @ScottBroden.

Read or Share this story: http://on.dnj.com/1N2nACA

Murfreesboro council to discuss road funds

Scott Broden , sbroden@dnj.com 8:04 a.m. CDT October 11, 2016

(Photo: Submitted)

MURFREESBORO — The City Council will discuss 2017 Tennessee General Assembly priorities such as road funding this week.

"It's imperative that we get that Highway 99 widened," Mayor Shane McFarland said.

The special-called meeting will be at 5 p.m. Thursday, Oct. 13 in Room 218 on the second floor of City Hall, 111 W. Vine St.

The seven-member council hopes tax dollars from the General Assembly will pay for improvements to federal and state roads that pass through a fast-growing Murfreesboro that reached a U.S. Census estimated population of 126,118 on July 1, 2015.

State Highway 99, for example, includes a New Salem Highway area that leads southwest of the city to where the Rutherford County Board of Education plans to open a Rockvale High School by 2019 to relieve overcrowding at other campuses.

Mayor McFarland also mentioned funding to improve Thompson Lane between Broad Street and Memorial Boulevard on the northwest side of Murfreesboro and Bradyville Pike, a road that's also part of state Highway 99 on the southeast side of Murfreesboro.

"As many people in the area know, one of the biggest challenges is transportation moving forward," McFarland said.

City Councilman Eddie Smotherman agreed that funding is important for the federal and state roads that pass through Murfreesboro.

"That's where we're having our main traffic jams, in our thoroughfares," Smotherman said. "We continuously look for funding and for our budget to make ends meet."

In addition to road funding, the council will talk about annexation laws in recent years that made conditions harder for property owners to make annexation requests for their land that's not contiguous to the city boundary because neighbors that are contiguous reject annexation.

Although people make negative arguments about forced annexation, law makers should look at the property rights of individuals "if they do want to be annexed," Mayor McFarland said.

Another legislative issue is what's going on with education, the mayor and Councilman Smotherman said.

Buy Photo

Eddie Smotherman *(Photo: DNJ file)*

"We need to make sure we have emphasis on education as we continue to improve our schools," Smotherman said.

Education in Murfreesboro includes the city's pre-kindergarten through sixth-grade district, Rutherford County Schools that serve prekindergarten through 12th grade, and Middle Tennessee State University.

The council will be meeting with lobbyist Russ Farrar of the Nashville lobbying firm Farrar & Bates. The elected council at the recommendation of City Manager Rob Lyons hired the firm in February 2016 to advise the Council on numerous intergovernmental issues and legislation that impact local governments, including Murfreesboro, financially, operationally, and strategically, states a news release from the city.

The firm also assists the city with advise on other tax and transportation-related issues.

Contact Scott Broden at 615-260-0523. Follow him on Twitter @ScottBroden.

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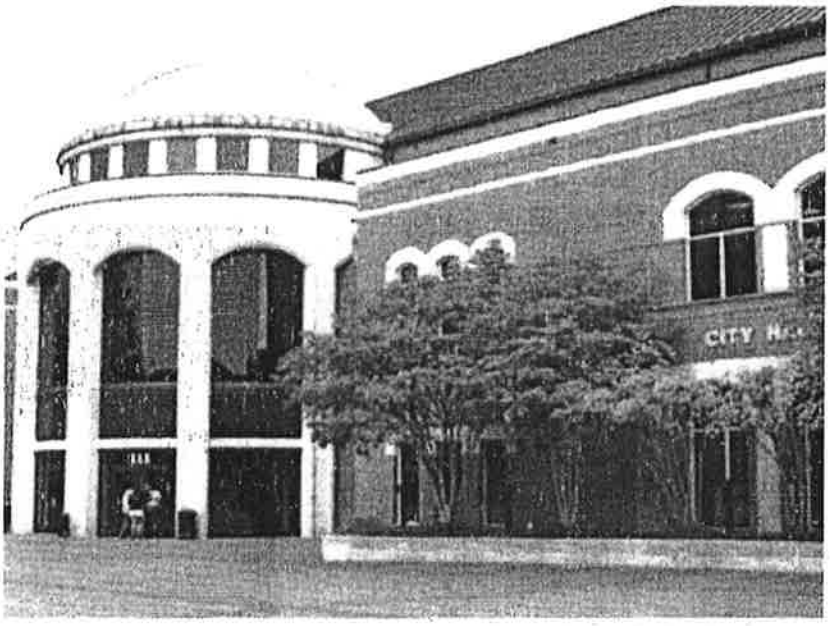

(Photo: DNJ staff)

Public comment, other City Council meetings

Residents will get the chance to speak to the Murfreesboro City Council between two other scheduled meetings. The meeting involving public comment will last up to 30 minutes and begin at 6:30 p.m. Thursday in Council Chambers on the first floor of City Hall, 111 W. Vine St. Those interested can call the city administration in advance at 615-849-2629 to request a speaking time.

In addition to the public comment meeting, the council will meet at 5 p.m. Thursday to discuss legislative priorities in Room 218 on the second floor of City Hall. The regular weekly meeting is scheduled to begin at 7 p.m. in Council Chambers.

City Hall is by Linebaugh Library, and both are a part of Civic Plaza. Free parking is available under the plaza in a two-story garage with access from Vine, Church and Broad streets.

Read or Share this story: http://on.dnj.com/2enEuFb

Smyrna seeks I-24 interchange at Rocky Fork Road

Scott Broden , sbroden@dnj.com 7:01 a.m. CDT October 31, 2016

(Photo: Scott Broden /DNJ)

SMYRNA — Town officials hope upgrades to Sam Ridley Parkway and other roads will lead to the long coveted third Interstate 24 interchange at Rocky Fork Road.

"We have about eight to 10 projects just over $13 million in the pipeline as far as road improvements going on," said Tim Morrell, who is one of the seven elected members of a Smyrna Town Council that seeks I-24 access beyond the parkway and Almaville Road. "Our large focus is getting the interchange at Rocky Fork. In order to do that, we have to follow the TDOT (Tennessee Department of Transportation) mandate to improve Sam Ridley Parkway."

Smyrna officials see road improvements that include better timed traffic lights as a way to attract more jobs, retail and shopping opportunities while maintaining the quality of life for a fast-growing town that has reached an estimated population of about 47,521 after a U.S. Census count of 39,974 in 2010.

The council is pursuing a $6.5 million extension of Enon Springs Road from Old Nashville Highway to Rocky Fork Road near the proposed I-24 interchange and where the Rutherford County Board of Education plans to open a middle school by August 2017 and an elementary school by August 2018, said Tom Rose, the public works director for the Smyrna government.

"It will be a gateway entrance," said Rose, who expects the Enon Springs extension to be done by summer 2018 and attract commercial and residential development. "We are pushing this project as quickly as we can. There's a lot of growth that's happening before that road is going to be done."

Other projects include the widening of StoneCrest Boulevard at the Sam Ridley Parkway intersection, Florence Road between Enon Springs and Rebel roads, and the Weakley Lane intersection at Swan Drive.

Sam Ridley Parkway should move faster once the access road for StoneCrest Medical Center near I-24 is widened, Rose said.

"Right now there's a lot of backup," Rose said.

Stonecrest Boulevard will go from three lanes to five lanes: two will be for left-hand turns; two will be to go straight across Sam Ridley; and one will be for right-hand turns. TDOT is funding 80 percent of the $400,000 intersection project while the town is covering the other 20 percent with impact fees.

The council also is building an Intelligent Transportation System that allows government staff to improve traffic-light timing at 48 of the town's 49 intersections through monitoring cameras for non law-enforcement purposes.

"No red light cameras," quipped Rose, who expects the system to be complete by November 2018. "We have some great projects for the growth."

The town will be spending $180,000 while TDOT provides $720,000 to add fiber optic lines that connect with existing ones, Rose said.

"We have some really great projects for growth," Rose said.

Contact Scott Broden at 615-278-5158. Follow him on Twitter @ScottBroden.

Smyrna road projects

Florence Road

Project: Widening from two lanes to three between Enon Springs and Rebel roads

Completion date: August

Cost: $4.2 million

Funding source: Impact fees for development and $350,000 from two industrial companies

StoneCrest Boulevard at Sam Ridley Parkway

Project: Widening from three lanes to five

Completion date: July

Cost: $400,000

Funding source: 80% TDOT; 20% impact fees

Enon Springs Road

Project: Extension of Enon Springs from Old Nashville Highway to Rocky Fork Road

Construction start date: Summer 2017

Completion date: Summer 2018

Cost: $6.5 million

Expected funding source: bond

Intelligent Transportation System

Project: Adding fiber optic lines and connecting to existing ones for government staff to monitor and improve traffic light timing through cameras at 48 of town's 49 traffic signals

Completion date: November 2018

Cost: $900,000

Funding source: 80% TDOT; 20% town government

Weakley Lane and Swan Drive

Project: adding four left-hand turn lanes

Start date: June 2017

Completion date: October 2017

Cost: $950,000

Funding source: 80% TDOT; 20% town impact fees

Source: *Smyrna Public Works Director Tom Rose*

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Sam Ridley, Almaville jams annoy town

Scott Broden , sbroden@dnj.com 9:30 a.m. CDT September 1, 2016

(Photo: Nancy Broden/DNJ)

SMYRNA — Traffic jams on Sam Ridley Parkway and Almaville Road continue to be a concern for the Town Council.

"It's frustrating," Smyrna Mayor Mary Esther said during a Tuesday workshop with the other six elected officials on the Town Council.

Town Manager Harry Gill Jr. told the council members that he will be giving them a presentation during next month's workshop scheduled at 5 p.m. Sept. 29 about addressing the traffic in particular on both of these Smyrna roads that have Interstate 24 interchanges.

"Hopefully, we'll see some improvements on Sam Ridley and Almaville Road," said Gill, adding that other road projects will be discussed during the presentation.

Mayor Reed said it's important for the town to do everything it can to improve Sam Ridley Parkway and Almaville Road while continuing to ask state and federal officials to approve a third I-24 interchange at Rocky Fork Road.

"It's a long, drawn-out process," said Reed, who serves with other mayors in Middle Tennessee as a member of a Metropolitan Planning Organization that makes decisions on spending federal transportation funding. "Everybody wants a piece of that pie."

The third interchange would be near where the Rutherford County Board of Education is building a middle school and elementary school, and tie in with the town's plans to extend Enon Springs Road to this area from Old Nashville Highway.

While waiting for the long sought interchange, traffic jams remain a concern on Sam Ridley Parkway and Almaville Road, the mayor said.

"It's frustrating," Reed said.

In addition to improving roads, Councilman H.G. Cole said the town and the Middle Tennessee region need to expand bike lanes and mass transportation options, such as light rail, buses and subways, to provide people with other ways to travel and compete with what's going on in cities such as Seattle and Portland.

Nashville will no longer continue to be the "It city," unless more is done to promote mass transportation and bike lanes "because we're choking ourselves with growth," said Cole, adding that too many builders and developers oppose these transportation options.

"That closed mindedness is deliberating to our growth," Cole said.

Mayor Reed agreed and said transportation has to go beyond just getting people from Smyrna to downtown Nashville.

Another issue of concern is drivers speeding through subdivisions and ignoring stop signs, said Gill, adding that the town plans to impose hefty fines on those caught "flying through" neighborhood streets to make conditions dangerous where children ride bikes and play.

Contact Scott Broden at 615-278-5158. Follow him on Twitter @ScottBroden (http://twitter.com/ScottBroden).

Read or Share this story: http://on.dnj.com/2bTnT71

Smyrna Candidates: Traffic, growth top concerns

Michelle Willard , mwillard@dnj.com 9:13 a.m. CDT October 21, 2016

(Photo: HELEN COMER/DNJ)

Elections for Eagleville, La Vergne and Smyrna will be held along with state and federal elections on Nov. 8 and candidates across the county are vying for seats on their local municipal councils.

In Smyrna, seven candidates — Bradley Austin, Dennis Johnson, Tim Morrell, Robert "Bob" New, Racquel Peebles, Steve Sullivan and Michelle Mastin Wesnofske — are running for three open, at-large seats on the Town Council.

The candidates were asked the same questions and given an opportunity to share their thoughts with the voters. Here are their answers:

Name: Bradley Austin

Experience: I have worked for Discount Auto Sales in Murfreesboro for two years now. I started as a sales representative and now I am an assistant manager in training. I want to work for the people of Smyrna. I got involved with my community by helping state Rep. Mike Sparks, R-Smyrna, since I was 19. He has been a great influence in my life.

What is the biggest issue facing Smyrna? What is my solution?

Our budget is out of control. We spend more money on our parks than we do on our police and fire departments. We need a new budget and responsible people to use our tax dollars.

Name: Dennis Johnson

Dennis Johnson *(Photo: Submitted)*

Experience: Throughout my life in Smyrna I have been an active citizen, teacher, small business owner, coach and volunteer. I was awarded the lifetime service award in 2015, the same award my father won in 1999. I have served on our Parks Advisory Board for the past two years.

What is the biggest issue facing Smyrna? What is my solution?

One of our biggest issues is making sure our roads can handle the amount of traffic we are facing due to the amount of growth in our town.

I feel the solution requires us to work together with TDOT on road projects that will help alleviate traffic on state roads such as Sam Ridley Parkway, Jefferson Pike, Almaville Road interchange and trying to obtain a third interchange on Rocky Fork Road. I also believe it's important to continue and complete current projects such as Florence Road, Rocky Fork Road to the new school and Enon Springs Road tying into Rocky Fork Road.

Name: Tim Morrell

Tim Morrell *(Photo: Submitted)*

Experience: Current councilman for the Smyrna Town Council; Smyrna Planning Commission; Rutherford County Economic Development Board, Town Representative; Lowry Street Revitalization Committee Member; Board of Trustees; Rotary Club of Smyrna; United Way Board for Rutherford & Cannon Counties, former Board of Directors; North Rutherford YMCA, former Board of Directors

What is the biggest issue facing Smyrna? What is your solution?

Smyrna is the 14th largest city in Tennessee with the third lowest tax rate. Additionally, we have one of the lowest unemployment rates in Tennessee. Due to these factors and our continual focus on quality of life, we are experiencing explosive growth that is putting a strain on our infrastructure such as waste water capacities and on our roadways.

For infrastructure solutions, we are currently in a $25 million waste-water expansion that will increase our capacities to meet the demands of our growing population.

As far as roadways, first and foremost, the Town Council continues to seek approval at the state and federal level to obtain an interchange at Rocky Fork Road and I-24.

Even more importantly, we are continuing to work with TDOT (Tennessee Department of Transportation) on improving traffic flow on Sam Ridley Parkway and Almaville Road/Lee Victory Parkway.

Name: Bob New

Bob New *(Photo: Submitted)*

Experience: I've been a registered nurse for 40 years and retired last year. My wife and I have been involved in politics since moving here. We've worked on several campaigns and I've run for office in the past. I've dedicated me life to serving others and look forward to serving the people of Smyrna.

What is the biggest issue facing Smyrna? What is your solution?

Unbridled growth is the main problem facing Smyrna. This causes most of the other issues. Our infrastructure can't keep up with the rapid growth. We need improved planning that will take into consideration the impact on our roads and services. The impact on our environment is causing storm-water problems, air pollution and noise pollution that impacts our homes and quality of life. There needs to be a balance between the impact of growth on our economy, environment and quality of life. We need leaders who will make the tough choices. Sometime you just need to say no.

Name: Steve Sullivan

Steve Sullivan *(Photo: Courtesy of Facebook)*

Experience: Bachelor's and master's degrees from Trevecca Nazarene University; former U.S. Marine, Desert Storm Veteran; Volunteer Board member for slow-pitch, fast-pitch, and adult softball, baseball, and soccer; Volunteer of the Year 2014, Smyrna Adult Softball League; member of the Board of Zoning Appeals and Parks Athletic Committee; 20-plus years in IT Management at IBM and Nissan

What is the biggest issue facing Smyrna? What is your solution?

The biggest issue facing Smyrna today is exponential growth. Growth is a great issue to have and is required for Smyrna's sustainability, but unbridled growth is a disaster. Our thoroughfares and infrastructure must be managed carefully to accommodate this growth. To meet these demands, continued fiscal responsibility is a must. A healthy cash reserve and managed budget are mandatory to be in a position to fund the infrastructure upgrades and expansions needed to support this growth. Vote for me, starting Oct. 19, and I will work with the mayor and other council members to find common sense solutions to these issues.

Name: Racquel Peebles

Raquel Pebbles *(Photo: Submitted)*

Experience: I have practiced law for 20 years, which requires listening to people's concerns and resolving them. I have owned a small business in Smyrna for 13 years, so I understand how critical good planning and budgeting are. Lastly, I have served on various boards and as a community volunteer.

What is the biggest issue facing Smyrna? What is your solution?

The biggest issue facing Smyrna is infrastructure, which overlaps with other issues. We should continue allocating more funds toward alleviating traffic concerns, and that includes expanding current roads and constructing new ones. We have to be proactive with effective planning so the necessary infrastructure is in place for businesses and residents and people moving to Smyrna.

Additionally, we need to work with our county, state and federal leaders to secure funding for an additional interchange at I-24, which will bring more retail and job opportunities for our residents so that they can work, eat, shop, and play here in Smyrna.

Name: Michelle Martin Wesnofske

Experience: As a small business owner, I understand the need for economic growth balanced with controlled spending. I grew up in Smyrna, raised my children here and my children are raising their children here. I serve on the Historic Zoning Board and have been in attendance with the citizens' committee regarding the Lowry Street overlay project. Smyrna's past, present and future are of utmost importance to me.

Michelle Wesnofske *(Photo: Submitted)*

What is the biggest issue facing Smyrna? What is your solution?

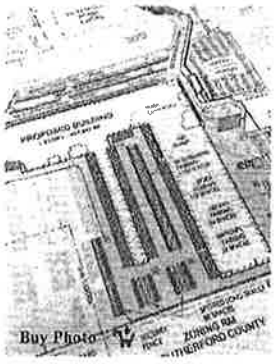
The biggest issue facing our town is economic growth. We have stagnated in our proactive efforts to attract businesses (with exception to the retail sales tax revenue generated on the west end of Sam Ridley Parkway). We enjoy lots of amenities in Smyrna, including a beautiful park system. We have spent a great deal of money and resources making Smyrna an attractive place to live. However, we must refocus our attention to updating our infrastructure in an effort to attract more industry and create more local jobs. I am interested in promoting the concept of being proactive in preparing our infrastructure to attract new businesses to Smyrna so that our residents can live and work amid this wonderful community.

Reach Michelle Willard at 615-278-5164, on Twitter @MichWillard or on Facebook at facebook.com/DNJBusiness.

Read or Share this story: http://on.dnj.com/2eYjzJa

Murfreesboro paves way for FedEx Ground facility

Michelle Willard , mwillard@dnj.com 8:54 p.m. CST November 17, 2016



(Photo: Michelle Willard / DNJ)

MURFREESBORO — Traffic concerns dominated the conversation at the Murfreesboro City Council on Thursday night surrounding zoning requests for a proposed FedEx Ground facility.

FedEx Ground has asked for annexation into the Murfreesboro city limits and rezoning the 217-acre undeveloped property located along the south side of South Rutherford Boulevard east of the CSX railroad tracks and west of Broad Street.

Surprisingly no one spoke in either of the public hearings held for the plan of services, annexation and rezoning before the City Council gave its approval in a 5-1 vote with Councilman Rick LaLance dissenting.

LaLance spoke out on the project's potential negative impact on traffic with a projected 750 trips per day coming into and out of the site.

The project's site plan was approved Wednesday by the Murfreesboro Planning Commission, contingent on approval of the plan of services, annexation and rezoning by the City Council.

"FedEx already has a facility in town. They are looking to expand because of the increased volume we see from the growth in Middle Tennessee," Cherie Akers from Stantec said on behalf of the logistics company.

When 947,842 square-foot facility (/story/money/business/2016/08/31/fedex-ground-build-hub-murfreesboro/89644276/) is completed, the hub will have hundreds of bays for tractor trailers to load and unload into the proposed one-story building. It will also have spaces for "inbound parking," "outbound parking" and employees, according to the preliminary site plan.

The site plan has separate entrances for employees and trucks and vans with primary access about a quarter mile from Broad Street on South Rutherford Boulevard.

During the meeting Thursday, the City Council asked about how the facility will impact traffic on Church Street and surrounding roadways.

"We have adopted many options to accommodate our traffic," Akers said.

Given the potential impact on traffic in south Murfreesboro (/story/money/business/2016/09/02/fedex-submits-plans-ground-hub-murfreesboro/89737798/), FedEx and city officials have worked with consultants from RPM Transportation Consultants to develop a traffic plan for the site.

By the time it reaches full capacity, RPM estimates as many as 750 pickup and delivery vans and tractor trailers coming into and out of the site daily, said Robert Murphy, president RPM Transportation Consultants.

He explained at a neighborhood meeting in October that most of the van and truck traffic at the facility will happen in mid-afternoon and late evening.

Preliminary proposals include a turning lane from Broad Street to South Rutherford Boulevard and retiming signals at both the intersections of South Rutherford and South Church and Broad streets, Murphy said.

Murphy explained the company studied the current traffic situation and developed recommendations that could actually improve traffic flow on Church Street.

Ram Balachandran, traffic engineer for the city of Murfreesboro, explained the project will be completed in two phases, the first which will be fully completed in 2019. Full build out is set for a 2026.

He said the plan for the first phase "looks good" and he asked them to study the timing of the traffic lights at three intersections on South Church Street — Rutherford Boulevard, Interstate 24 west off ramp and I24 east off bound — and two on Broad Street — Rutherford Boulevard and Joe B. Jackson Parkway.

"They are going to synchronize the lights with their truck traffic," Balachandran told The DNJ. "And all the analysis they did is based on 2026 projected numbers."

FedEx has agreed to do an initial synchronization when the first phase is completed in 2019 and to revisit it in 2026, Balachandran said.

The company will also be required to submit a new traffic study when it starts on the second phase in 2026, explained Matthew Blomeley, assistant planning director.

FedEx Ground estimates the facility will be a $189.5 million investment that will create an estimated 41 full-time jobs (/story/money/business/2016/10/05/logistics-jobs-questioned-fedex-hearing/91615028/) with an average wage of $53,500 and 160 full-time equivalent, part-time jobs at $24,000 annually. It is tentatively set to open in early 2018. The estimate does not include 300 drivers who are contract employees.

Reach Michelle Willard at 615-278-5164 or on Twitter @MichWillard.

Read or Share this story: http://on.dnj.com/2fBvLyS

Tab 8

Attachment Section A-10

Letter of Support

Saint Thomas Health

Gordon B. Ferguson, FACHE
President and Chief Executive Officer
Saint Thomas Rutherford Hospital
Saint Thomas Regional Hospitals

July 13, 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 Rutherford Hospital and its CON application to expand its inpatient services by 72 beds. As the current President and CEO of Saint Thomas Rutherford Hospital and President of the Saint Thomas Regional Hospitals, I know firsthand the need to expand our ability to continue to serve our growing community.

I have served as the president and chief executive officer of Saint Thomas Rutherford Hospital since 2006 with more than 30 years of healthcare experience. In addition to serving as the president and chief executive officer of Saint Thomas Rutherford Hospital, I have served since 2015 as the president of the Saint Thomas Regional Hospitals which include: Saint Thomas Dekalb Hospital, Saint Thomas Highlands Hospital, Saint Thomas River Park Hospital, and Saint Thomas Stones River Hospital.

As a Murfreesboro resident for the past 20 years, I am highly invested in the communities and patients we serve through my involvement as a member of the following boards: Business Education Partnership, United Way of Rutherford and Cannon Counties, Leadership Middle Tennessee, Tennessee State Board of Education and Alive Hospice Murfreesboro.

Our existing medical-surgical beds at Saint Thomas Rutherford Hospital have been operating at over 90% utilization for a prolonged period of time. We have routinely had to hold patients in the emergency room due to capacity concerns in our medical-surgical beds and on occasion had greater than 20 patients holding in one day. These capacity concerns are the result of multiple factors such as:

- increasing inpatient utilization from Rutherford County
- population growth in Rutherford County of 10%
- increasing inpatient in-migration from throughout the region
- increasing observation patient utilization
- increasing observation patient utilization exceeding 24 hours

1700 Medical Center Parkway
Murfreesboro, Tennessee 37129

p 615-396-4100
STHealth.com

Ms. Hill, thank you for considering Saint Thomas Rutherford Hospital's application. This project is vital for providing safe care to the patients and families we serve throughout Rutherford and the surrounding counties. I hope the Agency members will grant a favorable decision in this matter.

In His Service,

Gordon B. Ferguson, FACHE
President and Chief Executive Officer, Saint Thomas Rutherford Hospital
President, Saint Thomas Regional Hospitals

Section B

Tab 9 - Official Bed Need Projections
Tab 10 - Construction Cost Verification Letter
Tab 11 - Funding Letter
Tab 12 - Financial Statements
Tab 13 - Financial Assistance Policies
Tab 14 - Quality Management & Utilization Management
Tab 15 - Clinical Affiliation Agreements
Tab 16 - Hospital License
Tab 17 - Accreditation

Tab 18 - HSDA Letter of Intent
Tab 19 - Evidence of Publication

Tab 9

Attachment Section B-A1

Official Bed Need Projections

ACUTE-CARE BED NEED PROJECTIONS FOR 2017 AND 2021, BASED ON FINAL 2015 HOSPITAL JARS

COUNTY	2015		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2015 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2015	2017	2021	ADC-2017	NEED 2017	ADC-2021	NEED 2021	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	48,085	132	165	89,974	91,031	92,959	133	167	136	170	301	210	-131	-40
Beford	6,017	17	26	13,710	14,171	15,089	17	27	18	28	60	52	-32	-24
Benton	1,584	4	9	2,119	2,125	2,129	4	9	4	9	25	25	-16	-16
Bledsoe	2,014	6	11	3,374	3,414	3,480	6	11	6	11	25	25	-14	-14
Blount	46,823	128	160	91,491	93,805	98,298	132	164	138	172	304	238	-132	-66
Bradley	35,690	98	122	82,083	83,654	86,686	100	125	103	129	351	186	-222	-57
Campbell	20,009	55	72	17,341	17,463	17,652	55	72	56	73	120	106	-47	-33
Cannon	5,338	15	24	4,017	4,067	4,159	15	24	15	24	60	50	-36	-26
Carroll	8,101	22	33	13,632	13,654	13,653	22	33	22	33	115	70	-82	-37
Carter	16,411	45	61	29,804	29,997	30,330	45	61	46	62	121	74	-59	-12
Cheatham	1,934	5	11	1,732	1,737	1,742	5	11	5	11	12	12	-1	-1
Chester	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Claiborne	5,488	15	24	13,063	13,252	13,589	15	24	16	25	85	33	-60	-8
Clay	3,561	10	17	3,704	3,720	3,740	10	17	10	17	36	34	-19	-17
Cocke	6,693	18	28	14,223	14,389	14,674	19	29	19	29	74	36	-45	-7
Coffee	26,086	72	91	48,676	49,554	51,229	73	93	75	95	209	163	-114	-68
Crockett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Cumberland	19,659	54	71	42,137	43,360	45,669	55	73	58	76	189	85	-113	-9
Davidson	869,249	2,382	2,977	1,607,173	1,654,863	1,746,211	2,452	3,065	2,588	3,234	3,786	3,258	-552	-24
Decatur	2,411	7	13	3,296	3,316	3,352	7	13	7	13	40	27	-27	-14
DeKalb	3,477	10	17	6,551	6,648	6,828	10	17	10	17	71	56	-54	-39
Dickson	20,230	55	73	37,450	38,213	39,662	57	74	59	77	157	120	-80	-43
Dyer	13,691	38	52	30,953	31,225	31,716	38	52	38	53	225	115	-172	-62
Fayette	8	0	0	.	.	.	.	.	.	.	46	10	.	.
Fentress	6,658	18	28	10,552	10,712	10,989	18	28	19	29	85	54	-56	-25
Franklin	19,371	53	70	32,002	32,205	32,534	53	70	54	71	152	144	-81	-73
Gibson	2,386	7	12	4,051	4,087	4,156	7	13	7	13	70	28	-57	-15
Giles	8,034	22	33	11,995	12,022	12,054	22	33	22	33	95	81	-62	-48
Grainger	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Greene	24,026	66	85	49,044	49,812	51,231	67	86	69	88	240	171	-152	-83
Grundy	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Hamblen	32,359	89	111	68,666	69,668	71,509	90	112	92	115	302	196	-187	-81
Hamilton	419,591	1,150	1,437	741,159	755,974	784,918	1,173	1,466	1,217	1,522	1,596	1,225	-74	297
Hancock	909	3	6	1,454	1,463	1,473	3	6	3	6	10	10	-4	-4
Hardeman	908	3	6	2,501	2,501	2,500	3	6	2	6	51	21	-45	-15
Hardin	6,441	18	27	13,952	14,042	14,186	18	28	18	28	58	49	-30	-21
Hawkins	3,397	9	16	8,490	8,571	8,709	9	17	10	17	50	25	-33	-8
Haywood	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Henderson	1,011	3	7	3,299	3,353	3,454	3	7	3	7	45	45	-38	-38
Henry	13,198	36	50	28,180	28,409	28,768	36	51	37	51	142	101	-91	-50
Hickman	837	2	6	802	818	849	2	6	2	6	25	25	-19	-19
Houston	1,843	5	10	2,909	2,954	3,045	5	10	5	11	25	25	-14	-14
Humphreys	1,257	3	8	2,537	2,553	2,578	3	8	3	8	25	25	-17	-17

ACUTE-CARE BED NEED PROJECTIONS FOR 2017 AND 2021, BASED ON FINAL 2015 HOSPITAL JARS

COUNTY	2015		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2015 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2015	2017	2021	ADC-2017	NEED 2017	ADC-2021	NEED 2021	LICENSED	STAFFED	LICENSED	STAFFED
Jackson	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Jefferson	6,948	19	29	16,170	16,519	17,171	19	30	20	31	58	58	-27	-27
Johnson	45	0	1	206	208	211	0	1	0	1	2	2	-1	-1
Knox	467,467	1,281	1,601	835,028	854,181	891,061	1,310	1,638	1,367	1,708	2,195	1,644	-487	64
Lake	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lauderdale	2,154	6	12	3,108	3,138	3,192	6	12	6	12	25	0	-13	12
Lawrence	7,743	21	32	15,293	15,422	15,647	21	32	22	33	99	80	-66	-47
Lewis	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lincoln	7,650	21	32	17,683	17,893	18,289	21	32	22	33	59	49	-26	-16
Loudon	8,172	22	33	15,136	15,628	16,574	23	34	25	36	50	30	-14	6
McMinn	11,248	31	44	15,270	15,477	15,848	31	44	32	45	190	135	-145	-90
McNairy	1,464	4	9	3,781	3,819	3,884	4	9	4	9	45	45	-36	-36
Macon	3,611	10	17	5,442	5,531	5,705	10	17	10	18	25	25	-7	-7
Madison	181,446	497	621	293,793	296,782	302,191	502	628	511	639	787	763	-148	-124
Marion	8,340	23	34	1,519	1,537	1,569	23	34	24	35	70	20	-35	15
Marshall	1,245	3	8	3,510	3,594	3,759	3	8	4	8	25	12	-17	-4
Maury	41,228	113	141	103,371	105,363	109,139	115	144	119	149	255	194	-106	-45
Meigs	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Monroe	10,652	29	42	19,924	20,345	21,130	30	43	31	44	59	59	-15	-15
Montgomery	38,261	105	131	115,932	121,512	132,661	110	137	120	150	270	172	-120	-22
Moore	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Morgan	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Obion	8,214	23	34	17,768	17,789	17,792	23	34	23	34	137	63	-103	-29
Overton	13,789	38	52	19,211	19,538	20,124	38	53	40	54	114	82	-60	-28
Perry	4,438	12	20	3,802	3,851	3,936	12	21	13	21	53	39	-32	-18
Pickett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Polk	25,182	69	88	15,922	16,116	16,470	70	89	71	91	25	25	66	66
Putnam	58,215	160	199	110,673	113,319	118,083	163	204	170	213	247	243	-34	-30
Rhea	3,911	11	18	8,963	9,135	9,463	11	19	11	19	25	25	-6	-6
Roane	10,144	28	40	19,011	19,192	19,494	28	40	29	41	54	52	-13	-11
Robertson	11,485	32	45	25,425	26,284	27,976	33	46	35	48	109	62	-61	-14
Rutherford	108,244	297	371	263,190	277,183	305,592	312	390	344	430	496	494	-66	-64
Scott	2,740	8	14	5,450	5,498	5,577	8	14	8	14	25	25	-11	-11
Sequatchie	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sevier	16,736	46	62	41,276	42,745	45,616	48	64	51	67	79	75	-12	-8
Shelby	963,807	2,641	3,301	1,533,822	1,553,981	1,592,744	2,675	3,344	2,742	3,428	4,179	3,193	-751	235
Smith	6,235	17	27	3,121	3,170	3,263	17	27	18	28	35	35	-7	-7
Stewart	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sullivan	220,780	605	756	397,781	402,852	412,733	613	766	628	785	1,056	796	-271	-11
Sumner	56,890	156	195	125,865	129,838	137,610	161	201	170	213	303	220	-90	-7
Tipton	3,438	9	17	11,933	12,241	12,837	10	17	10	18	100	44	-82	-26
Trousdale	1,477	4	9	1,879	1,915	1,990	4	9	4	9	25	12	-16	-3
Unicoi	2,773	8	14	4,458	4,496	4,568	8	14	8	14	48	11	-34	3

ACUTE-CARE BED NEED PROJECTIONS FOR 2017 AND 2021, BASED ON FINAL 2015 HOSPITAL JARS

COUNTY	2015		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2015 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2015	2017	2021	ADC-2017	NEED 2017	ADC-2021	NEED 2021	LICENSED	STAFFED	LICENSED	STAFFED
Union	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Van Buren	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Warren	11,920	33	46	20,905	21,070	21,378	33	46	33	47	125	125	-78	-78
Washington	165,085	452	565	215,396	219,192	226,435	460	575	475	594	581	547	13	47
Wayne	1,801	5	10	4,919	4,955	5,014	5	10	5	10	80	32	-70	-22
Weakley	4,989	14	22	14,211	14,300	14,331	14	22	14	22	65	65	-43	-43
White	5,234	14	23	8,933	9,087	9,370	15	23	15	24	60	24	-36	0
Williamson	30,066	82	104	103,381	107,719	115,932	86	107	92	116	185	150	-69	-34
Wilson	28,411	78	98	44,107	45,659	48,685	81	101	86	107	245	245	-138	-138

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Jan 9, 2017

Hospital Data from Final JAR-Hospitals Schedules F and G.
Underlying Tennessee population estimates and projections from University of Tennessee, Center for Business and Economic Research (2015 series).
Projections and estimates for TN border states obtained from those respective states.

Tab 10

Attachment Section B-A5

Construction Cost Verification Letter

GRESHAM
SMITH AND
PARTNERS

July 11, 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: Verification of costs for St Thomas Rutherford Hospital Acute-Care Patient Tower Addition

Dear Ms. Hill:

As I understand the initial scope and schedule, St Thomas Rutherford Hospital of Murfreesboro, TN is planning on expanding their existing hospital's West wing with two (2) additional stories of thirty-six (36) patients each floor for a total of seventy-two (72) beds. The addition assumes a total of approximately 52,000 GSF and will match the facility's existing fenestration. The project will also be designed in accordance with applicable codes and standards.

Preliminary construction costs prepared by a General Contractor has estimated the construction cost to be $22,188,000 ($427 / SF). In my opinion this current construction estimate along with the total estimated project estimate of $47,383,943.00 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
TN Registration #103032

Tab 11

Attachment Section B-B5

Funding Letter

ASCENSION

June 30, 2017

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 Rutherford Hospital

Dear Ms. Hill:

Ascension Health has a centralized cash management program for managing and investing operational funds for Ascension Health hospitals and clinics, including Saint Thomas Rutherford Hospital. This letter is to confirm Ascension Health has available more than sufficient resources to fund the projected CON cost of $47,478,943 required to implement Saint Thomas Rutherford Hospital's 72 inpatient bed project.

Ascension Health will be funding the $47,478,943 from cash reserves. As evidence of Ascension Health's ability to provide necessary capital, the following information is offered.

1. Ascension Health, the parent company of Saint Thomas Health, had $696,237,000 in cash and cash equivalents as of June 30, 2016. Ascension Health had $15,069,123,000 in long-term investments as of June 30, 2016.

2. Ascension Health has a current rating of Aa2, Aa2/VMIG 1, and Aa2/P-1, subordinated debt ratings of Aa3 and Aa3/VMIG 1, and commercial paper rating of P-1 by Moody's Investor Service.

Thank you for attention to this matter.

Sincerely,

ASCENSION

Elizabeth C Foshage

Elizabeth C. Foshage
Senior Vice-President, Finance

Tab 12

Attachment Section B-F1

Ascension Health Audited Financial Statements

Tab 13

Attachment Section B-G

Saint Thomas Health Non-Discrimination Statement

Saint Thomas – Rutherford Posted Non-Discrimination Policy

Saint Thomas Health Financial Non-Discrimination Procedure

Saint Thomas Health

WITH YOU. FOR LIFE.

Saint Thomas Health does not discriminate against any person on the basis of race, color, national origin, disability, sexual orientation, religion, or age in admission, treatment, or participation in its programs, services and activities, or in employment, or on the basis of sex in its health programs and activities. For further information about this policy, contact: Corporate Responsibility Officer at 615-222-6102.

NONDISCRIMINATION POLICY

Discrimination is Against the Law

Saint Thomas Health does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, national origin, disability, sexual orientation, religion, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by Saint Thomas Health directly or through a contractor or any other entity with which Saint Thomas Health arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (nondiscrimination on the basis of race, color, national origin), Section 504 of the Rehabilitation Act of 1973 (nondiscrimination on the basis of disability), the Age Discrimination Act of 1975 (nondiscrimination on the basis of age), regulations of the U.S. Department of Health and Human Services issued pursuant to these three statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91. Additionally, in accordance with Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, Saint Thomas Health does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of sex (including gender identity) in admission to, participation in, or receipt of the services and benefits under any of its health programs and activities, and in staff and employee assignments, whether carried out by Saint Thomas Health directly or through a contractor or any other entity with which Saint Thomas Health arranges to carry out its programs and activities. Saint Thomas Health provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (audio, accessible electronic formats, other formats)

Saint Thomas Health provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Corporate Responsibility Officer. If you believe that Saint Thomas Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Corporate Responsibility Officer, 2000 Church Street, Nashville, TN 37236, Telephone 615-284-5488, TTY-711, Fax 615-284-5497, cfigaro@sth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Corporate Responsibility Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English or any other language, language assistance services, free of charge, are available to you. Call 1-855-284-2255 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-284-2255 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-284-2255 (رقم هاتف الصم والبكم: 117).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-284-2255 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-284-2255 (TTY: 711)。

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-284-2255 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-284-2255 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-284-2255 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-284-2255 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-284-2255 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-284-2255 (TTY: 711) पर कॉल करें।

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-284-2255 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-284-2255 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます1-855-284-2255(TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-284-2255 (መስማት ለተሳናቸው: 711).

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1-855-284-2255 (117) YTT بکە.

Saint Thomas Health

Saint Thomas Health
Nondiscrimination Statement
Distribute in Admission/Registration Process
Background (Sections 1557 and 504): Distribute a nondiscrimination statement for significant publications and signification communications that are small-size. Include the statement that Covered entity does not discriminate and taglines in at least two of the languages spoken by individuals with LEP.

Instructions:

Please enter in the following statements in the Registration Systems (Hospital System and STMP Athena System) so that when a patient is registered, the following will print out and given to the patient.

Please implement by Friday, October 14th. Contact Cynthia Figaro is you have any questions 615-284-5488.

As a recipient of Federal financial assistance, Saint Thomas Health does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, national origin, disability, sexual orientation, religion, or age.

Como beneficiario de asistencia financiera Federal, Saint Thomas Health no excluye ni deniega beneficios, o de otra manera discrimina contra cualquier persona en base a raza, color, nacionalidad de origen, discapacidad, orientación sexual, religión, o edad.

ATTENTION: If you speak English or any other language, language assistance services, free of charge, are available to you. Call 1-855-284-2255 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-284-2255 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-284-2255 (رقم هاتف الصم والبكم: 117).

Tab 14

Attachment Section B-C2

Quality Management Plan

Utilization Management 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:

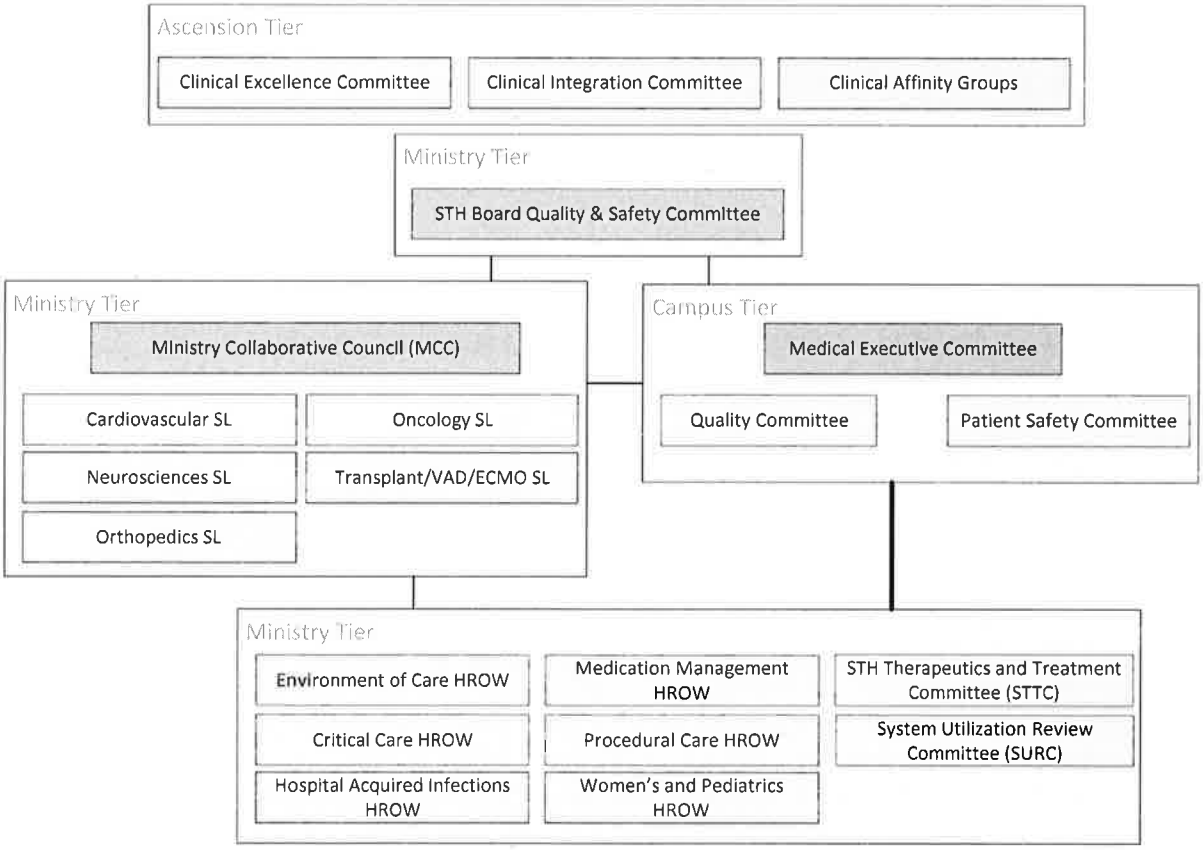
- Commitment to person-centered care
- Broad cultural understanding of, and commitment to, high reliability principals
- Development and application of evidence-based medicine (EBM)
- Design of standardized clinical care workflows that leverage health information technology (HIT) in a manner that enhances 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.

ST. THOMAS HEALTH
2016 System Utilization Plan

I. INTRODUCTION

St. Thomas Health, 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 System Utilization Plan. The Utilization Plan applies to the staff and committees responsible for the Utilization Program within each individual facility. The STH System Utilization Review Committee (SURC) assists the STH Ministry Collaborative Council (MCC), campus specific Utilization Review Committees and MEC committees in overseeing the utilization review functions of the health system as required by the Conditions of Participation of the CMS. The network committee intends to be an action-oriented group and will submit regular reports on their findings and recommendations to the individual MECs and/or established campus specific UR Committees. This committee, in collaboration with the above mentioned entities, will direct activities and policies intended to change practice patterns that are identified as potentially wasteful, unnecessary, and or not generally considered as hospital "best practices".

II. AUTHORITY

The Saint Thomas Health Services Board of Directors has the ultimate responsibility for review of quality, appropriateness and medical necessity of admissions, continued stays, medical procedures performed, utilization and optimization of therapeutic resources, and optimization of diagnostic testing. It delegates specific functions to the Medical Staffs at the individual hospitals comprising St. Thomas Health to implement a comprehensive Utilization Plan. The Board of Directors' approval of the Plan verify acknowledgement of this responsibility. The System Utilization Plan is under the direction of the System Utilization Review Committee, which is a sub-committee of the STH Ministry Collaborative Council. The STH MCC reports to the STH Clinical Quality Committee. The Committee shall review the Plan annually for its scope and objectives.

III. PURPOSE

The purpose of the System Utilization Plan includes:

- To ensure the quality, appropriateness, and efficiency of care and resources furnished by the health system, facilities, and their medical staffs.
- To promote and support effective and efficient utilization of the facilities and services provided through an on-going monitoring program.
- To identify and review problematic patterns of over-, under-, and inefficient utilization of resources.
- To provide education regarding identified areas of concern to the medical staffs and associated ancillary health care providers.
- To develop and incorporate practical solutions to resolve these identified inefficient and/or unnecessary practice patterns.
- To proactively support and promote the One Saint Thomas Care Management process and facility specific Care Management Plans.
- To present findings and recommendations to established campus specific Utilization Review Committees or to campus specific Medical Executive Committees for further discussion and action.

IV. SYSTEM UTILIZATION REVIEW COMMITTEE (42 CFR 456.106)

A. Organization:

1. **Voting Members**
   a. System Chief Quality Officer (chair)
   b. If the campus has an established UR Committee, the chair of that committee will appoint 3 physicians from the active medical staff to represent that hospital at the SURC.
   c. If the campus has no established UR Committee, the MEC chair will appoint 3 physicians from that facility's active medical staff to represent the campus at the SURC.

2. **Non-voting Members**
   a. Invited physician guests
   b. Physician Advisors
   c. Executive Director of Care Coordination
   d. Director of Laboratory Services
   e. Director of Diagnostic Imaging
   f. Representatives from Revenue Cycle
   g. Representative from Quality
   h. Representatives from Nursing
   i. Representatives from Pharmacy

3. **Attendance and Voting Requirements**
   a. Members will serve a 1 year term with extension by mutual desire and approval from the MEC and campus specific UR Committee (if established).
   b. A simple majority of the voting members present will affirm a motion.
   c. All voting members are required to attend at least 50% of the meetings throughout the calendar year.
   d. A quorum will be at least 50% of the voting members present.

B. Responsibilities:

The responsibilities of the Committee include:

- To develop, maintain, and execute an effective Utilization 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.
- To provide efficient utilization of beds and professional services through concurrent and retrospective reviews of the necessity for inpatient admissions, appropriate durations of stay, and timely appropriate use of professional, diagnostic and therapeutic services.
- 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 the Quality Committee.
- To effect the development, maintenance, and execution of the functional elements of the Quality Improvement Organization Program (QIO), to include: admission request and certification, pre-admission request /testing, length of stay review, discharge planning, and retrospective evaluation of performance measured to clinically valid criteria.
- To review patterns/profiles generated by the Quality Improvement Organization and Hospital, to identify opportunities to improve provision of care and to initiate appropriate actions.
- To collaborate in monitoring and analyzing the review activities of non-physician reviewers, and the Hospital appointed Physician Advisor(s).

- To collaborate and establish criteria, standards, and norms for pre-admission/admission review, continued stay review and professional services furnished including drugs and biologicals.

C. **Meetings:**
The Committee shall meet a minimum of six times annually and report to the STH MCC and the individual facilities following the meeting, or more frequently as needed.

V. UTILIZATION

A. **Plan of Care** (42 CFR 456.80)
The Attending Physician, along with 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:

- Diagnosis, symptoms, complaints, and complications indicating reason for admission
- A description of the functional level of the individual
- Orders for medications, therapy, restorative, and rehabilitative services
- Activities
- Social services and discharge planning
- Diet
- 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.

B. **Methods of Review/Review Process**
Utilization review consists of a pre-admission and/or admission certification, and appropriateness of continued stay. These determinations, using standard criteria sets, physician documentation, observations, and/or conversations with the attending physician are performed by members of the Care Management Program and the utilization review specialists.

Reviews may be focused on certain selected diagnoses, procedures with identified or suspected utilization related problems, regardless of payer type. All reviews will address over- and under-utilization as well as ineffective scheduling of resources. Patients selected for review are evaluated according to national standard criteria, professional standards of care, and/or medical staff endorsed evidence-based guidelines.

1. **Preadmission Review** (42 CFR 456.127)
   a. Review and final decision prior to the patient's admission may be accomplished for certain providers or categories of admission identified by the SURC as potential utilization issues. This may include patients accessing inpatient services through the emergency department, direct admits and/or transfers from other facilities.

   b. If the pre-admission review does not meet established criteria, the case will first be discussed with the attending physician to explore alternate level of care services and, if necessary forwarded to the Medical Advisor, Care Management Program.

c. If needed, the case is escalated to the applicable physician chief of the particular service or the CMO; if necessary, a Hospital Issued Notice of Non-Coverage (HINN) letter is issued to the patient before they are formally admitted to the hospital and the hospital has reason to believe the admission will not be covered by Medicare.

2. **Admission Review** (42 CFR 456.123)
   a. When a patient is admitted to the hospital, the utilization review specialist will identify a day by which the need for continued stay will be evaluated. Assignment of the continued stay review date is based on
      1. The individuals condition
      2. The individuals projected discharge date
      3. Applicable clinical criteria

   b. In cases of seemingly non-qualified admission, a case escalation process is followed. In this process, discussions regarding the case or clinical situation and potentially mitigating circumstances involve the case manager, Team Lead/Manager, Care Management Director and/or Contracted Second Level Review Agent. The UR Committee Physician/or Contracted Second Level Review Agency provides initial physician - level case review.

3. **Continued Stay** (42 CFR 456.128 - 137)
   a. Continued stay reviews are based on established norms such as those developed by third party payers or by national standard criteria sets.

   b. A more focused review may be used for cases that, by experience, have been associated with high cost, frequent use of excessive services or are attended by a physician whose patterns of care have caused quality of care or safety concerns.

   c. If continued stay appears inappropriate, the utilization review specialist will consult with the Case Manager and/or the attending physician and discuss alternate level of care services. If necessary, the Physician Advisor to the Care Management Program will be consulted. The Physician Advisor provides initial physician - level case review.

   d. If needed, the case is escalated to the applicable physician chief of the particular service or the CMO; if necessary, a Hospital Issued Notice of Non-Coverage (HINN) letter is issued to the patient.

4. **Additional and Second Level Physician Review** (42 CFR 456.123-126, 136-137)
   a. If it is determined that a patient's medical care is no longer consistent with medical management at the in-patient level of care, the case may be referred to the hospital's Physician Advisor, Utilization Review Committee (which the facility may designate by a different title), or contracted Second Level Review Provider.

   b. In event that the Physician Advisor or SURC has reason to believe the admission or continued stay is no longer medically appropriate or necessary at the in-patient level, and/or discharge criteria is met, he/she will confer with the attending physician and afford him/her an opportunity to discuss the specifics of the case or situation in question. If the attending physician concurs that medical necessity for continued stay does not exist, the attending physician will discharge the patient. If, however, the attending physician does not concur with the determination made by the Medical

Advisor, the case will be referred to a second physician in the same specialty area for case review or the particular service Chief or the Chief Medical Officer. In such situations, the attending physician's judgment is given considerable weight. If this additional second physician review indicates justification for admission/ continued stay, the admission or continued stay will be deemed medically appropriate.

c. If, however, it is determined by another physician reviewer in the same specialty or the Chief Medical Officer that continued stay is not medically necessary, then the Hospital follows the denial of benefits procedure. It should be noted that Hospital care is not being denied, however, the patient (and/or insured) will be informed of potential financial liability for non-covered services. The Director of Care Management or designee will complete a written denial of benefit notice. This denial notification will be given to the patient and/or patient representative when the determination is made that the patient does not meet criteria for admission or continued stay and the attending physician or two reviewing physicians are in concurrence with this decision. Notification of an adverse final decision will be provided within 2 working days after the assigned continue stay review dates. Copies will be distributed to the Care Management file, the medical record, Patient Financial Services, The Office of Compliance, (hospital administration), the Medicare Contractor or QIO, and the attending physician.

5. **Review by entire Utilization Review Committee** (42 CFR 456.123)
   a. If the attending physician still believes that the admission or continued stay is medically justified after such a second physician – level review, the attending physician will be asked as to whether he or she would like to exercise the right to request that the entire Utilization Review Committee review the particular case or situation. This review of the case by the entire Utilization Review Committee may be retrospective.

   b. If the attending physician indicates a desire for the case to be reviewed by the Utilization Review committee, the review will be conducted at the next UR Committee meeting.

6. **Discharge Planning**

   Early discharge planning is acknowledged as an important aspect in the efficient use of available health care services and in the protection of our patients against the risks of hospitalization. The care manager is responsible for coordinating the efforts of the multidisciplinary team for planning a patient's discharge when consulted. In order to facilitate and accomplish a smooth and safe discharge from acute care to the appropriate level, the attending physician will work in conjunction with the Care Manager to assure that by the time discharge occurs, post-acute needs have been addressed.

7. **Medical Care Evaluation Studies** (42 CFR 456.132-133, 141-144)
   a. **Delays in Care, Inefficient Scheduling of Resources**

      Review of professional services provided will be done ongoing to determine medical necessity and to promote the most efficient use of available health facilities and services.

Utilization related concerns including delays in supportive/professional services, are identified through both the Care 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 in the Case Management System. Avoidable Days will be analyzed by the Care Management Director for patterns or trends. This information will be reported to the SURC for recommendation of appropriate measures to improve the process.

b. **Under-Utilization of Services**

Under-utilization of services will be screened by the Care Managers during the concurrent review process.

Re-admissions within 30 days will be reviewed for inappropriate discharge on first admission or complications as a result of the original discharge plan. The Care Managers will receive a daily list of admissions that were discharged within the preceding 30 days. As patterns/trends are identified, they will be reported to the SURC.

When any concerns are identified regarding a premature discharge, the Care Manager will conduct a discharge screen. If the screen is 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 Care Management will compare data to peer norms to identify any pattern of under-utilization by physician or DRG.

c. **Appropriateness of Services**

At the Utilization Management Committee meetings, appropriateness review of designated high volume radiology, cardiopulmonary, laboratory, physical therapy services and drugs and biologicals may be reported. In-patient orders for routine outpatient procedures, such as MRI's, mammograms, bone scans, etc. are reviewed to determine there are approved criteria, 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 Utilization Management Committee for their review.

8. **Data Collection** (42 CFR 456.144)

Each patient's record must include specific information needed to efficiently perform the UR function. This information shall include, but not be limited to accurate identification of the patient; name of the patient's attending physician; name of the patient's third party insurer (when applicable); date of admission; the documented plan of care; date of operation of procedure; the justification of an emergency admission (when applicable); and other supporting documentation that the SURC believes appropriate to be include for the determination process.

VI. 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 QIO Confidentiality Statement. All team members of St. Thomas Health and 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 Quality/Performance Improvement process for St. Thomas Health and all records, minutes, and reviews are protected under process for quality improvement/quality assurance. All data shall be considered the property of St. Thomas Health.

VII. 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 direct financial interest in the hospital or was professionally involved in the care of the patient whose case is being reviewed. It is the responsibility of the member or prospective member to notify the Committee of any such interest.

VIII. COMMITTEE REPORTS AND RECORDS

The SURC shall maintain the minutes and records of each Committee meeting and will include the actions taken regarding the findings of reports and necessary 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 SURC shall make a summary report to the Medical Executive Committees, MCC, and Governing Board.

IX. DEVELOPING A CORRECTIVE PLAN LINKING THE RESULTS TO CONTINUING MEDICAL EDUCATION

When medical staff performance improvement opportunities are identified through concurrent review, recommendations for action shall be the responsibility of the Medical Staff and shall be documented as part of the continuing education function.

X. RELATIONSHIP TO THIRD PARTY PAYERS

The Hospital is responsible through the Care Management function 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 QIO. Information and data shall be protected to assure confidentiality.

XI. COLLABORATION WITH RISK MANAGEMENT

During the conduct of concurrent review the Care 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.). Any concerns identified through the review process will be reported to Risk Management for further investigation

XIII. COLLABORATION WITH QUALITY IMPROVEMENT

Utilization is one of the components of the hospital Quality Improvement Program. During the course of concurrent and retrospective review, the Care Managers will screen patient records for quality concerns, including those specific events designated by the Chief Quality Officer. Any concerns identified through Care Management review will be reported to the Quality Department for further investigation.

XIV. REVISION AND REVIEW

The Utilization Management Plan shall be reviewed annually by the SURC and revised as necessary. The Medical Executive Committees, MCC, and the STHS Board of Directors will approve any revisions.

ACCEPTANCE AND APPROVAL

_____	_____
Chairman, St. Thomas Midtown Medical Executive Committee	Date
_____	_____
Chairman, St. Thomas West Medical Executive Committee	Date
_____	_____
Chairman, St. Thomas Rutherford Medical Executive Committee	Date
_____	_____
Chairman, Ministry Collaborative Council, St. Thomas Health	Date
_____	_____
Chairman, Board of Directors, St. Thomas Health	Date

Tab 15

Attachment Section B-C3

Clinical Affiliation Agreements

Comprehensive Contract Listing

Contract No. (Status)	Contract Name / Contract Description	Organization	Department	Commencement Date & Termination Date		Primary Party List	Responsible Party List
49 Active	Belmont University - STHeR - Clinical Affiliation Agreement - Nursing Program Originally with STH only.	Saint Thomas Health	Clinical Education	9/1/2004	7/31/2018	Belmont University, Saint Thomas Health	Rachel McGee
134 Active	University of Tennessee, Chattanooga - STHe - Clinical Affiliation Agreement - Physical Therapy	Saint Thomas Health	Clinical Education	5/1/2006	4/30/2017	University of Tennessee, Chattanooga, Saint Thomas Health	Debbie Ingram, Rachel McGee
216 Active	Aquinas College - STHeR - Clinical Affiliation Agreement - Nursing Program	Saint Thomas Health	Clinical Education	9/1/2004	8/31/2018	Aquinas College	Rachel McGee
310 Active	Middle Tennessee School of Anesthesia - West - Cardiovascular Anesthesiologist, P.C. - Clinical Affiliation Agreement - Anesthesiology	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	1/1/1980	9/13/2021	Saint Thomas WEST Hospital (St. Thomas Hospital)	Rachel McGee, Shalin Shah
767 Active	University of Alabama, Huntsville - STHeR - Clinical Affiliation Agreement, Nursing	Saint Thomas Health	Clinical Education	7/1/2002	8/31/2018	University of Alabama in Huntsville, Saint Thomas Health	Rachel McGee
1554 Active	Fortis Institute - Cookeville - STHeR - Clinical Affiliation Agreement - Pharmacy Technician, Medical Laboratory	Saint Thomas Health	Clinical Education	2/1/2008	4/15/2021	MedVance Institute, Saint Thomas Health	Peter Lindquist, Rachel McGee
1715 Active	Saint Thomas Campus Surgicare, L.P. d/b/a St. Thomas Surgicare (USPI) - West - Patient Transfer	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	6/25/2002	6/25/2020	Saint Thomas WEST Hospital (St. Thomas Hospital)	Kathy McGee, Shalin Shah
2046 Active	Belmont University - STHeR - Clinical Affiliation Agreement - Physical and Occupational Therapy (PT, OT)	Saint Thomas Health	Clinical Education	9/1/2005	6/30/2021	Belmont University, Saint Thomas Health	Rachel McGee
2179 Active	Middle Tennessee School of Anesthesia - Anesthesia Medical Group, P.C. (AMG) - West - Clinical Affiliation Agreement - Anesthesiology	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	5/1/2005	9/15/2021	Saint Thomas WEST Hospital (St. Thomas Hospital)	Rachel Mcgee, Shalin Shah
2446	Motlow State Community College - STHeR - Clinical Affiliation Agreement - Nursing - Emergency Medical Services	Saint Thomas Health	Clinical Education	3/21/2001	2/9/2022	Motlow State Community College, Saint Thomas Health	Rachel McGee

Comprehensive Contract Listing

Active							
2868 Active	Middle Tennessee State University (MTSU) - STHeR - Clinical Affiliation Agreement - Nutrition and Food Services, Exercise Formally STH only	Saint Thomas Health	Clinical Education	6/1/2004	3/21/2021	Middle Tennessee State University	Rachel McGee
2960 Active	University of Tennessee, Memphis - STHeR - Clincal Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	8/1/2004	9/20/2018	University of Tennessee at Memphis (Nursing), Saint Thomas Health	Rachel McGee
3107 Active	Meharry Medical College - Rutherford - Residency Teaching	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Clinical Education	1/1/2005	8/31/2018	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Tristin Casteel, Robbie Grissom
3269 Active	Cumberland University - STHeR - Clinical Affiliation Agreement - Nursing Program	Saint Thomas Health	Clinical Education	3/1/2007	2/28/2018	Cumberland University, Saint Thomas Health	Carol Ann Bach, Rachel McGee
3520 Active	Lipscomb University - STHe - Clinical Affiliation Agreement - Dietetic Internship Program	Saint Thomas Health	Clinical Education	9/1/2005	8/31/2016	Lipscomb University, Saint Thomas Health	Autumn Marshall, PhD, Rachel McGee
3573 Active	Chattanooga State Community College - STHeR - Clinical Affiliation - Diagnostic Medical Sonography, Radiation Therapy, Nuclear Medicine, Echo Tomography and Magnetic Resonance previously with Baptist only	Saint Thomas Health	Clinical Education	8/29/2005	6/30/2021	Chattanooga State Technical Community College, Saint Thomas Health	Julie Land, Rachel McGee
3611 Active	Tennessee Board of Regents (TBR) - STHe - Clinical Affiliation Agreement - Master of Science in Nursing Regents Online Degree Program Includes: APSU, ETSU, MTSU, TSU, TTU, and Memphis	Saint Thomas Health	Clinical Education	9/1/2005	7/31/2017	Saint Thomas Health Services - DO NOT USE, Tennessee Board of Regents	Lori Stephens, Rachel McGee
3770 Active	Middle Tennessee School of Anesthesia - Murfreesboro Anesthesiology Group, PC - Rutherford - Clinical Affiliation Agreement - Anesthesiology	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Clinical Education	3/1/2006	9/15/2018	Middle Tennessee School of Anesthesia, Murfreesboro Anesthesia Group, Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Mitzi Birdwell, Rachel McGee
3951	University of Tennessee, Memphis - STHe - Clinical Affiliation Agreement - Pharmacy	Saint Thomas Health	Clinical Education	7/1/2006	9/30/2016	University of Tennessee, Memphis, Saint Thomas Health	Sandra Pulliam, Rachel McGee

Active	Formally with Baptist only						
4013	Tennessee Technological University - STHeR - Clinical Affiliation Agreement - Nursing, Child Life Services and Food, Nutrition and Dietetics	Saint Thomas Health	Clinical Education	9/25/2006	1/3/2021	Tennessee Technological University, Saint Thomas Health	Cathy Cunningham, Rachel Mcgee
Active							
4159	Vanderbilt School of Nursing - STHeR - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	5/1/2007	4/30/2018	Vanderbilt University School of Nursing, Saint Thomas Health	Rachel McGee
Active							
4438	Columbia State Community College - STHeR - Clinical Affiliation Agreement - EMS Education, Nursing and	Saint Thomas Health	Clinical Education	8/1/2007	8/31/2018	Columbia State Community College, Saint Thomas Health	Rachel McGee
Active							
4453	Volunteer State Community College - STHeR - Clinical Affiliation - Mult-Programs	Saint Thomas Health	Clinical Education	9/1/2007	7/6/2021	Volunteer State Community College, Saint Thomas Health	Rachel Mcgee
Active	Diagnostic Medical Sonograpy, Emergency Medical Training, Health Information Technology, Medical Laboratory Technology, Ophthalmic Technology, Sleep Diagnostics, Physical Therapist Assistant,						
4474	Nashville State Community College - STHS - Clinical Affiliation Agreement - Nursing - Surgical Technician Program - Surgical Assist Program - Occupational Therapy	Saint Thomas Health	Clinical Education	1/1/2008	9/30/2017	Nashville State Technical Community College, Saint Thomas Health	Rachel McGee
Active	Nursing added December 2010						
4564	Auburn University - STHe - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	9/1/2007	8/31/2016	Saint Thomas Health, Auburn University School of Nursing	Linda Spencer, Rachel McGee
Active	Auburn and Montgomery Campus :: have separate agreements, see documents						
4679	Middle Tennessee School of Anesthesia - Anesthesia Medical Group, P.C (AMG) - Midtown - Clinical Affiliation Agreement - Anesthesiology	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	9/1/2003	9/15/2021	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Rachel McGee, Shalin Shah
Active							
4754	Miller-Motte Technical College - STHeR - Clinical Affiliation - Respiratory Therapy, Surgical Technology and Sterile	Saint Thomas Health	Clinical Education	1/1/2008	12/31/2018	Saint Thomas Health, Miller-Motte Technical College	Rachel McGee
Active	Surgical Technology and Sterile Processing added in January 2011 to combine and replace K# 3305						
4767	Samford University - STHeR - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	2/8/2008	2/1/2021	Samford University, Saint Thomas Health	Rachel McGee
Active	Graduate Nursing Clinical Experience Management, Nurse Executive and Nurse Educator Students						
4848	Lipscomb University - STHe - Clinical Affiliation Agreement - Exercise Science	Saint Thomas Health	Clinical Education	5/1/2008	5/31/2017	David Lipscomb University, Saint Thomas Health	Rachel McGee

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Active	Formally with STH only - 08-10						
4849	University of Tennessee, Martin - STHe - Clinical Affiliation Agreement - Exercise Sceince	Saint Thomas Health	Clinical Education	5/1/2008	5/31/2017	University of Tennessee-Martin, TN, Saint Thomas Health	Rachel McGee
Active	Formally with STH only - 08-10						
4885	Belmont University, School of Pharmacy - West - Residency Education Agreement	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	7/1/2008	6/30/2016	Belmont University, School of Pharmacy, Saint Thomas WEST Hospital (St. Thomas Hospital)	Carmen Leffler, Shalin Shah
Active							
4912	University of Alabama, Tuscaloosa - STHeR - Clinical Affiliation - Health Care Management, Food and Nutrition, Nursing and Speech-Language Pathology Programs	Saint Thomas Health	Clinical Education	6/1/2008	4/14/2018	Saint Thomas Health, University of Alabama at Tuscaloosa	Rachel McGee
Active							
4997	University of Tennessee, Knoxville - STHeR - Clinical Affiliation Agreement - Nursing and Social Work	Saint Thomas Health	Clinical Education	9/1/2008	11/8/2021	Saint Thomas Health, University of Tennessee College of Social Work	Rachel McGee
Active	Nursing						
5295	Walden University - STHe - Clinical Affiliation Agreement - MS Nursing	Saint Thomas Health	Clinical Education	4/30/2009	4/30/2017	Saint Thomas Health, Walden University	Rachel McGee
Active							
5296	Lipscomb University College of Pharmacy - STHS - Clinical Affiliation Agreement - Pharmacy Students (Lipscomb pays STHS Stipend)	Saint Thomas Health	Clinical Education	5/1/2009	4/30/2019	Saint Thomas Health, Lipscomb University College of Pharmacy	Brandy Greene
Active	Lipscomb is paying STHS a $600 stipend per Advanced Pharmacy Practice Experience student placed at STHS.						
5350	Belmont University - STHe - Clinical Affiliation - Pharmacy - Stipend	Saint Thomas Health	Clinical Education	6/1/2009	5/31/2019	Saint Thomas Health	Brandy Greene
Active	$600 to be paid to STHe facility per Advanced Pharmacy Practice Experience student precepted						
5379	Austin Peay State University - STHeR - Clinical Affiliation (Medical Technology, Nursing and Radiation Therapy	Saint Thomas Health	Clinical Education	6/1/2009	8/22/2018	Saint Thomas Health	Rachel Mcgee
Active							
5533	Daymar Institute f/k/a Draughons Junior College - STHe - Clinical Affiliation - Physical Therapist Assistant, Medical	Saint Thomas Health	Clinical Education	9/8/2009	12/31/2016	Saint Thomas Health, Draughons Junior College	Rachel McGee
Active							

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5773	Lincoln Memorial University - West - Clinical Affiliation Agreement - Physician Assistant (David Gibson, MD)	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	3/1/2010	1/19/2017	Saint Thomas WEST Hospital (St. Thomas Hospital)	Rachel Mcgee, Shalin Shah
Active	Dr. DeBoer and student Jared Johnson (original Agreement)						
5806	Trevecca Nazarene University - STH - Clinical Affiliation Agreement - Physician Assistants - Jim Bob Fault, M.D.	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	5/1/2010	4/30/2019	Trevecca Nazarene University, Saint Thomas WEST Hospital (St. Thomas Hospital)	Rachel Mcgee, Shalin Shah
Active							
6007	Pennsylvania State University - STHe - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	11/1/2010	10/31/2017	Saint Thomas Health, Pennsylvania State University	Rachel Mcgee
Active							
6040	Madisonville Community College - STHeR - Clinical Affiliation Agreement - Surgical First Assistant, Medical Equipment and Instrumentation Students	Saint Thomas Health	Clinical Education	2/11/2011	4/5/2021	Saint Thomas Health, Madisonville Community College	Rachel Mcgee
Active							
6062	Lipscomb University - STHe - Clinical Affiliation Agreement (Department of Nursing)	Saint Thomas Health	Clinical Education	11/5/2010	11/11/2017	Saint Thomas Health, Lipscomb University	Rachel Mcgee
Active							
6144	Lipscomb University College of Pharmacy - West - Clinical Affiliation Agreement - Clinical Pharmacy Services (Faculty)	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	6/1/2011	5/1/2019	Saint Thomas WEST Hospital (St. Thomas Hospital)	Carmen Leffler, Shalin Shah
Active	STH will have a shared clinical faculty pharmacist on site to develop a practice in internal medicine and round with one of the Hospitalist teams and precept P4 (4th year) pharmacy students. This will be						
6207	Creighton University - STHeR - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	3/15/2011	1/12/2022	Saint Thomas Health, Creighton University	Rachel McGee
Active							
6275	Tennessee Technology Center at Murfreesboro - STHS - Clinical Affiliation Agreement (Pharmacy Technician, Phlembotomy, and Surgical Tech)	Saint Thomas Health	Clinical Education	5/15/2011	5/16/2016	Saint Thomas Health, Tennessee Technology Center at Murfreesboro	Rachel Mcgee
Active	***MOTLOW STATE COMMUNITY COLLEGE HAS OVERSIGHT OF THESE CONTRACT** CONTACT CAMILLA STAFFORD AT MOTLOW AT 931-393-1930 OR CSTAFFORD@MSCC.EDU						
6297	Vanderbilt University - STHe - Clinical Affiliation Agreement - Medical Students	Saint Thomas Health	Clinical Education	5/31/2011	5/31/2016	Saint Thomas Health, Vanderbilt University	Rachel Mcgee
Active							
6337	University of Alabama at Birmingham - STHeR - Clinical Affiliation Agreement - School of Nursing	Saint Thomas Health	Clinical Education	8/1/2011	2/8/2022	Saint Thomas Health	Rachel McGee
Active	*****This cannot be combined with other programs*****						

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6344 Active	National Institute of First Assisting - STHeR - Clinical Affiliation Agreement - First Assist First Assist Students	Saint Thomas Health	Clinical Education	8/1/2011	6/30/2018	Saint Thomas Health, National Institute of First Assisting	Rachel Mcgee
6420 Active	Belmont University - STHe - Agreement for Provision of Clinical Pharmacy Services (Faculty) For placement at STH Lindsey Hahn.	Saint Thomas Health	Clinical Education	7/1/2011	6/30/2016	Saint Thomas Health	Rachel Mcgee, Carmen Leffler
6475 Active	University of Tennessee - Memphis - STHeR - Clinical Affiliation Agreement - Physical Therapy Students	Saint Thomas Health	Clinical Education	11/4/2011	10/12/2018	Saint Thomas Health, University of Tennessee, Memphis	Rachel Mcgee
6594 Active	University of Southern Mississippi - STHe - Clinical Affiliation Agreement - Speech and Hearing Sciences	Saint Thomas Health	Clinical Education	2/1/2012	1/29/2022	Saint Thomas Health	Rachel McGee
6608 Active	Trevecca Nazarene University - Midtown - Clinical Affiliation Agreement - Physician Assistants (see documents for physicians)	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	2/23/2012	2/23/2019	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital), Trevecca Nazarene University	Rachel Mcgee, Shalin Shah
6622 Active	Hopkinsville Community College - STHe - Clinical Affiliation (Nursing Students)	Saint Thomas Health	Clinical Education	7/31/2012	7/31/2017	Saint Thomas Health, Hopkinsville Community College	Rachel Mcgee
6623 Active	Frontier Nursing University - STHe - Clinical Affiliation Agreement (Nurse Practitioner Students)	Saint Thomas Health	Clinical Education	5/4/2012	5/6/2017	Saint Thomas Health, Frontier Nursing University	Rachel Mcgee
6624 Active	KIMC Nashville, LLC d/b/a Fortis Institute (f/k/a MedVance) - STHe - Clinical Affiliation Agreement - (Information Technology This contract includes the following programs:	Saint Thomas Health	Clinical Education	3/28/2012	3/31/2017	Saint Thomas Health, Fortis Institute	Rachel Mcgee
6693 Active	Concordia University -Chicago - STHeR - Clinical Affiliation Agreement (Exercise Students)	Saint Thomas Health	Clinical Education	4/18/2017	4/17/2022	Saint Thomas Health, Concordia University-Chicago	Rachel McGee
6750 Active	University of Wisconsin, La Crosse - STHe - Clinical Affiliation Agreement (Exercise Physiology)	Saint Thomas Health	Clinical Education	5/23/2012	6/16/2017	Saint Thomas Health, University of Wisconsin La Crosse	Rachel Mcgee

Comprehensive Contract Listing

6755	University of Michigan-Flint - STHe - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	10/1/2012	9/30/2017	Saint Thomas Health, University of Michigan-Flint	Rachel Mcgee
Active							
6758	Miller-Motte Technical College (Madison Campus) - STHe - Clinical Affiliation Agreement (Medical Assisting and Healthcare	Saint Thomas Health	Clinical Education	6/7/2012	6/30/2017	Saint Thomas Health, Miller-Motte Technical College	Rachel Mcgee
Active							
6797	Morrison Management Specialists, Inc. - STHe - Clinical Affiliation Agreement (for Dietetic Internship)	Saint Thomas Health	Clinical Education	7/18/2012	8/31/2017	Saint Thomas Health, Morrison Management Specialists, Inc.	Sharolyn Balsley, Rachel Mcgee
Active							
6802	Wake Forest School of Medicine - Baptist - Clinical Affiliation Agreement - Physician Assistant (Dr. Reagan Saig)	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	7/16/2012	7/15/2017	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital), Wake Forest School of Medicine/Dr. Reagan Saig	Rachel McGee
Active	Clinical Affiliation Agreement for Physician Students with Dr. Reagan Saig at Baptist Hospital						
6862	Auburn University - STHe - Clinical Affiliation Agreement - Physical Activity and Health Program	Saint Thomas Health	Clinical Education	10/1/2012	9/30/2017	Saint Thomas Health	Rachel Mcgee
Active							
6863	University of Southern Indiana - STHeR - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	10/1/2012	8/29/2018	Saint Thomas Health	Rachel Mcgee
Active							
6864	East Carolina University - STHe - Clinical Affiliation Agreement (Physical Therapy, Occupational Therapy, Speech Language	Saint Thomas Health	Clinical Education	9/20/2012	10/10/2017	Saint Thomas Health, East Carolina University	Rachel Mcgee
Active							
6895	Union University - STHeR - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	11/5/2012	4/20/2022	Saint Thomas Health, Union University	Rachel Mcgee
Active							
6899	Regis University - STHeR - Clinical Affiliation Agreement - Nursing and Healthcare Leadership	Saint Thomas Health	Clinical Education	7/2/2014	7/1/2017	Saint Thomas Health, Regis University	Rachel Mcgee
Active							
6921	Texas Woman's University - STHe - Clinical Affiliation Agreement - Occupational Therapy	Saint Thomas Health	Clinical Education	11/6/2012	5/4/2018	Saint Thomas Health, Texas Woman's University	Rachel Mcgee
Active							
6925	Emory University - School of Medicine - STHeR - Clinical Affiliation Agreement - Physical Therapy	Saint Thomas Health	Clinical Education	1/7/2013	1/5/2019	Saint Thomas Health	Rachel Mcgee

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Active							
6934	University of Pikeville (Kentucky College of Osteopathic Medicine) - STH - Clinical Affiliation Agreement - Osteopathic Medicine (Dr. Graves and Dr. Blount)	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	12/12/2012	2/11/2018	University of Pikeville, Saint Thomas WEST Hospital (St. Thomas Hospital)	Rachel McGee, Shalin Shah
Active							
6972	Lincoln Memorial University - Rutherford - Clinical Affiliation Agreement - Physician Assistant and Doctor of Osteopatic Medicine (Sally Bullock, MD; Kevin Beier, MD, Paul LeDoux, MD, Wayne Westmorland, MD and Mark Akins, MD, Marcie	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Clinical Education	12/19/2012	12/18/2017	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Rachel Mcgee
Active							
7152	University of Tennessee, Health Science Center College of Pharmacy - MTMC - Clinical Affiliation Agreement - Pharmacy Students (UT pays MTMC Stipend)	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Clinical Education	1/1/2013	12/31/2017	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Robbie Grissom
Active							
7168	University of Tennessee on behalf of its Health Science Center, through its Department of Physician Assistant Studies - STHe - Jacob Unger, M.D.	Saint Thomas Health	Clinical Education	1/1/2014	12/31/2018	Saint Thomas Health	Tristin Casteel
Active							
7169	Duquesne University - Baptist - Clinical Affiliation Agreement Physician Assistant Program - (Oglesby, Siegel, Willis, Smith, Stahlman, Kurtz)	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	8/8/2013	8/7/2018	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital), Duquesne University	Rachel Mcgee, Shalin Shah
Active							
7236	Allied Health Careers Institute - STHe - Clinical and Education Affiliation Agreement - Phlebotomy and Medical Assistants	Saint Thomas Health	Clinical Education	8/8/2013	8/7/2016	Saint Thomas Health	Rachel Mcgee
Active							
7326	Lincoln Memorial University - Midtown - Clinical Affiliation Agreement - Physician Assistant (Damon Petty, MD and Matthew Willis, M.D.)	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	11/13/2013	11/12/2018	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Rachel Mcgee, Shalin Shah
Active							
7361	Acadia University - Midtown - Clinical Affiliation Agreement, Physician Assistant - Habib Doss, M.D.	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	1/17/2014	1/16/2019	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Rachel Mcgee, Shalin Shah
Active							

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7382 Active	The University of Tennessee (Memphis) - STHeR - Clinical Affiliation Agreement - Medical Technology, Histotechnology	Saint Thomas Health	Clinical Education	6/1/2014	7/25/2021	Saint Thomas Health	Rachel McGee
7396 Active	Trevecca Nazarene University - Rutherford - Clinical Affiliation Agreement - Physician Assistants Paul Pasarilla, M.D.	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Clinical Education	3/1/2014	2/28/2018	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Rachel McGee, Robbie Grissom
7430 Active	University of Tennessee, Chattanooga - STHe - Clinical Affiliation Agreement - Occupational Therapy	Saint Thomas Health	Clinical Education	5/7/2014	5/6/2017	Saint Thomas Health, University of Tennessee at Chattanooga	Rachel Mcgee
7433 Active	Southern Illinois University - STHe - Clinical Affiliation Agreement - Kinesiology	Saint Thomas Health	Clinical Education	4/16/2014	4/15/2017	Saint Thomas Health	Rachel Mcgee
7434 Active	University of St. Augustine for Health Sciences - STHe - Clinical Affiliation Agreement - Occupational Therapy	Saint Thomas Health	Clinical Education	4/16/2014	4/15/2017	Saint Thomas Health	Rachel Mcgee
7435 Active	Tennessee College of Applied Technology - Dickson (TCAT) - STHeR - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	4/17/2014	3/21/2021	Saint Thomas Health	Rachel Mcgee, Rachel Mcgee
7455 Active	Medical University of South Carolina - STHe - Clinical and Educational Affiliation Agreement - Medicine	Saint Thomas Health	Clinical Education	5/1/2014	4/30/2019	Saint Thomas Health	Rachel Mcgee
7457 Active	The University of Tennessee Health Science Center - STHe - Clinical Affiliation Agreement - Occupational Therapy Students	Saint Thomas Health	Clinical Education	7/23/2014	7/22/2019	Saint Thomas Health	Rachel Mcgee
7459 Active	University of Alabama at Birmingham - STHe - Clinical Affiliation - Physical Therapy and Genetic Counseling	Saint Thomas Health	Clinical Education	7/23/2014	7/22/2019	Saint Thomas Health	Rachel Mcgee
7468 Active	Lincoln Memorial University - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	7/16/2014	7/15/2018	Saint Thomas Health	Tristin Casteel
7470	Michigan State University College of Nursing - STHe - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	7/23/2014	7/22/2019	Saint Thomas Health	Rachel Mcgee

Comprehensive Contract Listing

Active							
7476	University of Pikeville - Kentucky, College of Ostopathic Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/17/2014	7/17/2018	Saint Thomas Health	Tristin Casteel
Active							
7477	Albany Medical College - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	7/18/2014	7/17/2018	Saint Thomas Health	Tristin Casteel
Active							
7479	Mercer University School of Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/20/2014	8/19/2017	Saint Thomas Health	Sherry Davidson, Tristin Casteel
Active							
7491	University of Alabama at Birmingham- STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/20/2014	8/19/2017	Saint Thomas Health	Tristin Casteel, Sherry Davidson
Active							
7495	Temple University - STHe - Clinical Affiliation Agreement Physical Therapy Students	Saint Thomas Health	Clinical Education	10/6/2014	10/5/2019	Saint Thomas Health	Rachel McGee
Active							
7504	Medical University of South Carolina - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	10/6/2014	10/5/2017	Saint Thomas Health	Tristin Casteel
Active							
7513	University of Tennessee, Health Science Center College of Pharmacy - Midtown - Clinical Affiliation Agreement - Pharmacy Students (UT pays Midtown Stipend)	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	7/1/2014	6/30/2019	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Shalin Shah, Brandy Greene
Active							
7516	Western University of Health Sciences - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	10/6/2014	10/5/2017	Saint Thomas Health	Sherry Davidson, Tristin Casteel
Active							
7554	Vanderbilt University Medical Center (VUMC) - STHeR - Clinical Affiliation (Public Health Students)	Saint Thomas Health	Clinical Education	10/6/2014	10/5/2019	Saint Thomas Health	Rachel Mcgee
Active							
7561	Meharry Medical College - STHe - Clinical Affiliation Agreement - Public Health	Saint Thomas Health	Clinical Education	10/6/2014	10/5/2019	Saint Thomas Health	Rachel Mcgee
Active							

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7564 Active	Thomas Edison State College - STHe - Clinical Affiliation Agreement - Nursing Informatics	Saint Thomas Health	Clinical Education	10/6/2014	10/5/2019	Saint Thomas Health	Rachel Mcgee
7574 Active	Tennessee College of Applied Technology - Murfreesboro (TCAT) - STHe - Clinical Affiliation Agreement - Surgical	Saint Thomas Health	Clinical Education	11/25/2014	2/4/2021	Saint Thomas Health	Rachel Mcgee
7575 Active	University of Northern Alabama - STHe - Clinical Affiliation Agreement - Health, Physical Education and Recreation	Saint Thomas Health	Clinical Education	12/4/2014	12/3/2019	Saint Thomas Health	Rachel Mcgee
7582 Active	University of Tennessee Health Science Center - STHe - Clinical Affiliation Agreement Audiology and Speech Pathology	Saint Thomas Health	Clinical Education	12/22/2014	12/21/2019	Saint Thomas Health	Rachel Mcgee
7583 Active	Virginia Commonwealth University School of Allied Health Professionals - STHe - Clinical Affiliation Agreement for	Saint Thomas Health	Clinical Education	5/1/2015	4/30/2018	Saint Thomas Health	Rachel McGee
7602 Active	Ithaca College - STHe - Clinical Affiliation Agreement for Health Science and Human Performance Students	Saint Thomas Health	Clinical Education	12/9/2014	12/8/2019	Saint Thomas Health	Rachel Mcgee
7620 Active	American University of Antigua - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	11/21/2014	11/20/2017	Saint Thomas Health	Sherry Davidson
7637 Active	Nashville State Community College - STHe - Clinical Affiliation Agreement - Central Sterile Processing	Saint Thomas Health	Clinical Education	10/24/2014	10/23/2017	Saint Thomas Health	Rachel Mcgee
7646 Active	Concordia University - STHe - Clinical Affiliation Agreement - Occupational Therapy	Saint Thomas Health	Clinical Education	1/22/2015	1/21/2020	Saint Thomas Health	Rachel Mcgee
7673 Active	Marian University - STHe - Clinical Affiliation Agreement - Nursing Education K# 7668 - Orbis Education Services	Saint Thomas Health	Clinical Education	1/1/2014	12/31/2018	Saint Thomas Health	Rachel McGee, Peter Lindquist
7928 Active	Texas Tech University, Health Science Center, School of Medicine - STHe - Visiting Medical Student Agreement Medical Student Rotations agreement	Saint Thomas Health	Clinical Education	8/3/2015	8/2/2018	Saint Thomas Health	Sherry Davidson, Tristin Casteel

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7933 Active	University of Mississippi, School of Medicine - STHe - Visiting Medical Student Agreement Medical Student Rotations agreement	Saint Thomas Health	Clinical Education	5/22/2015	5/21/2018	Saint Thomas Health	Sherry Davidson, Tristin Casteel
7973 Active	Kansas City University of Medicine and BioSciences - STHe - Visiting Medical Student Agreement Visiting medical student rotation.	Saint Thomas Health	Clinical Education	6/12/2015	6/11/2018	Saint Thomas Health	Tristin Casteel, Sherry Davidson
7991 Active	Rocky Vista University, LLC - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	6/12/2015	6/11/2018	Saint Thomas Health	Sherry Davidson
8006 Active	Meridian Institute of Surgical First Assisting, Inc. - STHe - Clinical Affiliation Agreement	Saint Thomas Health	Clinical Education	6/16/2015	6/15/2017	Saint Thomas Health	Rachel Mcgee
8007 Active	William Carey University College of Ostopathic Medicine - STHe - Visiting Medical Student	Saint Thomas Health	Clinical Education	6/12/2015	6/11/2018	Saint Thomas Health	Sherry Davidson
8008 Active	Des Moines University - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	5/22/2015	5/21/2018	Saint Thomas Health	Sherry Davidson
8071 Active	Lake Erie College of Osteopathic Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/3/2015	8/2/2018	Saint Thomas Health	Sherry Davidson, Tristin Casteel
8076 Active	University of Tennessee Health Science Center - STHe - Data Use Agreement - Research Biostatistics and Epidemiology Consulting Projects	Saint Thomas Health	Clinical Education	7/21/2015	7/20/2017	Saint Thomas Health	Sara Hollis
8093 Active	A.T. University - Arizona School of Health Sciences - STHe - Clinical Affiliation Agreement - Audiology, Occupational	Saint Thomas Health	Clinical Education	6/16/2015	6/15/2020	Saint Thomas Health	Rachel Mcgee
8250 Active	Edward Via College of Osteopathic Medicine, Carolinas Campus - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	9/22/2015	9/21/2018	Saint Thomas Health	Sherry Davidson, Tristin Casteel
8422 Active	Independence University - STHeR - School Affiliation Agreement - Respiratory Therapy School Affiliation Agreement - Clinical Program - (Respiratory Therapy)	Saint Thomas Health	Clinical Education	4/7/2010	6/30/2021	Saint Thomas Health	Rachel McGee, Robert (Dale) Humphrey

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8559	Trevecca Nazarene University - Rutherford - Clinical Affiliation Agreement - Physician Assistant (James Carter, M.D.)	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Clinical Education	10/1/2015	9/30/2017	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Rachel McGee, Robbie Grissom
Active	Clinical Affiliation Agreement						
8561	Tennessee State University - STHeR - Clinical and Educational Affiliation Agreement - Various Programs	Saint Thomas Health	Clinical Education	12/2/2015	8/31/2018	Saint Thomas Health	Rachel Mcgee
Active	Clinical and Educational Affiliation Agreement - Various Programs - combined #2066 and #3609 Nursing into this agreement						
8562	Bethel University - Rutherford - Clinical Affiliation Agreement - Physician Assistant to Dr. Wayne Westmoreland	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Clinical Education	9/14/2015	9/13/2017	Saint Thomas RUTHERFORD Hospital (Middle Tennessee Medical Center, Inc.)	Rachel McGee, Robbie Grissom
Active	Dr. Zakaria Botros						
8642	Tennessee College of Applied Technology - Elizabethton - STHeR - Clinical and Educational Affiliation Agreement -	Saint Thomas Health	Clinical Education	12/10/2015	12/9/2017	Saint Thomas Health	
Active	Clinical and Educational Affiliation Agreement - Nutrition and Food Services						
8663	Vanderbilt University Medical Center (VUMC) - STHeR - Clinical and Educational Affiliation Agreement (Hearing and	Saint Thomas Health	Clinical Education	12/1/2015	11/30/2017	Saint Thomas Health	Rachel Mcgee
Active							
8664	University of North Texas Health Science Center - STHeR - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/21/2015	8/20/2017	Saint Thomas Health	Tristin Casteel
Active							
8682	Tennessee College of Applied Technology - Nashville - STHeR - Clinical Affiliation Agreement for Obstetrical, Practical Nursing	Saint Thomas Health	Clinical Education	1/13/2016	3/20/2018	Saint Thomas Health	Rachel Mcgee
Active							
8685	Maryville University - STHeR - Clinical Affiliation Agreement for Online Nursing	Saint Thomas Health	Clinical Education	12/10/2015	12/9/2017	Saint Thomas Health	Rachel Mcgee
Active	Clinical Affiliation for Online Nursing						
8692	Western Kentucky University - STHeR - Clinical Affiliation Agreement for (Physical Therapy, Nursing, Exercise Science	Saint Thomas Health	Clinical Education	12/8/2015	12/7/2018	Saint Thomas Health	Rachel McGee
Active	Physical Therapy, Nursing, Exercise Science and Speech Language Pathology						
8703	Bethel University - West - Clinical Affiliation Agreement - Physician Assistants - Dr. Evelio Rodriguez	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	2/8/2016	2/7/2018	Saint Thomas WEST Hospital (St. Thomas Hospital)	Shalin Shah, Rachel Mcgee
Active	Dr. Douglas Adkisson						

Comprehensive Contract Listing

8731	St. Ambrose University - STHeR - Clinical Affiliation for Speech Language	Saint Thomas Health	Clinical Education	2/12/2016	2/11/2018	Saint Thomas Health	Rachel Mcgee
Active							
8782	University of the Cumberlands - Midtown - Clinical Affiliation Agreement for Physician Assistant Program	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	4/4/2016	4/3/2018	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Shalin Shah
Active	Jane Siegel, M.D.						
8805	Tennessee College of Applied Technology - Crossville - (TCAT) - STHeR - Clinical Affiliation Agreement - Surgical	Saint Thomas Health	Clinical Education	3/3/2016	3/2/2018	Saint Thomas Health	Rachel Mcgee
Active							
8806	Western Governors University - STHeR - Clinical Affiliation Agreement - Nursing Program	Saint Thomas Health	Clinical Education	3/21/2016	3/20/2021	Saint Thomas Health	Rachel Mcgee
Active							
8807	Lynchburg College - STHeR - Clinical Affiliation Agreement - Physical Therapy Program	Saint Thomas Health	Clinical Education	3/21/2016	3/20/2021	Saint Thomas Health	Rachel Mcgee
Active							
8811	Miami University - STHeR - Clinical Affiliation Agreement - Speech Pathology and Audiology	Saint Thomas Health	Clinical Education	1/4/2016	1/3/2021	Saint Thomas Health	Rachel Mcgee
Active							
8819	Tennessee College of Applied Technology - McMinnville - (TCAT) - STHeR - Clinical Affiliation Agreement - Licensed	Saint Thomas Health	Clinical Education	3/21/2016	3/20/2018	Saint Thomas Health	Rachel Mcgee
Active							
8821	Bethel University - Midtown - Clinical Affiliation Agreement - Physician Assistants - Dr. Richard Garman	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	4/27/2016	4/26/2018	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Shalin Shah, Rachel Mcgee
Active	Dr. George Lynch						
8847	Marywood University - STHe - Clinical Affiliation Agreement - Nutrition and Dietetic Program	Saint Thomas Health	Clinical Education	4/29/2016	4/28/2018	Saint Thomas Health	Rachel Mcgee
Active							
8861	Wake Forest School of Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	5/31/2016	5/30/2018	Saint Thomas Health	Sherry Davidson
Active							
8877	Marian University College of Osteopathic Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	5/27/2016	5/26/2018	Saint Thomas Health	Sherry Davidson

Comprehensive Contract Listing

Active							
8917	Saint Thomas Campus Surgicare, L.P. - West - Graduate Medical Education Affiliation Agreement	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	7/1/2016	6/30/2018	Saint Thomas WEST Hospital (St. Thomas Hospital)	Tristin Casteel
Active	Allow UT Residents to work in Ambulatory Surgery Center						
8935	University of Tennessee, through its Health Science Center, College of Pharmacy - Midtown - Agreement for Pharmacy Residents	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	7/1/2016	6/30/2021	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Shalin Shah, Jennifer Miller
Active	Midtown pays UT for Pharmacy Residents - Max of $134,320.04						
8986	Harding University - STHeR - Clinical Affiliation Agreement-Exercise Science	Saint Thomas Health	Clinical Education	6/29/2016	6/28/2021	Saint Thomas RIVER PARK Hospital, Saint Thomas Health	Rachel Mcgee
Active							
9020	University of Southern California on behalf of Keck School of Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	6/23/2016	6/22/2018	Saint Thomas Health	Sherry Davidson
Active							
9067	Georgetown University - STHeR - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	7/1/2016	6/30/2018	Saint Thomas Health, Saint Thomas Health, Saint Thomas Health, Saint Thomas Health	Rachel Mcgee
Active							
9087	Florida Institute of Ultrasound - STHeR - Clinical Affiliation Agreement - Ultrasound	Saint Thomas Health	Clinical Education	7/27/2016	7/26/2018	Saint Thomas Health, Saint Thomas Health, Saint Thomas Health, Saint Thomas Health	Rachel Mcgee
Active							
9136	Alabama College of Osteopathic Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/22/2016	8/21/2018	Saint Thomas Health	Sherry Davidson
Active							
9137	Meharry Medical College - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	5/27/2016	5/26/2018	Saint Thomas Health	Sherry Davidson
Active							
9146	East Tennessee State University College of Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/18/2016	8/17/2017	Saint Thomas Health	Sherry Davidson
Active							
9151	Marshall University Joan C. Edwards School of Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/30/2016	8/29/2017	Saint Thomas Health	Sherry Davidson

Active							
9160 Active	University of South Carolina School of Medicine Greenville - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	6/23/2016	6/22/2018	Saint Thomas Health	Sherry Davidson
9167 Active	Campbell University, Incorporated - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	9/2/2016	9/1/2018	Saint Thomas Health	Sherry Davidson
9168 Active	Creighton University School of Medicine - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	7/27/2016	7/26/2018	Saint Thomas Health	Sherry Davidson
9175 Active	Mississippi College - West - Clinical Affiliation Agreement for Physician Assistant Program Mark Zenker, M.D.	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	7/26/2016	7/25/2018	Saint Thomas WEST Hospital (St. Thomas Hospital)	Shalin Shah, Rachel Mcgee
9177 Active	Grantham University - STHeR - Clinical Affiliation Agreement - Nursing	Saint Thomas Health	Clinical Education	8/23/2016	8/22/2018	Saint Thomas Health, Saint Thomas Health, Saint Thomas Health, Saint Thomas Health	Rachel Mcgee
9221 Active	Philadelphia College of Medicine - Georgia Campus - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	8/30/2016	8/29/2018	Saint Thomas Health	Sherry Davidson
9226 Active	Alabama State University - STHe - Clinical and Educational Affiliation Agreement - Physical Therapy	Saint Thomas Health	Clinical Education	9/22/2016	9/21/2021	Saint Thomas Health	Rachel Mcgee
9241 Active	Capella University - STHeR - Clinical Affiliation Agreement - Nursing Students	Saint Thomas Health	Clinical Education	7/1/2016	6/30/2018	Saint Thomas Health	Rachel Mcgee
9277 Active	Oakland University - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	9/29/2016	9/28/2018	Saint Thomas Health	Sherry Davidson, Jennie Towry
9358 Active	University of Mississippi - STHeR - Clinical Affiliation Agreement - Communication Sciences and Disorders students	Saint Thomas Health	Clinical Education	4/27/2016	4/26/2018	Saint Thomas Health	Rachel Mcgee

Comprehensive Contract Listing

9392	Samford University - Anesthesia Medical Group, P.C. (AMG) - West - Clinical Affiliation Agreement - Anesthesiology	Saint Thomas WEST Hospital (St. Thomas Hospital)	Clinical Education	12/8/2016	12/7/2021	Saint Thomas WEST Hospital (St. Thomas Hospital)	Rachel McGee
Active							
9393	Samford University - Anesthesia Medical Group, P.C. (AMG) - Midtown - Clinical Affiliation Agreement - Anesthesiology	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Clinical Education	12/5/2016	12/5/2021	Saint Thomas MIDTOWN Hospital (Seton Corporation d/b/a Baptist Hospital)	Rachel Mcgee, Ashley Knight
Active							
9435	Jackson State Community College - STHeR - Clinical Affiliation Agreement - Medical Laboratory Technician	Saint Thomas Health	Clinical Education	1/20/2017	1/20/2022	Saint Thomas Health	Rachel McGee
Active							
9507	Argosy University - STHeR - Clinical Affiliation Agreement - Medical Diagnostic Sonography	Saint Thomas Health	Clinical Education	4/20/2017	4/19/2022	Saint Thomas Health	Rachel McGee
Active							
9508	Purdue University - STHeR - Clinical Affiliation Agreement - Speech Pathology	Saint Thomas Health	Clinical Education	5/1/2017	4/30/2022	Saint Thomas Health	Rachel McGee
Active							
9554	South College - Knoxville - STHeR - Clinical Affiliation Agreement - Physical Therapy	Saint Thomas Health	Clinical Education	5/22/2017	5/21/2022	Saint Thomas Health	Rachel McGee
Active							
9571	Louisiana State University Health Sciences Center - STHe - Visiting Medical Student Agreement	Saint Thomas Health	Clinical Education	5/22/2017	5/21/2018	Saint Thomas Health	Sherry Davidson, Jennie Towry
Active							
9572	South College - Nashville - STHeR - Clinical Affiliation Agreement - Diagnostic Medical Sonography	Saint Thomas Health	Clinical Education	5/22/2017	5/21/2022	Saint Thomas Health, Saint Thomas Health, Saint Thomas Health, Saint Thomas Health, Saint Thomas Health	Rachel McGee
Active							
9578	University of South Carolina - STHeR - Clinical Affiliation Agreement - Nursing Program	Saint Thomas Health	Clinical Education	4/18/2017	4/17/2022	Saint Thomas Health, Saint Thomas Health, Saint Thomas Health, Saint Thomas Health, Saint Thomas Health	Rachel McGee
Active							

Tab 16

Attachment Section B-D1

Hospital License

Board for Licensing Health Care Facilities

State of Tennessee

0000000100

No. of Beds 0286

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SAINT THOMAS RUTHERFORD HOSPITAL *to conduct and maintain a*

Hospital SAINT THOMAS RUTHERFORD HOSPITAL

Located at 1700 MEDICAL CENTER PARKWAY, MURFREESBORO

County of RUTHERFORD *, Tennessee.*

This license shall expire NOVEMBER 26 *,* 2017 *, 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 3RD *day of* NOVEMBER *,* 2016 *.*

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC PRIMARY HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner, MD
COMMISSIONER

DCF011

Tab 17

Attachment Section B-D1

The Joint Commission Accreditation Certificate
Follow-Up Survey Letter and Medicare Compliance

Saint Thomas Rutherford Hospital

Murfreesboro, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

January 14, 2016

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #7883
Print/Reprint Date: 04/08/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

The Joint Commission

April 7, 2016

Re: # 7883
CCN: #440053
Program: Hospital
Accreditation Expiration Date: January 14, 2019

Gordon B. Ferguson
President and CEO
Saint Thomas Rutherford Hospital
1700 Medical Center Parkway
Murfreesboro, Tennessee 37129

Dear Mr. Ferguson:

This letter confirms that your January 11, 2016 - January 13, 2016 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on March 08, 2016 and April 05, 2016, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of January 14, 2016.

The Joint Commission is also recommending your organization for continued Medicare certification effective January 14, 2016. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Ministry in Motion Mobile Health Unit
1700 Medical Center Parkway, Murfreesboro, TN, 37129

Saint Thomas Rutherford Hospital
d/b/a Saint Thomas Rutherford Hospital
1700 Medical Center Parkway, Murfreesboro, TN, 37129

Saint Thomas Rutherford Hospital Outpatient Cardiac Imaging
d/b/a Saint Thomas Rutherford Hospital Outpatient Cardiac Imaging
1840 Medical Center Parkway, Murfreesboro, TN, 37129

STRH Wound Care & Hyperbaric Medicine
d/b/a STRH Wound Care & Hyperbaric Medicine,

The Joint Commission

1840 Medical Center Parkway, Seton Building Suite 404, Murfreesboro, TN, 37129

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. 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

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Tab 18

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 Rutherford & Surrounding (County), Tennessee, on or before 07/10 (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 Rutherford Hospital (Name of Applicant) Hospital Provider (Facility Type-Existing)

owned by: Saint Thomas Health with an ownership type of not-for-profit

and to be managed by: Saint Thomas Rutherford Hospital intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the expansion of its existing acute care services by seventy-two (72) beds at 1700 Medical Center Parkway in Murfreesboro, TN, 37129 (Rutherford County). The project involves the construction of 52,000 square feet of new hospital space. No major medical equipment is involved. Total project costs are estimated to be $47,478,943.

The anticipated date of filing the application is: July 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) (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 19

JUL 14'17 PM12:43

Evidence of Publication

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
St. Thomas Health
102 Woodmont Blvd, Suite 800
Nashville, TN 37205

RE: Certificate of Need Application -- St. Thomas Rutherford Hospital - CN1707-021
The expansion of acute care beds by 72 beds from 198 beds to 270 beds located at 1700 Medical Center Parkway, Murfreesboro (Rutherford County), TN 37129. If approved, the total licensed beds will increase from 286 beds to 358 beds. **The estimated project cost is $47,478,943.**

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 by the Division of Policy, Planning and Assessment. 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 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 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
St. Thomas Rutherford Hospital - CN1707-021

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

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

JUL 10 '17 PM3:51

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 Rutherford & Surrounding (County), Tennessee, on or before 07/10 (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 Rutherford Hospital (Name of Applicant) Hospital Provider (Facility Type-Existing)

owned by: Saint Thomas Health with an ownership type of not-for-profit

and to be managed by: Saint Thomas Rutherford Hospital intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the expansion of its existing acute care services by seventy-two (72) beds at 1700 Medical Center Parkway in Murfreesboro, TN, 37129 (Rutherford County). The project involves the construction of 52,000 square feet of new hospital space. No major medical equipment is involved. Total project costs are estimated to be $47,478,943.

The anticipated date of filing the application is: July 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) 7/10/17 (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 Hospital-Rutherford

CN1707-021

JUL 26 '17 PM 2:39

SUPPLEMENTAL #1

July 26, 2017
2:40 pm

71 Vickery Street
Atlanta, Georgia 30075
Telephone 770-394-8465
Facsimile 770-394-5470
www.thestrategyhouse.net

July 26, 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 CN1707-021
Saint Thomas Hospital-Rutherford

Dear Mr. Earhart:

Thank you for your letter of July 21, 2017 acknowledging the receipt of our July 14, 2017 application for a Certificate of Need for the expansion of acute care beds by 72 beds from 198 beds to 270 beds, at Saint Thomas Rutherford Hospital ("STRH"), located at 1700 Medical Center Parkway, Murfreesboro (Rutherford County), TN 37129.

The following responses are provided for clarification or additional documentation. As requested, **this information is being submitted in triplicate prior to the 12:00 p.m., Friday, July 28, 2017 deadline.**

---

1. **Section A, Executive Summary, Item 3.A.5 Project Cost**

   The applicant references $22,199,000 as construction costs on page 3 while the Project Costs Chart lists the cost as $22,188,000. Please clarify.

   Please make all necessary revisions and submit a replacement page 3 (R-3).

   RESPONSE: $22,188,000 is correct. A replacement page (3-R) is provided in **Attachment 1**.

2. **Section A: Project Details Item 6B Plot Plan**

The plot plan is noted. However, please provide an overview of MOB Phase 1, MOB Phase 2, Hospital Phase, Phase 4A, and Phase 4B listed on the plot plan.

RESPONSE: The STRH campus was designed for growth, to meet the needs of a very rapidly increasing service area population.

a. MOB Phase 1 – DePaul MOB, opened in May 2008
b. MOB Phase 2 – Seton MOB, opened January 2012
c. Hospital Phase – replacement facility opened October 2010
d. Phase 4A – reserved for future uses
e. Phase 4B – employee parking lot

3. **Section A: Project Details Item 6B (2) Floor Plan**

The floor plan is noted. However, please provide enlarged legible copies of the proposed floor plan.

RESPONSE: The proposed sixth and seventh floors will have the same room layout and configuration as the fifth floor below. The patient care floor plan provided in Tab 6 has been divided in to multiple sections to provide an enlarged view of each room. Please see **Attachment 2**. Again, the layout on the sixth and seventh floors will be identical to the existing fifth floor.

Please complete the following chart showing room changes from current to proposed:

Private/Semi-Private Room and Bed Mix

Bed Type	Current Private Rooms/Beds		Current Semi-Private Rooms/Beds			Proposed Private Rooms/Beds		Proposed Semi-Private Rooms/Beds	
	Rooms	Beds	Rooms	Beds		Rooms	Beds	Rooms	Beds
Acute Beds (Med-Surg only)	198	198	0	0		+72 =270	+72 =270	0	0

4. **Section A: Project Details, Square Footage and Cost Per Square Footage Chart**

It is noted the construction cost of $427 PSF is above the 3rd quartile of similar hospital projects. Please indicate the reasons the proposed construction cost is above the 3rd quartile.

RESPONSE: The term "similar" is relative and must be placed in context. Although this STRH project was compared to other hospital construction projects (as opposed to hospital renovation projects or nursing home construction projects), the similarities within the hospital construction category essentially end here.

The STRH project is unique in the following respects, as it involves:

- Construction atop an existing, fully-functional hospital
- Construction approximately 90 feet above ground level

As described in the Square Footage and Cost Per Square Footage Chart on page 12 of the application and elaborated upon here, this type of construction is more costly than average due to the following factors:

- Temporary vertical circulation for construction workers, equipment, supplies and construction debris, separate from existing patient and staff flows
- Construction location and height requires significant equipment, cranes and hoisting
- Crane locations are remote and require extensive pick and drop locations
- Staging of materials onsite within an occupied, rather dense campus present challenges and assumes additional deliveries and offsite storage
- Infection control throughout a working hospital, with added dust and debris created during construction
- Noise and vibration abatement above a working hospital
- Utility relocation and construction necessary to reach new upper floors

Regardless, STRH was originally constructed for vertical expansion. While these costs are above the third quartile for hospital construction, they are in-line with extensive tower additions similar in scope. As certified by the architect, the proposed costs are reasonable.

5. **Section C, Need, Item 1. (Service Specific Criteria-Acute Bed Services)**

It is noted the applicant did not include TrustPoint Hospital (licensed by the Department of Health) located in Murfreesboro (Rutherford County), TN in the acute bed need services criteria. Please include TrustPoint Hospital and revise any responses (narrative, charts, tables, etc.) in the application and submit replacement pages.

RESPONSE: Though licensed by the Department of Health, the services provided by TrustPoint Hospital and STRH are separate, distinct and do not overlap. As documented in **Attachment 3**, excerpts from TrustPoint CN1606-024 indicate that:

- the TrustPoint beds are for medical detoxification, adult psychiatric services, geriatric psychiatric services and rehabilitation as opposed to the acute medical-surgical beds proposed by STRH (application, page 9)

- "However, the beds being requested are not general med-surg beds but will be utilized as psychiatric and rehab beds. Therefore, the Applicant respectfully replies that the Service Specific Criteria for Acute Bed Services are not applicable to this project." (application, page 18)

- "Importantly, the services provided at TrustPoint Hospital are a direct and natural complement to the important and life sustaining services provided at St. Thomas Rutherford Hospital. TrustPoint Hospital and St. Thomas Rutherford Hospital do not, *in any way*, compete for services." (application, page 28)

- "In fact, all beds being requested in the application are for psych and rehab. No new med/surg beds are requested." (DOH report, page 11)

Further, at the October 2016 Agency meeting when the TrustPoint application was heard, STRH CEO Gordon Ferguson spoke in support due to the complementary rather than competitive nature of the TrustPoint project. On July 25, 2017, he spoke again at the TrustPoint groundbreaking ceremony.

STRH respectively concludes that while TrustPoint Hospital is in Rutherford County and additional beds have been approved for development, the TrustPoint project does not have any bearing on the STRH acute medical-surgical bed project due to the separate and distinct services offered at each facility and the separate and distinct review criteria applicable to each project. In fact, approval of the TrustPoint project only amplifies the population growth in the service area and supports the need for the additional acute medical-surgical beds requested by STRH.

As a follow up item, the applicant was also asked to discuss the alternative of developing an area with non-licensed beds for observation days which would make [existing] licensed beds more available for inpatients.

As described in the CON application at pages 4-5 and elsewhere, observation patient volume (excluding other outpatients) continues to increase at STRH. Within this increase, shorter stay observation patients (eight hours or less) are declining as a percentage of the total. The increase in observation lengths of stays of 24+ hours has increased significantly during this same time period.

As the Agency is aware, there is a push among both government and commercial payors to implement so-called "two midnight" rules and other methods to reduce payment as inpatient hospital stays. On any given day, STRH will have more than 60 patients in a hospital bed, many still undergoing a "status" determination for inpatient or outpatient reimbursement purposes. This can go on for more than 36 hours, rendering traditional ER holding areas inappropriate.

The 72 licensed beds requested by STRH are part of a specialty inpatient unit intended to meet the needs of both traditional inpatients and these extended stay outpatient status and observation status patients who require monitoring, staffing and facilities comparable to a traditional inpatient.

The 2014 AIA Facility Guidelines Institute defines an observation unit as, "An area usually associated with an emergency department where one or more patients can be clinically monitored, assessed, and treated by staff for up to 24 hours." However, the STRH project does not meet these criteria because its target patient population has stays near and above 24 hours. Furthermore, this target patient population is increasing in numbers.

Furthermore, the following AIA design standards for traditional observation areas allow:

- cubicles to be used instead of private rooms,
- sharing one toilet among six patients and
- sharing one shower among twelve patients.

The level of care that can be provided in a traditional observation unit according to these design standards with non-licensed beds simply is not an appropriate setting for placing a patient who will stay 24, 36 or more hours, regardless of their reimbursement (IP/OP) status.

6. **Section C, Need, Item 1. (Service Specific Criteria-Acute Bed Services) Item 2.a.**

   Please list all existing hospital's occupancy levels based on the number of licensed beds that are staffed for two consecutive years listing which ones meet or do not meet an occupancy level greater than or equal to 80%.

   RESPONSE: As listed on pages 28-29 of the CON application, none of the service area hospitals had an occupancy level greater than or equal to 80% in 2014 or 2015. This is one reason why STRH, by far the hospital with the most beds and offering the most comprehensive range of services in the service area, is seeking special consideration for its project. The breadth and depth of STRH's specialized care is needed for this region, not just "a hospital bed".

   - Tri-Star StoneCrest Medical Center – 43.9% (2014), 45.9% (2015)
   - Heritage Medical Center – 28.4%, 27.4%
   - Saint Thomas Stones River Hospital – 22.0%, 25.0%
   - Harton Regional Medical Center – 41.6%, 41.7%
   - United Regional Medical Center – 20.3%, 21.1%
   - Saint Thomas River Park Hospital – 24.9%, 26.3%
   - Saint Thomas Rutherford Hospital – 56.3%, 61.0%

7. **Section C, Need, Item 1. (Service Specific Criteria-Acute Bed Services) Item 2.b.**

   It appears there are TrustPoint Hospital outstanding projects involving acute beds in the proposed service area. Please discuss.

   RESPONSE: Please note that this matter was addressed in Item 5, above, and is summarized here. Though licensed by the Department of Health, the services provided by TrustPoint Hospital and STRH are separate, distinct and do not overlap. As documented in **Attachment 3**, excerpts from TrustPoint CN1606-024 indicate that:

   - the TrustPoint beds are for medical detoxification, adult psychiatric services, geriatric psychiatric services and rehabilitation as opposed to the acute medical-surgical beds proposed by STRH (application, page 9)

   - "However, the beds being requested are not general med-surg beds but will be utilized as psychiatric and rehab beds. Therefore, the Applicant respectfully replies that the Service Specific Criteria

for Acute Bed Services are not applicable to this project." (application, page 18)

- "Importantly, the services provided at TrustPoint Hospital are a direct and natural complement to the important and life sustaining services provided at St. Thomas Rutherford Hospital. TrustPoint Hospital and St. Thomas Rutherford Hospital do not, *in any way*, compete for services." (application, page 28)

- "In fact, all beds being requested in the application are for psych and rehab. No new med/surg beds are requested." (DOH report, page 11)

STRH respectively concludes that while TrustPoint Hospital is in Rutherford County and additional beds have been approved for development, the TrustPoint project does not have any bearing on the STRH acute medical-surgical bed project due to the separate and distinct services offered at each facility and the separate and distinct review criteria applicable to each project.

8. Section B. Need, Item F

Your response to this item is noted. Please complete the following chart showing historical licensed bed utilization of the primary and contiguous service area.

RESPONSE: The information provided in the table below was reformatted from data reported on pages 28-29 of the original CON application. TrustPoint Hospital has also been added, consistent with the requests above.

Please note that patient day growth far exceeds population growth in the service area.

At STRH, 76,003 patient days were reported in 2016. This represents another 19.3% growth in just a single year.

2013-2015 Service Area Acute Care Hospitals Occupancy

Facility	County	2015 Licensed Beds	Patient Days			Licensed Occupancy			% Change in patient days 2013-2015
			2013	2014	2015	2013	2014	2015	
Saint Thomas Rutherford Hosp	Rutherford	286	63,503	58,744	63,688	60.8%	56.3%	61.0%	0.3%
TriStar StoneCrest Medical Center	Rutherford	109	5,124	5,277	5,208	40.9%	43.9%	45.9%	1.6%
TrustPoint Hospital	Rutherford	100	14,451	21,095	26,613	39.6%	57.8%	72.9%	84.2%
Heritage Med Ctr	Bedford	60	5,723	6,220	6,002	26.1%	28.4%	27.4%	4.9%
Saint Thomas Stones River	Cannon	60	4,525	4,816	5,469	20.7%	22.0%	25.0%	20.9%
Harton Regional	Coffee	135	19,549	20,521	20,532	39.7%	41.6%	41.7%	5.0%
United Regional	Coffee	79	7,536	6,065	3,768	25.3%	20.3%	21.1%	-50.0%
Saint Thomas River Park	Warren	125	11,395	11,341	11,996	25.0%	24.9%	26.3%	5.3%
Total		**954**	**133,819**	**136,093**	**145,291**	**38.4%**	**39.1%**	**41.7%**	**8.6%**

The Rutherford County-Saint Thomas Hospital utilization table on page 29 is noted. However, the staffed beds of 268 in 2015 appear incorrect. In the 2015 JAR the applicant listed 285 staffed beds. Please clarify.

RESPONSE: The 285 is correct. A replacement page (29-R) is provided in **Attachment 1**.

The Rutherford County-Saint Thomas Hospital utilization table on page 33 is noted. However, the 2016 staffed and licensed occupancy % of 80.2% appears to be incorrect. Please revise and submit a replacement page (R-33).

RESPONSE: 75.2% is correct. A replacement page (33-R) is provided in **Attachment 1**.

9. **Section B. Economic Feasibility Item C. Historical Data Chart**

The Historical Data Chart is noted. However, please provide a more legible copy (both pages).

RESPONSE: Reprinted pages are provided in **Attachment 4**.

10. Section B. Economic Feasibility Item D. Projected Data Chart

There appears to be calculation errors in the 2020 column of the Projected Data Chart. Please review and submit a revised Projected Data Chart if necessary.

RESPONSE: Net operating revenue should be $338,631,000 as opposed to $338,681,000. A replacement page (41-R) is provided in **Attachment 1**.

11. Section B. Economic Feasibility, Item F (1), Audited Financial Statements

As prescribed in the application, please provide the most recent audited financial documents for Ascension.

RESPONSE: The document is provided in **Attachment 5**.

12. 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 original information included outpatient-weighted data. A replacement page (43-R), based on inpatient days only and total gross revenues (inpatient, outpatient, etc.) is provided in **Attachment 1**.

13. Section B, Economic Feasibility, Item F. (2) and Item f (3)

The table representing the net margin ratios of the applicant is noted. However, the ratios do not match any existing Projected or Historical Data Charts. Please revise and submit a replacement page 44.

RESPONSE: A replacement page (44-R), based on Earnings Before Interest, Taxes and Depreciation rather than Net Income, is provided in **Attachment 1**.

The capitalization ratio is noted. However, the applicant incorrectly listed the capitalization formula that is listed in the HSDA application. Please revise and include in replacement page 44.

RESPONSE: The division sign in the formula has been changed to a plus sign. The calculations, however, remain unchanged. A replacement page (44-R) is provided in **Attachment 1**.

14. Section B, Economic Feasibility, Item G. Payor Mix

The payor mix table is noted. However, the total gross operating revenue does not match the Projected Data Chart. Please revise.

RESPONSE: The original information excluded other operating revenue. The payor mix table has been revised to include this revenue. A replacement page (45-R) is provided in **Attachment 1**.

15. Section B. Economic Feasibility, Item H, Staffing

The staffing table on page 45 is noted. However, please complete the direct patient care positions and area wide/statewide coverage wage portions of the table and submit a replacement page 45 (R-45).

RESPONSE: A replacement page (45-R) is provided in **Attachment 1**.

The staffing levels for just the 72 beds in Year 1 are reported below.

- RNs - 19 FTEs
- LPNs - 2 FTEs
- Techs - 10 FTEs

16. Section B. Orderly Development, Item C (1).

The applicant states STRH is currently and appropriately staffed for a census of 277 patients. However, other parts of the application mention staffing at 285 beds. Please clarify.

RESPONSE: The current bed census, including outpatients, is 277 patients. Item C (1) cites a Year 2 census projection of 285 patients.

In 2015, STRH staffed 285 beds. In 2016, STRH began staffing all 286 licensed beds.

STRH is currently staffing all 286 licensed beds, which have a census of 277 patients including outpatients in beds. A replacement page (46-R) is provided in **Attachment 1**.

17. Section B. Orderly Development, Item D (2).

Please provide a copy of the most recent licensure and/or Joint Commission survey.

RESPONSE: The most recent survey results are provided in **Attachment 6**.

18. Section B. Contribution to Orderly Development Item F.2 Outstanding Projects

Please provide a brief status update for the project Providence Surgery Center, CN1608-031A.

RESPONSE: The project has been fully implemented as a multispecialty ASTC without any restrictions as to the surgical specialties provided.

19. Section B. Quality Measures

Please verify and acknowledge the applicant will be evaluated annually whether the proposal will provide health care that meets appropriate quality standards upon the following factors:

RESPONSE: The applicant acknowledges this requirement and will comply.

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

RESPONSE: STRH is part of Saint Thomas Health and Ascension. Providing care to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent is at the very core of the mission of these faith-based, charitable organizations. STRH has every intention to comply with the payor mix as projected.

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

RESPONSE: To continue to provide quality patient care, STRH has every intention to comply with the staffing levels as projected.

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

RESPONSE: To continue to provide quality patient care, STRH has every intention to maintain all applicable state licenses in good standing.

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

RESPONSE: To continue to provide quality patient care, STRH has every intention to continue to maintain TennCare and Medicare certifications.

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

RESPONSE: STRH has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application.

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

RESPONSE: STRH has not been decertified within the prior three years, or ever decertified.

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable. Other acceptable accrediting organizations may include, but are not limited to, the following:

RESPONSE: To continue to provide quality patient care, STRH has every intention to continue to conduct self-assessments and maintain accreditation by The Joint Commission.

A notarized affidavit accompanies these responses and is found at **Attachment 7**. On behalf of Saint Thomas Rutherford 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

Attachments

1. Application Replacement Pages
2. Enlarged Floor Plan
3. TrustPoint CON Application Excerpts
4. Reprinted Historical Data Chart
5. Ascension Audit
6. Licensure/Accreditation Report
7. Affidavit

SUPPLEMENTAL #1

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Attachment 1

County, the primary service area county, is the most distinguishing characteristic of the population served. Rutherford County leads the state of Tennessee (number one ranking of 95 counties) in projected population growth from 2017 to 2021 – 36,154 persons. As the ranking implies, this number exceeds the growth projected for even Davidson or Shelby counties. In terms of percentage population growth, Rutherford County is second in the state – 11.2%.

In 2017, the total service area had an estimated population of 485,746. Official sources indicate that the service area population will grow by approximately 8.5%, or 41,310 persons, by 2021. This is significantly higher growth than the 4.4% projected for Tennessee.

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

4) Existing similar service providers;

RESPONSE: Besides STRH, TriStar StoneCrest Medical Center is the only other medical-surgical hospital in the primary service area (Rutherford County). Each of the secondary service area counties also has a medical-surgical hospital. However, as the data indicates, STRH is approximately three times larger than the second largest service area medical-surgical hospital. This is true across a range of metrics – beds, admissions, patient days, average daily census. The other service area medical-surgical hospitals are simply not an alternative to the proposed project in terms of the level of care provided at STRH.

5) Project cost;

RESPONSE: The cost to construct 52,000 square feet of new space is $22,188,000. Total project costs are $47,478,943. Constructing two floors atop an existing patient bed tower (originally designed for vertical expansion) was deemed the least costly, most effective and most efficient alternative to address the very high utilization of hospital beds at STRH.

6) Funding;

RESPONSE: Funding for the project will come from Saint Thomas Health's corporate parent, Ascension.

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, STRH was financially feasible before the proposed bed addition and is expected to remain financially feasible with the proposed bed addition.

Coffee County – United Regional Medical Center (incl. Med Ctr of Manchester)

	2013	2014	2015	% change from 2013-2015
Licensed Beds	79	79	49	
Staffed Beds	51	51	36	
Admissions	2,160	1,914	1,136	
Patient Days	7,536	6,065	3,768	-50.0% (consolidated in 2015)
ADC	20	16	10	
ALOS	3.5	3.2	3.3	
%Staffed Occupancy	39.2%	31.4%	28.7%	
% Licensed Occupancy	25.3%	20.3%	21.1%	-16.6% or -4.2 pct pts

Warren County – Saint Thomas River Park Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	125	125	125	
Staffed Beds	125	125	125	
Admissions	3,207	2,935	2,875	
Patient Days	11,395	11,341	11,996	+5.3%
ADC	31	31	33	
ALOS	3.6	3.9	4.2	
%Staffed Occupancy	25.0%	24.9%	26.3%	
% Licensed Occupancy	25.0%	24.9%	26.3%	+5.2% or 1.3 pct pts

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: From the data reported below, it appears at least initially that inpatient bed utilization at STRH has remained relatively constant over the past three reporting years.

Rutherford County – Saint Thomas Rutherford Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	286	286	286	
Staffed Beds	268	268	285	
Admissions	16,176	15,642	15,873	
Patient Days	63,503	58,744	63,688	+0.3%
ADC	174	161	174	
ALOS	3.9	3.8	4.0	
% Staffed Occupancy	64.9%	60.1%	61.2%	
% Licensed Occupancy	60.8%	56.3%	61.0%	+0.3% or +0.2 pct pts

However, this is too simplistic a view of the true bed utilization at STRH. Even by expanding staffed beds to fully licensed capacity, STRH's true bed utilization has approached 90% utilization the past two years.

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With one of the busiest emergency departments in the state, STRH records more than 90,000 patient visits per year. Through a partnership with the University of Tennessee College of Medicine, STRH's emergency department is the home for the UT Emergency Medicine Residency Program. STRH is addressing short duration ED observation patient volumes outside the scope of this CON application.

Both growth in population and traffic congestion are major drivers in ED utilization and overall services at STRH. The largest physician group in the community, Murfreesboro Medical Clinic, is constantly adding providers to its staff and supports this bed expansion project. The Clinic sees over 30,000 patients per month. More significantly, the Clinic averages more than 1,429 new patients per month. This is one component driving incresed bed utilization at STRH.

Another component is the recently opened Saint Thomas Medical Partners – New Salem, a full-service care site designed to meet medical needs close to home. Saint Thomas is consistently exploring less costly outpatient alternatives to care, even if it results in less revenue for the health system.

Rutherford County is the fastest growing county in Tennessee. Despite the rapid population growth in the service area, STRH is projecting relatively modest gains in bed utilization – less than 1% per year overall – due to inpatient and observation bed hold conditions. Even at this rate, without additional beds, STRH will be runing 97.9% occupancy by 2019. Therefore, the major impact of this project is to reduce bed occupancy to a more manageable 80%, including outpatient and observation patients, thus averting many bed holds.

Rutherford County – Saint Thomas Rutherford Hospital

	2016 Actual	2017 Interim	2018 Interim	2019 Interim	2020 Year 1	2021 Year 2
Licensed Beds	286	286	286	286	358	358
Staffed Beds	286	286	286	286	358	358
Admissions	18,931	19,320	19,709	20,098	20,487	20,782
Patient Days	78,502	79,108	79,714	80,320	80,924	82,089
ADC	215	217	218	220	222	225
ALOS	4.1	4.1	4.0	4.0	4.0	4.0
% Staffed Occupancy	75.2%	76.1%	76.5%	77.2%	62.0%	62.8%
% Licensed Occupancy	75.2%	76.1%	76.5%	77.2%	62.0%	62.8%
Outpatients in Beds	60	60	60	60	60	60
Adjusted ADC	275	277	278	280	282	285
% Licensed Occupancy	96.2%	96.9%	97.2%	97.9%	78.8%	79.6%

SUPPLEMENTAL #1

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■ 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 CY Jan reported (Month).

	Year 2020	Year 2021
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **RESPONSE:** Units of measure are patient days.	80,924	82,089
B. Revenue from Services to Patients		
1. Inpatient Services	$808,078,000	$860,555,000
2. Outpatient Services	276,060,800	293,856,000
3. Emergency Services	414,091,200	440,784,000
4. Other Operating Revenue (Specify)_____	13,245,000	13,510,000
Gross Operating Revenue	$1,511,475,000	$1,608,705,000
C Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$1,055,559,600	$1,132,732,800
2. Provision for Charity Care	93,827,520	100,687,360
3. Provisions for Bad Debt	23,456,880	25,171,840
Total Deductions	$1,172,844,000	$1,258,592,000
NET OPERATING REVENUE	$338,631,000	$ 350,113,000
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	84,144,960	87,250,560
b. Non-Patient Care	3,506,040	3,635,440
2. Physician's Salaries and Wages	11,014,300	11,385,440
3. Supplies	48,235,000	51,076,000
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates	3,407,000	3,414,000
5. Management Fees:		
a. Paid to Affiliates	59,606,000	61,710,000
b. Paid to Non-Affiliates		
6. Other Operating Expenses	50,573,700	52,166,560
Total Operating Expenses	$ 260,487,000	$ 270,638,000
E. **Earnings Before Interest, Taxes and Depreciation**	$ 78,144,000	$ 79,475,000
F. Non-Operating Expenses		
1. Taxes	$_____	$_____
2. Depreciation	17,349,000	17,865,000
3. Interest	2,802,000	3,026,000
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	$ 20,151,000	$ 20,891,000
NET INCOME (LOSS)	$ 57,993,000	$ 58,584,000

Chart Continues Onto Next Page

SUPPLEMENTAL #1

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NET INCOME (LOSS)	$ 57,993,000	$ 58,584,000
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$	$
NET BALANCE	$ 57,993,000	$ 58,584,000
DEPRECIATION	17,349,000	17,865,000
FREE CASH FLOW (Net Balance + Depreciation)	$ 75,342,000	$ 76,449,000

■ Total Facility
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2020	Year 2021
1. Purchased Services	$ 28,170,000	$ 28,986,000
2. Provider Tax Expense	12,983,000	13,358,000
3. All Other	9,420,700	9,822,560
4.		
5.		
6.		
7.		
Total Other Expenses	**$ 50,573,700**	**$ 52,166,560**

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 2016	Current Year 2017	Year One 2020	Year Two 2021	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	16,494	15,656	18,678	19,597	25.18%
Deduction from Revenue *(Total Deductions/Utilization Data)*	12,208	11,782	14,493	15,332	30.13%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	4,286	3,874	4,185	4,265	10.10%

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: Data in the table above actually cover a six-year period, beginning in 2016 and ending in 2021. As indicated in the table above, the charges for services (discharges) at STRH will not be impacted significantly by the proposed project. Gross charges increase at 3.5% per year while net charges actually decrease by 0.1% per year.

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: The only medical-surgical hospital in the service area remotely comparable to STRH in terms of size and services is TriStar StoneCrest Medical Center. A comparison of the 2015 JAR data indicate an average gross charge per admission of $31,001 at STRH compared to $37,367 at StoneCrest.

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, STRH was financially feasible before the proposed bed addition and is expected to remain financially feasible with the proposed bed addition.

Funding for the project will come from Ascension, the parent of Saint Thomas Health. The substantial resources of this organization is documented in the attachments. See **Tab 12 – 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	23.8%	23.9%	23.6%	23.1%	22.7%

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 STRH and Saint Thomas Health is appropriately capitalized to undertake the proposed bed 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
Subtotal	24,020,656	23,942,746
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 hospital. Furthermore, STRH will follow the same financial assistance policies that are currently in place. Please refer to **Tab 13 – Attachment Section B-G** for a copy of the STRH financial assistance policies.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$ 705,858,825	46.7%
TennCare/Medicaid	155,681,925	10.3%
Commercial/Other Managed Care	467,045,775	30.9%
Self-Pay	137,544,225	9.1%
Other (Other gov't, Workers Comp)	45,344,250	3.0%
Total	$1,511,475,000	100.0%
Charity Care	93,827,520	6.2%

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 STRH before and after the proposed bed addition.

Position Classification	Existing FTEs (enter year) 2017	Projected FTEs Year 1 2020	Average Wage (Contractual Rate) 2020	Area Wide/Statewide Average Wage 2016
A. Direct Patient Care Positions				
RNs	522	+19 = 541	32.98	28.08
LPNs	10	+2 = 12	22.84	18.23
Tech	337	+10 = 347	15.07	11.46
PT/SP/OT/Resp Ther	55	+0 = 55	36.14	34.78
Social Worker	105	+0 = 105	32.34	28.98
Total Direct Patient Care Positions	1,029	+31 = 1,060		
B. Non-Patient Care Positions				
Management	36	+1 = 37	44.47	39.82
Clerical	7	+0 = 8	19.14	14.62
Total Non-Patient Care Positions	43	+1 = 44		
Total Employees *(A+B)*	1,072	1,104		
C. Contractual Staff				
Total Staff *(A+B+C)*	1,072	1,104		

RESPONSE: STRH 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: Constructing two floors atop an existing patient bed tower (originally designed for vertical expansion) was deemed the least costly, most effective and most efficient alternative to address the very high utilization of hospital beds at STRH.

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

RESPONSE: STRH is currently staffing all 286 of its 286 licensed beds. There are no alternatives to new construction.

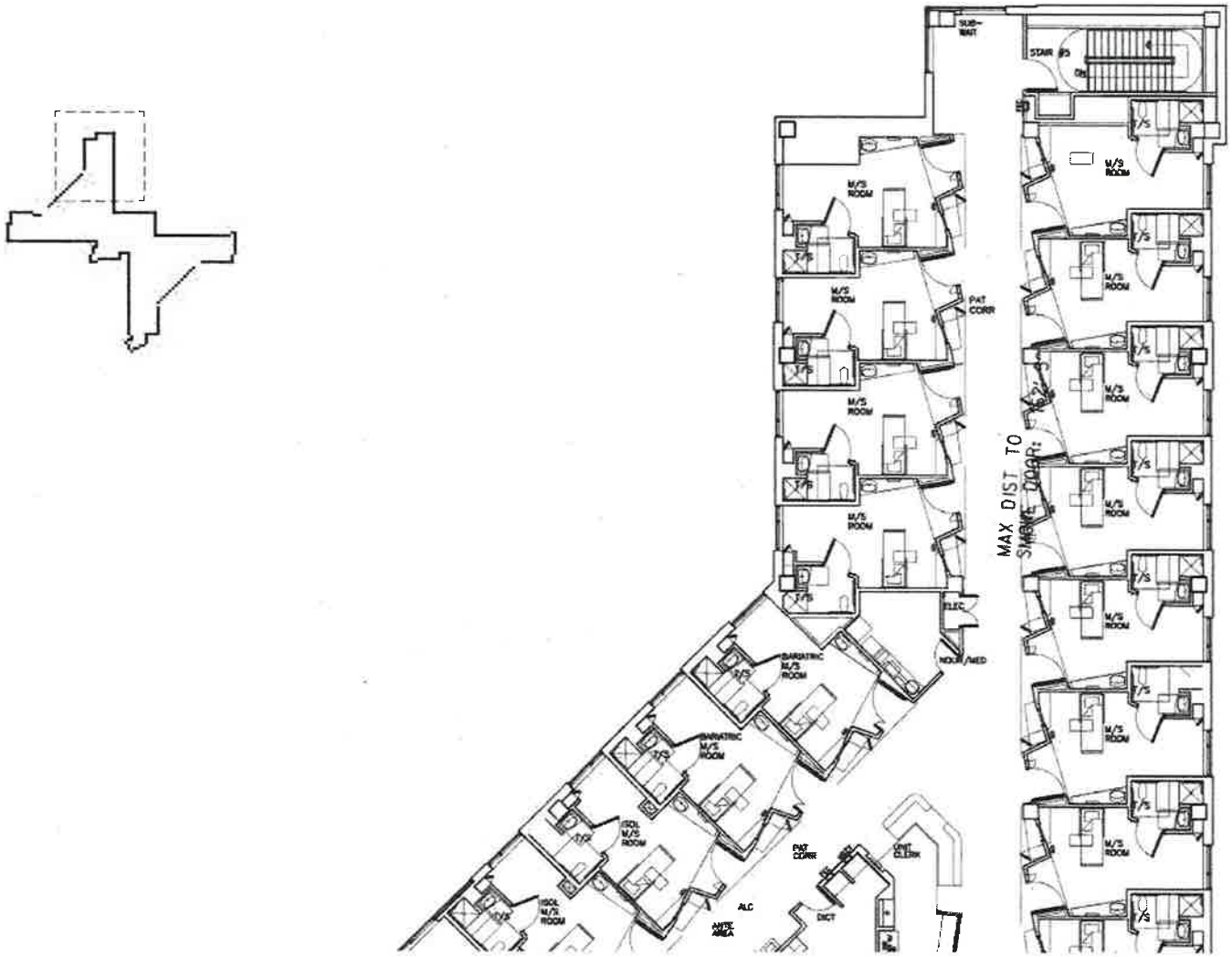
SECTION B: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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: STRH 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)*

Attachment 2



ST. THOMAS RUTHERFORD HOSPITAL - TOWER EXPANSION - TYP. 6TH/7TH FLOOR

NOT TO SCALE

7/26/17

SUPPLEMENTAL #1

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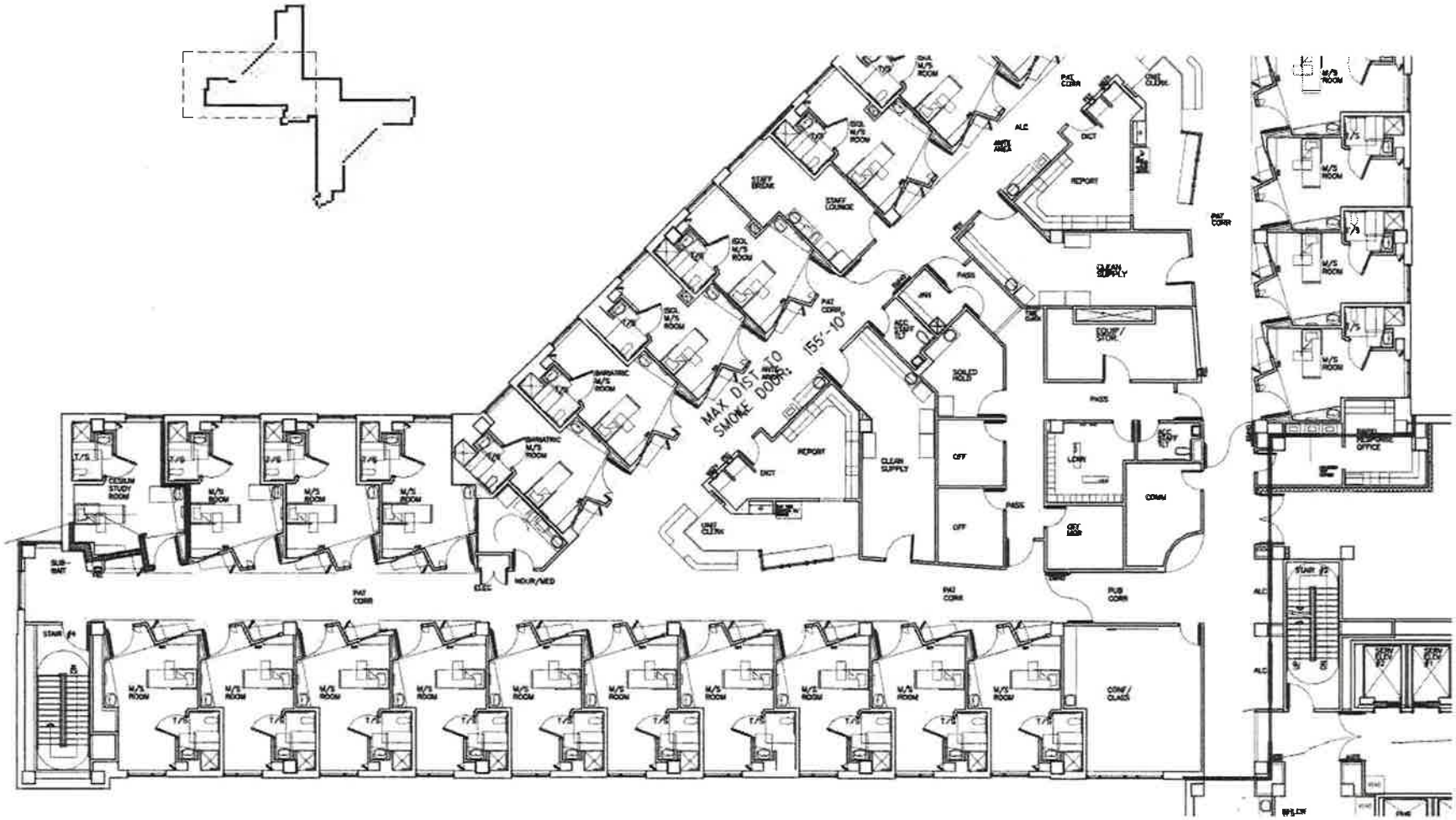

ST. THOMAS RUTHERFORD HOSPITAL - TOWER EXPANSION - TYP. 6TH/7TH FLOOR

NOT TO SCALE

7/26/17

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Attachment 3

HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
OCTOBER 26, 2016
APPLICATION SUMMARY

NAME OF PROJECT:	TrustPoint Hospital, LLC
PROJECT NUMBER:	CN1606-024
ADDRESS:	1009 North Thompson Lane Murfreesboro, TN (Rutherford County), TN 37129
LEGAL OWNER:	Acadia Healthcare Company, Inc. 6100 Tower Circle, Suite 1000 Franklin (Williamson County), TN 37067
OPERATING ENTITY:	N/A
CONTACT PERSON:	E. Graham Baker, Attorney (615) 370-3380
DATE FILED:	June 15, 2016
PROJECT COST:	$57,320,105
FINANCING:	Commercial Loan
PURPOSE FOR FILING:	The addition of 88 licensed psychiatric hospital beds

DESCRIPTION:

TrustPoint Hospital, LLC (formerly, SeniorHealth of Rutherford, LLC) is a general acute care hospital located in Murfreesboro (Rutherford County) TN, owned and managed by Acadia Healthcare Company, Inc. proposes to increase licensed inpatient beds from 129 to 217 beds as follows: Adult Psychiatric Beds for ages 18-64 will increase from 59 to 111 beds; and Geriatric Psychiatric Beds will remain at 36 beds; Medical Detoxification Beds will remain at 18 beds; Physical Rehabilitation Beds will increase from 16 beds to 24 beds; Child Psychiatric beds will increase from no beds to 14 beds; and Adolescent Beds will also increase from no beds to 14 beds. In addition to the requested 88 additional psychiatric beds, there will be (32) residential beds (not subject to CON review,

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9. **Bed Complement Data**

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

Response: Except for Licensed and Total line, the chart below represents STAFFED beds.

	Current Beds Licensed	Current Beds CON*	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A. Medical (Detox)	10	+8	10		18
B. Surgical					
C. Long-Term Care Hospital					
D Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric	44	+15	44	+52	111
I. Geriatric Psychiatric	28	+8	28		36
J. Child/Adolescent Psychiatric				+28	28
K. Rehabilitation	19	-3	19	+8	24
L. Nursing Facility (non-Medicaid Certified)					
M. Nursing Facility Level 1 (Medicaid only)					
N. Nursing Facility Level 2 (Medicare only)					
O. Nursing Facility Level 2 (dually-certified)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child & Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	101	28	101	+88	217

* CON Beds approved but not yet in service

Item J above: 14 Child Psychiatric Beds plus 14 Adolescent Beds

Another 32 residential beds, not subject to CON review, will be constructed to hospital standards.

11. Section C, Need, Item 1. (Service Specific Criteria-Acute Bed Services)

Please address the service specific criteria for acute bed services for the addition of acute beds to the hospital's license.

Response: Based on the data furnished by the TN Department of Health, Acute Care Bed Need Projections for 2016 and 2010, Based on Final 2014 Hospital JARS report, there is a shortage of 31 licensed hospital beds in Bedford County, and a shortage of 102 licensed hospital beds in Rutherford County, for a total of 133 "needed" hospital beds in the two counties. This application is to add 88 beds at Trustpoint Hospital.

However, the beds being requested are not general med-surg beds, but will be utilized as psychiatric and rehab beds. Therefore, the Applicant respectfully replies that the Service Specific Criteria for Acute Bed Services are not applicable to this project.

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work due to disability and premature death are directly tied to serious mental illness (USDHHS, 2014). The impact on the individual, their families, businesses and communities is staggering and resonates as a *call-to-action* to ensure high quality mental health services are available to meet the needs of this at-risk population.

According to USDHHS (2014), the most recent data for prevalence of serious mental illness among the pre-teen and teenage population (12-17 years) indicates that major depression affects 9.1% of the population and requires intensive treatment. Suicide attempts and completed suicides for this same population are a staggering 1.9 per 100 pre-teen and teenagers in the general population. Placing these numbers in perspective, the United States Census Bureau reported that 25% of the population living in Rutherford county, or approximately 74,653 pre-teen and teenagers, and 26.2% of the population living in Bedford County, or 11,838 pre-teen and teenagers, are in this high risk group for major depression and suicide (USCB, 2015). This information translates to combined pre-teen and teenage major depression for both counties of more than 7,870 pre-teens and teenagers and suicide attempts and successful suicides of more than 864 pre-teens and teenagers (USDHHS). These staggering numbers reflect the tremendous need for child and adolescent services for the residents of Rutherford and Bedford counties.

As a leader in health care delivery that considers the whole person, mind, body, and spirit, TrustPoint Hospital provides or arranges a full spectrum of inpatient and outpatient services to meet the clinical needs of its patients, their loved ones, and professional colleagues. In support of this mission, TrustPoint Hospital actively participates with and supports the local chapters of the American Heart Association, Alzheimer's Association, United Way, the Family Center and a host of other important partners that seek to strengthen the health and wellbeing of our community. Additionally, TrustPoint Hospital sponsors various support groups for patients, families, and caregivers to ensure best outcomes and sustained wellness. Located adjacent to St. Thomas Rutherford Hospital, TrustPoint Hospital and St. Thomas Rutherford Hospital have developed a very close and collaborative relationship in which we share best practices, policy development, interventions, staff training, shared medical staff, and community response and action planning in the event of a natural or other disaster. **Importantly, the services provided at TrustPoint Hospital are a direct and natural complement to the important and life sustaining services provided at St. Thomas Rutherford Hospital. TrustPoint Hospital and St. Thomas Rutherford Hospital do not, *in any way*, compete for services.**

Attachment 4

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■ 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 CY Jan reported (Month).

		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.	57,127	66,567	78,502
B.	Revenue from Services to Patients			
	1. Inpatient Services	$ 463,131,361	$ 550,171,044	$ 658,073,091
	2. Outpatient Services	306,484,464	341,935,627	342,868,123
	3. Emergency Services	179,833,849	192,610,130	214,926,111
	4. Other Operating Revenue *(Provider Tax, JV Imaging, USPI)*	12,711,815	13,212,264	13,138,168
	Gross Operating Revenue	$ 962,161,489	$1,097,929,065	$1,229,005,493
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$ 639,973,486	$ 739,881,294	$ 829,540,194
	2. Provision for Charity Care	48,738,222	52,925,661	75,100,095
	3. Provisions for Bad Debt	16,440,606	19,829,756	20,276,736
	Total Deductions	$ 705,152,314	$ 812,636,711	$ 924,917,025
NET OPERATING REVENUE		$ 257,009,175	$ 285,292,354	$ 304,088,468
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Direct Patient Care	$ 64,941,293	71,988,473	77,953,112
	b. Non-Patient Care	2,705,887	2,999,520	3,248,046
	2. Physician's Salaries and Wages	5,963,118	6,829,013	8,591,535
	3. Supplies	34,177,396	38,918,207	40,859,772
	4. Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates	3,607,725	3,298,565	3,314,231
	5. Management Fees:			
	a. Paid to Affiliates	36,159,231	43,726,719	51,082,626
	b. Paid to Non-Affiliates			
	6. Other Operating Expenses	48,205,725	49,349,241	47,122,863
	Total Operating Expenses	$195,760,375	$217,109,738	$232,172,185
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 61,248,800	$ 68,182,616	$ 71,916,283
F.	Non-Operating Expenses			
	1. Taxes	$	$	$
	2. Depreciation	21,004,272	20,385,133	16,988,133
	3. Interest	1,934,343	1,928,631	1,969,776
	4. Other Non-Operating Expenses			
	Total Non-Operating Expenses	$ 22,938,615	$ 22,313,764	$ 18,957,909
NET INCOME (LOSS)		$ 38,310,185	$ 45,868,852	$ 52,958,374

Chart Continues Onto Next Page

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NET INCOME (LOSS)	$ 38,310,185	$ 45,868,852	$ 52,958,374
G. Other Deductions			
1. Annual Principal Debt Repayment	$_____	$_____	$_____
2. Annual Capital Expenditure	_____	_____	_____
Total Other Deductions	$_____	$_____	$_____
NET BALANCE	$ 38,310,185	$ 45,868,852	$ 52,958,374
DEPRECIATION	21,004,272	20,385,133	16,988,133
FREE CASH FLOW (Net Balance + Depreciation)	$ 59,314,457	$ 66,253,985	$ 69,946,507

■ Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2014	Year 2015	Year 2016
1. Purchased Services	$ 21,273,122	$ 23,319,233	$ 26,147,847
2. Provider Tax Expense	18,498,669	16,658,601	10,526,695
3. All Other	8,433,934	9,371,407	10,448,321
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	**$48,205,725**	**$49,349,241**	**$47,122,863**

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Attachment 5

SUPPLEMENTAL #1
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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

SUPPLEMENTAL #1
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Ascension

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2016 and 2015

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Building a better working world

Ernst & Young LLP
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St. Louis, MO 63105-3434

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ey.com

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

A member firm of Ernst & Young Global Limited

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.

SUPPLEMENTAL #1
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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.

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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.

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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

SUPPLEMENTAL #1
July 26, 2017
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Ascension

Consolidated Statements of Cash Flows (continued)

(Dollars in Thousands)

	Year Ended June 30, 2016	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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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	Year Ended June 30, 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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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 %

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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	June 30, 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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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:

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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)

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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 %

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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)

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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.

Ascension

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

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

SUPPLEMENTAL #1

July 26, 2017
2:40 pm

Supplementary Information

SUPPLEMENTAL #1
July 26, 2017
2:40 pm

Building a better working world

Ernst & Young LLP
The Plaza in Clayton
Suite 1300
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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

SUPPLEMENTAL #1
July 26, 2017
2:40 pm

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	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

SUPPLEMENTAL #1
July 26, 2017
2:40 pm

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.

SUPPLEMENTAL #1
July 26, 2017
2:40 pm

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).

SUPPLEMENTAL #1
July 26, 2017
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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.

SUPPLEMENTAL #1
July 26, 2017
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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.

SUPPLEMENTAL #1
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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 %

Attachment 6

SUPPLEMENTAL #1
July 26, 2017
2:40 pm

Official Accreditation Report

Saint Thomas Rutherford Hospital
1700 Medical Center Parkway
Murfreesboro, TN 37129

Organization Identification Number: 7883

Unannounced Full Event: 1/11/2016 - 1/13/2016

Report Contents

Executive Summary

Requirements for Improvement

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 either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. 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.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	01/11/2016-01/13/2016

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:

- 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.

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 either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. 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.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.01	EP8,EP15
	PC.01.03.01	EP1
	PC.02.01.03	EP1

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.03.05	EP13
	EC.02.05.09	EP3
	EC.02.06.01	EP1
	IC.02.01.01	EP1
	LS.02.01.10	EP4
	LS.02.01.30	EP11
	MS.01.01.01	EP5
	PC.01.02.03	EP8
	RC.01.01.01	EP19

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP1	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

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.02.05.01/EP8, EC.02.06.01/EP1	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.03.05/EP13, EC.02.05.09/EP3	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP4, LS.02.01.30/EP11	Standard

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CoP: §482.42 **Tag:** A-0747 **Deficiency:** Standard

Corresponds to: HAP - EC.02.05.01/EP15

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

Requirements for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.05

ESC 60 days

Standard Text: The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Element(s) of Performance:

13. Every 6 months, the hospital inspects any automatic fire-extinguishing systems in a kitchen. The completion dates of the inspections are documented.
Note 1: Discharge of the fire-extinguishing systems is not required.
Note 2: For additional guidance on performing inspections, see NFPA 96, 1998 edition.

4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 13
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
In 2 of 6 Kitchen Hood Life Safety Systems, OBSERVATION: During the document review on 1/11/2016, it was noted that the May 2015, semi-annual vendor report for the kitchen automatic extinguishing system indicated that the automatic natural gas shut-off valve was not tested.

OBSERVATION: During the document review on 1/11/2016, it was noted that the November 2015, semi-annual vendor report for the kitchen automatic extinguishing system indicated that the automatic natural gas shut-off valve was not tested

Observed in Document Review at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
In 2 of 6 Kitchen hood Life Safety Systems, OBSERVATION: During the document review on 1/11/2016, it was noted that the May 2015, semi-annual vendor report for the kitchen automatic extinguishing system indicated that the automatic electrical shut-off system was not tested.

OBSERVATION: During the document review on 1/11/2016, it was noted that the November 2015, semi-annual vendor report for the kitchen automatic extinguishing system indicated that the automatic electrical shut-off system was not tested.

Chapter:	Environment of Care
Program:	Hospital Accreditation
Standard:	EC.02.05.01 ESC 45 days
Standard Text:	The hospital manages risks associated with its utility systems.

Element(s) of Performance:

8. The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.

Scoring Category : A
Score : Insufficient Compliance

15. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies. (See also EC.02.06.01, EP 13)
Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in 'protective environment' rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 8
§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 Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
OBSERVATION: During the building tour on 1/11/2016 it was noted that circuit number 29 located in electrical distribution panel 7LSL1 was not listed on the panel legend, making the panel legend inaccurate.
NOTE: THIS DEFICIENCY WAS CORRECTED DURING THE SURVEY ON JANUARY 11 AND 12, 2016.

EP 15
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
OBSERVATION: During the building tour on 1/11/2016 it was noted that there was a Specimen Storage room in the Operating Room area which was being used as a storage room for chemicals to which exposure could cause cancer. This information was stated clearly on signage posted on the door to the room. When checked, the room had a positive pressure relationship to the corridor.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Element(s) of Performance:

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
In 2 of 2 medical gas shutoff valve panel checks, OBSERVATION: During the building tour on 1/12/2016 it was noted that the bulk oxygen source valve serving the DePaul and Seton buildings was not labeled.
NOTE: THIS DEFICIENCY WAS CORRECTED DURING THE SURVEY ON JANUARY 11 AND 12, 2016.

OBSERVATION: During the building tour on 1/12/2016 it was noted that the bulk oxygen source valve serving the main hospital building was not labeled with a description of what the valve served. The valve only had a sign that indicated it was a main shutoff valve.
NOTE: THIS DEFICIENCY WAS CORRECTED DURING THE SURVEY ON JANUARY 11 AND 12, 2016.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01

ESC 60 days

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.

Scoring Category : C
Score : Insufficient Compliance

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 Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
In 3 of 16 Cylinder Storage Room Checks, OBSERVATION: During the building tour on 1/11/2016 it was noted that the organization was storing oxygen and nitrous oxide cylinders in the OR storage room located between OR#2 and OR#3. Within this storage room there were two cylinder storage racks. One rack was labeled "Empty" and the other rack was labeled as a "Partial" rack. The signage on the Partial rack instructed staff to use this rack for cylinders that were between 2000 psi (full) and 500 psi (empty). These were non-inclusive pressure values, in other words, cylinders AT 2000 psi or 500 psi were not to be included in this rack.
Within this rack was located a mixture of cylinders, some with gauges showing full and others that were still sealed from the vendor and had never been used (also full), and ONE cylinder that had a gauge reading between the values of 2,000 psi and 500 psi. All cylinders but the one between 2,000 and 500 psi were full and not partial cylinders but were being stored in the Partial rack.
The organization was not following its own policy with regard to the proper storage of compressed gas cylinders.

OBSERVATION: During the building tour on 1/12/2016 it was noted that the organization was storing oxygen cylinders in room 2-OP-125. Within this storage room there were two cylinder storage racks. One rack was labeled "Empty" and the other rack was labeled as a "Partial" rack. The signage on the Partial rack instructed staff to use this rack for cylinders that were between 2000 psi (full) and 500 psi (empty). These were non-inclusive pressure values, in other words, cylinders AT 2000 psi or 500 psi were not to be included in this rack.
Within this rack was located a mixture of cylinders, some with gauges showing full and others that were still sealed from the vendor and had never been used (also full)i. All cylinders were full and not partial cylinders but were being stored in the Partial rack.
The organization was not following its own policy with regard to the proper storage of compressed gas cylinders. .

OBSERVATION: During the building tour on 1/12/2016 it was noted that the organization was storing oxygen cylinders in room 2-PA-115. Within this storage room there were two cylinder storage racks. One rack was labeled "Empty" and the other rack was labeled as a "Partial" rack. The signage on the Partial rack instructed staff to use this rack for cylinders that were between 2000 psi (full) and 500 psi (empty). These were non-inclusive pressure values, in other words, cylinders AT 2000 psi or 500 psi were not to be included in this rack.
Within this rack was located a mixture of cylinders, some with gauges showing full and others that were still sealed from the vendor and had never been used (also full)i. All cylinders were full and not partial cylinders but were being stored in the Partial rack.
The organization was not following its own policy with regard to the proper storage of compressed gas cylinders

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01

ESC 60 days

Standard Text: The hospital implements its infection prevention and control plan.

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1

Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site.
In 2 of 2 ice machines in patient care areas, while conducting a building tour of the emergency department it was observed that there were two ice machines in the patient care area that were grossly contaminated with biofilm in the delivery spouts for ice and water.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

ESC 60 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
In 2 of 20 fire barrier door checks, OBSERVATION: During the building tour on 1/11/2016 it was noted that door number 8-ME-100 to an elevator equipment room located on the 8th floor had no rating label. This door was located in a 2-hour fire-rated assembly and consequently, this door should have a fire protection rating of 90 minutes.

OBSERVATION: During the building tour on 1/11/2016 it was noted that door number 8-ME-101 to an elevator equipment room located on the 8th floor had no rating label. This door was located in a 2-hour fire-rated assembly and consequently, this door should have a fire protection rating of 90 minutes.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

ESC 60 days

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 fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door.
(For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 11
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
In 2 of 2 smoke barrier door checks, OBSERVATION: During the building tour on 1/12/2016 it was noted the corridor sliding doors to the ED Trauma#1 room did not have self-latching hardware. The ED area was not classified as a non-sleeping suite on the organizations Life Safety Drawing information.

OBSERVATION: During the building tour on 1/12/2016 it was noted the corridor sliding doors to the ED Trauma#2 room did not have self-latching hardware. The ED area was not classified as a non-sleeping suite on the organizations Life Safety Drawing information.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.01.01.01

ESC 60 days

Standard Text: Medical staff bylaws address self-governance and accountability to the governing body.

Element(s) of Performance:

5. The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5

Observed in Individual Tracer at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site.
While conducting an inpatient tracer of the surgical record, it was observed that the hand- written pre-operative History and Physical was performed without including the patient's vital signs as required on the form and as an element of the by-laws.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.03

ESC 60 days

Standard Text: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

Element(s) of Performance:

8. The hospital completes a functional screening (when warranted by the patient's needs or condition) within 24 hours after inpatient admission. (See also PC.01.02.01, EP 2; RC.02.01.01, EP 2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 8

Observed in Individual Tracer at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site.
In 2 of 6 tracers conducted, there was no evidence that the organization used criteria to determine when a more in depth or specialized functional evaluation would be indicated, and had used those criteria within 24 hours after inpatient admission.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

ESC 45 days

Standard Text: The hospital plans the patient's care.

Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
§482.23(b)(4) - (A-0396) - (4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at STRH Wound Care & Hyperbaric Medicine (1840 Medical Center Parkway, Seton Building Suite 404, Murfreesboro, TN) site for the Hospital deemed service.
In 2 of 2 patient records reviewed, the Plan of Care was not completed and did not reflect treatment and services needed based on the nursing assessment. The nurse stated this form was usually completed at the initial patient visit. Both patients had been seen multiple times for wound treatment. One patient's nutrition risk screening was scored at high risk indicating need for a nutrition referral. There was no evidence that a nutrition referral had been ordered.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.03

ESC 45 days

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).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1

Observed in Individual Tracer at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site.
In the review of a patient record, the administration of a 100cc bolus of normal saline during dialysis, was observed. There was no physician order for the administration of that normal saline bolus.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site.
While conducting a inpatient tracer of a surgical patient it was observed that there were two instances of the physician and one instance of the nurse not timing the operative consent and perioperative exam forms.

Observed in Individual Tracer at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
The immediate post operative note was signed by the physician, however neither the signature nor the form was timed or dated.

Observed in Individual Tracer at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway, Murfreesboro, TN) site for the Hospital deemed service.
During patient tracer medical review, an anesthesia evaluation was observed. It had not been dated or timed.

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP5
	IC.02.02.01	EP4
	LS.02.01.10	EP5
	LS.02.01.20	EP18
	MM.05.01.11	EP2

Opportunities for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway,Murfreesboro,TN) site.
While conducting the building tour of the pharmacy it was observed that there was no eyewash station within 10 seconds of the hazardous chemicals storage locker. The eyewash station in the department was behind a door in the sterile processing area for intravenous fluids. A plumbed sink was immediately adjacent to the locker.

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:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway,Murfreesboro,TN) site.
While conducting the building tour of the emergency department it was observed that the refrigerator in the patient nutrition area was dirty and had dried caked spilled food in the freezer and bottom of the refrigerator and crisper box.

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:

5. Doors required to be fire rated 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 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1 -11.4)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway,Murfreesboro,TN) site.
OBSERVATION: During the building tour on 1/12/2016 it was noted the double doors by room 2-OP-102 had a fire protection rating of 90 minutes and had a door gap greater than 1/8"

Chapter:	Life Safety
Program:	Hospital Accreditation
Standard:	LS.02.01.20
Standard Text:	The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

18. Suites of patient sleeping rooms are limited to 5,000 square feet, and suites used for other purposes are limited to 10,000 square feet. The suites are arranged so that no intervening rooms are hazardous areas. (See also LS.02.01.30, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.5.5-7)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP18
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway,Murfreesboro,TN) site.
OBSERVATION: During the building tour on 1/12/2016 it was noted the NICU area was designated as a patient sleeping suite on the organization's Life Safety Drawing information. The area of the suite was shown as 7,243 square feet. A sleeping suite cannot exceed 5,000 square feet.

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.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Building Tour at Saint Thomas Rutherford Hospital (1700 Medical Center Parkway,Murfreesboro,TN) site.
observed during a building tour of the Intensive Care Unit, the ward stock narcotic reconciliation log was missing the signature of the witness on two occasions, 7 December PM shift and 12 December AM shift.

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 4

Site: Saint Thomas Rutherford Hospital
Building Name: Hospital_HAP
PFI Id: 2015-01
Description:
Smoke curtain failed to deploy
ILSM Access: Yes
Projected Completion Date: 10/1/2015
Funds Committed: Yes
Accepted Date: 1/11/2016

Site: Saint Thomas Rutherford Hospital
Building Name: Hospital_HAP
PFI Id: 2015-02
Description:
Smoke curtain failed to deploy
ILSM Access: Yes
Projected Completion Date: 10/1/2015
Funds Committed: Yes
Accepted Date: 1/11/2016

Site: Saint Thomas Rutherford Hospital
Building Name: Hospital_HAP
PFI Id: 2015-03
Description:
Smoke curtain failed to deploy

ILSM Access:	Yes
Projected Completion Date:	10/1/2015
Funds Committed:	Yes
Accepted Date:	1/11/2016

Site:	Saint Thomas Rutherford Hospital
Building Name:	Hospital_HAP
PFI Id:	2015-04

Description:

Smoke curtain failed to deploy

ILSM Access:	Yes
Projected Completion Date:	10/1/2015
Funds Committed:	Yes
Accepted Date:	1/11/2016

SUPPLEMENTAL #1

July 26, 2017
2:40 pm

Attachment 7

2:40 pm

SUPPLEMENTAL #1

July 26, 2017
2:40 pm

JUL 26 '17 PM 2:39

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Saint Thomas Rutherford 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 26 day of July, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

Stephanie Lynch
NOTARY PUBLIC

My commission expires 9/10, 2018.

STEPHANIE LYNCH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

HF-0043

Revised 7/02

Supplemental #2

Saint Thomas Rutherford Hospital

CN1707-021

JUL 31 '17 AM 9:32

SUPPLEMENTAL #2
July 31, 2017
9:33 am

71 Vickery Street
Atlanta, Georgia 30075
Telephone 770-394-8465
Facsimile 770-394-5470
www.thestrategyhouse.net

July 31, 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 CN1707-021
Saint Thomas Hospital-Rutherford

Dear Mr. Earhart:

Thank you for your letter of July 28, 2017 acknowledging the receipt of our July 26, 2017 supplemental response for a Certificate of Need for the expansion of acute care beds by 72 beds from 198 beds to 270 beds, at Saint Thomas Rutherford Hospital ("STRH"), located at 1700 Medical Center Parkway, Murfreesboro (Rutherford County), TN 37129.

The following responses are provided for clarification or additional documentation. As requested, **this information is being submitted in triplicate prior to the 12:00 p.m., Monday, July 31, 2017 deadline.**

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1. **Section C, Need, Item 1. (Service Specific Criteria-Acute Bed Services)**

   It is noted the applicant did not include TrustPoint Hospital (licensed by the Department of Health) located in Murfreesboro (Rutherford County), TN in the acute bed need services criteria. Please note Service Specific Criteria-Acute Bed Services was addressed by TrustPoint Hospital in CN1606-024A in supplemental #2 of that application because TrustPoint Hospital, LLC is a general acute care hospital and **all** beds at TrustPoint hospital count in the acute bed formula since the beds are licensed by the Department of Health.

RESPONSE: Thank you for clarifying the licensure status, i.e., Department of Health versus Department of Mental Health. Additional information is provided here for TrustPoint Hospital, as requested.

Please note, too, that the Department of Health has classified STRH as a "Med-Surg" hospital while it classified TrustPoint in the "Other" category, thus highlighting a fundamental difference in the services provided at both facilities. Please see excerpts from the Department of Health's last three years annual Report for Hospitals in **Attachment 1**.

Please include TrustPoint Hospital in the responses to the service specific criteria-acute bed services and revise any responses (narrative, charts, tables, etc.) in the application and submit replacement pages.

RESPONSE: Replacement pages are provided in **Attachment 2**.

According to the acute bed formula, what is the licensed and staffed shortage/surplus for the proposed service area for 2017 and 2021?

RESPONSE: The source for information summarized below, including TrustPoint Hospital, is found at Tab 9 in the original application. These official bed need projections do include TrustPoint.

DOH Bed Need Projections - STRH Service Area

	Projected Beds		Actual Beds		Projected Surplus		Projected Surplus	
	(a) 2017 Need	(b) 2021 Need	(c) 2015 Licensed	(d) 2015 Staffed	(a-c) 2017 Licensed	(a-d) 2017 Staffed	(b-c) 2021 Licensed	(b-d) 2021 Staffed
Rutherford	390	430	496	494	-106	-104	-66	-64
Bedford	27	28	60	52	-33	-25	-32	-24
Cannon	24	24	60	50	-36	-26	-36	-26
Coffee	93	95	209	163	-116	-70	-114	-68
Warren	46	47	125	125	-79	-79	-78	-78
Total	580	624	950	884	-370	-304	-326	-260

As illustrated above, the official bed need formula results in a projected surplus of beds in the service area. Despite the extraordinary historical and projected population growth in Rutherford County, this same need projection methodology has produced very erratic results for Rutherford County. This is discussed in the CON application text and will not be repeated here,

2. **Section C, Need, Item 1. (Service Specific Criteria-Acute Bed Services) Item 2.a.**

The list of all existing hospital's occupancy levels based on the number of licensed beds that are staffed for two consecutive years listing which ones meet or do not meet an occupancy level greater than or equal to 80% is noted. However, please include TrustPoint Hospital in the response.

RESPONSE: Despite an increase in utilization, none of the eight service area hospitals has had occupancy levels greater than or equal to 80% as shown on the following tables. However, as explained in the CON application, STRH qualifies for special consideration.

Service Area Hospitals: Licensed Beds and Occupancy Rates

Hospital	Licensed Beds		Occupancy Rate	
	2014	2015	2014	2015
Saint Thomas Rutherford	286	286	56.3%	61.0%
TriStar StoneCrest	109	109	43.9%	45.9%
TrustPoint Hospital	96	101	60.2%	72.2%
Heritage Medical Center	60	60	28.4%	27.4%
Saint Thomas Stones River	60	60	22.0%	24.9%
Harton Regional	135	135	41.6%	41.7%
United Regional	79	49	21.0%	21.1%
Saint Thomas River Park	125	125	24.9%	26.3%
TOTAL	**950**	**925**	**42.2%**	**46.3%**

Source: TN HSDA Joint Annual Reports, as shown on CON pages 28-R and 29-R

Service Area Hospitals: Staffed Beds and Occupancy Rates

Hospital	Staffed Beds		Occupancy Rate	
	2014	2015	2014	2015
Saint Thomas Rutherford	268	285	60.1%	61.2%
TriStar StoneCrest	109	109	43.9%	45.9%
TrustPoint Hospital	96	100	60.2%	72.9%
Heritage Medical Center	52	52	32.8%	31.6%
Saint Thomas Stones River	50	50	26.4%	30.0%
Harton Regional	107	115	52.5%	48.9%
United Regional	51	36	32.6%	28.7%
Saint Thomas River Park	125	125	24.9%	26.3%
TOTAL	**858**	**872**	**46.7%**	**49.1%**

Source: TN HSDA Joint Annual Reports, as shown on CON pages 28-R and 29-R

According to the most recent JAR published by the Tennessee Department of Health, how many licensed and staffed acute care beds are in the applicant's service area, and what was the overall licensed and staffed bed occupancy for those beds?

RESPONSE: According to the 2015 JAR, there were 925 licensed beds and 872 staffed beds with respective occupancies of 46.3% and 49.1% in the applicant's service area.

3. **Section C, Need, Item 1. (Service Specific Criteria-Acute Bed Services) Item 2.b.**

It appears there are TrustPoint Hospital outstanding projects involving acute beds in the proposed service area. Please discuss the number and type of beds that are outstanding.

RESPONSE: STRH is not affiliated with TrustPoint through ownership, management, etc. STRH is aware that TrustPoint held a groundbreaking ceremony on July 25, 2017 for a bed expansion project but is not aware of the proposed completion date.

As indicated in STRH Supplemental 1, Attachment 3, TrustPoint requested approval for the following bed changes: +8 medical detox, +15 adult psychiatric, +8 geriatric psychiatric and -3 rehabilitation.

The Agency's October 26, 2016 Agenda results reports approval conditioned as follows: "Limited to an additional 52 Adult Psychiatric Beds, 8 Physical Rehabilitations *(sic)* Beds, 14 Adolescent Psychiatric beds, and 14 Child Psychiatric beds."

While STRH will defer to the Agency's own internal records and progress reports for additional information, it is clear that the TrustPoint beds are very different than the medical-surgical beds proposed by STRH. Approval of the STRH project will not duplicate beds approved for the TrustPoint project.

4. **Section B, Economic Feasibility, Item F. (2) and Item F (3)**

The capitalization ratio is noted. However, the applicant incorrectly listed the capitalization formula that is listed in the HSDA application. The formula for this ratio is: (Long-term debt/(Long-term debt+Total Equity (Net assets)) x 100). Please revise and include in replacement page 44.

RESPONSE: The division sign has been replaced with a plus sign. A replacement page (44-R) is provided in **Attachment 2**.

A notarized affidavit accompanies these responses and is found at **Attachment 3**. On behalf of Saint Thomas Rutherford 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 31, 2017
9:33 am

Attachment 1

REPORT 2A
REPORT FOR HOSPITALS 2015

HOSPITALS LICENSED IN TENNESSEE
SELECTED UTILIZATION BY TYPE OF HOSPITAL

MID-CUMBERLAND REGION

County	Facility	Type of Service	Staffed Beds	Discharge/ Inpatient Days	Staffed Bed Days Open	Staffed Beds Percent Occupancy	Licensed Beds	Licensed Bed Days Open	Licensed Beds Percent Occupancy	Discharges or Admissions	Average Length of Stay	Average Daily Census
		GENERAL HOSPITALS, SPECIALTY HOSPITALS, MEDICAL CENTERS										
REGION TOTAL			1,537	298,044	561,005	53.1	1,852	675,980	44.1	71,400	4.2	817
Cheatham	TriStar Ashland City Medical Center	Med-Surg	12	1,938	4,380	44.2	12	4,380	44.2	307	6.3	5
Dickson	TriStar Horizon Medical Center	Med-Surg	120	20,347	43,800	46.5	157	57,305	35.5	5,221	3.9	56
Houston	Houston County Community Hospital	Med-Surg	25	1,775	9,125	19.5	25	9,125	19.5	407	4.4	5
Humphreys	Three Rivers Hospital	Med-Surg	25	1,259	9,125	13.8	25	9,125	13.8	361	3.5	3
Montgomery	Gateway Medical Center	Med-Surg	172	35,816	62,780	57.1	270	98,550	36.3	9,804	3.7	98
Robertson	NorthCrest Medical Center	Med-Surg	62	11,186	22,630	49.4	109	39,785	28.1	2,899	3.9	31
Rutherford	Saint Thomas Rutherford Hospital	Med-Surg	285	63,688	104,025	61.2	286	104,390	61.0	15,873	4.0	174
	TriStar StoneCrest Medical Center	Med-Surg	109	18,252	39,785	45.9	109	39,785	45.9	5,208	3.5	50
	Trustpoint Hospital	Other	100	26,613	36,500	72.9	101	36,865	72.2	2,941	9.0	73
Sumner	Portland Medical Center	Other	0	0	0	--	38	13,870	0.0	0	#Num!	0
	Sumner Regional Medical Center	Med-Surg	121	36,470	44,165	82.6	155	56,575	64.5	8,079	4.5	100
	TriStar Hendersonville Medical Center	Med-Surg	99	20,052	36,135	55.5	110	40,150	49.9	5,879	3.4	55
Trousdale	Trousdale Medical Center	Other	12	1,483	4,380	33.9	25	9,125	16.3	345	4.3	4
Williamson	Williamson Medical Center	Med-Surg	150	30,647	54,750	56.0	185	67,525	45.4	8,582	3.6	84
Wilson	McFarland Hospital	Psych	75	8,268	27,375	30.2	75	27,375	30.2	965	8.6	23
	University Medical Center	Med-Surg	170	20,250	62,050	32.6	170	62,050	32.6	4,529	4.5	55
		MENTAL HEALTH INSTITUTES, MENTAL HEALTH CENTERS										
REGION TOTAL			111	29,560	40,515	73.0	111	40,515	73.0	3,511	8.4	81
Montgomery	Behavioral Healthcare Center at Clarksville	Psych	26	4,109	9,490	43.3	26	9,490	43.3	275	14.9	11
Williamson	Rolling Hills Hospital	Psych	85	25,451	31,025	82.0	85	31,025	82.0	3,236	7.9	70

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SUPPLEMENTAL #2
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REPORT 2A
REPORT FOR HOSPITALS 2014

HOSPITALS LICENSED IN TENNESSEE
SELECTED UTILIZATION BY TYPE OF HOSPITAL

MID-CUMBERLAND REGION

County	Facility	Type of Service	Staffed Beds	Discharge/ Inpatient Days	Staffed Bed Days Open	Staffed Beds Percent Occupancy	Licensed Beds	Licensed Bed Days Open	Licensed Beds Percent Occupancy	Discharges or Admissions	Average Length of Stay	Average Daily Census
		GENERAL HOSPITALS, SPECIALTY HOSPITALS, MEDICAL CENTERS										
REGION TOTAL			1,654	289,234	603,710	47.9	1,847	674,155	42.9	69,867	4.1	792
Cheatham	TriStar Ashland City Medical Center	Med-Surg	12	1,613	4,380	36.8	12	4,380	36.8	276	5.8	4
Dickson	TriStar Horizon Medical Center	Med-Surg	120	19,198	43,800	43.8	157	57,305	33.5	4,668	4.1	53
Houston	Houston County Community Hospital	Med-Surg	25	2,527	9,125	27.7	25	9,125	27.7	546	4.6	7
Humphreys	Three Rivers Hospital	Med-Surg	25	1,282	9,125	14.0	25	9,125	14.0	372	3.4	4
Montgomery	Gateway Medical Center	Med-Surg	220	36,792	80,300	45.8	270	98,550	37.3	9,784	3.8	101
Robertson	NorthCrest Medical Center	Med-Surg	66	12,263	24,090	50.9	109	39,785	30.8	2,937	4.2	34
Rutherford	Saint Thomas Rutherford Hospital	Med-Surg	285	58,744	104,025	56.5	286	104,390	56.3	15,642	3.8	161
	TriStar StoneCrest Medical Center	Med-Surg	109	17,480	39,785	43.9	109	39,785	43.9	5,277	3.3	48
	Trustpoint Hospital	Other	96	21,095	35,040	60.2	96	35,040	60.2	2,418	8.7	58
Sumner	Portland Medical Center	Other	0	0	0	--	38	13,870	0.0	0	#Num!	0
	Sumner Regional Medical Center	Med-Surg	155	36,733	56,575	64.9	155	56,575	64.9	8,142	4.5	101
	TriStar Hendersonville Medical Center	Med-Surg	99	19,295	36,135	53.4	110	40,150	48.1	5,692	3.4	53
Trousdale	Trousdale Medical Center	Other	12	2,133	4,380	48.7	25	9,125	23.4	450	4.7	6
Williamson	Williamson Medical Center	Med-Surg	185	29,465	67,525	43.6	185	67,525	43.6	7,989	3.7	81
Wilson	McFarland Hospital	Psych	75	9,055	27,375	33.1	75	27,375	33.1	1,036	8.7	25
	University Medical Center	Med-Surg	170	21,559	62,050	34.7	170	62,050	34.7	4,638	4.6	59
		MENTAL HEALTH INSTITUTES, MENTAL HEALTH CENTERS										
REGION TOTAL			111	29,879	40,515	73.7	111	40,515	73.7	3,503	8.5	82
Montgomery	Behavioral Healthcare Center at Clarksville	Psych	26	5,213	9,490	54.9	26	9,490	54.9	318	16.4	14
Williamson	Rolling Hills Hospital	Psych	85	24,666	31,025	79.5	85	31,025	79.5	3,185	7.7	68

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SUPPLEMENTAL #2
July 31, 2017
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REPORT 2A
REPORT FOR HOSPITALS 2013

HOSPITALS LICENSED IN TENNESSEE
SELECTED UTILIZATION BY TYPE OF HOSPITAL

MID-CUMBERLAND REGION

County	Facility	Type of Service	Staffed Beds	Discharge/ Inpatient Days	Staffed Bed Days Open	Staffed Beds Percent Occupancy	Licensed Beds	Licensed Bed Days Open	Licensed Beds Percent Occupancy	Discharges or Admissions	Average Length of Stay	Average Daily Census
		GENERAL HOSPITALS, SPECIALTY HOSPITALS, MEDICAL CENTERS										
REGION TOTAL			1,602	286,264	584,730	49.0	1,837	670,505	42.7	69,510	4.1	784
Cheatham	TriStar Ashland City Medical Center	Med-Surg	12	1,397	4,380	31.9	12	4,380	31.9	197	7.1	4
Dickson	TriStar Horizon Medical Center	Med-Surg	120	18,892	43,800	43.1	157	57,305	33.0	4,533	4.2	52
Houston	Houston County Community Hospital	Med-Surg	25	2,454	9,125	26.9	25	9,125	26.9	616	4.0	7
Humphreys	Three Rivers Hospital	Med-Surg	25	1,420	9,125	15.6	25	9,125	15.6	404	3.5	4
Montgomery	Gateway Medical Center	Med-Surg	220	36,609	80,300	45.6	270	98,550	37.1	9,804	3.7	100
Robertson	NorthCrest Medical Center	Med-Surg	66	13,916	24,090	57.8	109	39,785	35.0	3,230	4.3	38
Rutherford	Saint Thomas Rutherford Hospital	Med-Surg	268	63,503	97,820	64.9	286	104,390	60.8	16,176	3.9	174
	TriStar StoneCrest Medical Center	Med-Surg	109	16,254	39,785	40.9	109	39,785	40.9	5,124	3.2	45
	Trustpoint Hospital	Other	86	14,232	31,390	45.3	86	31,390	45.3	1,516	9.4	39
Sumner	Portland Medical Center	Other	0	0	0	--	38	13,870	0.0	0	#Num!	0
	Sumner Regional Medical Center	Med-Surg	133	32,682	48,545	67.3	155	56,575	57.8	7,529	4.3	90
	TriStar Hendersonville Medical Center	Med-Surg	97	20,567	35,405	58.1	110	40,150	51.2	5,828	3.5	56
Trousdale	Trousdale Medical Center	Other	11	1,880	4,015	46.8	25	9,125	20.6	427	4.4	5
Williamson	Williamson Medical Center	Med-Surg	185	30,171	67,525	44.7	185	67,525	44.7	7,981	3.8	83
Wilson	McFarland Hospital	Psych	75	9,864	27,375	36.0	75	27,375	36.0	1,065	9.3	27
	University Medical Center	Med-Surg	170	22,423	62,050	36.1	170	62,050	36.1	5,080	4.4	61
		MENTAL HEALTH INSTITUTES, MENTAL HEALTH CENTERS										
REGION TOTAL			106	30,643	38,690	79.2	106	38,690	79.2	3,384	9.1	84
Montgomery	Behavioral Healthcare Center at Clarksville	Psych	26	6,486	9,490	68.3	26	9,490	68.3	326	19.9	18
Williamson	Rolling Hills Hospital	Psych	80	24,157	29,200	82.7	80	29,200	82.7	3,058	7.9	66

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SUPPLEMENTAL #2
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Attachment 2

Following these guidelines, STRH and the Rutherford County hospitals served patients from 21 counties in 2015.

In terms of the population, Rutherford County leads the state of Tennessee (number one ranking of 95 counties) in projected population growth from 2017 to 2021 – 36,154 persons.[1] As the ranking implies, this number exceeds the growth projected for even Davidson or Shelby counties. In terms of percentage population growth, Rutherford County is second in the state – 11.2%.

This official acute care bed need projection methodology is currently under review for revision by the Agency. Across the entire state, only two counties have any projected need for licensed beds – Polk and Washington. Despite the extraordinary historical and projected population growth in Rutherford County, a surplus of 66 beds is projected for 2021.

In the past, this same need projection methodology has produced very erratic results for Rutherford County. Just three years ago (based on 2012 JARs), Rutherford County had an average daily census of 220 and a current year need projection of 275 beds. The current projections (based on 2015 JARs), report an average daily census of 297 patients and a current year need projection of 371 beds.

Stated differently, the Rutherford County actual official hospital average daily census increased by 77 patients (297 – 220). The current year hospital bed need projection increased by 96 beds (371-275). From this perspective alone, the STRH request for 72 additional licensed acute care beds, projected four years out, is not unreasonable. With additional documentation, STRH will demonstrate that its request for 72 additional licensed acute care beds is necessary to maintain quality and cost-effective hospital services in Rutherford County and the larger tertiary referral area.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

   a. All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

      RESPONSE: Despite an increase in utilization, this guideline has not been met at the eight service area hospitals, as shown on the following table. However, as explained below, STRH qualifies for special consideration.

      In addition, the existing medical-surgical beds at STRH have been operating at nearly 90% utilization, resulting in inpatient/observation bed holds. This is a result of multiple factors: (1) increasing inpatient utilization from Rutherford County, (2) increasing inpatient in-migration from throughout the region, (3) increasing observation patient utilization and (4) increasing observation patient utilization exceeding 24 hours.

[1] Davidson County is number two, followed by Williamson County at number three.

Service Area Hospitals: Staffed Beds and Occupancy Rates

Hospital	Staffed Beds		Occupancy Rate	
	2014	2015	2014	2015
Saint Thomas Rutherford	268	285	60.1%	61.2%
TriStar StoneCrest	109	109	43.9%	45.9%
TrustPoint Hospital	96	100	60.2%	72.9%
Heritage Medical Center	52	52	32.8%	31.6%
Saint Thomas Stones River	50	50	26.4%	30.0%
Harton Regional	107	115	52.5%	48.9%
United Regional	51	36	31.4%	28.7%
Saint Thomas River Park	125	125	24.9%	26.3%
TOTAL	**858**	**872**	**46.7%**	**49.1%**

Source: TN HSDA Joint Annual Reports, as shown on CON pages 28-R and 29-R.

Rutherford County - TriStar StoneCrest Medical Center

	2013	2014	2015	% change from 2013-2015
Licensed Beds	109	109	109	
Staffed Beds	109	109	109	
Admissions	5,124	5,277	5,208	
Patient Days	16,254	17,480	18,252	+12.3%
ADC	45	48	50	
ALOS	3.2	3.3	3.5	
%Staffed Occupancy	40.9%	43.9%	45.9%	
% Licensed Occupancy	40.9%	43.9%	45.9%	+12.2% or 5.0 pct pts

Rutherford County – TrustPoint Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	86	96	101	
Staffed Beds	86	96	100	
Admissions	1,527	2,418	2,941	
Patient Days	14,451	21,095	26,613	+84.2%
ADC	40	58	73	
ALOS	9.5	8.7	9.0	
%Staffed Occupancy	46.0%	60.2%	72.9%	
% Licensed Occupancy	46.0%	60.2%	72.2%	+57.0% or 26.2 pct pts

Bedford County – Heritage Medical Center

	2013	2014	2015	% change from 2013-2015
Licensed Beds	60	60	60	
Staffed Beds	60	52	52	
Admissions	1,930	1,793	1,594	
Patient Days	5,723	6,220	6,002	+4.9%
ADC	16	17	16	
ALOS	3.0	3.5	3.8	
%Staffed Occupancy	26.1%	32.8%	31.6%	
% Licensed Occupancy	26.1%	28.4%	27.4%	+5.0% or 1.3 pct pts

Cannon County – Saint Thomas Stones River Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	60	60	60	
Staffed Beds	50	50	50	
Admissions	696	794	840	
Patient Days	4,525	4,816	5,469	+20.9%
ADC	12	13	15	
ALOS	6.5	6.1	6.5	
%Staffed Occupancy	24.8%	26.4%	30.0%	
% Licensed Occupancy	20.7%	22.0%	25.0%	+20.8% or 4.3 pct pts

Coffee County – Harton Regional Medical Center

	2013	2014	2015	% change from 2013-2015
Licensed Beds	135	135	135	
Staffed Beds	107	107	115	
Admissions	4,815	4,834	4,742	
Patient Days	19,549	20,521	20,532	+5.0%
ADC	54	56	56	
ALOS	4.1	4.2	4.3	
%Staffed Occupancy	50.1%	52.5%	48.9%	
% Licensed Occupancy	39.7%	41.6%	41.7%	+5.0% or 2.0 pct pts

Coffee County – United Regional Medical Center (incl. Med Ctr of Manchester)

	2013	2014	2015	% change from 2013-2015
Licensed Beds	79	79	49	
Staffed Beds	51	51	36	
Admissions	2,160	1,914	1,136	
Patient Days	7,536	6,065	3,768	-50.0% (consolidated in 2015)
ADC	20	16	10	
ALOS	3.5	3.2	3.3	
%Staffed Occupancy	39.2%	32.6%	28.7%	
% Licensed Occupancy	25.3%	21.0%	21.1%	-16.6% or -4.2 pct pts

Warren County – Saint Thomas River Park Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	125	125	125	
Staffed Beds	125	125	125	
Admissions	3,207	2,935	2,875	
Patient Days	11,395	11,341	11,996	+5.3%
ADC	31	31	33	
ALOS	3.6	3.9	4.2	
%Staffed Occupancy	25.0%	24.9%	26.3%	
% Licensed Occupancy	25.0%	24.9%	26.3%	+5.2% or 1.3 pct pts

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: From the data reported below, it appears at least initially that inpatient bed utilization at STRH has remained relatively constant over the past three reporting years.

Rutherford County – Saint Thomas Rutherford Hospital

	2013	2014	2015	% change from 2013-2015
Licensed Beds	286	286	286	
Staffed Beds	268	268	285	
Admissions	16,176	15,642	15,873	
Patient Days	63,503	58,744	63,688	+0.3%
ADC	174	161	174	
ALOS	3.9	3.8	4.0	
% Staffed Occupancy	64.9%	60.1%	61.2%	
% Licensed Occupancy	60.8%	56.3%	61.0%	+0.3% or +0.2 pct pts

However, this is too simplistic a view of the true bed utilization at STRH. Even by expanding staffed beds to fully licensed capacity, STRH's true bed utilization has approached 90% utilization the past two years.

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	23.8%	23.9%	23.6%	23.1%	22.7%

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 STRH and Saint Thomas Health is appropriately capitalized to undertake the proposed bed 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
Subtotal	24,020,656	23,942,746
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 hospital. Furthermore, STRH will follow the same financial assistance policies that are currently in place. Please refer to **Tab 13 – Attachment Section B-G** for a copy of the STRH financial assistance policies.

SUPPLEMENTAL #2

July 31, 2017
9:33 am

Attachment 3

SUPPLEMENTAL #2
July 31, 2017
9:33 am

JUL 31 '17 AM 9:33

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Saint Thomas Rutherford 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 31 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.

HF-0043

Revised 7/02

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