COPY

-Application

St. Thomaas Midtown Hospital

CN1412-049

DEC 15 '14 PM 1:00

SATELLITE EMERGENCY DEPARTMENT
IN
BRENTWOOD, DAVIDSON COUNTY

CERTIFICATE OF NEED APPLICATION
DECEMBER 2014

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate *"N/A."* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

For Section A, Item 1, *Facility Name* ***must be*** *applicant facility's name and address* ***must be*** *the site of the proposed project.*

For Section A, Item 3, *Attach a copy of the partnership agreement, or corporate charter* ***and*** *certificate of corporate existence, if applicable, from the Tennessee Secretary of State.*

For Section A, Item 4, *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% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in* Tennessee Code Annotated, §68-11-1602 *in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.*

For Section A, Item 5, *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.*

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, *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.

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

Saint Thomas Midtown Hospital (Emergency Department at Brentwood)
Name

791 Old Hickory Boulevard	Davidson	
Street or Route	County	
Brentwood	Tennessee	37027
City	State	Zip Code

2. ***Contact Person Available for Responses to Questions***

Blake Estes		Executive Director, Strategy & Planning	
Name		Title	
Saint Thomas Health		Blake.Estes@stthomas.org	
Company Name		Email address	
102 Woodmont Boulevard, Suite 800	Nashville	Tennessee	37205
Street or Route	City	State	Zip Code
Exec. Director, Strategy & Planning		615-284-3990	615-284-7403
Association with Owner		Phone Number	Fax Number

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

Saint Thomas Midtown Hospital		615-284-6869
Name		Phone Number
102 Woodmont Blvd, Suite 800		Davidson
Street or Route		County
Nashville	Tennessee	37205
City	State	Zip Code

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

A.	Sole Proprietorship	_____	F.	Governmental (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		_____	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

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

Name

Street or Route

County

City

ST

Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

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

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

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

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

A.	Hospital (Specify) Acute Care	X	I.	Nursing Home	____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	____	J.	Outpatient Diagnostic Center	____
C.	ASTC, Single Specialty	____	K.	Recuperation Center	____
D.	Home Health Agency	____	L.	Rehabilitation Facility	____
E.	Hospice	____	M.	Residential Hospice	____
F.	Mental Health Hospital	____	N.	Non-Residential Methadone Facility	____
G.	Mental Health Residential Treatment Facility	____	O.	Birthing Center	____
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)	____	P.	Other Outpatient Facility (Specify)	____
			Q.	Other (Specify) _____	____

8. **Purpose of Review *(Check as appropriate--more than one response may apply)***

A.	New Institution	____	G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	____
B.	Replacement/Existing Facility	____			
C.	Modification/Existing Facility	____			
D.	Initiation of Significant Health Care Service as defined in TCA § 68-11-1607(4) (Specify) Emergency Dept	X	H.	Change of Location	____
E.	Discontinuance of OB Services	____	I.	Other (Specify) Add Satellite Emergency Department	X
F	Acquisition of Equipment	____			

9. **Bed Complement Data**

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

		Current Beds Licensed	Current Beds *CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical	355		147		355
B.	Surgical (General Med/Surg)	102		96		102
C.	Long-Term Care Hospital					
D.	Obstetrical	104		97		104
E.	ICU/CCU	46		37		46
F.	Neonatal	52		52		52
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation	24		24		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 Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	683		453		683

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** 044-0133

Certification Type Acute Care Hospital

11. **Medicaid Provider Number** 044-0133

Certification Type Acute Care Hospital

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** N/A

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or *plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

RESPONSE: Midtown Hospital participates in the major TennCare MCOs serving the majority of the patients in the area: UnitedHealthcare Community Plan and Amerigroup. Final negotiations with TennCare Select and BlueCare are expected to be completed by January 1, 2015. In the meantime, these patients are still authorized at Midtown Hospital and out of network rates are accepted until fully contracted. In total, Midtown Hospital participates in approximately 44 managed care organizations/behavioral health organizations. Please see **Attachment A,13 (Tab 6)** for a list of managed care contracts in which Midtown Hospital participates.

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE: Please see the following executive summary.

CREATE A SATELLITE EMERGENCY DEPARTMENT ("ED") IN BRENTWOOD, DAVIDSON CO., ADJACENT TO PREMIER RADIOLOGY (CN1203-014A)

APPLICANT OVERVIEW: For more than 90 years, Saint Thomas Midtown Hospital ("Midtown Hospital") has been devoted to physical, emotional and spiritual healing. Midtown Hospital is among the largest not-for-profit regional tertiary referral centers in Middle Tennessee, licensed for 683 acute and rehab care beds. Midtown Hospital's heritage of healing is one of continuous growth, community service and superior care. Recent achievements in clinical care include:

- Nation's 100 Top Hospitals by Thomson Reuters and 100 Top Hospitals Everest Award
- Three-Year Approval with Commendation from the Commission on Cancer of the American College of Surgeons

EXISTING RESOURCES. Saint Thomas Health's Emergency Departments are designated full-service EDs for all of the surrounding communities. EDs are staffed with board-certified emergency medicine physicians and experienced registered nurses that provide patients immediate access to the most advanced diagnostic services and lifesaving care available.

Saint Thomas Health's emergency services include accredited Chest Pain Centers at each hospital location, and specialized treatment for stroke, as well as a vast array of illness and injury. Whether a patient has an emergency, accident or suffers a traumatic injury, Saint Thomas Health provides holistic care for the body, mind and spirit.

Saint Thomas Health's EDs provide advanced care 24 hours a day, seven days a week with several notable designations:

- Dedicated Chest Pain Center by the Society of Chest Pain Centers
- On call 24 / 7 / 365 Cardiac Interventionalist Physician

- Designated as an Advanced Primary Stroke Center by The Joint Commission
- Dedicated Primary Pediatrics Care

Saint Thomas Emergency Medical Services ("STEMS") offers emergency medical transportation services in the Middle Tennessee area. STEMS has critical care paramedics for safe and reliable ALS transport of critically ill patients. STEMS also provides quality medical coverage at sporting events (such as Titans NFL football and local high school football games), concerts at L.P. Field, CMA Music Festival, graduations, and more.

In Brentwood, adjacent to the proposed Satellite ED, Saint Thomas Health is the majority owner of Middle Tennessee Imaging, LLC ("MTI"), a/k/a Premier Radiology Brentwood. This full-service imaging center provides x-ray, ultrasound, CT, MRI, bone densitometry, cardiac calcium scoring CT, coronary CTA, lung screening CT, mammography, PAD screening, pain management and wellness imaging.

Proposed Services and Equipment: Midtown Hospital is not proposing any new services or CON reviewable equipment. As described more fully in the need section below, this project is to add eight Satellite Emergency Department treatment rooms (including one "flex" psychiatric room and one trauma room) in Brentwood to the existing 25 treatment rooms and 11 "fast track" rooms at Midtown Hospital and the 29 treatment rooms at West Hospital. Additionally, one existing ambulance and crew will be reassigned from the STEMS fleet to the Brentwood Satellite ED. 24/7 imaging services will be provided under contract by MTI/Premier Radiology Brentwood.

Ownership Structure: Midtown Hospital is a member of Nashville-based Saint Thomas Health, which is part of Ascension Health. Ascension Health is a Catholic organization that is the largest not-for-profit health system in the United States. Other members of Saint Thomas Health include Saint Thomas West Hospital in Nashville, Saint Thomas Rutherford Hospital in Murfreesboro and Saint Thomas Hickman Hospital in Centerville. In Brentwood, Saint Thomas Health is the majority owner of Middle Tennessee Imaging, LLC ("MTI"). The proposed project will not result in a change in ownership structure.

Service Area: Davidson and Williamson counties are the top two inpatient referral sources for both Midtown Hospital and West Hospital. Based on historical patient origin data and area driving distances/times, Midtown Hospital's service area for this Satellite ED project is comprised of nine zip codes (including three with post office boxes only) primarily in Davidson and Williamson counties.

37024 – PO Boxes in 37027	37027 – Brentwood/Nashville	37064 – Franklin
37065 – PO Boxes in 37064	37067 – Franklin	37068 – PO Boxes in 37064
37069 – Franklin	37135 – Nolensville	37179 – Thompson's Station

Midtown Hospital and West Hospital also draw 29.7% of their Williamson County ED patients from another four zip codes in the Williamson County area – 37014, 37046, 37062 and 38476. However, due to location and road access, these zip codes are not expected to result in many referrals to the proposed Brentwood Satellite ED.

Need: The proposed Satellite ED is in full alignment with Saint Thomas Health's long term goal of accountable care in partnership with MissionPoint Health Partners. Rather than traveling to downtown, urban Nashville for treatment, this project brings convenient, accessible healthcare services to Middle Tennessee communities so patients can receive healthcare closer to where they live and work. Specific needs include:

- Better meet community demand for emergency services – Population growth from 2014 to 2019 in Davidson and Williamson counties will generate demand for 15 additional treatment rooms at the same time that West Hospital will lose two treatment rooms to provide space for a CT scanner and TriStar Centennial Medical Center will reduce its treatment rooms by four.

- Reduce high utilization of existing ED treatment rooms – Both Midtown Hospital and West Hospital have very active emergency services today. Rather than expanding for the future on site at the existing downtown hospitals, a satellite ED location will better distribute vital resources throughout the service area.

- Improve patient flow and operational efficiency – By adding ED capacity to the healthcare delivery system, this Satellite ED project will help improve patient treatment times for Davidson and Williamson county residents whether they seek care locally or now travel to Midtown Hospital and West Hospital.

- Improve quality of care – With emergency services, every minute counts. Saint Thomas Health and its emergency services team members seek to bring their experience and expertise closer to the patient in order to improve the patient experience and outcomes.

PROJECT COST: The total estimated cost of the proposed project is $6,757,172 (actual capital costs of $4,373,972 plus fair market value land lease payments of $2,383,200). Project costs include $2,477,683 for new construction (plus $208,125 for related site work) of 9,250 square feet of space. Construction cost per square foot is $268 ($290 with related site work). The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

FUNDING: Midtown Hospital will fund the project through centralized and unrestricted cash reserves held by Saint Thomas Health.

FINANCIAL FEASIBILITY: Midtown Hospital expects that construction will be completed and the project will be operational by July 2016. Projections for FY2017 and FY2018 indicate that the project is financially feasible. As explained below, this project is being proposed in order to improve access to care and quality of care without increasing charges to government and third-party payors.

STAFFING: This project will be staffed with the assistance of the 39 existing board-certified emergency medicine physician groups now providing services at Midtown Hospital and West Hospital. This project will require only a modest increase in total staff, approximately 30.3 new FTEs. Saint Thomas Health's salaries and wages are competitive with the market. Saint Thomas Health has a history of successfully recruiting and retaining professional and administrative staff.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

RESPONSE: This project involves construction of 9,250 square feet of new space, to be connected to an existing, affiliated imaging center – Premier Radiology Brentwood (CN1203-014A). Eight emergency department treatment rooms will be created, including one including one "flex" psychiatric room and one trauma room. Space will also support one full-time ambulance and crew from Saint Thomas Health's existing fleet.

The total estimated cost of the proposed project is $6,757,172 (actual capital costs of $4,373,972 plus fair market value land lease payments of $2,383,200). Project costs include $2,477,683 for new construction (plus $208,125 for related site work) of 9,250 square feet of space. Construction cost per square foot is $268 ($290 with related site work). The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

No temporary relocation is required.

B. Identify the number and type of beds increased, decreased, converted, relocated,designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

RESPONSE: Not applicable. The proposed project does not affect the total bed complement at the hospital.

Square Footage Exhibit

A. Unit/Department	Existing Location	Existing Sq. Ft.	Temporary Location	Proposed Final Location	Proposed Final Sq. Footage			Proposed Final Cost/Sq. Ft.*		
					Renovated	New	Total	Renovated	New	Total
Public Area	N/A	N/A	N/A	791 OHB	N/A	856	856	N/A	$290	$290
Patient Intake Area	N/A	N/A	N/A	791 OHB	N/A	490	490	N/A	$290	$290
Ambulance Entry	N/A	N/A	N/A	791 OHB	N/A	853	853	N/A	$290	$290
Main Clinical Treatment Areas	N/A	N/A	N/A	791 OHB	N/A	2,206	2,206	N/A	$290	$290
Clinical Support Spaces	N/A	N/A	N/A	791 OHB	N/A	2,416	2,416	N/A	$290	$290
Ancillary Support Areas	N/A	N/A	N/A	791 OHB	N/A	845	845	N/A	$290	$290
Staff Support Areas	N/A	N/A	N/A	791 OHB	N/A	710	710	N/A	$290	$290
B. Unit/Dept GSF Sub-Total	**N/A**	**N/A**	**N/A**	**791 OHB**		**8,375**	**8,375**	**N/A**	**$290**	**$290**
C. Mechanical/Electrical GSF	**N/A**	**N/A**	**N/A**	**791 OHB**		**449**	**449**	**N/A**	**$290**	**$290**
D. Circulation/Structure GSF	**N/A**	**N/A**	**N/A**	**791 OHB**		**426**	**426**	**N/A**	**$290**	**$290**
E. Total GSF	**N/A**	**N/A**	**N/A**			**9,250**	**9,250**	**N/A**	**$290**	**$290**

*$268/sq.ft. (excluding site work)

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

RESPONSE: Not applicable. Midtown Hospital is not requesting new services or additional pieces of major medical equipment.

D. Describe the need to change location or replace an existing facility.

RESPONSE: This project involves the expansion of Midtown Hospital's existing emergency department services to a second location in Brentwood, Davidson County. It is expected to serve patients primarily from portions of Davidson and Williamson counties.

Renovating and enlarging the existing emergency departments at either Midtown Hospital or West Hospital is not a more viable option. Although major construction is now taking place at West Hospital, two emergency department treatment rooms are being lost to provide space for a CT scanner. As both downtown Nashville campuses become increasingly crowded, Saint Thomas Health has been actively pursuing a strategy of moving outpatient services into other areas of the surrounding communities. This is evidenced generally by the development of outpatient diagnostic services.

Emergency services are an essential hospital responsibility to the community. This proposal will enhance Saint Thomas Health's current service line by expanding emergency department capacity off the main hospital campus. This will accomplish two important goals. First, it will decompress services already limited by space constraints in downtown Nashville. Second, it will bring services closer to the communities where Midtown Hospital's patients now work and reside. This is vitally important for emergency services where ever minute counts.

With regard to this particular project, Saint Thomas Health is the majority owner of MTI's adjacent Premier Radiology Brentwood imaging center. Rather than duplicating expensive CT and MRI services at the proposed Satellite ED, Saint Thomas Health will expand existing imaging center hours of operation to 24/7 and thus save millions of dollars in duplicate equipment and construction costs.

Thus, this project addresses the site deficiencies of both Midtown Hospital's and West Hospital's existing downtown campuses and does so in a cost-effective approach by leveraging existing imaging services in Brentwood.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

   a. Describe the new equipment, including:
      1. Total cost; (As defined by Agency Rule).
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval.

   b. Provide current and proposed schedules of operations.

RESPONSE: Not applicable, as Midtown Hospital is not proposing to acquire any single piece of major medical equipment that exceeds $1.5 million or is a MRI, PET, extracorporeal lithotripter or linear accelerator.

2. For mobile major medical equipment:

   a. List all sites that will be served;
   b. Provide current and/or proposed schedule of operations;
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment; and
   e. List the owner for the equipment.

RESPONSE: Not applicable. No major mobile equipment is proposed.

3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not applicable. No major equipment is proposed.

III. **(A)** Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

RESPONSE: Please see **Attachment B, III.(A) (Tab 7)** that depicts the 0.78-acre site.

(B) 1. 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: Midtown Hospital's proposed Satellite ED site is conveniently located at 791 Old Hickory Boulevard, Brentwood, Davidson County, approximately 0.2 miles northeast of Exit 74 on I-65. The site is easily accessible by car. Saint Thomas Health will relocate an ambulance and crew to the site from its existing fleet. As a Satellite ED, patients are not expected to access the site via public transportation. The existing Premier Radiology Brentwood imaging center is adjacent to the proposed site and will provide expanded 24/7 coverage.

Please see **Attachment B, III.(B).1 (Tab 8)** for maps depicting the service area and the thoroughfares that connect Davidson and Williamson counties to the proposed site.

IV. 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 1/2" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

RESPONSE: Please see **Attachment B, IV (Tab 9)** for the floor plan schematics.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

RESPONSE: Not applicable. The project does not involve a Home Health Agency or Hospice.

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SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 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, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) 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. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

   RESPONSE: One category is applicable to the project and is addressed below.

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: Not applicable. The Midtown Hospital Satellite ED project does not include the addition of beds, services or medical equipment.

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 Midtown Hospital Satellite ED project does not include the relocation or replacement of an existing licensed health care institution.

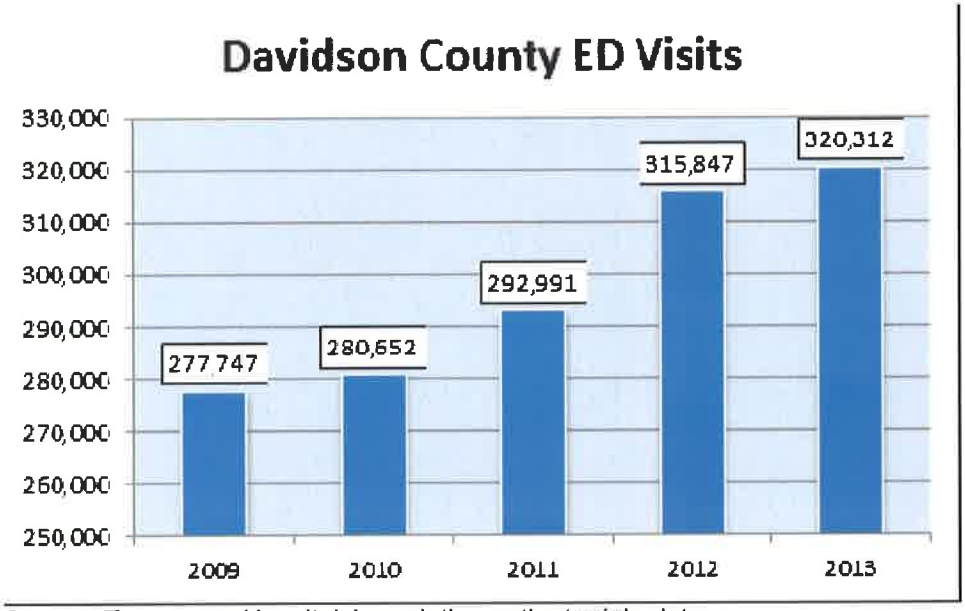
3. For renovation or expansions of an existing licensed health care institution:

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

RESPONSE: As illustrated below, Tennessee Hospital Association patient origin data indicate that emergency department visits have increased significantly throughout the proposed service area the past five years from 2009 to 2013.

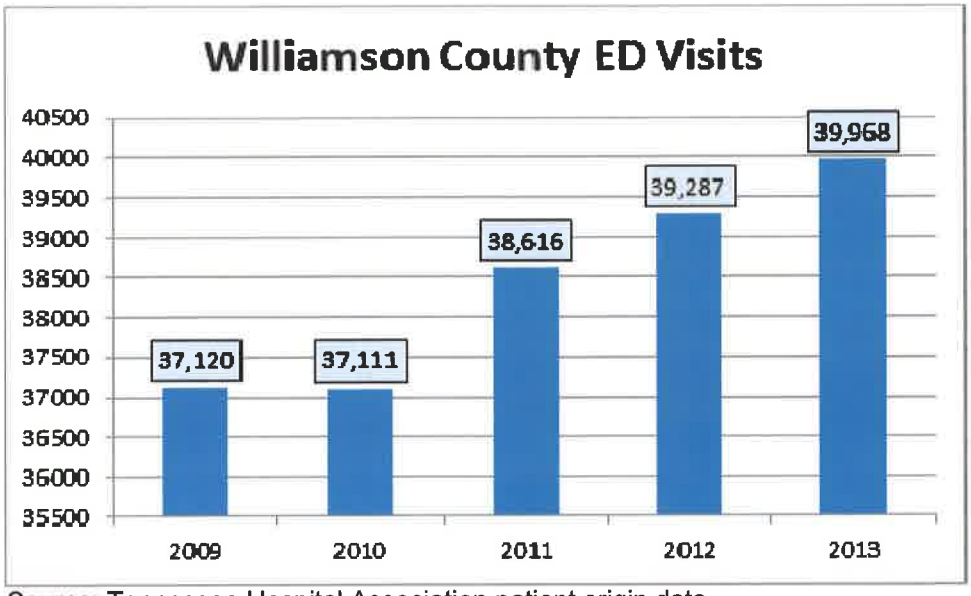
- Davidson County – 42,565 visits or 15.3%
- Williamson County – 2,848 visits or 7.7%
- 9 Zip Code Area – 2,695 visits or 8.5%

Exhibit 1



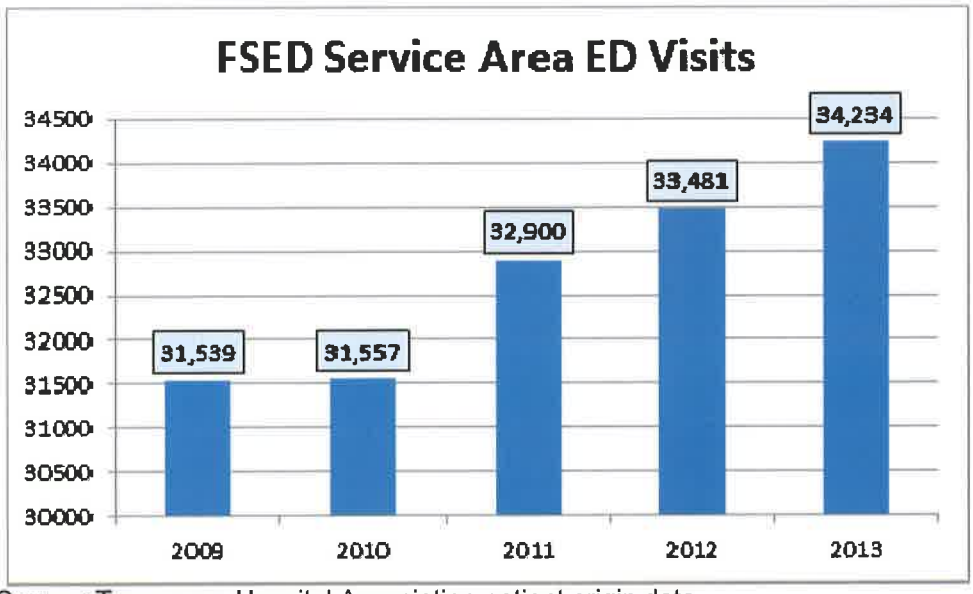
Source: Tennessee Hospital Association patient origin data

Exhibit 2



Source: Tennessee Hospital Association patient origin data

Exhibit 3



Source: Tennessee Hospital Association patient origin data

This robust growth in emergency department visits is projected to continue the next five years as well, from 2014 to 2019.

Based upon age cohort ED use rates for 2013, utilization within Williamson County is less than half that within the adjacent counties of Davidson and Maury as well as for the state of Tennessee overall.

Exhibit 4
ER Visits per 1,000 Population in Williamson County and Surrounding Areas

ER Visits by County and Age Cohort, 2013

Patient County	0-19	20-44	45-64	65+	Total
Davidson	71,337	134,985	74,649	39,951	320,922
Maury	9,878	17,057	9,860	7,075	43,870
Williamson	9,033	11,980	9,655	9,300	39,968
Total	**90,248**	**164,022**	**94,164**	**56,326**	**404,760**
Tennessee	717,489	1,250,214	745,892	533,636	3,247,231

Population by County and Age Cohort, 2013

Patient County	0-19	20-44	45-64	65+	Total
Davidson	161,587	259,218	156,751	71,951	649,507
Maury	21,324	25,982	22,799	11,924	82,029
Williamson	60,393	59,224	56,662	21,766	198,045
Total	**243,304**	**344,424**	**236,212**	**105,641**	**929,581**
Tennessee	1,670,916	2,158,175	1,748,746	950,177	6,528,014

ER Visits per 1,000 Population by County and Age Cohort, 2013

Patient County	0-19	20-44	45-64	65+	Total
Davidson	441.5	520.7	476.2	555.3	494.1
Maury	463.2	656.5	432.5	593.3	534.8
Williamson	149.6	202.3	170.4	427.3	201.8
Total	**370.9**	**476.2**	**398.6**	**533.2**	**435.4**
Tennessee	429.4	579.3	426.5	561.6	497.4

Sources: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics (6/13); THA Database 2013 data

Applying the age cohort ED use rates for 2013 to the 2019 projected population suggests that emergency department visits will continue to increase significantly throughout the proposed service area over the next five years from 2014 to 2019.

- Davidson County – 15,616 visits or 4.8%
- Williamson County – 6,245 visits or 15.2%
- Combined 2 Counties – 21,861 visits or 6.0%

Applying the Tennessee age cohort ED use rates for 2013 to the 2019 projected Williamson County population suggests even stronger projected growth – 71,804 visits. While this level of growth does not appear reasonable over so short a period of time, it does reflect the disparity of current ED use rates within Williamson County compared to Davidson and Maury counties and the state of Tennessee overall.

Exhibit 5

Projected Growth in ER Visits in Williamson and Davidson Counties

Projected ER Visits for 2 County Area, 2014 (at 2013 actual county Visits/1,000 rates)

	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	
Patient County	**2014 Pop**	**Visits/1,000**	**Proj Visits**	**2014 Pop**	**Visits/1,000**	**Proj Visits**	**2014 Pop**	**Visits/1,000**	**Proj Visits**	**2014 Pop**	**Visits/1,000**	**Proj Visits**	**2014 Pop**	**Proj Visits**
Davidson	164,744	441.5	72,731	259,374	520.7	135,066	157,892	476.2	75,192	74,375	555.3	41,297	656,385	324,286
Williamson	60,980	149.6	9,121	61,497	202.3	12,440	57,418	170.4	9,784	23,028	427.3	9,839	202,923	41,184
Total	225,724	370.9	81,852	320,871	476.2	147,506	215,310	398.6	84,976	97,403	533.2	51,136	**859,308**	**365,470**

Projected ER Visits for 2 County Area, 2019 (at 2013 actual county Visits/1,000 rates)

	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	
Patient County	**2019 Pop**	**Visits/1,000**	**Proj Visits**	**2019 Pop**	**Visits/1,000**	**Proj Visits**	**2019 Pop**	**Visits/1,000**	**Proj Visits**	**2019 Pop**	**Visits/1,000**	**Proj Visits**	**2019 Pop**	**Proj Visits**
Davidson	180,604	441.5	79,733	255,305	520.7	132,947	163,597	476.2	77,909	88,812	555.3	49,313	688,318	339,902
Williamson	63,833	149.6	9,548	74,423	202.3	15,054	61,525	170.4	10,484	28,889	427.3	12,343	228,670	47,429
Total	244,437	370.9	89,280	329,728	476.2	148,002	225,122	398.6	88,393	117,701	533.2	61,657	**916,988**	**387,331**
Williamson at TN Use Rate	*63,833*	*429.4*	*27,410*	*74,423*	*579.3*	*43,113*	*61,525*	*426.5*	*26,240*	*28,889*	*561.6*	*16,224*	*228,670*	*112,988*

Change in Projected Population and ER Visits for 2 County Area, 2014 - 2019

	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	
Patient County	**2019 Pop**	**Visits/1,000**	**Proj Visits**	**2019 Pop**	**Visits/1,000**	**Proj Visits**	**2019 Pop**	**Visits/1,000**	**Proj Visits**	**2019 Pop**	**Visits/1,000**	**Proj Visits**	**2019 Pop**	**Proj Visits**
Davidson	15,860		7,002	-4,069		-2,119	5,705		2,717	14,437		8,016	31,933	15,616
Williamson	2,853		427	12,926		2,615	4,107		700	5,861		2,504	25,747	6,245
Total	18,713		7,429	8,857		496	9,812		3,417	20,298		10,520	**57,680**	**21,861**
Williamson at TN Use Rate	*2,853*		*18,289*	*12,926*		*30,673*	*4,107*		*16,457*	*5,861*		*6,385*	*25,747*	*71,804*

Percent Change in Projected Population and ER Visits for 2 County Area, 2014 - 2019

	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total		Annual
Patient County	**Proj Pop**	**Visits/1,000**	**Proj Visits**	**Proj Pop**	**Visits/1,000**	**Proj Visits**	**Proj Pop**	**Visits/1,000**	**Proj Visits**	**Proj Pop**	**Visits/1,000**	**Proj Visits**	**Proj Pop**	**Proj Visits**	**Proj Visits**
Davidson	9.6%		9.6%	-1.6%		-1.6%	3.6%		3.6%	19.4%		19.4%	4.9%	4.8%	0.9%
Williamson	4.7%		4.7%	21.0%		21.0%	7.2%		7.2%	25.5%		25.5%	12.7%	15.2%	2.9%
Total	8.3%		9.1%	2.8%		0.3%	4.6%		4.0%	20.8%		20.6%	6.7%	6.0%	1.2%
Williamson at TN Use Rate	*4.7%*		*200.5%*	*21.0%*		*246.6%*	*7.2%*		*168.2%*	*25.5%*		*64.9%*	*12.7%*	*174.4%*	*22.4%*

Sources: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics (6/13); THA Database 2013 data

Within the proposed nine zip code service area, ED visits are projected to increase from 2014 to 2019 at the same rate as Williamson County overall – 2.9% per year. As illustrated below, this is an increase of 6,406 visits.

Exhibit 6
Midtown Hospital 9 Zip Code ED Visit Projections
With Increase From 2013 Baseline

Actual 2013	Projected 2014	Projected 2015	Year 1 2016	Year 2 2017	Year 3 2018	Year 4 2019
34,234	35,227	36,248	37,300	38,381	39,494	40,640
--	993	2,014	3,066	4,417	5,260	6,406

Based on a standard of 1,500 visits per treatment room per year from the American College of Emergency Physicians, this volume alone is sufficient to support five treatment rooms at 100% utilization or seven treatment rooms at 70% utilization. These treatment room projections would not take any patients away from existing providers and does not consider in-migration from surrounding areas such as other portions of Davidson County.

In summary, population growth alone from 2014 to 2019 is expected to generate demand for an additional 15,616 emergency department visits in Davidson County and 6,245 emergency department visits in Williamson County and (21,861 visits total). At 1,500 visits per treatment room at 100% capacity, population growth will generate demand for 15 additional treatment rooms. West Hospital will lose two treatment rooms to provide space for a CT scanner as part of a previously approved renovation project. TriStar Centennial Medical Center was just approved in October to reduce its treatment rooms by four.

While population growth will generate demand for 15 additional treatment rooms, six existing treatment rooms are coming off line at the same time. Thus, the utilization rates of existing providers in the service area are not expected to experience a negative effect on utilization as a result of Midtown Hospital's project.

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

RESPONSE: Renovating and expanding the existing emergency departments at either Midtown Hospital or West Hospital is not a more viable option than the proposal here. Although major construction is now taking place at West Hospital, two emergency department treatment rooms are being lost to provide space for a CT scanner. As both downtown Nashville campuses become increasingly crowded, Saint Thomas Health has been actively pursuing a strategy of moving outpatient services into other areas of the surrounding communities.

Emergency services are an essential hospital responsibility to the community. This proposal will enhance Saint Thomas Health's current facility options by expanding emergency department capacity off the main hospital campus. This will accomplish two important goals. First, it will decompress services already limited by space constraints in downtown Nashville. Second, it will bring services closer to the communities where Midtown Hospital's patients now reside. This is vitally important for emergency services where ever minute counts.

Rather than duplicating expensive CT and MRI services at the proposed Satellite ED location, Saint Thomas Health will expand existing imaging center hours of operation to 24/7 at the adjacent Premier Radiology Brentwood imaging center. Saint Thomas Health is the majority owner of this MTI facility. This approach will save millions of dollars by avoiding duplicate equipment and construction costs.

Thus, this project addresses the site deficiencies of both Midtown Hospital's and West Hospital's existing downtown campuses and does so in a cost-effective approach by leveraging existing imaging services in Brentwood.

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

RESPONSE: Not applicable. This project does not include a change of site for a health care institution but rather a second, satellite location.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

RESPONSE: For more than 90 years, Midtown Hospital has been devoted to physical, emotional and spiritual healing. Midtown Hospital is among the largest not-for-profit regional tertiary referral hospitals in Middle Tennessee, licensed for 683 acute and rehab care beds. Routine facility planning and refurbishment is a necessary part of maintaining quality hospital services. This is especially critical in such key service lines as emergency care.

The proposed Satellite ED is in full alignment with Saint Thomas Health's long term goal of accountable care in partnership with MissionPoint Health Partners. Rather than traveling to downtown, urban Nashville for treatment, this project brings convenient, accessible healthcare services to Middle Tennessee communities so patients can receive healthcare closer to where they live and work.

This project also is consistent with the following goals of Ascension Health and Midtown Hospital.

- Be a mission-focused, clinically integrated delivery system with a demonstrated ability to deliver high quality, low cost person-centered care.
- Extend the influence of our ministry and serve people more comprehensively in their communities.
- Successful integration will achieve four things: improved outcomes, enhanced patient experience, enhanced provider experience, reduced cost of care.
- Position the ministry to better respond to the unique needs of the communities we serve.

This project is part of Ascension's increased emphasis on delivering care in the most appropriate outpatient setting possible, as close to the patient and community as possible. Innovations in care delivery and reimbursement continue to favor outpatient settings over traditional inpatient-based settings.

These goals are also similar to the Five Principals for Achieving Better Health as articulated in the 2009 State Health Plan.

1. Healthy Lives. This project will improve the health of Tennesseans by bringing life-saving emergency services closer to their community, when every minute counts, as opposed to downtown Nashville.

2. Access to Care. This project will improve access to emergency services for Tennesseans by bringing life-saving emergency services closer to their community, where they live and work, as opposed to downtown Nashville.

3. Economic Efficiencies. Saint Thomas Health is the majority owner of MTI's adjacent Premier Radiology Brentwood imaging center. Rather than duplicating expensive CT and MRI services at the proposed Satellite ED, Saint Thomas Health will expand existing imaging center hours of operation to 24/7 and thus save millions of dollars in duplicate equipment and construction costs.

4. Quality of Care. Midtown Hospital will continue to improve its quality of care through the adoption of best practices and data-driven evaluation. The Satellite ED will rely on the experience and expertise of the 28 emergency department physicians now at Midtown Hospital and the 11 emergency department physicians now at West Hospital to support the Satellite ED. In addition, the Satellite ED will be supported through the basing of one ambulance and crew from STEMS.

5. Health Care Workforce. Midtown Hospital is committed to the recruitment and retention of a sufficient and quality health care workforce. In recent years, Midtown Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE: Based on historical patient origin data, Midtown Hospital's service area for this Satellite ED project is two counties – Davidson and Williamson.

As reported in the hospital's FY2013 patient origin data, this two county area represents 65.2% of Midtown Hospital's total 23,292 inpatient discharges – Davidson 13,574 discharges or 58.3% of total, Williamson 1,609 discharges or 6.9% of total. Davidson and Williamson counties are also the top two inpatient referral sources for both Nashville-based Midtown Hospital and West Hospital.

Similar patient origin referral patterns exist for emergency services as well, according to Tennessee Hospital Association patient origin data.

Exhibit 7
Williamson County Emergency Department Visits
At Saint Thomas Health

	2011	2012	2013
All Williamson Co			
All ED Patients, All Hospitals	38,616	39,287	39,968
Num Hospitals Serving Pats	112	105	112
Williamson Co Only at			
Midtown Hosp	1,341	1,377	1,237
West Hosp	2,607	2,476	2,360
Total	3,948	3,853	3,597
Facility Total (Tennessee)			
Midtown Hosp	46,867	48,613	45,178
West Hosp	31,084	31,552	29,793
Total	77,951	80,165	74,971
Pct Williamson Co			
Midtown Hosp	2.9%	2.8%	2.7%
West Hosp	8.4%	7.8%	7.9%
Total	5.1%	4.8%	4.8%

Source: Tennessee Hospital Association patient origin data

Based on these historical patient origin data and refined further by area driving distances/times, the proposed service area is defined by a subset of zip codes. Midtown Hospital's service area for this Satellite ED project is comprised of nine zip codes (including three with post office boxes only) primarily in Davidson and Williamson counties.

37024 – PO Boxes in 37027	37027 – Brentwood/Nashville	37064 – Franklin
37065 – PO Boxes in 37064	37067 – Franklin	37068 – PO Boxes in 37064
37069 – Franklin	37135 – Nolensville	37179 – Thompson's Station

Midtown Hospital and West Hospital also draw 29.7% of their Williamson County ED patients from another four zip codes in the Williamson County area – 37014, 37046, 37062 and 38476. However, due to location and road access, these zip codes are not expected to result in many visits to the proposed Brentwood Satellite ED.

Accounting for patient in-migration, approximately 10% of patients served are expected to reside outside the nine zip codes identified.

Please see **Attachment C, Need – 3 (Tab 10)** for county and zip code maps related to the service area.

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE: Midtown Hospital's Satellite ED service area is comprised of nine zip codes primarily within Davidson and Williamson counties.

Between 2014 and 2019, the population of the service area is projected to increase by 7.1%, or by 61,766 residents. This represents an annual growth rate of 1.4% and is greater than the projected growth rate of the state within that same five-year period, which is 0.7% annually, or 3.8% total growth, and twice the rate of growth of the United States as a whole. Please see **EXHIBIT 8,** which illustrates the projected changes in population of the service area between 2014 and 2019 and denotes population growth within the state of Tennessee, and the United States.

EXHIBIT 8
TOTAL POPULATION PROJECTIONS

	Total Population				
	2014	**2019**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	664,655	709,211	44,556	1.3%	6.7%
Williamson	199,481	216,691	17,210	1.7%	8.6%
Total Service Area	**864,136**	**925,902**	**61,766**	**1.4%**	**7.1%**
Tennessee	6,531,577	6,778,877	247,300	0.7%	3.8%
United States	317,199,353	328,309,464	11,110,111	0.7%	3.5%

SOURCE: NIELSEN, INC.

The anticipated growth in the 65 and older population within the service area is much greater; nearly four times that of the total growth. Between 2014 and 2019, projections indicate that the senior population will increase 27.9%, or by 27,515 residents. For Tennessee, projections are that the total five-year growth within this age cohort will be 19.3%, for the United States, 18.0%. Because seniors are among the highest users of healthcare services, such an explosive growth rate foretells the need for Midtown Hospital to anticipate increasing demand for services as result of this growth as well as that of the general population. Please see **EXHIBIT 9**.

EXHIBIT 9
65 AND OLDER POPULATION PROJECTIONS

	65+ Population				
	2014	**2019**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	75,873	95,113	19,240	4.6%	25.4%
Williamson	22,885	31,160	8,275	6.4%	36.2%
Total Service Area	**98,758**	**126,273**	**27,515**	**5.0%**	**27.9%**
Tennessee	968,443	1,155,791	187,348	3.6%	19.3%
United States	45,157,410	53,278,626	8,121,216	3.4%	18.0%

SOURCE: NIELSEN, INC.

B. 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: Midtown Hospital has a history of providing high quality healthcare that is accessible to all segments of the community. It provides services without regard to gender, race, socio-economic status, or ability to pay, and participates in the Medicare and TennCare programs.

In 2014, the 65 and older population will account for 11.4% of the total population in the service area. As a major demographic subgroup of Midtown Hospital's patient base, seniors will continue to expect of Midtown Hospital the same level of service while becoming an increasingly larger segment of the total service area population, with 2019 projections placing the 65 and older population at 13.6% of the total service area population.

The female population will represent 51.4% of the total population in the service area by 2019. As shown in **EXHIBIT 10**, the female population is expected to grow at the same annual rate for both sexes in service area, 1.4% per year.

EXHIBIT 10
FEMALE POPULATION PROJECTIONS

	Female Population				
	2014	**2019**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	342,524	364,539	22,015	1.3%	6.4%
Williamson	102,093	110,955	8,862	1.7%	8.7%
Total Service Area	**444,617**	**475,494**	**30,877**	**1.4%**	**6.9%**
Tennessee	3,345,908	3,468,589	122,681	0.7%	3.7%

SOURCE: NIELSEN, INC.

EXHIBITS 11-13 illustrate the racial composition of the Midtown Hospital service area. By 2019, the white population will comprise 67.3% of the total population of the service area, while the black population will account for 21.5% and other races, 11.2%.

EXHIBIT 11
WHITE POPULATION PROJECTIONS

	White Population				
	2014	**2019**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	408,515	436,103	27,588	1.3%	6.8%
Williamson	175,644	186,957	11,313	1.3%	6.4%
Total Service Area	**584,159**	**623,060**	**38,901**	**1.3%**	**6.7%**
Tennessee	5,008,888	5,123,236	114,348	0.5%	2.3%
United States	226,254,684	229,546,283	3,291,599	0.3%	1.5%

SOURCE: NIELSEN, INC.

EXHIBIT 12
BLACK POPULATION PROJECTIONS

	Black Population				
	2014	**2019**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	179,871	185,690	5,819	0.6%	3.2%
Williamson	10,334	13,670	3,336	5.8%	32.3%
Total Service Area	**190,205**	**199,360**	**9,155**	**0.9%**	**4.8%**
Tennessee	1,102,940	1,163,366	60,426	1.1%	5.5%
United States	40,263,108	42,033,755	1,770,647	0.9%	4.4%

SOURCE: NIELSEN, INC.

EXHIBIT 13
"OTHER" POPULATION PROJECTIONS

	Other Population				
	2014	**2019**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	76,269	87,418	11,149	2.8%	14.6%
Williamson	13,503	16,064	2,561	3.5%	19.0%
Total Service Area	**89,772**	**103,482**	**13,710**	**2.9%**	**15.3%**
Tennessee	419,749	492,275	72,526	3.2%	17.3%
United States	50,681,561	56,729,426	6,047,865	2.3%	11.9%

SOURCE: NIELSEN, INC.

The service area counties as a whole have a Median Household Incomes higher than the state of Tennessee. Likewise, the annual growth in median household income is higher than that of the state, which remains flat over the period. Please see **EXHIBIT 14.**

EXHIBIT 14
SERVICE AREA MEDIAN HOUSEHOLD INCOME

	Median Household Income	
	2014	**2019**
Davidson	$44,608	$47,370
Williamson	$86,706	$94,370
Total Service Area	**$65,657**	**$70,870**
Tennessee	$43,390	$43,130

SOURCE: NIELSEN, INC.

In terms of the TennCare population, 14.4% of the service area population is enrolled compared to 18.3% for the state overall. Please see **Attachment C, Need – 4 (Tab 11)**.

As a member of Ascension Health, the nation's largest Catholic healthcare system, Midtown Hospital continues to build and strengthen sustainable collaborative efforts that benefit the health of individuals, families, and society as a whole. The goal of Midtown Hospital is to perpetuate the healing mission of the church. Midtown Hospital furthers this goal through delivery of patient services, care to the elderly, indigent, and impoverished persons/families, patient education and health awareness programs for the community, and medical research. Our concern for the human life and dignity of all persons leads the organization to provide medical services to all people in the community without regard to the patient's race, creed, national origin, economic status, or ability to pay.

Midtown collaborates with many community organizations to improve the community health and expand access to health care including support for the Faith Family Clinic, an independent faith-based clinic for the poor located on the hospital campus at no cost to the clinic. In addition, Midtown continues to be active in networking with other healthcare providers in the Nashville area as part of the Bridges to Care (BTC) program, which links uninsured residents of Nashville to a network of some 35 safety net primary care, dental, mental health, and substance abuse clinics that serve patients based on their ability to pay. The Baptist UT (University of Tennessee) Resident Clinic housed on the Baptist campus is a BTC referral clinic. BTC also provides help with prescription medications and transportation. In the last year, the hospital's Health Ministry has encouraged physician participation in the Bridges to Care program. This program, administered by the Nashville Academy of Medicine, links BTC participants to physician specialists upon referral by their primary care physician. Midtown Hospital provides the appropriate inpatient care services as a participant of this program.

Midtown Hospital also participates in a program developed by Saint Thomas Health to assist in the provision of vital medications to those challenged by poverty called the Dispensary of Hope Program. This program started from a network of physician offices donating sample medications and has evolved to obtaining huge donations of medications from pharmaceutical companies and wholesale distributors. The expansion of the Dispensary as a region-wide program now allows broader and cost effective distribution of medications to persons who are poor through a collaborative network of pharmacies at existing healthcare providers. Medications are shared with safety net clinic sites and the Bridges to Care program, as well as with many of the transplant patients of the hospital who would otherwise not be able to afford costly pharmaceutical post-transplant care. The Dispensary has recently added a 90 day mail supply capability, which greatly expands its ability to respond to those in need.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions 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. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE: Six hospitals control 87.6% of the Williamson County ED visits according to Tennessee Hospital Association 2013 patient origin data.

According to 2013 JAR data, these same six hospitals treated almost 330,000 ED patients in 2013, or 30,004 more than in 2011. Since ED treatment rooms are not reported on the JAR, utilization by room cannot be calculated. However, average annual growth of 4.9% suggests strong demand for ED services.

Exhibit 15
ED Utilization Trends Among Market Share Leaders

	2011	2012	2013	Annual Growth
Williamson Medical Center	35,396	37,716	36,176	1.1%
Vanderbilt University Hospital	109,987	114,051	119,225	4.1%
Saint Thomas West Hospital	33,637	33,490	33,006	-0.9%
TriStar Centennial Medical Center	34,534	38,774	48,146	18.1%
Saint Thomas Midtown Hospital	50,050	52,064	51,643	1.6%
TriStar Southern Hills Medical Center	36,083	40,632	41,495	7.2%
Total	299,687	316,727	329,691	4.9%

Source: Joint Annual Reports for Hospitals

Despite this growth, West Hospital will lose two treatment rooms to provide space for a CT scanner as part of a major renovation project. TriStar Centennial Medical Center was just approved in October to reduce its treatment rooms by four.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) 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: As indicated below, both Midtown Hospital and West Hospital serve approximately 85,000 emergency department patients annually with 65 treatment rooms. Planning guidelines from the American College of Emergency Physicians ("ACEP") recommend 1,500 patients per treatment room per year. At this level, Saint Thomas Health operated at above 85% capacity while Midtown Hospital operated above 95% capacity.

Exhibit 16
STH ED Patient Utilization Trends

	Historical			Interim		Year 1	Year 2
	2011	2012	2013	2014	2015	2016	2013
Saint Thomas Midtown							
Patients Treated	50,050	52,064	51,643	51,939	52,237	52,536	52,837
ED Treatment Rooms*	36	36	36	36	36	36	36
ACEP Capacity @1,500	54,000	54,000	54,000	54,000	54,000	54,000	54,000
Utilization	92.7%	96.4%	95.6%	96.2%	96.7%	97.3%	97.8%
Saint Thomas West							
Patients Treated	33,637	33,490	33,006	33,195	33,385	33,576	33,768
ED Treatment Rooms**	29	29	29	29	27	27	27
ACEP Capacity @1,500	43,500	43,500	43,500	43,500	40,500	40,500	40,500
Utilization	77.3%	77.0%	75.9%	76.3%	82.4%	82.9%	83.4%
Combined							
Patients Treated	83,687	85,554	84,649	85,134	85,622	86,112	86,605
ED Treatment Rooms	65	65	65	65	63	63	63
ACEP Capacity @1,500	97,500	97,500	97,500	97,500	94,500	94,500	94,500
Utilization	85.8%	87.7%	86.8%	87.3%	90.6%	91.1%	91.6%

Asumption: ED visits will increase at the same annual rate as 2011-2013 for the system -- 0.573%
*Includes 11 "Fast Track" rooms
** 2 rooms lost for CT placement
Source: Joint Annual Reports for Hospitals

Projections are based on actual system growth from 2011 to 2013, a very conservative 0.573% per year and well under projected population growth.

In addition, West Hospital will soon lose two treatment rooms to make space available for a CT scanner in the emergency department. With this loss, and only very minimal projected volume growth, the emergency departments are projected to function at over 90% of capacity overall and over 97% of capacity at Midtown Hospital.

Detailed projections for the Satellite ED's nine zip code service area were presented previously in the need section. The results are presented here, again, for reference.

Exhibit 17
Midtown Hospital 9 Zip Code ED Visit Projections
With Increase From 2013 Baseline

Actual 2013	Projected 2014	Projected 2015	Year 1 2016	Year 2 2017	Year 3 2018	Year 4 2019
34,234	35,227	36,248	37,300	38,381	39,494	40,640
--	993	2,014	3,066	4,417	5,260	6,406

As indicated above, demand for ED visits is expected to increase by 3,066 in 2016 and 4,417 in 2017 due to population growth alone when current age cohort use rates are applied.

Saint Thomas Health already served 2,527 ED patients from the nine zip code service area in 2013 and 3,597 from all of Williamson County. Serving 15% of the ED patient population in Year 1 is not unrealistic given Saint Thomas Health's current ED patient base plus projected service area population increases (2,527 + 3,066 = 5,593 versus 37,300 x 15% = 5,595). Furthermore, Midtown Hospital can achieve its projected patient volumes with little or no adverse impact on existing providers.

Exhibit 18
Midtown Hospital Satellite ED Visit Projections

	Year 1 2016	Year 2 2017
Service Area ED Patients	37,300	38,381
STH Market Share	15%	20%
Satellite ED Patients	5,595	7,672
In-Migration	10%	10%
Total Satellite ED Patients	6,155	8,439
Treatment Rooms	8	8
ACEP Capacity @1,500	12,000	12,000
Utilization	51.3%	70.3%

Redirecting existing ED patients from Midtown Hospital and West Hospital to the Satellite ED would also relieve very high utilization at the Saint Thomas Health hospitals.

In conclusion, the Satellite ED can be expected to achieve 70% utilization by its second year of operation. The Saint Thomas Health hospital EDs will remain at approximately 90% utilization even if existing patients shift to the Satellite ED.

ECONOMIC FEASIBILITY

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

   - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
   - 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.
   - 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.
   - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

   RESPONSE: The CON filing fee is calculated at a rate of $2.25 per $1,000 of project costs as reported on Line D.

   Moveable equipment in Line A.8, over $50,000, includes a lab chemistry analyzer.

   This project involves a ground lease for the site. The sum of the lease payments over the initial 15 year term totals $2,383,200. This amounts to $3,055,385 on a per acre basis. As an approximation of purchase value, the adjacent MTI site was purchased in 2012 at a cost of $1,319,444 per acre. For CON valuation purchases, the sum of the lease payments is the higher of the two values and was used in the Project Costs Chart.

   Please see **Attachment C, Economic Feasibility – 1 (Tab 12)** for a letter supporting the construction costs.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	$327,811
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$117,145
3.	Acquisition of Site	
4.	Preparation of Site	$208,125
5.	Construction Costs	$2,477,683
6.	Contingency Fund (Owner's Contingency)	$134,290
7.	Fixed Equipment (Not included in Construction Contract)	$402,871
8.	Moveable Equipment (Lab chemistry equipment $105,000)	$268,581
9.	Other (Furnishings, signage, computers, etc.)	$422,296
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	$2,383,200
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)	$6,742,002
E.	CON Filing Fee	$15,170
F.	Total Estimated Project Cost (D+E)	$6,757,172
	TOTAL	$6,757,172

Actual Capital Costs	$4,373,972
FMV Land Lease Payments	$2,383,200

2. Identify the funding sources for this project.
Please 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 C, Economic Feasibility-2.)***

___ A. 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;

___ B. 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;

___ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants--Notification of intent form for grant application or notice of grant award; or

_X_ E. Cash Reserves **(See Letter - Tab 13; See Cash line - Tab 15, Page 3)**

___ F. Other—Identify and document funding from all other sources.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE: At an average construction cost of $268 ($290 with related site work) per square foot, this project is comparable to other recently approved Tennessee CON projects. In fact, it falls at the median value for new construction. **Exhibit 19**, below, lists the average hospital construction cost per square foot for all CON-approved applications for years 2011 through 2013.

EXHIBIT 19
HOSPITAL CONSTRUCTION COST PER SQUARE FOOT
APPROVED PROJECTS, 2011 - 2013

	Renovated Construction	New Construction	Total Construction
1st Quartile	$107.15/sq ft	$235.00/sq ft	$151.56/sq ft
Median	$179.00/sq ft	$274.63/sq ft	$227.88/sq ft
3rd Quartile	$249.00/sq ft	$324.00/sq ft	$274.63/sq ft

Source: Tennessee HSDA

4. Complete Historical and Projected 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 for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. 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).

   RESPONSE: Please refer to the completed hospital-wide charts on the four following pages.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

   RESPONSE: Based on Year 2 projections (FY2018), the average gross patient charge per emergency department visit is $2,482. The average deduction from gross patient charges, based on contractual allowances and allowances for charity care and bad debt, is approximately 77.3%, resulting in average net revenue per visit of approximately $563.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July. (Dollars reported in thousands, entire hospital)

	Fiscal Yr 2012	Fiscal Yr 2013	Fiscal Yr 2014
A. Utilization Data (Patient Days)	112,163	110,408	100,820
B. Revenue from Services to Patients			
1. Inpatient Services	$780,339	$862,034	$881,742
2. Outpatient Services	408,992	399,432	379,702
3. Emergency Services	71,046	69,385	81,950
4. Other Operating Revenue (Specify) - Misc.	29,405	27,821	20,297
Gross Operating Revenue	$1,289,782	$1,358,672	$1,363,691
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$806,267	$883,666	$897,978
2. Provision for Charity Care	53,683	36,117	47,790
3. Provisions for Bad Debt	9,962	21,308	9,069
Total Deductions	$869,913	$941,090	$954,837
NET OPERATING REVENUE	$419,869	$417,582	$408,854
D. Operating Expenses			
1. Salaries and Wages	$133,380	$127,496	$115,142
2. Physician's Salaries and Wages	0	0	0
3. Supplies	74,598	77,106	77,183
4. Taxes	0	0	0
5. Depreciation	16,425	16,627	13,674
6. Rent	0	0	0

7. Interest, other than Capital	9,195	8,524	7,777
8. Management Fees:			
a. Fees to Affiliates	0	0	0
b. Fees to Non-Affiliates	0	0	0
9. Other Expenses (See details below)	152,984	150,771	153,156
Total Operating Expenses	$386,582	$380,524	$366,932
E. Other Revenue (Expenses) - Net (Specify)	$0	$0	$0
NET OPERATING INCOME (LOSS)	$33,286	$37,058	$41,922
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	$0	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$33,286	$37,058	$41,922

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Fiscal Yr 2012	Fiscal Yr 2013	Fiscal Yr 2014
1. Purchased Services	$34,902	$34,181	$34,625
2. Professional Fees	10,955	9,588	8,895
3. Miscellaneous	107,127	107,002	109,636
4.			
5.			
6.			
7.			
Total Other Expenses	**$152,984**	**$150,771**	**$153,156**

PROJECTED DATA CHART

Give us information for the two (2) years following the completion of this proposal. The fiscal ye begins in July. (Dollars reported in thousands)

		Fiscal Yr 2017	Fiscal Yr 2018
A.	Utilization Data (Patient Days)	101,021	101,171
B.	Revenue from Services to Patients		
1.	Inpatient Services	$1,000,893	$1,002,379
2.	Outpatient Services	$408,997	$409,604
3.	Emergency Services	$91,021	$91,526
4.	Other Operating Revenue (Specify)	$22,209	$22,242
	Gross Operating Revenue	$1,523,120	$1,525,751
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$1,020,434	$1,022,029
2.	Provision for Charity Care	$36,612	$36,664
3.	Provisions for Bad Debt	$26,286	$26,325
	Total Deductions	$1,083,333	$1,085,018
NET OPERATING REVENUE		$439,787	$440,733
D.	Operating Expenses		
1.	Salaries and Wages	$133,243	$133,468
2.	Physician's Salaries and Wages		
3.	Supplies	$83,330	$83,461
4.	Taxes		
5.	Depreciation	$17,799	$17,829
6.	Rent		

7. Interest, other than Capital	$9,287	$9,301
8. Management Fees:		
a. Fees to Affiliates	0	0
b. Fees to Non-Affiliates	0	0
9. Other Expenses (See details below)	$152,644	$153,125
Total Operating Expenses	$396,304	$397,184
E. Other Revenue (Expenses) -- Net (Specify)	$0	$0
NET OPERATING INCOME (LOSS)	$43,483	$43,549
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$43,483	$43,549

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Fiscal Yr 2017	Fiscal Yr 2018
1. Purchased Services	$32,208	$32,616
2. Professional Fees	$9,464	$9,341
3. Miscellaneous	$110,973	$111,168
4.		
5.		
6.		
7.		
Total Other Expenses	**$152,644**	**$153,125**

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

RESPONSE: Midtown Hospital presents the current and projected charges for an emergency department visit in **Exhibit 20**. An annual increase of 3% between FY2014 and Year 1 of the project, FY2017, is projected. Afterwards, the hospital assumes that charges will increase by 3% annually. As demonstrated in **Exhibit 21**, Midtown Hospital's emergency department charges compare favorably with other providers in Nashville.

EXHIBIT 20
MIDTOWN HOSPITAL EMERGENCY DEPARTMENT, HOSPITAL-BASED AND SATELLITE
AVERAGE GROSS CHARGE PER VISIT, CURRENT AND PROJECTED

	Current	FY2017	FY2018
Gross Charge	$2,205	$2,410	$2,482
Adjustment	$1,818	$1,863	$1,919
Net Revenue	$387	$547	$563

B. 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: Comparison charge data for emergency department visits is very limited. To compare its charges with similar facilities, Midtown Hospital relied upon Medicare data from the American Hospital Directory (AHD) or ahd.com, as a source. Midtown Hospital profiled six area hospitals serving Davidson and Williamson counties from the AHD database.

Average charges per visit ranged from a low of $478 to a high of $1,443 with Midtown Hospital at $1,144. However, service mix indexes, a measure of patient severity, ranged from a low of 2.09 to a high of 4.64 with Midtown Hospital at 3.91. Adjusting the average charge by the service mix index resulted in a range of charges from a low of $155 to a high of $318 with Midtown Hospital at $293. Please see **Exhibit 21**, which profiles the emergency department average charge data for the area hospitals.

EXHIBIT 21
NASHVILLE AREA HOSPITALS
2013 AVERAGE GROSS CHARGE AND ACUITY PER MEDICARE EMERGENCY ROOM VISIT
MEDICARE CLAIMS DATA FOR CALENDAR YEAR ENDING 12/31/2013 (FINAL RULE OPPS)

Service - Emergency Room	Patient Claims	Units of Service	Average Charge	Service Mix Index	Svc Mix Adjusted Avg Charge to 1.00
Saint Thomas Midtown Hosp	4,145	4,146	$1,144	3.91	$293
Saint Thomas West Hosp	5,001	5,002	$1,147	3.78	$303
Williamson Med Ctr	5,416	5,527	$478	3.08	$155
Vanderbilt Univ Hosps	6,082	6,091	$1,443	4.64	$311
TriStar Centennial Med Ctr	7,520	7,891	$665	2.09	$318
TriStar Southern Hills Med Ctr	4,736	5,014	$644	2.13	$302

Source: American Hospital Directory, ahd.com

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

RESPONSE: Midtown Hospital is already financially feasible. Emergency services are an essential hospital responsibility to the community. This proposal will enhance Saint Thomas Health's current service line by expanding emergency department capacity off the main hospital campus. This will accomplish two important goals. First, it will decompress services already limited by space constraints in downtown Nashville. Second, it will bring services closer to the communities where Midtown Hospital's patients now work and reside. This is vitally important for emergency services where ever minute counts. As indicated in the Projected Data Chart, projected utilization will be sufficient to continue to allow Midtown Hospital to operate efficiently and effectively.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

RESPONSE: As indicated in the Projected Data Chart, projected cash flow will ensure financial viability within two years and over the long-term.

9. 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. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

RESPONSE: Midtown Hospital currently participates in both the Medicare and TennCare/Medicaid programs and has a history of providing care regardless of payor source. Using 2013 Joint Annual Report data, Midtown Hospital had an estimated payor mix (based on gross charges) that was 39.5% Medicare, 10.9% Medicaid/TennCare and 4.3% self pay. Additionally, based on the 2013 JAR, Midtown provided $36,116,714 in care to charity/medically indigent patients (accounting for 9.3% of net patient charges of $388,860,628). During the first year of operation, Midtown Hospital's payor mix is anticipated to be 39.5% Medicare and 10.9% Medicaid/TennCare. This amounts to approximately $601,412,834 in Medicare gross charges in Year 1 and $165,308,670

Medicaid/TennCare gross charges in Year 1. In addition, Midtown Hospital proposes to provide $36,612,000 in charity care in Year 1.

10. 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 new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

RESPONSE: Please see **Attachment C, Economic Feasibility – 10 (Tabs 14 and 15)**.

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

a. A discussion regarding 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, the applicant should justify why not; including reasons as to why they were rejected.

RESPONSE: Although studied, Saint Thomas Health did not consider renovating and enlarging the existing emergency departments at either Midtown Hospital or West Hospital to be a more viable option. Although major construction is now taking place at West Hospital, two emergency department treatment rooms are being lost to provide space for a CT scanner. As both downtown Nashville campuses become increasingly crowded, Saint Thomas Health has been actively pursuing a strategy of moving outpatient services into other areas of the surrounding communities. This is evidenced generally by the development of outpatient diagnostic services.

In particular, with regard to this project, Saint Thomas Health is the majority owner of MTI's adjacent Premier Radiology Brentwood imaging center. Rather than duplicating expensive CT and MRI services at the proposed Satellite ED, Saint Thomas Health will expand existing imaging center hours of operation to 24/7 and thus save millions of dollars in duplicate equipment and construction costs.

Thus, this project addresses the site deficiencies of both Midtown Hospital's and West Hospital's existing downtown campuses and does so in a cost-effective approach by leveraging existing imaging services in Brentwood.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

RESPONSE: As discussed above, modernization of the existing emergency departments in downtown Nashville was not considered a more viable alternative. Although major construction is now taking place at West Hospital, two emergency department treatment rooms are being lost to provide space for a CT scanner. As both downtown Nashville campuses become increasingly crowded, Saint Thomas Health has been actively pursuing a strategy of moving outpatient services into other areas of the surrounding communities.

Instead, this project will utilize a sharing arrangement with an adjacent imaging center to reduce the amount of new construction that would have been required otherwise. Saint

Thomas Health is the majority owner of MTI's adjacent Premier Radiology Brentwood imaging center. Rather than duplicating expensive CT and MRI services and new construction at the proposed Satellite ED, Saint Thomas Health will expand existing imaging center hours of operation to 24/7 and thus save millions of dollars in duplicate equipment and construction costs.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., 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, e.g., transfer agreements, contractual agreements for health services.

RESPONSE: As a member of Saint Thomas Health, Midtown Hospital is a member of an integrated healthcare system of four hospitals. Additionally, Midtown Hospital has many active relationship and several formal agreements in place to provide for seamless care of its patients, including:

Managed Care Contracts

- Aetna / US Healthcare
- Aetna Institutes of Quality Bariatric Surgery Facility
- Aetna Institutes of Quality Orthopedic Care
- Alive Hospice
- UnitedHealthcare Community Plan (f/k/a Americhoice)
- AMERIGROUP Community Care
- Avalon Hospice
- Beech
- BC/BS of TN
- CCN
- Blue Distinction Center for Bariatric Surgery
- Blue Distinction Center for Knee and Hip Replacement
- Blue Distinction Center for Spine Surgery
- Bluegrass Family Health
- CenterCare Managed Care Programs
- Cigna Healthplan
- CorVel Corporation
- Coventry Health Care
- Division of Rehabilitation Services
- First Health
- FOCUS Healthcare Management
- Great West
- HealthMarkets Care Assured
- Health Payors Organization, Ltd. / Interplan Healthgroup
- HealthSpring
- Humana Health Care Plans
- KY Medicaid
- MultiPlan
- NovaNet
- OccuComp
- Odyssey Healthcare
- Prime Health
- Private Healthcare Systems, Ltd.
- Pyramid Life - Today's Options
- Signature Health Alliance
- Southern Benefit Administrators, Inc.
- Starbridge Choice
- Sterling Healthcare

- TriCare for Life
- TRICARE North
- TRICARE South
- United Healthcare
- UnitedHealthcare Community Plan (f/k/a Americhoice)
- USA Managed Care Organization
- Windsor HealthCare

Transfer Agreements

- American Endoscopy Center, P.C.
- Baptist Plaza Surgicare, LP (USPI)
- Baptist Women's Health Center, LLC d/b/a The Center for Spinal Surgery (USPI)
- Biomat USA, Inc.
- Blakeford at Green Hills d/b/a Woodcrest Healthcare Center
- Clarksville Health System, G.P.
- Cool Springs Surgery Center
- Crockett Hospital, LLC
- Cumberland Medical Center, Inc.
- Decatur County General Hospital
- Decatur County General Hospital
- Digestive Disease Endoscopy Center, Inc
- Emergency Patient Transfer - Mutual Agreement for Emergency Patient Transfer
- Eye Surgery Center of Nashville
- Hardin Medical Center
- Joseph B. Delozier, III, PLLC - Baptist
- Lincoln Medical Center
- Lincoln Medical Center - Baptist
- Livingston Regional Hospital, LLC
- Maxwell Aesthetics, PLLC - Baptist
- Nashville Vision Correction - Baptist
- Office of Emergency Management
- Oral Facial Surgery Center, Inc.
- Pinelake Regional Hospital, LLC d/b/a Jackson Purchase Medical Center
- Renal Care Group, Inc
- Saint Thomas Hospital
- Southern Tennessee Medical Center
- Specialty MRI (Radiology Alliance)
- Tullahoma HMA, LLC d/b/a Harton Regional Medical Center
- Urology Surgery Center, L.P.
- Vanderbilt University
- Vanderbilt University - Burn Patient
- Vanderbilt University - Organ Transplant and Intensive Care Pediatrics
- Wellmont Bristol Regional Medical Center

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition 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.

RESPONSE: Midtown Hospital's proposal will have a positive impact on the health care system. As documented previously, population growth alone from 2014 to 2019 is expected to generate

demand for an additional 15,616 emergency department visits in Davidson County and 6,245 emergency department visits in Williamson County (21,861 visits total). At 1,500 visits per treatment room at 100% capacity, population growth will generate demand for 15 additional treatment rooms. West Hospital will lose two treatment rooms to provide space for a CT scanner. TriStar Centennial Medical Center was just approved in October to reduce its treatment rooms by four.

Population growth will generate demand for 15 additional treatment rooms at the same time that six existing treatment rooms are coming off line. Thus, the utilization rates of existing providers in the service area are not expected to experience a negative effect on utilization as a result of Midtown Hospital's project.

Service area residents will experience a positive impact by having increased access to Saint Thomas Health's emergency services closer to their communities, where they work and live. This is vitally important for emergency services where ever minute counts.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

RESPONSE: **EXHIBIT 22** illustrates current and proposed staffing levels for the proposed project. Midtown Hospital proposes adding 30.3 FTEs.

EXHIBIT 22
CURRENT AND PROPOSED STAFFING LEVELS
SATELLITE ED AT BRENTWOOD
(FULL TIME EQUIVALENTS)

Position	Current	Proposed	Difference
Registered Nurses	0.0	14.5	14.5
EVS Tech	0.0	4.8	4.8
Lab Tech	0.0	4.8	4.8
Registration	0.0	4.8	4.8
Pharmacy	0.0	1.3	1.3
TOTAL	**0.0**	**30.3**	**30.3**

Midtown Hospital has a history of successfully retaining professional and administrative staff because it provides competitive benefits and compensation, and provides a supportive work environment. As mentioned previously, in recent years, Midtown Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

EXHIBIT 23 profiles comparable positions and salaries for the Nashville-Davidson-Murfreesboro MSA. Midtown Hospital's salaries and wages, before benefits, are competitive with the market. The proposed project's average proposed annual salary for registered nurses is $58,406 while the average salary for laboratory techs is 49,920, respectively. These values are within the ranges for the Nashville-Davidson-Murfreesboro MSA.

EXHIBIT 23
NASHVILLE-DAVIDSON-MURFREESBORO MSA
MAY 2013 ANNUAL WAGE RATES

Position	25th Pctile	Mean	Median	75th Pctile
Registered Nurse	$48,890	$59,110	$58,990	$69,560
Lab Technologist	$48,640	$58,690	$57,810	$68,540
Lab Technician	$27,240	$34,880	$33,350	$42,170

SOURCE: ANNUAL SALARY BLS OCCUPATIONAL EMPLOYMENT STATISTICS SURVEY DATA

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

RESPONSE: Midtown Hospital proposes adding 30.3 FTEs. Midtown Hospital has a history of successfully recruiting professional and administrative staff. It provides competitive benefits and compensation, and is committed to the retention of existing personnel. In recent years, Midtown Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

RESPONSE: Midtown Hospital has reviewed and understands the licensure and certification requirements for medical and clinical staff. The Satellite ED will rely on the experience and expertise of the 28 emergency department physicians now at Midtown Hospital and the 11 emergency department physicians now at West Hospital to support the Satellite ED. The proposed full service, 24-hour-per-day/7-day-per-week satellite emergency department facility will be a satellite of the main emergency department at Saint Thomas Midtown Hospital and will be under the sole administrative control of Saint Thomas Midtown Hospital. As an existing licensed and Joint Commission-accredited facility, Midtown Hospital has administrative policies and procedures in place to ensure that licensure and certification requirements are followed. Furthermore, Midtown Hospital maintains quality standards that are focused on continual improvement. Please see **Attachment C, Contribution to the Orderly Development of Health Care – 5** for copies of its Quality and Patient Safety Improvement Plan **(Tab 17)**, and Utilization Review Plan **(Tab 18)** and Patient Bill of Rights **(Tab 19)**.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

RESPONSE: Midtown Hospital participates in many regional healthcare teaching and training programs including:

- Aquinas College - Nursing Program
- Aquinas College - RN-BSN Program
- Auburn University – Nursing
- Austin Peay State University - Exercise Science Students
- Austin Peay State University - Medical Technology
- Austin Peay State University – Nursing

- Belmont University - Nursing Program
- Belmont University – Pharmacy
- Belmont University - Physical and Occupational Therapy (PT, OT)
- Central Michigan University - Exercise Science Program
- Chattanooga State Technical Community College - Diagnostic Medical Sonography, Radiation Therapy and Nuclear Medicine
- Columbia State Community College - Respiratory Care, EMS Education & Nursing
- Creighton University – Nursing
- Cumberland University - Nursing Program
- Draughons Junior College - Physical Therapy, Assistant Cardiographic and Medical Assistant
- Draughons Junior College, Inc d/b/a Daymar Institute - Pharmacy Technology
- Dyersburg State Community College - Health Information Technology
- Hospital Authority of Metropolitan Government of Nashville & Davidson County d/b/a Nashville General Hospital - Radiologic Technology
- Johns Hopkins University School of Nursing
- Lipscomb University - Dietetic Internship Program
- Lipscomb University - Exercise Science
- Lipscomb University College of Pharmacy - Pharmacy Students
- Lipscomb University Department of Nursing
- Madisonville Community College - Medical Equipment and Instrumentation Students
- Medvance Institute - Medical Laboratory Technician
- Medvance Institute - Surgical Technology and Sterile Technology Programs
- Middle Tennessee State University (MTSU) - Exercise Science
- Middle Tennessee State University (MTSU) - Medical Nutrition Therapy Dietetic Practicum
- Middle Tennessee State University (MTSU) - Nursing program
- Middle Tennessee State University (MTSU) - Social Work
- Miller-Motte Technical College - Respiratory Therapy, Surgical Technology and Sterile Processing
- Motlow State Community College – Nursing
- Mountain State University - Radiology Students
- Murray State University – Nursing
- Nashville State Community College - Nursing - Surgical Technician Program - Surgical Assist Program
- Nashville State Technical Community College - Occupational Therapy Program
- Pennsylvania State University - Nursing Program
- Samford University - Nursing (Graduate Nursing Clinical Experience Management, Nurse Executive and Nurse Educator Students)
- South Carolina College of Pharmacy - Doctor of Pharmacy
- Southeastern Institute - Paramedic Students
- Southern Adventist University – Nursing
- St. Louis University, School of Nursing
- Tennessee Board of Regents (TBR) - Master of Science in Nursing Regents Online Degree Program (APSU, ETSU, MTSU, TSU, TTU, and Memphis)
- Tennessee State University (TSU) - Health Exercise Science (Baptist Sports Medicine)
- Tennessee State University (TSU) – Nursing
- Tennessee State University (TSU) - Physical, Occupational Therapy, Health Information Management and Cardio-Respiratory Care
- Tennessee Technological University - Nursing and Dietetics Program
- Tennessee Technology Center at Murfreesboro - Pharmacy Technician, Phlebotomy, and Surgical Tech
- Tennessee Technology Center at Nashville - LPN, Phlebotomy & Pharmacy Tech
- Tennessee Technology Center at Shelbyville and Murfreesboro Campuses - Practical

Nursing Program

- Trevecca Nazarene University - Social Work Students
- University of Alabama, Huntsville – Nursing
- University of Alabama, Tuscaloosa – Nursing
- University of Florida - Pham. D. Program
- University of St. Francis - Nursing Students
- University of Tennessee (Memphis) - Physical Therapy, Occupational Therapy, Medical Technology, Cytotechnology and Histotechnology
- University of Tennessee at Chattanooga - Physical Therapy
- University of Tennessee at Martin - Clinical Nutrition and Food Service Management
- University of Tennessee, Knoxville – Nursing
- University of Tennessee, Knoxville - Social Work
- University of Tennessee, Martin - Exercise Science
- University of Tennessee, Memphis - Pharmacy Program
- Vanderbilt School of Nursing – Nursing
- Vanderbilt University - Hearing and Speech Sciences
- Volunteer State Community College - Multi-Programs
- Walden University - MS Nursing Students)
- Western Kentucky University - Nursing Program

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

RESPONSE: As an existing hospital, Midtown Hospital is licensed by the Tennessee Department of Health. Midtown Hospital has reviewed and understands the licensure requirements. The proposed full service, 24-hour-per-day/7-day-per-week satellite emergency department facility will be a satellite of the main emergency department at Saint Thomas Midtown Hospital and will be under the sole administrative control of Saint Thomas Midtown Hospital.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Board of Licensing Health Care Facilities, State of Tennessee, Department of Health.

Accreditation: Midtown Hospital is accredited by The Joint Commission (on Accreditation of Healthcare Organizations). Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(b) (Tab 20)** for the most recent report.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

RESPONSE: Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(c) (Tab 21).** The current license is valid until April 30, 2014.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

RESPONSE: Please see **Attachment C, Contribution to the Orderly Development of Health**

Care – 7.(d) for a copy of the most recent licensure/certification inspection report **(Tab 22)** and plan of corrective action **(Tab 23)**.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

   RESPONSE: There have been no final orders or judgments placed against Midtown Hospital or any entity or person with more than 5 percent ownership.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

   RESPONSE: There have been no civil or criminal judgments against Midtown Hospital or any entity or person with more than 5 percent ownership.

10. If the proposal is approved, please discuss whether the applicant will 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.

    RESPONSE: Yes, Midtown Hospital will 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. Additionally, Midtown Hospital submits a Joint Annual Report (JAR) to the Department of Health and will continue to do so.

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 as proof of the publication of the letter of intent.

Please see **Attachment D – Proof of Publication (Tabs 24-25).**

DEVELOPMENT SCHEDULE

Tennessee Code Annotated §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. **Please 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: The project completion schedule below reflects the anticipated schedule for the construction project.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT FORECAST COMPLETION CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-160 December, 2014

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	0	Mar-15
2. Construction documents approved by the Tennessee Department of Health	120	Jul-15
3. Construction contract signed	150	Aug-15
4. Building permit secured	150	Aug-15
5. Site preparation completed	180	Sep-15
6. Building construction commenced	180	Sep-15
7. Construction 40% complete	270	Dec-15
8. Construction 80% complete	390	Apr-16
9. Construction 100% complete (approved for occupancy)	450	Jun-16
10. *Issuance of license	480	Jul-16
11. *Initiation of service	480	Jul-16
12. Final Architectural Certification of Payment	480	Jul-16
13. Final Project Report Form (HF0055)	480	Jul-16

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

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

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Davidson

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

EXECUTIVE DIRECTOR, STRATEGY & PLANNING
SIGNATURE/TITLE

Sworn to and subscribed before me this 11th day of December, 2014 a Notary
(Month) (Year)

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

Sonja Rene Ward
NOTARY PUBLIC

My commission expires March 8, 2016.
(Month/Day) (Year)

SONJA RENE WARD
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.
My Commission Expires MAR. 8, 2016

Check Date: Dec/11/2014 | Vendor Number: 0000061298 | Check No. 0970257

Invoice Number	Invoice Date	Voucher ID	Gross Amount	Discount Taken	Late Charge	Paid Amount
CONFILINGFEE-120414	Dec/04/2014	00219511	15,170.00	0.00	0.00	15,170.00

Check Number	Date	Total Gross Amount	Total Discounts	Total Late Charges	Total Paid Amount
0970257	Dec/11/2014	$15,170.00	$0.00	$0.00	$15,170.00

RE

THIS DOCUMENT CONTAINS SECURITY FEATURES — SEE BACK FOR DETAILS

Ascension Health Ministry SVC CTR
4040 Vincennes Circle
Indianapolis, IN 46268
317-334-VEND (8363)

The Bank of New York Mellon
Pittsburgh, Pennsylvania

0970257

60-160
433

Date Dec/11/2014 Pay Amount $15,170.00***

Pay ****FIFTEEN THOUSAND ONE HUNDRED SEVENTY AND XX / 100 DOLLAR****

To The Order Of
TN HEALTH SVCS
500 DEADERICK ST
OFC BL
NASHVILLE, TN 37242

Authorized Signature

Authorized Signature

VOID AFTER 90 DAYS

VOID

TABLE OF CONTENTS

Attachment A
Tab 1 - Corporate Charter
Tab 2 - Organizational Chart
Tab 3 - Board Roster
Tab 4 - Certificate of Corporate Existence
Tab 5 - Site Lease
Tab 6 - MCO/BHO Participation

Attachment B
Tab 7 - Plot Plan
Tab 8 - Maps of Service Area Access
Tab 9 - Schematics

Attachment C
Tab 10 - Service Area Map
Tab 11 - TennCare Population Data
Tab 12 - Construction Costs Verification Letter
Tab 13 - Verification of Funding
Tab 14 - Balance Sheet and Income Statement
Tab 15 - Audited Financials
Tab 16 - Letters of Support
Tab 17 - Performance Improvement Plan
Tab 18 - Utilization Review Plan
Tab 19 - Patient Bill of Rights
Tab 20 - The Joint Commission Documentation
Tab 21 - Hospital License
Tab 22 - Inspection Report
Tab 23 - Plan of Corrective Action

Attachment D
Tab 24 - Copy of Published Public Notice
Tab 25 - Letter of Intent

Attachment A

Corporate Charter
Organizational Chart
Board Roster
Certificate of Corporate Existence
Site Lease
MCO/BHO Participation

Tab 1

Attachment A, 3

Corporate Charter

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

Saint Thomas Midtown Hospital
ATTN: CONTRACT ADMINSTRATION
STE 800
102 WOODMONT BLVD
NASHVILLE, TN 37205-2221

July 10, 2013

Filing Acknowledgment

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

Control # : 414306 Status: Active
Filing Type: Corporation Non-Profit - Domestic

Document Receipt

Receipt # : 1089206	Filing Fee:	$20.00
Payment-Check/MO - BRADLEY ARANT BOULT CUMMINGS LLP, Nashville, TN		$20.00

Amendment Type: Articles of Amendment Image # : 7221-1974
Filed Date: 07/10/2013 11:26 AM

This will acknowledge the filing of the attached articles of amendment with an effective date as indicated above. When corresponding with this office or submitting documents for filing, please refer to the control number given above.

You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee.

Tre Hargett
Secretary of State

Processed By: Cheryl Donnell

Field Name	Changed From	Changed To
Filing Name	SETON CORPORATION	Saint Thomas Midtown Hospital

ARTICLES OF AMENDMENT

OF

SETON CORPORATION

CONTROL NO. 0414306

FILED

To the Tennessee Secretary of State:

Pursuant to Section 48-60-105 of the Tennessee Nonprofit Corporation Act, as amended, the undersigned officer of Seton Corporation, a domestic nonprofit corporation (the "Corporation"), hereby submits these Articles of Amendment to its Charter on July 10, 2013:

(1) The name of the Corporation as it appears of record is Seton Corporation.

(2) The Corporation is not for profit.

(3) The text of the Amendment is as follows: Article I, Section 1.1 of the Amended and Restated Charter of the Corporation is deleted and the following language shall be substituted in its place:

1.1 The name of the corporation is "Saint Thomas Midtown Hospital"

(4) The Articles of Amendment were duly adopted by the sole member of the Corporation on June 27, 2013.

(5) Approval of the amendment to the charter by some person or persons other than the sole member of the Corporation, the Board of Trustees, or the incorporator, is not required pursuant to Section 48-60-301 of the Tennessee Nonprofit Corporation Act, as amended.

(6) The Articles of Amendment shall be effective on the date of filing.

SETON CORPORATION

By: Bernard J. Sherry

Bernard J. Sherry, President/CEO

7/3156641.1

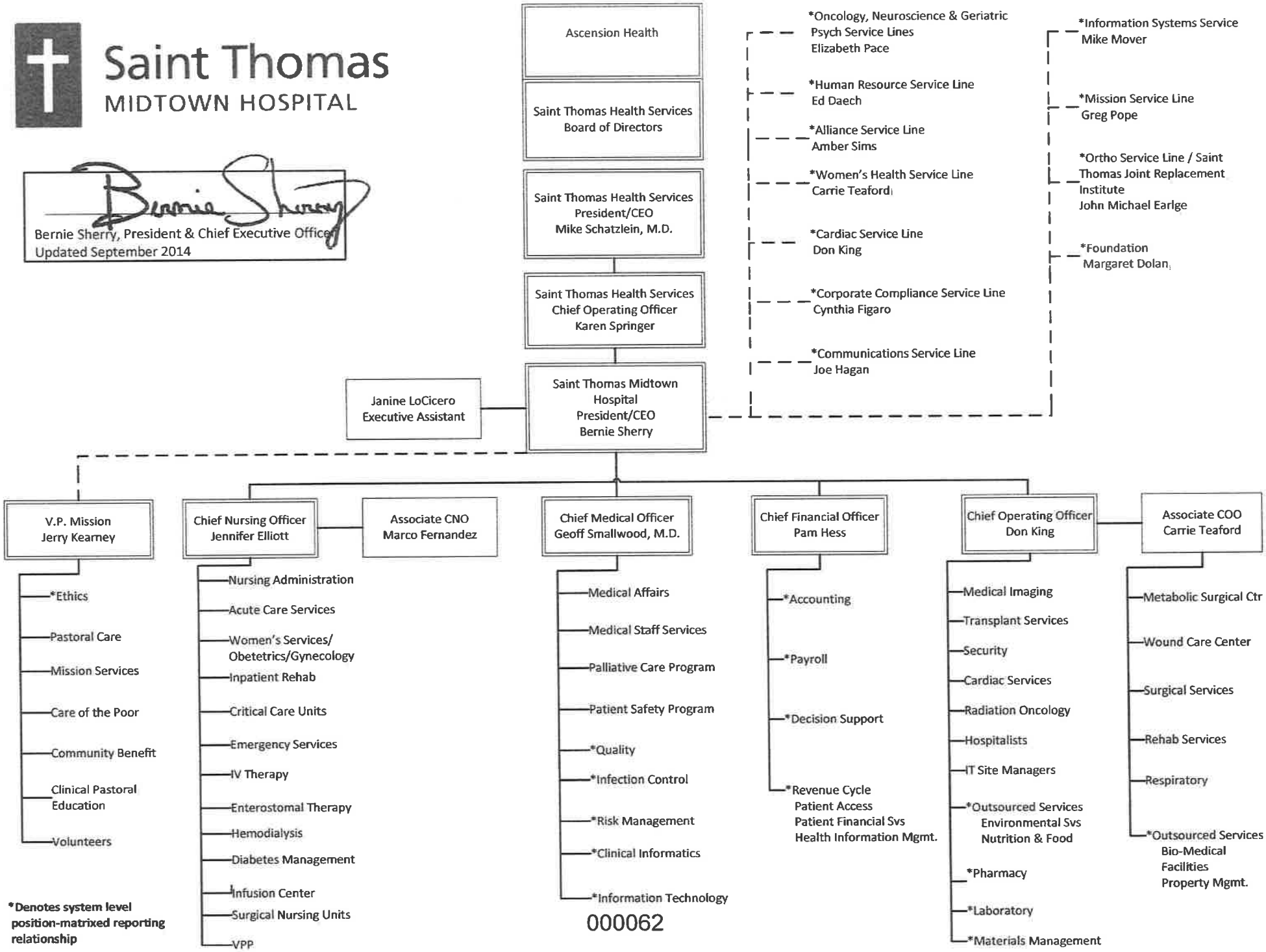
Tab 2

Attachment A, 4

Organizational Chart

Saint Thomas
MIDTOWN HOSPITAL

Bernie Sherry, President & Chief Executive Officer
Updated September 2014



***Denotes system level position-matrixed reporting relationship**

Saint Thomas
WEST HOSPITAL

Bernie Sherry, President & Chief Executive Officer
Updated September 2014

Ascension Health

Saint Thomas Health Services Board of Directors

Saint Thomas Health Services President/CEO Mike Schatzlein, M.D.

Saint Thomas Health Services Chief Operating Officer Karen Springer

Saint Thomas West Hospital President/CEO Bernie Sherry

Janine LoCicero Executive Assistant

- *Oncology, Neuroscience & Geriatric Psych Service Lines Elizabeth Pace
- *Human Resource Service Line Ed Daech
- *Alliance Service Line Amber Sims
- *Women's Health Service Line Carrie Teaford
- *Cardiac Service Line Don King
- *Corporate Compliance Service Line Cynthia Figaro
- *Communications Service Line Joe Hagan
- *Information Systems Service Line Mike Mover
- *Mission Service Line Greg Pope
- *Ortho Service Line / Saint Thomas Joint Replacement Institute John Michael Eargle
- *Foundation Margaret Dolan

V.P. Mission Jerry Kearney

- *Ethics
- Pastoral Care
- Mission Services
- Care of the Poor
- Clinical Pastoral Education
- Community Benefit
- Volunteers

Chief Nursing Officer Jennifer Elliott

Associate CNO Marco Fernandez

- Nursing Administration
- Acute Care Services
- Acute Psychiatric Unit
- Critical Care Units
- Emergency Services
- IV Therapy
- Enterostomal Therapy
- Hemodialysis
- Diabetes Management
- Surgical Nursing Units

Chief Medical Officer Mark Marsden, MD

- Medical Affairs
- Medical Staff Services
- Palliative Care
- Patient Safety Program
- Chiefs of Service
  - Dept of Medicine(Hospitalists)
  - Dept of Surgery
  - Dept of Cardiac Services
  - Dept of Radiology
  - Dept of Pathology
- *Infection Control
- *Quality
- *Risk Management
- *Continuing Medical Education
- *Information Technology

Chief Financial Officer Pam Hess

- *Accounting
- *Payroll
- *Decision Support
- *Revenue Cycle
  - Patient Access
  - Patient Financial Svs
  - Health Info. Mgmt.

Chief Operating Officer Don King

Associate COO Carrie Teaford

- Medical Imaging
- Transplant Services
- Security
- Cardiac Services
- Radiation Oncology
- Hospitalists
- IT Site Managers
- *Pharmacy
- *Laboratory
- *Materials Management
- *Outsourced Services
  - Environmental Svs
  - Nutrition & Food
  - Bio-Medical
  - Facilities
  - Property Mgmt.

- Metabolic Surgical Ctr
- Wound Care Center
- Surgical Services
- Rehab Services
- Respiratory

***Denotes system level position-matrixed reporting relationship**

Tab 3

Attachment A, 4

Board Roster

Board of Directors

Updated July 2013

Chairman	Mike Schatzlein, M.D.
Vice Chair	Karen Springer
Secretary/Treasurer	Craig Polkow

Tab 4

Attachment A, 4

Certificate of Corporate Existence

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

KEVIN KIMBELL
71 VICKERY STREET
ROSWELL, GA 30075

December 5, 2014

Request Type: Certificate of Existence/Authorization
Request #: 0147226

Issuance Date: 12/05/2014
Copies Requested: 1

Document Receipt

Receipt # : 1725297 — Filing Fee: $22.25

Payment-Credit Card - State Payment Center - CC #: 159551135 — $22.25

Regarding: **Saint Thomas Midtown Hospital**
Filing Type: Corporation Non-Profit - Domestic
Formation/Qualification Date: 09/18/2001
Status: Active
Duration Term: Perpetual
Business County: DAVIDSON COUNTY

Control # : 414306
Date Formed: 09/18/2001
Formation Locale: TENNESSEE
Inactive Date:

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 Midtown 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 #: 009807728

Tab 5

Attachment A, 6

Site Lease

GROUND LEASE
Lot 1 Highlands of Brentwood, Resub of Sec 3
791 Old Hickory Blvd., Brentwood, TN 37027

THIS LEASE made and entered into as of April __, 2014 (the "Effective Date"), by and between Old Hickory Partners, LLC, a Tennessee limited liability company ("Lessor") and Middle Tennessee Imaging, LLC, a Tennessee limited liability company dba Premier Radiology ("Premier").

WITNESSETH

WHEREAS, Lessor is the owner of certain lands comprising approximately .78 acres and known as Lot 1 Highlands of Brentwood, Resub of Sec 3 with an address of 791 Old Hickory Boulevard, Brentwood, County of Davidson, State of Tennessee, more particularly described in Exhibit A hereunto annexed and made a part hereof, and Lessee is desirous of leasing said site from Lessor on the terms and conditions hereinafter set forth; and

WHEREAS, the majority owner of Premier is Saint Thomas Health, a Tennessee not-for-profit hospital system ("Hospital").

NOW, THEREFORE, in consideration of the premises and the respective undertakings of the parties hereinafter set forth, it is hereby agreed as follows:

1. **Definitions.** As used herein, the following terms have the following meanings:

A. "Premises" means the land described in Exhibit A attached hereto and all easements, licenses, privileges, rights and appurtenances related thereto. The term "Premises" shall not include the "Improvements" (as hereinafter defined).

B. "Improvements" means all buildings, structures and improvements now or hereafter situated or erected on the Premises or any part thereof and all fixtures, machinery, equipment, all building equipment, and, without limitation, other property of every kind or nature situated thereon or pertaining thereto or used in connection therewith, excluding only the "Personal Property" (as hereinafter defined) and property owned by third persons who are not Affiliates of Lessee.

C. "Personal Property" means the trade fixtures, furniture, furnishings and business equipment now or hereafter located on or used in connection with the Premises or Improvements, which are movable and not attached to the Premises or the Improvements or any part thereof and not necessary for the proper and efficient operation of the Improvements, excluding any property owned by third persons who are not Affiliates of Lessee.

D. "Property" means the Premises, the Improvements and the Personal Property.

E. "Taxes" means:

(1) All real estate taxes, special assessments, water taxes, excises, levies, license and permit fees and other governmental shares and costs of every kind and nature, general and special, ordinary and extraordinary, foreseen and unforeseen, of any kind or nature whatsoever (including, but not limited to, assessments for streets, sidewalks, sewers, lights and other improvements and general and special state, county, village, and city taxes, benefit taxes and assessments), and payments in lieu of taxes, which at any time or times

prior to or during the "Term" (as hereinafter defined), or at any time or times after the Term but with respect to a period or periods or event or events occurring in whole or in part during the Term, may or shall become a lien on or be assessed, levied, confirmed, imposed upon or become due or payable on or with respect to (a) the Premises, Improvements, Personal Property or any part thereof, (b) the rent, receipts, income or other payments received by or from Lessee or anyone claiming by, through or under Lessee, (c) any use or occupation of the Property or (d) this transaction or any document to which Lessee is a party creating or transferring an interest or estate in the Property;

(2) Without limitation on any of the foregoing, any license fee or business tax measured by the rent or other charges or sums payable hereunder, and any tax, assessment, levy, fee or other charge imposed upon Lessee or Lessor, which is levied, assessed or imposed on or measured by or based, in whole or in part, upon (a) the rents received from or with the use of the Property or any part thereof, (b) the Premises, or (c) the rent payable by Lessee under this Lease, if the methods of taxation prevailing at the commencement of the Term shall be altered so that such license fee, business tax or any other such tax, assessment, levy, fee or other charge shall be in lieu of or in addition to or as a substitute for the whole or any part of the taxes, assessments, levies, fees or charges now levied, assessed or imposed on real estate or the improvements thereon or on personal property.

The term "Taxes" does not include Federal, state or, subject to the provisions of subparagraph (2) above, local income or franchise taxes assessed against Lessor.

F. "Sublease" means any lease, sublease, license or concession agreement involving the use or occupancy of the Property or any part thereof (other than this Lease). "Sublessee" means the Person (other than Lessee) that has acquired rights to use or occupancy under a Sublease.

G. "Rent" shall have the meaning set forth in Section 4 hereof.

H. "Leasehold" means Lessee's right, title and interest in and to the Property as set forth in this Lease.

I. "Leasehold Deed of Trust" means a deed of trust, secured by a first lien on the Lessee's interest under this Lease provided that the holder thereof is an Institutional Mortgagee; the collateral therefore is solely the Lessee's interest under this Lease and such Personal Property as is used or useable at the Property; there are no defaults thereunder which could occur by virtue of a default under a monetary obligation relating to property other than the permitted collateral or under the note secured by the Leasehold Deed of Trust (the "LDT Note"); and it provides for regular monthly payments of principal and interest, or of interest only, but in any event, the principal balance of such loan shall never increase over the amount of the original principal balance (the loan is a non-accrual loan).

J. "Leasehold Mortgagee" means the holder of any Leasehold Deed of Trust at any time.

K. "Affiliates" mean a person controlled by, under common control with or controlling the person in question.

L. "Control" or words of similar import mean the ability of one person to direct the affairs and business of another person.

M. "Person" or "person" shall mean and include an individual, corporation, partnership, unincorporated organization, or government or any agency or political subdivision thereof.

N. "Institutional Mortgagee" means any bank, savings bank or Affiliate thereof, investment bank, mortgage conduit, savings and loan association, trust company, credit union of which the borrower is a member, insurance company or governmental entity which is duly authorized to issue a loan secured by an interest in real estate or Affiliate thereof, or pension fund, which is then currently extending similarly secured loan commitments.

O. "Affiliate" with respect to any person or entity, means any other person or entity that directly or indirectly, through one or more intermediaries, controls, is controlled by or is under common control with, such specified person or entity.

2. Lease of the Premises. Lessor hereby demises and leases unto Lessee, and Lessee hereby takes and hires from Lessor, the Premises, for and in consideration of the rents, covenants and agreements, and upon the terms and conditions set forth herein, subject to any and all encumbrances, conditions, covenants, easements, restrictions, rights-of-way, and all other matters of any nature affecting the Premises during the Term (in each case whether or not of record), such matters as may be disclosed by an inspection or survey, and all zoning, land use, subdivision, and all other laws, rules, regulations and judicial or administrative orders now or hereafter applicable to the Premises or any part thereof or any use or occupancy thereof (herein collectively called "Restrictions").

3. Term. The initial term of this Lease ("Initial Term") shall be 15 years, beginning July 1, 2014, and terminating at midnight, June 30, 2029, subject to earlier termination or extension as herein set forth. Following the Initial Term, Lessee shall have the option to extend this Lease for three successive five (5) year periods (each an "Option Period", and collectively the "Option Periods"). The Initial Term together with the Option Periods that are exercised by Lessee shall be referred to herein as the "Term". Other than the payment of rent as set forth below, Lessee shall assume all other obligations created under the terms of this Lease on the day following the date upon which this Lease is fully executed by all parties.

4. Rent. As rental for the Premises, Lessee shall pay the sums hereinafter set forth (the "Rent"):

Months 1-60	$12,000 per month
Months 61-120	$13,200 per month
Months 121-180	$14,520 per month

During the Option Periods described herein, if the Option Period is exercised by Lessee, Lessee shall pay the following sums as Rent:

Months 181-240 (Option Period 1)	$15,972 per month
Months 241-300 (Option Period 2)	$17,569 per month
Months 301-360 (Option Period 3)	$19,326 per month

C. Rent Commencement Date. The Rent Commencement date shall be July 1, 2014.

E. Rent Payments. All payments of Rent shall be in lawful money of the United States of America without abatement, offset or deduction, and shall be paid to Lessor at the following address: 1163 Saddle Springs Drive, Thompson Station, TN 37179; or at such other place as Lessor may designate by notice in writing from time to time and may be made by check or draft payable to the order of such payee, which check or draft must be paid in full when presented. All payments of Rent shall be made without notice in equal monthly installments in advance on the first day of each and every month during the Term commencing on the Rent Commencement Date.

F. Net Lease. It is the purpose and intent of Lessor and Lessee and they agree that Rent payable hereunder shall be absolutely net to Lessor so that this Lease shall yield to Lessor the Rent specified, free of any charges, assessments, or impositions of any kind charged, assessed, or imposed on or against the Property, and without abatement, counterclaim, deduction, defense, deferment or set-off by the Lessee, except as hereinafter specifically otherwise provided, and Lessor shall not be expected or required to pay any such charge, assessment or imposition, or be under any obligation or liability hereunder except as herein expressly set forth, and that all costs, expenses and obligations of any kind relating to the maintenance and operation of the Property, including all alterations, repairs and replacements as hereinafter provided, which may arise or become due during the Term shall be paid by Lessee, the Lessor shall be indemnified and saved harmless by Lessee from and against such costs, expenses and obligations. Except as set forth in an express provision of this Lease, and except as may be provided by a final, unappealable judgment or order by a court of competent jurisdiction, this Lease shall not terminate, nor shall Lessee be entitled to any abatement, deduction, deferment or reduction of rent, nor shall Lessee have any right to terminate this Lease or to be released, relieved or discharged from any obligations or liabilities hereunder, for any reason, it being the intention of the parties hereto that the Rent shall be payable in all events, and that the obligations of Lessee under this Lease shall be separate and independent covenants and shall continue unaffected unless otherwise expressly provided in this Lease. Nothing in this Paragraph 4.F. shall constitute a waiver by Lessee of its right to bring an independent cause of action against Lessor for any default or breach by Lessor under this Lease or under any other agreement to which Lessor and the Lessee may be parties; provided, however, that no such cause of action, prior to judgment, shall under any circumstances entitle the Lessee to offset, abate, deduct from or defer the payment of Rent, or such other sums as are payable by Lessee under this Lease.

G. Late Charge and Interest. If Lessee shall fail to pay any Rent required to be paid by Lessee hereunder within ten (10) days after the due date therefore, each such unpaid amount shall be subject to 1) a one-time late charge equal to five percent (5%) of such unpaid amount to cover Lessor's additional administrative costs resulting from Lessee's failure to pay and not as interest, and 2) interest at the rate of the lesser of the highest rate permitted by law or the Prime Rate as reported in the Wall Street Journal on such unpaid amount for each day or portion of a day that the same shall remain unpaid. Such late charges and interest shall be paid to Lessor together with such unpaid amounts, without further notice to or demand upon Lessee. Such late charges and interest shall be additional rent. The payment of the sums set forth in the foregoing provisions shall in no way relieve Lessee of the obligation to pay the monthly installments of Rent on or before the first day of each calendar month.

5. Use of the Premises.

A. Lessee shall use the Premises for the purpose of constructing and operating thereon a building that is similar to the building described at Exhibit C to be used for the provision of health care services and for no other use without Lessor's prior written consent in each instance, which may be withheld if the proposed use will, in Lessor's reasonable discretion, be materially detrimental to the value of the Premises. In no event shall the Property or any portion thereof be used for the operation of an establishment offering the provision of goods, services, or amusements from which minors would customarily be excluded because of the sexually explicit nature thereof or for any other reason, such as adult book stores, massage parlors, brothels, public or private bathhouses, escort services, adult movie theaters, adult video or movie arcades or other establishments which display adult movies or adult video recordings, or establishments which display erotic, strip, nude or semi-nude dancers, or an abortion clinic or clinic offering abortions among its services.

B. Lessee shall comply with all federal, state, county and municipal laws, regulations and ordinances affecting the Property or any portion thereof and shall procure and maintain in force during the Term all permits, authorizations and licenses necessary for Lessee's use or operation of in the Property or any portion thereof (including, without limitation, the making, placing, maintaining or altering of the

Improvements or any portion thereof). Lessee shall not use the Property or any portion thereof for any purpose or use which is in violation of any applicable certificate of occupancy, building permit, or any of the Restrictions. Lessee covenants that neither it nor any assignee nor any subtenant will (a) use or permit to be used any part of the Property for any dangerous or noxious trade or business, (b) transport to or from, dispose of, use, store, handle, or generate any flammable explosives or hazardous or toxic substances on, at, in, or near, the Property, or (c) use the Property for any purpose or business which is noxious or unreasonably offensive because of the emission of noise, smoke, dust or odors or cause or maintain any nuisance in, at or on the Property.

C. Lessee shall hold harmless and indemnify Lessor from and against any claim, penalty, loss, damage, charge, liability or expense (including, without limitation, reasonable attorney's fees) threatened, incurred or imposed for any act or omission in violation of Lessee's covenants and obligations under this paragraph 5 or by reason of any action or proceeding which may be brought against Lessor or the Property in connection with the foregoing.

D. Lessee will not suffer any act to be done or condition to exist on the Property, or any part thereof, or any article to be brought thereon which may be dangerous unless safeguarded as required by law, or which may, in law, constitute a nuisance, public or private. Lessee shall not suffer or permit the Property or any portion thereof to be used by the public, as such, without restriction or in such manner as might reasonably tend to impair the interest of Lessor or Lessor's designees in the Property or any portion thereof, or in such manner as might reasonably make possible a claim or claims of adverse usage or adverse possession by the public, as such, or of implied dedication of the Property or any portion thereof. Lessee agrees not to permit the accumulation (unless in concealed containers) or burning of any rubbish or garbage in, on or about any part of the Premises and to keep it free from insects, rodents and other pests and vermin. All garbage shall be maintained in a manner so that canisters are not visible from adjacent parcels or roads. Lessee shall cause and pay for all garbage or rubbish to be collected or disposed of from the Property. Lessee agrees that it will comply with and observe all restrictive covenants of record or of which Lessee has been given actual notice which affect or are applicable to the Property, provided same do not prohibit Lessee's use of the Premises in accordance with the provisions of this Lease.

E. Lessor will cooperate with Lessee in obtaining any permits, zoning or easement modifications or other governmental approvals that may be required from time to time for Lessee to operate its business on the Property in accordance with the intended use herein. However, Lessee will not seek to change the current zoning status of the Property without first obtaining written consent from Lessor. Lessor shall have the right to deny any such request which it deems detrimental to the marketability or value of the Premises. Lessor acknowledges that Lessee may desire to physically connect the Improvements on the Premises with the building on the adjoining property known as Premier Radiology. Following the termination of the Lease, Lessee shall, at Lessee's cost, remove any portions of the Improvements that connect with the buildings on the adjoining property, and restore the Premises and the Improvements to a condition as if the adjoining structures had not been constructed.

F. Lessee shall have full responsibility for protecting the Property and all property and persons located thereon from theft and robbery.

6. Utilities. Lessee agrees to make its own arrangements, at Lessee's sole cost and expense, for, and Lessee shall pay or cause to be paid before delinquency all charges, claims, or liens of water, gas, electricity, sewer, telephone service, steam, cable television and any other commodities or services furnished to or for the Premises or the Improvements, or any part thereof, beginning on the day following the date upon which this Lease is fully executed by all parties and continuing during the Term of this Lease.

7. Taxes. As additional rental hereunder, Lessee shall pay all Taxes directly to the appropriate authority or authorities before any delinquency thereon shall occur, and shall deliver evidence of payment thereof to Lessor before said delinquency, without demand. In the event any Taxes are permitted by law to be paid in installments (whether by subjecting this Lease or the Property to bond, or otherwise), Lessee shall have the option to pay such Taxes in installments, but only if the assessment has been levied on account of and in proportion to value added to the Premises and only if the installments will be in proportion to reasonable amortization of that value. In the event of such election, Lessee shall be liable only for those installments of such Taxes which become due and payable during the Term of this Lease or which are payable with respect to a year which occurs in whole or in part during the Term of this Lease. Lessor, at Lessee's sole cost and expense, agrees to execute or join with Lessee in the execution of any application or other instrument that may be necessary to permit the payment of such Taxes in installments as described above. All Taxes for or relating to the tax year in which this Lease shall terminate shall be prorated between Lessor and Lessee as of the date of such termination.

Lessee shall have the right, upon prior written notice to Lessor, to contest or review the amount, applicability or validity of any Taxes and all assessments or levies of such Taxes by one or more appropriate lawful proceedings, which, if instituted, shall be diligently conducted by Lessee in good faith at its own cost and expense, and free of any expense to Lessor (all such expenses of Lessor must be paid by Lessee), and, if necessary, in the name of Lessor and Lessor shall, upon the request of Lessee, execute all documents reasonably necessary to accomplish such contest or review. Lessee shall indemnify and hold Lessor harmless from and against all claims arising out of such contest or review conducted by Lessee. If at any time the Property or any part thereof shall then be imminently subject to forfeiture, or if Lessor shall be subject to any criminal liability arising out of the nonpayment of Taxes, Lessee shall, notwithstanding any pending contest or review, either pay such Taxes or post such bonds as the taxing authority may require to prevent such forfeiture or criminal liability.

At Lessor's option, from time to time or at all times, but only after all or any portion of the payments of annual real estate taxes and assessments on the Property are once delinquent for sixty (60) days or more, Lessee will, within thirty (30) days of written notice from Lessor, monthly pay into escrow to Lessor, until further notice from Lessor, an amount reasonably determined by Lessor, in accordance with the provisions of Paragraph 36 below, necessary to cover Lessor discharging Lessee's duties under this Paragraph 7.

8. Insurance. Commmencing on the day following the date upon which this Lease is fully executed by all parties and continuing during the term of this Lease, Lessee shall, at its sole cost and expense, procure and maintain insurance against the hazards and liabilities, and in the amounts hereinafter set forth. At Lessor's option, from time to time or at all times, but only after the Property is not insured as required by this Paragraph 8 on any two occasions throughout the Term of this Lease and Lessee is so notified in writing by Lessor (whether or not Lessee cures such default), Lessee will, within thirty (30) days of written notice from Lessor, monthly pay into escrow to Lessor, until further notice from Lessor, an amount reasonably determined by Lessor, in accordance with the provisions of Paragraph 36 below, necessary to cover Lessor discharging Lessee's duties under this Paragraph 8. Certificates of all policies evidencing such insurance shall be delivered to Lessor, without demand. All policies of insurance provided for herein shall be in such form and include such deductibles, endorsements and waivers and be with such insurance companies as shall be reasonably designated or approved by Lessor in writing, provided that such deductibles, endorsements and waivers shall be comparable to those included in insurance policies for property comparable to the Property in the vicinity of the Property. All such policies shall name Lessor and Lessee as insured's thereunder and shall name the Leasehold Mortgagee under a standard mortgagee clause, all as their respective interests may appear. All such policies shall provide that the same may not be canceled or amended without at least thirty (30) days prior written notice being given by the insurer to all insured's thereunder. Such insurance shall include at least the following:

A. Casualty Insurance - Casualty insurance covering the Property, in an amount at least equal to 100% of replacement value with a "deductible" of up to Fifty Thousand Dollars ($50,000), and with stipulated amount full replacement cost or agreed valuation endorsement, but in no event in an amount which would make Lessor a co-insurer of any loss, without any deduction for physical depreciation of the Improvements. Such "full replacement cost" shall be determined at Lessee's sole cost and expense from time to time (but not more frequently than once in any twenty-four (24) calendar months) at the request of Lessor, by an appraiser, engineer, architect or contractor designated by Lessee and approved in writing by Lessor (such approval not to be unreasonably withheld) or if not designated by Lessee within twenty (20) days of request, then designated by Lessor. No omission on the part of Lessor to request any such determination shall relieve Lessee of any of its obligations under this Article. Such policy shall insure against loss or damage by (i) fire, lightning, windstorm, hail, explosion, riot, civil commotion, damage from aircraft and vehicles, and smoke damage, and (ii) such other risks as are customarily covered with respect to improvements similar to the Improvements in the vicinity of the Property determined by Lessor in good faith. Such coverage shall provide for a full waiver of (i) subrogation by the insurer as to any and all claims against Lessor, and its agents, employees, contractors, and tenants, and (ii) all defenses based upon acts of the insured's or the existence of co-insurance. Lessor and Lessee, at the sole cost and expense of Lessee, shall cooperate in adjusting and settling any loss with the insurer under such policy. The amount of any deductible or portion of any loss not covered by said insurance policy shall be paid by Lessee to cover the first costs incurred in repairing or restoring any such loss prior to the distribution of any insurance proceeds as provided in Paragraph 10.

B. Public Liability Insurance - Comprehensive general liability and automobile liability insurance with liability limits at least equal to those obtained under insurance policies for improvements similar to the Improvements in the vicinity of the Property as determined by Lessor in good faith (but in no event less than $3,000,000 for injury or death to one or more persons arising from any occurrence and $1,000,000 for property damage) with combined bodily injury and broad form property damage coverage and protecting Lessor (and Lessor's designees) and Lessee, and their respective mortgagees, against any and all claims for damages to person or property or for loss of life, for personal injury or to property occurring upon, in or about the Property. Every five (5) years during the term of this Lease, Lessor may require that the policy limits set forth above increase up to fifteen (15%) percent by providing written notice to Lessee. Upon receipt of such notice, Lessee shall increase the existing policy limits in accordance with the Lessor's request, and shall provide Lessor an updated certificate of insurance within thirty (30) days of the initial notice.

D. Mandatory Insurance - All insurance required by any ordinance, law or governmental regulation.

F. No Work Without Insurance - Lessee shall not make any alterations, repairs or installation, or perform Lessee's Work or other work to or on the Property unless prior to the commencement of such work Lessee shall obtain (and during the performance of such work keep in force) builder's risk, public liability and worker's compensation insurance to cover every contractor to be employed, and any other insurance reasonably required by Lessor. Prior to commencement of such work, Lessee shall deliver originals or certificates of such insurance policies to Lessor as required by this Lease.

9. No Warranties by Lessor.

A. Lessee acknowledges that Lessee has full knowledge of all matters pertaining to the Premises, including, but not limited to, the condition of title to the same and the physical condition of the same, and that Lessee is leasing the Premises "AS IS" and Lessor shall not be required to perform any work or furnish any materials in connection with the Property. Lessor makes no warranty of any kind or nature, express, implied or otherwise, or any representations or covenants of any kind or nature in connection with the title to or

condition of the Premises or any part thereof, and Lessor shall not be liable for any latent or patent defects therein or be obligated in any way whatsoever to correct or repair any such latent or patent defects. Without limiting the above, Lessee acknowledges and agrees that neither Lessor, nor any brokers, any agents, employees or representatives of Lessor have made any representations or warranties on which Lessee is relying as to matters concerning the Premises including, without limitation, the land, improvements, development rights, taxes, bonds, permissible uses, covenants, conditions and restrictions, water or water rights, topography, utilities, zoning, soil, subsoil, the purposes for which the Premises are to be used, drainage, environmental or building laws, rules or regulations or any other representations or warranties of any nature whatsoever, and Lessee hereby assumes all risks relating to any of the foregoing and to all matters relating to the use and occupancy of the Premises, whether known or unknown, or foreseeable or unforeseeable. Lessor, however, expressly warrants that it has full corporate authority to enter into this Lease. Lessor also expressly covenants that is has not done or suffered any act or occurrence during the time it has owned the Premises which has impaired title to the same, except utility easements of record.

10. Demolition, Construction, Restoration, and Maintenance

A. In the event that Lessee intends to demolish the existing building on the Premises, all plans for demolition and construction shall first be provided to Lessor. Within thirty (30) days after the plans are presented to Lessor, it shall either approve the plans or give Lessee written notice of any specific objections to the plans. After Lessor provides its consent to the demolition and reconstruction, which Lessor shall not unreasonably withhold, Lessee shall have the right, at its own cost and expense, to demolish the existing building on the Premises. Within thirty (30) days after the date upon which the Landlord's consent is provided, Lessor shall remove, or cause to be removed, any Personal Property that Lessor does not desire for Lessee to dispose of or sell. After the expiration of thirty (30) days from the date of Lessor's consent, Lessee shall have the right to sell for salvage any Personal Property or parts of the existing structures that remain on the Premises. Lessor, in its discretion, may require Lessee to post a bond or other security in a form and amount satisfactory to Lessor to secure the successful completion of the project.

B. After Lessee obtains all necessary permits, approvals and financing (if any), and following the demolition of the existing building on the Premises, Lessee shall commence and thereafter diligently prosecute to completion the construction on the Premises, at Lessee's sole cost and expense, of the Improvements generally as outlined at Exhibit "C", attached hereto and made a part hereof. In the event that Lessee provides, constructs and/or obtains any utilities or other services to the Premises from any other property owned or controlled by Lessee, Lessor may require that Lessee establish and record a permanent, dedicated easement which will run with the Premises and be binding upon all future successors and assigns of Lessee. The project shall be completed within one (1) year of the date of Landlord's consent as set forth above.

C. If the Property or Leasehold is not encumbered by any unpaid mortgage, and if the Property, or any part thereof, is damaged or suffers loss (other than ordinary wear and tear) at any time by reason of any matter or thing whatsoever, foreseen or unforeseen, insured or uninsured, including, but without limitation on the generality of the foregoing, any fire, earthquake or other calamity, Lessee, at its own cost and expense, and whether or not the insurance proceeds, if any, shall be sufficient for the purpose, shall proceed with all reasonable diligence and speed (considering the availability of labor and materials) to obtain all necessary governmental permits for such repair or restoration and thereafter to repair, replace and restore the Property as nearly as possible to the same value, condition and character as existed immediately prior to such damage or loss. Lessee shall be entitled to use any proceeds of the insurance provided for in Paragraph 8 hereof payable with respect to such damage or loss for the purpose of accomplishing said restoration (but the payment of such insurance shall be subject to such conditions as shall reasonably satisfy Lessor that such insurance

proceeds shall be used only for the purpose of effecting such restoration). Any excess insurance proceeds remaining after such restoration is completed shall belong to Lessee.

C. If the Property or Leasehold is encumbered by any unpaid mortgage, and if the Property, or any part thereof, is damaged or suffers loss (other than ordinary wear and tear) at any time by reason of any matter or thing whatsoever, foreseen or unforeseen, including, but without limitation on the generality of the foregoing, any fire, earthquake or other calamity, Lessee shall, at its own cost and expense shall proceed with all reasonable diligence and speed (considering the availability of labor and materials) to obtain all necessary governmental permits for such repair or restoration and thereafter repair, replace and restore the Property as nearly as possible to the same value, condition and character as existed immediately prior to such damage or loss. Lessee shall be entitled to use any proceeds of the insurance provided for in Paragraph 8 hereof payable with respect to such damage or loss for the purpose of accomplishing said restoration (but the payment of such insurance shall be made to the Leasehold Mortgagee who shall disburse the same only as restoration work progresses as evidenced by architect's certificates). Any excess insurance proceeds remaining after such restoration is completed to the satisfaction of the Leasehold Mortgagee shall be applied first to the unpaid principal balance and accrued interest of the Leasehold Mortgagee and second shall pay over the balance to the Lessee. Provided however, that Lessee shall not be obligated to repair or restore the property at a cost in excess of the insurance proceeds, providing Lessee had adequately insured the Property pursuant to Paragraph 8 above.

Provided, however, that in the event the Leasehold Mortgage is in default at the time of the damage or loss to the Property, the Leasehold Mortgagee may at its option apply the insurance proceeds first to the unpaid principal balance and accrued interest due under the Leasehold Mortgage and second shall pay over the balance to the Lessor, unless Lessor shall cure the default of the Lessee pursuant to Paragraph 22, in which case the Property shall be restored and the insurance proceeds used as provided above as if there had been no default by the Lessee under the Leasehold Mortgage.

D. Lessee, at its own cost and expense, shall keep and maintain the Property and all landscaping, sidewalks, alleys and passages surrounding the same and each and every part thereof in good, first class, orderly, clean, safe and sanitary state of decor, repair and condition and as otherwise required by this Lease. Lessee shall perform all decorating, repairs and replacements necessary to accomplish the foregoing obligations, whether foreseen or unforeseen, structural or nonstructural, ordinary or extraordinary. Lessee will not take any action or omit to take any action required of Lessee hereunder, the taking or omission of which adversely impairs the value or usefulness of the Property or causes waste with respect thereto. When used in this Lease, the term "repairs" shall include all necessary replacements, renewals, alterations, additions and betterments. All repairs made by Lessee shall be equal in quality and class to the original Lessee's Work.

E. (1) Lessor shall have no obligation to make any repairs, decorating, replacements, restorations, alterations, additions or improvements whatsoever in or about the Property or any part thereof, or to restore the same or any part of the same in the event of its loss, destruction or damage unless such loss, destruction or damage is solely due to the fault of the Lessor, and Lessee hereby waives any right it may have to make repairs at the expense of Lessor.

(3) In the event Lessee fails for any reason (i) to apply for and diligently pursue the obtaining of any necessary governmental permits for the performance of its obligations under this Paragraph 10 within thirty (30) days after written notice from Lessor to do so, or (ii) commence performance of any of its obligations under this Paragraph 10 within thirty (30) days after obtaining any necessary permits therefore from the appropriate governmental agencies (if such permits are necessary for the work required to be performed) or (iii) to commence performance of any of its obligations under this Paragraph 10 within thirty (30) days after written notice from Lessor to do so (if such permits are not required), THEN, in addition to

any other remedies of Lessor hereunder for such failure, Lessor may make or perform the necessary restoration or repairs (and may use any proceeds of the insurance provided for in Paragraph 8 hereof for such purposes, superseding any right of Lessee or any mortgagee therefore), and Lessee shall pay to Lessor the cost thereof, as additional rent (in excess of such net insurance proceeds used for such purpose), on the date when the next installment of Rent falls due; but the making of such restoration or repairs by Lessor shall in no event be construed as a waiver of Lessor's right to require Lessee to keep the Property in repair and to restore the same in the event of its damage or loss as provided in this Lease. All work performed by Lessee under this Paragraph 10 shall be performed in accordance with the provisions of Paragraph 11 hereof.

11. Manner of Performance of Lessee's Work. All repairs, maintenance, restoration, construction, reconstruction, demolition, removal, replacement and alteration of the Property or any part thereof required or permitted to be made by Lessee under this Lease (collectively hereinafter called "Lessee's Work"), including the construction of the Improvements by Lessee, shall be made in accordance with the following:

A. Lessee shall comply with all applicable laws, ordinances, rules and regulations (including, but not limited to, all safety rules and regulations) relating to or governing the Lessee's Work and, without limitation on the generality of the foregoing, shall procure and maintain all permits and authorizations required to be obtained from any governmental authority in connection therewith.

B. All Lessee's Work shall be performed diligently and in a good and workmanlike manner, free from defects of any kind and nature.

12. Indemnity. Lessee shall hold harmless and indemnify Lessor from and against any claim, penalty, loss, damage, charge, liability or expense (including, without limitation, reasonable attorney's fees, both at trial and on any appeal or up to any settlement), threatened, sustained or incurred by reason of, directly or indirectly, (a) the death or loss of or damage or injury to person or property resulting from or caused by or claimed to have resulted from or been caused by: (i) the construction, use, operation, condition or lack of repair of the Property or any real or personal property at any time or times thereon, or (ii) any act or thing done or omitted to be done by Lessee, its agents, employee, servants, invitees, or, without limitation, any other person or persons other than Lessor or its employees; or (b) any failure on the part of Lessee to perform or comply with any of Lessee's covenants, obligations or liabilities hereunder; or (d) any storage, handling or disposal of any flammable explosives, hazardous or toxic substances on or from the Premises, or any leakage or contamination attributable to any underground tanks or other equipment whether formerly situated on the Premises or to be placed on the Premises by or at the direction of Lessee.

Lessor shall hold harmless and indemnify Lessee from and against any claim, penalty, loss, damage, charge, liability or expense (including, without limitation, reasonable attorney's fees, both at trial and on any appeal or up to any settlement), threatened, sustained or incurred by reason of, directly or indirectly, the actions or omissions, relating to the Premises, of Lessor, its agents, employees acting in official capacity, invitees and guests.

13. Interference. Except as otherwise provided herein, Lessee shall have no claim against Lessor for any damage, should Lessee's possession of the Premises or any part thereof be disturbed or interfered with or affected in any manner by reason of the acts or omissions of any person, or by reason of the enactment or adoption of any law, ordinance or regulation or by reason of any other act of any governmental authority. The foregoing shall not limit Lessor's liability for Lessor's wrongful interference with the rights of Lessee under this Lease or Lessor's breach of this lease.

14. Liens. Lessee shall at all times keep the Property, Lessee's leasehold interest under this Lease, and the rents, issues and profits of the Property or any part thereof, free and clear of all liens and claims for services, labor or materials supplied or claimed to have been supplied to Lessee or to or in connection with the Property, or any part thereof, and free and clear of all attachments, executions, levies, mortgages (except as expressly provided in Paragraph 17.E. herein), conditional sale agreements, or chattel mortgages, and Lessee shall not suffer any other matter or thing whereby the estate, rights, and/or interests of Lessor in the Property, or any part thereof, might be impaired. In the event of the filing or levy of any such lien, claim, attachment, execution or stop notice, Lessee shall, within thirty (30) days after notice of the filing thereof, cause the same to be discharged of record by payment, deposit, bond, order of a court of competent jurisdiction, or as otherwise approved by Lessor, provided in all events the procedure used is acceptable to Lessor's title insurance company so that said title insurance company would, without additional premium or cost, remove any exception for such encumbrance from any title insurance policy that it might thereafter issue. If Lessee shall fail to cause such lien or encumbrance to be discharged within the period aforesaid, Lessor may (in the exercise of its self-help rights under this Lease), but shall not be obligated to, discharge such lien or encumbrance either by paying the amount claimed to be due or by procuring the discharge of such lien or encumbrance by deposit, bonding or other proceedings, and in any such event, Lessor shall be entitled, if Lessor so elects, to compel the prosecution of an action for the foreclosure of such lien by or as the lienor and to pay the amount of judgment in favor of such lienor with interest, costs and allowances. Lessee agrees that the fund for the payment of any mechanic's liens shall consist solely of the Lessee's leasehold interest herein and Lessee's interest, subject to this Lease, in and to the Improvements situate on, or to be situate on, the Premises and shall not accrue against the fee of the land.

15. Alterations Required by Law. If any alterations, additions, improvements, repairs or renewals shall be required in or to the Property or any part thereof by any laws, ordinances, or regulations, or by any restrictions, the same shall be done by and the cost thereof borne by Lessee, subject to the provisions of Paragraph 11.

16. Condemnation.

A. If, as a result of the exercise of the power of eminent domain or a conveyance in lieu thereof (hereinafter in this Article referred to as a "Proceeding"), the entire Property or all of the Improvements shall be taken, this Lease and all right, title and interest of the Lessee hereunder shall cease and come to an end on the earlier of the date on which possession is taken by the condemning authority or the date of vesting of title pursuant to such Proceeding. All sums, including damages and interest, awarded in such Proceeding for the fee or leasehold or both shall be paid to the Leasehold Mortgagee in escrow if a Leasehold Mortgage is then outstanding, otherwise jointly to the Lessor and Lessee, and applied in payment of the following items in order of priority:

(1) All real and personal property taxes constituting a lien on the Premises or Improvements then due and payable shall be paid.

(2) Leasehold Mortgagee, if any, shall receive the amount of any outstanding principal and accrued interest thereon from the portion of the award attributable to the value of the leasehold interest in the Premises and of the Lessee's present interest in the Improvements, subject to this lease.

(3) Lessor shall receive the portion of the award attributable to the value of the Premises taken, valued as unimproved land exclusive of any Improvements, and as encumbered by this Lease, and the value of Lessor's reversionary interest in the Improvements.

(4) Subject to the rights of any Leasehold Mortgagee as provided above, Lessee shall receive the portion of the award or the balance of the award attributable to the value of the leasehold interest

in the Premises under this Lease as well as the value of Lessee's present interest in the Improvements, subject to this Lease.

(5) Lessor shall receive any expenses or disbursement reasonably paid or incurred by it in connection with the condemnation proceedings.

(6) Lessee shall receive any expenses or disbursements reasonably paid or incurred by it in connection with the condemnation proceedings.

B. If less than the entire Improvements shall be taken in any Proceeding, this Lease shall terminate as to the portion of the Improvements so taken and the portion of the Premises which is taken in connection therewith on the earlier of the date on which possession is taken by the condemning authority or the date of vesting of title pursuant to the Proceeding. In the event, and only in the event, that the remainder of the Improvements and the Real Property not so taken cannot reasonably or practicably be repaired or reconverted so as to permit the use thereof by Lessee for the purposes permitted hereunder, this Lease shall terminate as to such remainder of the Improvements and the Premises on the earlier of the date on which possession is taken by the condemning authority of the condemned portion of the Improvements and Premises or the date of vesting of title to said portion of the Improvements and the Premises pursuant to such Proceeding. Lessor shall initially determine whether or not the portion of the Improvements and Premises not taken can be repaired or reconverted as provided above, and shall notify Lessee in writing of its determination within thirty (30) days after the date on which Lessor receives notice that the taking has been confirmed by a court whose order is not appealable (or the time for which appeal has lapsed). If Lessee disagrees with Lessor's determination, then Lessee shall notify Lessor thereof within fifteen (15) days after Lessor has so notified Lessee. If, within fifteen (15) days after Lessee has so notified Lessor or Lessee's disagreement with Lessor's determination, the parties cannot mutually resolve their disagreement on this issue, the disagreement shall be settled by an arbitration proceeding undertaken in Davidson County, Tennessee, in accordance with the rules of the American Arbitration Association then existing, and judgment on the arbitration decision may be entered in any court having jurisdiction over the subject matter of the disagreement. The costs of the arbitration proceeding shall be evenly divided between the parties. If this lease is terminated as herein provided, then all sums, including damages and interest awarded for the fee or leasehold or both shall be paid to the Leasehold Mortgagee in escrow if a Leasehold Mortgage is then outstanding, otherwise jointly to the Lessor and Lessee, and applied in payment of the following items in order of priority:

(1) All real and personal property taxes constituting a lien on the Premises or Improvements then due and payable shall be paid.

(2) Leasehold Mortgagee, if any, shall receive the amount of any outstanding principal and accrued interest thereon from the portion of the award attributable to the value of the leasehold interest in the premises and of the Lessee's present interest in the improvements, subject to this lease, unless Leasehold Mortgagee shall, at its sole option, consent that it may be applied to restore the improvements in which event Leasehold Mortgagee shall not be required to expend more than the award for Improvements and leasehold interest, for such restoration.

(3) Lessor shall receive the portion of the award attributable to the value of the Premises taken, valued as unimproved land exclusive of any Improvements, and as encumbered by this Lease, and the value of Lessor's reversionary interest in the Improvements.

(4) Subject to the rights of any Leasehold Mortgagee as provided above, Lessee shall receive the portion of the award or the balance of the award attributable to the value of the leasehold interest

in the Premises under this Lease as well as the value of Lessee's present interest in the Improvements, subject to this Lease.

(5) Lessor shall receive any expenses or disbursements reasonably paid or incurred by it in connection with the condemnation proceedings.

(6) Lessee shall receive any expenses or disbursements reasonably paid or incurred by it in connection with the condemnation proceedings.

C. If less than the entire Improvements shall be taken in a Proceeding and this Lease shall not be terminated as provided in Paragraph 16B above, this Lease shall terminate only as to the portion of the Improvements taken and the portion of the Premises which is taken in connection therewith on the earlier of the date on which possession is taken by the condemning authority or the date of vesting of title pursuant to the Proceeding. In any such case, Lessee covenants and agrees, at Lessee's sole cost and expense, but not at a cost and expense in excess of any awards payable with respect thereto, promptly, and pursuant to the provisions of Paragraph 11, to restore those portions of the Improvements and the Premises not so taken to a complete architectural unit for the use and occupancy of the Lessee as permitted hereunder. If less than the entire Improvements shall be taken in any Proceeding, all sums, including damages and interest, awarded in the Proceeding for the fee or leasehold or both shall be applied first to the cost of restoring the Improvements, subject to the satisfaction of such reasonable disbursement conditions as Lessor and Lessee may mutually agree shall be required or in the event there is a Leasehold Mortgage outstanding, the award shall be payable to the mortgagee and disbursed as work progresses as evidenced by architect's certificates, except that if such mortgage is then in default, Leasehold Mortgagee shall have the right to apply the award attributable to the Improvements and leasehold interest first to its mortgage, unless Lessor shall exercise its right to cure. Any balance of such sums so awarded shall be applied as follows:

(1) Leasehold Mortgagee, if any, shall receive the amount of any outstanding principal and accrued interest thereon from the portion of the award attributable to the value of the leasehold interest in the Premises and of the Lessee's present interest in the improvements, subject to this lease (but reduced by the portion, if any, applied to the restoration of the improvements).

(2) Lessor shall receive the portion of the award attributable to the value of the Premises taken, which shall be determined as unimproved land exclusive of any Improvements and as encumbered by this Lease, and the value of Lessor's reversionary interest in the Improvements taken.

(3) Subject to the above rights of any Leasehold Mortgagee, Lessee shall receive the portion of the award attributable to the value of the leasehold interest in the Premises under this Lease as well as the value of Lessee's present interest in the Premises subject to the Lease (but the amounts payable to Lessee under this subparagraph (3) shall be reduced by the portion of the award which is applied to the cost of restoring the Improvements).

(4) Lessor shall receive any expenses or disbursements reasonably and necessarily incurred or paid by it in connection with the condemnation proceedings.

(5) Lessee shall receive any expenses or disbursements reasonably and necessarily incurred or paid by it in connection with the condemnation proceedings.

If less than the entire Improvements shall be taken in any Proceeding and this Lease shall not terminate under Paragraph 16B, then, as of the earlier of the date on which possession is taken by the condemning authority or the date of vesting of title pursuant to the Proceeding, the Rent shall be reduced by

an amount based upon the proportion which the net rentable square footage of the Improvements after the taking bears to the total net rentable square footage of the Improvements prior to the taking.

D. If a portion of the Premises, but no portion of the Improvements, is taken in a Proceeding, the provisions of this subparagraph shall apply. If less than five percent (5%) of the surface of the Premises, exclusive of the portion of the surface of the Premises covered by the Improvements, is taken, this Lease shall terminate with respect to the portion so taken and the Rent payable hereunder shall not be reduced. If more than five percent (5%) of the surface of the Premises, exclusive of the portion of the surface of the Premises covered by the Improvements, is taken, this Lease shall terminate with respect to the portion so taken and the Rent shall be reduced from the date of the taking by an amount determined by Lessor based on the degree to which such taking interferes with Lessee's normal use of the Premises as permitted hereunder. Lessor shall notify Lessee of such amount in writing. If Lessee disagrees with such amount, then Lessee shall notify Lessor thereof within fifteen (15) days after Lessor has so notified Lessee. If, within fifteen (15) days after Lessee has so notified Lessor, the parties cannot mutually resolve their dispute on this issue, the dispute shall be settled by an arbitration proceeding undertaken in Davidson County, Tennessee, in accordance with the rules of the American Arbitration Association then existing, and judgment on the arbitration decision may be entered in any court having jurisdiction over the subject matter of the dispute. The costs of the arbitration proceeding shall be divided evenly between the parties. In connection with any taking described in this Paragraph, the Lessor shall be entitled to and shall receive the award made in any Proceeding for direct damages, and Lessee hereby assigns such award to Lessor, and Lessee shall be entitled to and shall receive the award made for consequential damages and Lessor hereby assigns such awards to Lessee.

E. If the use or occupancy of the Premises or any portion thereof shall be temporarily taken by any governmental authority, civil or military, or by any entity having the power of eminent domain, then this Lease shall continue in full force and effect, and Lessee shall continue to pay in full all Rent and all other sums due hereunder. In the event of any such temporary taking, Lessee shall be entitled to receive that portion of any award which represents compensation for the use or occupancy of the Premises during the remaining portion of the Term, and Lessor shall be entitled to receive that portion of any award which represents the cost of restoration of the Premises and the use and occupancy of the Premises after the end of the Term.

F. Lessee hereby waives any rights it may have under any law or any judicial decision which would otherwise apply to the exercise of the power of eminent domain with respect to the Property, to the extent such law or judicial decision is inconsistent herewith.

17. Assignment, Subletting, Mortgage, and Sale of Lessee's Interests. Lessee shall not assign, sublet, mortgage or sell Lessee's interest or interest in the improvements except as hereinafter provided.

A. Assignment.

(1) Lessee shall not assign or otherwise transfer this Lease or any part thereof or interest therein, or permit the same to be assigned or otherwise transferred, voluntarily or involuntarily, by operation of law or otherwise, except (a) an assignment to an Affiliate of Lessee so long as Hospital becomes a guarantor of the Lease pursuant to the terms of the Guaranty Agreement attached hereto as Exhibit B, (b) as collateral for the repayment of a loan from an Institutional Lender which is also secured by a mortgage on the Lessee's interest in the Premises and Improvements or in the form of a deed in lieu of foreclosure or Foreclosure Referee's Deed to the mortgagee and (c) in connection with a sale of the Improvements.

(2) An assignment of this Lease by Lessee in connection with the sale of the Improvements shall require the prior written consent of the Lessor in each instance. Such consent shall not be unreasonably withheld, but shall be governed by the provisions of Paragraph 17C and be subject to the

provisions this Lease. No such assignment shall be effective unless and until Lessor shall have received an executed counterpart of such assignment, in recordable form, in form and content reasonably acceptable to the Lessor, under which the assignee shall have assumed this Lease and agreed to perform and be bound by the covenants and conditions of this Lease required to be performed and observed by Lessee. Upon such assignment and consent by Lessor, Lessee shall be relieved from its obligations hereunder.

(3) Lessee shall pay the reasonable costs and expenses of Lessor in connection with the granting or withholding by Lessor of its consent to any assignment, including, without limitation, reasonable attorney's fees. If Lessor shall at any time consent to one or more assignments or transfers, it shall not thereafter be precluded from withholding its consent to any one or more further assignments or transfers.

B. Subleases. Except for a sublease to an Affiliate of Lessee where Hospital becomes a guarantor of the Lease, Lessee is hereby strictly prohibited from subletting all or any portion of the Premises as defined in paragraph 1.A. above (the land) without the prior written consent of the Landlord in each instance, which consent may be withheld by the Landlord at its sole and absolute discretion. Use of the Premises under any such Sublease must be in compliance with the use restrictions set forth in Paragraph 5 and all other provisions of this Lease. Subject to the rights of any Leasehold Mortgagee to require assignment of rents, each Sublease shall contain a provision satisfactory to Lessor requiring the Sublessee thereunder, at the option of Lessor, to attorn to Lessor and to make all subsequent payments and perform its other obligations under such Sublease to Lessor, if Lessee defaults under this Lease and if such Sublessee is notified of such default and instructed to make its rental and other payments to Lessor, provided, however, that in the event of any termination of this Lease, no Sublease shall be binding upon Lessor whether or not Lessor shall have approved said Sublease and the Sublessee. Lessee shall pay all reasonable costs and expenses, if any, incurred by Lessor in connection with the consent of any Sublease, including, without limitation, reasonable attorney's fees.

C. Sale.

(1) Subject to the provisions of this Lease, Lessee shall have the right to sell the Improvements situated on the Premises, but only in their entirety and only if the Lessee's interest in this Lease is sold and assigned to the same party, it being the intention of the parties that the leasehold created hereby and title to the Improvements shall at all times be vested in the same party. Any sale of the Improvements shall be subject to the prior written consent of the Lessor, which consent shall not be unreasonably withheld.

(2) A request of Lessee to assign this Lease and sell the Improvements shall be accompanied by a complete description of the proposed transaction, including, without limitation, a full and complete description of the proposed assignee/purchaser and the business terms and conditions of the proposed transaction. The Lessee will provide the Lessor with such other information with respect to the proposed transactions as it may reasonably request. In determining whether to grant consent to the Lessee's request to assign and sell, the Lessor may consider (i) the ability of the proposed assignee/purchaser generally to perform the obligations of the Lessee under the Lease, (ii) the financial health and credit of the proposed assignee/purchaser, and (iii) the reputation of the proposed assignee/purchaser, including its owners and investors.

D. Lease of Improvements. (1) Lessee shall have the right to lease all or portions of the Improvements without Lessor's prior approval provided that such sublease or subleases meet the following requirements:

(i) use of the Improvements shall be limited to use in conformance with the provisions of Paragraph 5 ("Use of the Premises") herein;

(ii) the term of the sublease shall not exceed the original term or any subsequently modified term of this Lease; and

(iii) the sublease of said Improvements shall contain provisions acknowledging it is subject and subordinate to this Lease and agreeing that a termination or expiration of this Lease shall, at Lessor's sole option, constitute a termination or expiration of the sublease.

(2) Lessee shall have the right to lease all or portions of the Improvements with Lessor's prior written consent which shall not be withheld or delayed provided the following conditions are met:

(i) use of the Improvements shall be limited to use in conformance with the provisions of Paragraph 5 herein;

(ii) the term of the sublease shall not exceed the original term or any subsequently modified term of this Lease;

(iii) Lessee is not in default of any its obligations under this Lease beyond any applicable period of notice and opportunity to cure;

(iv) the sublease of the Improvements contains financial terms which were at or approximately at local prevailing market rates with common escalators for similar space at the time entered; and

(v) sub-tenants have attorned to Lessor in place of Lessee;

THEN, in such event, if requested, Lessor shall guarantee non-disturbance of such sublessee on the following terms:

(i) sub-tenant's right to possession under the sublease will not be cut-off by any termination of this Lease, except by reason of the expiration of the Lease term;

(ii) the sublease of the Improvements will remain in full force and effect except that neither Lessor nor any subsequent Lessor under this Lease shall be (a) liable for any previous act or omission of the landlord (the Lessee under this Lease); (b) obligated with respect to any security deposit under the sublease unless such security deposit has been physically delivered to Lessor; (c) bound by or liable for any provisions in the sublease relating to other than the Improvements or subtenant's occupancy thereof; and (d) bound by or liable for any provisions in the sublease which would require Lessor to spend funds other than the rents of the sublease.

(3) Any lease of the Improvements which does not meet all of the above-stated requirements shall not be valid without the prior written consent of the Lessor which may be withheld in Lessor's sole and absolute discretion. Lessee shall promptly provide Lessor with copies of all executed leases affecting the Improvements. No lease of the Improvements shall operate to relieve Lessee of any obligation under this Lease.

E. Leasehold Mortgages.

1) Lessee, may from time to time during the term of this Lease mortgage, hypothecate, or encumber, in whole or in part, its leasehold estate, subject to Lessor's prior written consent, which shall not be unreasonably withheld or delayed, and which consent shall not be withheld provided in each case that:

(a) The holder of the Leasehold Mortgage shall be an Institutional Lender whose lending activities are regulated or supervised by an agency of the federal government or the State of Tennessee, with a minimum tangible net worth (i.e. net worth less intangible assets such as goodwill, trade names, patent rights and the like) or capital and surplus, at the time of such encumbrance or hypothecation, of at least Two Million Dollars ($2,000,000) but in no event less than the minimum net worth required to be maintained by such lender under any applicable regulations of the Federal Deposit Insurance Corporation, the Federal Savings and Loan Insurance Corporation, or any other applicable federal or state governmental agency;

(b) In no event shall Lessor be required to encumber or subordinate its fee title to the Premises or any part thereof or interest therein for any reason;

(c) The Leasehold Mortgage shall not prohibit the disposition and application of insurance proceeds and condemnation awards as provided herein;

(d) The Leasehold Mortgage shall encumber only the Lessee's interest as Lessee in the Premises and its interest as owner of the Improvements;

(e) The Lessee or holder of the Leasehold Mortgage shall promptly deliver to the Lessor, in the manner herein provided for the giving of notice to Lessor, a true copy of the Leasehold Mortgage and any assignment thereof, and shall notify the Lessor of the address of the holder of the Leasehold Mortgage to which notices from the Lessor may be sent; and

(f) Until such time as construction of the Improvements contemplated by this lease is complete, all of the proceeds from any loan secured by the Lessee's interest in the Property shall be utilized in connection with the development and construction of such improvements.

Lessor's consent under this subparagraph 17.E.(1) shall be deemed to have been given if Lessor does not respond to Lessee's written request for Lessor's consent within ten (10) days of Lessor's receipt of such request accompanied by all information reasonably necessary to consider.

(2) In the event that Lessee encumbers or hypothecates its interest in this Lease as security for a loan as permitted above, and provided that Lessee delivers written notice to Lessor of the name and address of the lender of such loan, then Lessor hereby agrees that Lessor will give written notice of any default under the terms of this Lease, by registered or certified mail, to such lender at the address contained in such notice. Provided Lessee gives to Lessor written notice of the name and address of such lender as required above, no notice of a default by Lessor to Lessee shall be deemed to have been duly given to Lessee unless and until a copy thereof has been mailed to such lender at the address provided. Such lender, in case Lessee shall be in default under this Lease, shall, within the period and otherwise as herein provided, have the right to remedy such default, or cause the same to be remedied, and Lessor shall accept such performance by or at the instance of such lender as if the same had been made by Lessee. Provided Lessee gives to Lessor written notice of the name and address of such lender as required above, Lessor shall not take any action to terminate this Lease because of any default or breach thereunder on the part of Lessee if such lender (i) within sixty (60) days after mailing of written notice to such lender from Lessor of its intention to terminate the Lease for such default or breach, shall cure such default or breach if the same can be cured by the payment of expenditure of money, or (ii) shall diligently take action to obtain possession of the Premises (including possession by receiver) and to cure such default or breach in the case of a default or breach which cannot be cured unless

and until such lender has obtained possession and shall, during such time, pay all rental and all other payments required to be made under this Lease, or (iii) if such default or breach is not so curable under the foregoing subparagraphs (i) or (ii), shall institute and carry forward with due diligence foreclosure or sale proceedings under its mortgage or deed of trust securing such loan and pay all rental and all other payments required to be made under such Lease until such time as Lessee's interest in this Lease shall be sold upon such foreclosure or sale proceedings pursuant to said mortgage or deed of trust; provided, however, such lender shall not be required to continue such action for possession or such foreclosure or sale proceedings if such default or breach shall be cured by Lessee. Upon completion of any such foreclosure or sale proceedings under said mortgage or deed of trust, the purchaser (whether such lender or otherwise) at such sale will be recognized by Lessor as Lessee under the terms of this Lease for all purposes and shall be bound hereby for the remaining term hereof. A lender who acquires title to Lessee's interest in this Lease by acceptance of a deed in lieu of foreclosure shall be deemed a "purchaser" for these purposes.

18. Default.

A. Events of Default. The occurrence of any one of the following events shall constitute an event of default by Lessee under this Lease:

(1) Lessee shall fail to pay any installment of Rent when due and such failure shall continue for a period of ten (10) days after written notice thereof from Lessor; provided, however, that it shall not be considered an Event of Default under this Lease, and Lessor shall not be entitled to pursue the remedies set forth in Section 18.B if Hospital cures the failure to pay Rent pursuant to its guarantee obligations hereunder within 30 days of being informed of Lessee's failure to pay Rent.

(2) Lessee shall commence (by petition, application, assignment, or otherwise) a voluntary case or other proceeding under the laws of any jurisdiction seeking liquidation, reorganization, or other relief with respect to itself or its debts under any bankruptcy, insolvency, or other similar law now or hereafter in effect, or seeking the appointment of a trustee, self-trusteeship, receiver, assignee, custodian, or other similar official of it or any substantial part of its property; or shall consent (by answer or failure to answer, or otherwise) to any such relief or to the appointment of or taking possession by any such official in any involuntary case or other proceeding commenced against it; or shall generally not pay its debts as they become due; or admit in writing its inability to pay its debts as they become due; or shall take any corporate or other action to authorize any of the foregoing.

(3) An involuntary case or other proceeding shall be commenced against the Lessee under the laws of any jurisdiction seeking liquidation, reorganization, or other relief with respect to it or its debts under any bankruptcy, insolvency, or other similar law now or hereafter in effect, or seeking the appointment of a trustee, receiver, custodian, or other similar official of Lessee or any substantial part of Lessee's property, and such involuntary case or other proceeding shall remain undismissed and unstayed for a period of sixty (60) days or a trustee, receiver, custodian, or other official shall be appointed in such an involuntary case and is not removed within sixty (60) days of being appointed.

(4) Lessee shall abandon the Premises.

(5) Lessee shall fail to comply with any term, provision or covenant of this Lease not involving the payment of money, and shall not cure such failure within thirty (30) days after written notice thereof by Lessor to Lessee or, if such failure is not reasonably susceptible of cure within such thirty (30) day period, Lessee shall not commence to cure such failure within such thirty (30) day period or thereafter shall not diligently prosecute such cure to completion within a reasonable period of time.

B. Remedies for Default. In the event of any default by Lessee under this Lease, then, in addition to and without prejudice to any other right or remedy given hereunder or by law and notwithstanding any waiver of any former breach of covenant Lessor may:

(1) Terminate this Lease, and Lessee's right to possession of the Property, by giving to Lessee a notice of intention to terminate this Lease specifying a day not earlier than thirty (30) days after the date on which such notice of intention is given and, upon the giving of such notice, the term of this Lease and all right, title, and interest of the Lessee hereunder shall expire as fully and completely on the day so specified as if that day were the date herein specifically fixed for the expiration of the term, whereupon Lessee shall immediately surrender the Property to Lessor, and if Lessee fails to do so, Lessor may, without prejudice to any other remedy which it may have for possession or arrearages in rent, enter upon and take possession of the Property and expel or remove Lessee and any other person who may be occupying such Property or any part thereof without being liable for prosecution or any claim of damages therefore; and Lessee agrees to pay to Lessor on demand the amount of all loss and damage which Lessor may suffer by reason of such termination, whether through inability to relet the Property on satisfactory terms or otherwise.

(2) Terminate this Lease as aforesaid and, upon termination of this Lease, exercise the remedies permitted by Tennessee law.

(3) So long as Lessor has not terminated Lessee's right to possession of the Premises, pursue its right to collect, by suit or otherwise, each installment of Rent that becomes due hereunder, or to enforce, by suit or otherwise, performance or observance of any agreement, covenant or condition hereof on the part of Lessee to be performed or observed.

(4) Enter upon and take possession of the Property without terminating this Lease and expel or remove Lessee and any other person who may be occupying such Property or any part thereof without being liable for prosecution of any claim of damages therefore, and without terminating this Lease or releasing Lessee from its obligations hereunder for the full term hereof, endeavor to relet the Property for the account of Lessee for such time and upon such terms as the Lessor shall determine, and receive the rent therefore. In any case of reletting hereunder, the Lessor may make repairs, alterations and additions in or to the Property, and redecorate the same to the extent deemed by the Lessor necessary or desirable, and the Lessee shall, upon demand, pay the cost thereof, together with the Lessor's expenses of the reletting (including, without limitation, attorney's fees). If the consideration collected by the Lessor upon any such reletting for Lessee's account is not sufficient to pay monthly the full amount of the Rent reserved in this Lease, together with the cost of repairs, alterations, additions, redecorating and the Lessor's expenses, the Lessee shall pay to the Lessor the amount of each monthly or other deficiency upon demand. In the event Lessor is successful in reletting the Property at a rental in excess of that agreed to be paid by Lessee pursuant to the terms of this Lease, Lessor and Lessee each agrees that Lessee shall not be entitled, under any circumstances, to such excess rental, and Lessee does hereby specifically waive any claim to such excess rental.

(5) Have the right to have a receiver appointed, upon application by Lessor, to take possession of the Property and to apply any rental collected from the Property and to exercise all other rights and remedies granted to Lessor pursuant to Paragraph 18B(4) hereof.

C. Lessee hereby expressly waives, so far as permitted by law, the service of any notice of intention to re-enter provided for in any statute, or of the institution of legal proceedings to that end, and Lessee, for and on behalf of itself and all persons claiming through or under Lessee, also waives any and all right of redemption or re-entry or repossession or to restore the operation of this Lease in case Lessee shall be dispossessed by a judgment or by a warrant of any court or judge or in case of re-entry or repossession by Lessor or in case of any expiration or termination of this Lease. Lessee hereby expressly waives its right to

counterclaim and cross-claim for any reason, including but not limited to counterclaims for personal injury or property damage, in any summary proceeding commenced by Lessor.

D. No failure by Lessor or Lessee to insist upon the strict performance of any covenant, agreement, term or condition of this Lease or to exercise any right or remedy consequent upon a breach thereof, and no acceptance of full or partial Rent during the continuance of any such breach, shall constitute a waiver of any breach or of such covenant, agreement, term or condition hereof. No covenant, agreement, term or condition of this Lease to be performed or complied with by either party, and no breach thereof, shall be waived, altered or modified except by a written instrument executed by the other party hereto. No waiver of any breach shall affect or alter this Lease but each and every covenant, agreement, term and condition of this Lease shall continue in full force and effect with respect to any other then existing or subsequent breach thereof.

E. In the event of any breach or threatened breach by Lessee of any of the covenants, agreements, terms or conditions contained in this Lease, Lessor shall be entitled to enjoin such breach or threatened breach and shall have the right to invoke any right and remedy allowed at law or in equity or by statute or otherwise as though re-entry, summary proceedings, and other remedies were not provided for in this Lease.

F. Each right and remedy of Lessor provided for in this Lease, unless the words "sole remedy" or words of similar specific import are used, shall be cumulative and shall be in addition to every other right or remedy provided for in this Lease or now or hereafter existing at law or equity or by statute or otherwise, and the exercise or beginning of the exercise of Lessor of any one or more of the rights or remedies provided for in this Lease or now or hereafter existing at law or in equity or by statute or otherwise shall not preclude the simultaneous or later exercise by Lessor of any or all other rights or remedies provided for in this Lease or now or hereafter existing at law or in equity or by statute or otherwise.

19. Vesting of Improvements and Other Property and Interests; Removal of Personal Property

A. Lessee shall, on the last day of the Term hereof, or upon any earlier termination of this Lease, quit and surrender the Property into the possession and use of Lessor without delay, broom clean and in good order, condition and repair (reasonable wear and tear excepted), free and clear of all lettings and occupancies and subleases (except for those which Lessor has elected to recognize pursuant to Paragraph 17), and free and clear of all liens and encumbrances other than those, if any, created by Lessor. During the Term, the Improvements constructed upon the Premises by Lessee shall be, as between Lessor and Lessee, the property of Lessee, but Lessee shall have not right to remove said Improvements from the Premises without Lessor's prior written consent. However, upon the expiration or sooner termination of this Lease, Lessee's right, title and interest in all Improvements then located on the Premises shall, without compensation to Lessee, vest in Lessor free and clear of all encumbrances. In addition, upon and as of the expiration or sooner termination of this Lease, the following shall, without compensation to Lessee, vest in Lessor:

(1) All prepaid rents, prepaid payments and security deposits made under any Subleases which Lessor has previously approved or which Lessor has elected to recognize pursuant to Paragraph 17B that have not heretofore been applied against obligations under such Subleases, and the amount of the same shall be paid over to the Lessor by Lessee.

(2) Lessee's interest in all Subleases which Lessor has previously approved or which Lessor has elected to recognize pursuant to Paragraph 17B, subject to the provisions of Paragraph 17B hereof.

(3) All intangible property selected by Lessor within sixty (60) days after such termination and owned or held by Lessee at such termination in connection with the Property or any part thereof, including contract rights, assignable insurance policies, logos, trade names, assignable franchises, endorsements or trade ratings, trade association memberships, agreements, business licenses, tenant lists, copies of records (including but not limited to all those relating to Taxes, insurance, tenants, maintenance, repairs, capital improvements and services), booklets and manuals, advertising material, utility contracts and telephone exchange numbers.

Nothing herein contained shall be deemed to require Lessor to succeed to Lessee's interest in any such intangible property, nor to become obligated or liable thereunder in any respect or at all, except as selected by Lessor. In no event will Lessor be liable for any default of Lessee under any Sublease or in connection with any such intangible property which occurred prior to the later of the termination of this Lease or the selection of the particular item of intangible property by Lessor as aforesaid with respect to which such default relates.

Lessee shall upon Lessor's demand deliver to Lessor such assignments, deeds, instruments and documents as Lessor shall request to confirm Lessor's ownership of the Improvements and the other items acquired by Lessor as aforesaid.

B. The Personal Property owned by Lessee may be removed by Lessee at any time prior to the termination of this Lease, and shall be removed by Lessee upon such termination. If, upon the expiration of the Term or earlier termination of this Lease, Lessee shall not have removed such Personal Property from the Premises and the Improvements, then Lessor shall have the right, at its election, in addition or in the alternative to its other rights with respect to the same, to either (i) deem such Personal Property abandoned and retain the same as its property, or dispose of the same without accountability in such manner as Lessor may see fit, or (ii) remove and store the same in a place satisfactory to Lessor, in which event all expenses of such disposition (in excess of any amount received by Lessor upon such disposition), removal and storage shall be charged to and be borne by Lessee, and Lessor shall be reimbursed by Lessee for such expenses upon written demand therefore. Lessee shall repair any loss or damage to the Property or any part hereof caused or resulting from the removal of the Personal Property (whether removed by or at the direction of Lessor or Lessee).

20. Other Obligations. In addition to the other obligations under this Lease, Lessee at all times commencing on the day following the date upon which this Lease is fully executed by all parties and continuing during the Term shall be bound by and shall fully comply with all covenants, conditions, restrictions, limitations and requirements of every kind or nature, whether foreseen or unforeseen, ordinary or extraordinary, structural or non-structural, interior or exterior, which relate to the Property or any part thereof or the ownership, occupancy or use thereof and which are imposed by law statute, rule, order, regulation or ordinance, or by any policy of insurance or by any contract or instrument to which the Property or Lessor or Lessee is now subject or hereafter become subject, or any other agreement between Lessor and Lessee, including, but not limited to, all covenants, conditions and restrictions, easements, mortgages and deeds of trust to which the Property or any part thereof may now be hereafter the subject. Without limitation on the generality of the foregoing, in the event this Lease and the any such covenants, conditions, restrictions, limitations or requirements both include specific provisions relating to the same matter, then Lessee shall comply with both unless such provisions are in conflict and accordingly compliance with both is impossible, in which event it shall comply with whichever standard is higher to the extent of the conflict.

21. Lessor's Performance of Lessee's Obligations. In the event that Lessee shall fail to do or perform or comply with any covenant, term or condition hereof on Lessee's part to be performed or complied with (including, but not limited to, its covenant to pay any amount required to be paid by it hereunder or to perform the obligations secured by any mortgage), Lessor may, at its option and without being under any

obligation to do so, and without waiving any right it may have against Lessee by reason of Lessee's failure as aforesaid, after fifteen (15) days written notice to Lessee, do or perform the same and thereupon the amount of all expenses and disbursements incurred or paid by Lessor in doing or performing the same, together with interest as herein provided from the time the expenses or disbursements were incurred or paid by Lessor, shall become due and owing and payable from Lessee to Lessor. If, pursuant to the foregoing right of Lessor, Lessor performs, acquires or satisfies any lien, encumbrance or obligation of Lessee, Lessor shall thereupon be subrogated to all rights of the obligee against the Lessee or the Property or both, and no merger shall be construed which would defeat such subrogation. In the case of subrogation to the rights of a mortgagee, the Lessor shall not have the right to foreclose, except upon assignment (if any) of the mortgage to the Lessor by the mortgagee. All sums payable from Lessee to Lessor under the terms hereof, shall bear interest at a rate of interest equal to the prime rate as reported by the Wall Street Journal per annum from the date such sum becomes payable until actually paid.

22. Holding Over. Should Lessee hold over after the termination of this Lease, with or without the express consent of Lessor, and whether or not such consent is in writing, the resulting tenancy shall be construed to be a month-to-month tenancy at a monthly rental equal to one and one-half times the monthly rent payable under the terms hereof for the month immediately preceding such termination, but otherwise on the terms and conditions provided in this Lease, except as to terms and rental. The Term of this Lease shall not be renewed or extended by any matter or thing.

23. Successors and Assigns. Subject to the limitations hereinabove set forth, this Lease and the terms and provisions hereof shall inure to the benefit of and be binding upon the successors and assigns of the parties.

24. Further Documents. Lessor and Lessee will, whenever and as often as it shall be reasonably requested so to do by the other, execute, acknowledge and deliver, or cause to be executed, acknowledged or delivered any and all such further confirmation, instruments of further assurance, and any and all such further instruments and documents as may be reasonably necessary, expedient or proper, in order to evidence or complete any and all transactions or to accomplish any and all matters and things provided in this Lease.

25. Force Majeure. The period of time during which either party is prevented or delayed in the performance or the making of any improvement or repairs or fulfilling any obligation required under this Lease, other than the payment of Rent, due to unavoidable delays caused by fire, catastrophe, strikes or labor troubles, civil commotion, Acts of God or beyond such party's reasonable control, shall be added to such party's time for performance thereof, and such party shall have no liability by reason thereof, provided, however, that in no event shall the performance of an obligation under this Lease be deemed prevented or delayed by any of the foregoing reasons (collectively, "force majeure") if performance can be (or could have been) effectuated by, or any default thereof cured by, the proper payment of money with respect to any such obligation and in no event shall the inability of either party to make available sufficient funds be deemed to be a force majeure. If either Lessor or Lessee shall be able to perform any of the other party's obligations hereunder, claimed by the non-performing party to be subject to force majeure, then the non-performing party's claim of force majeure shall be ineffective against the Lessor or Lessee, as the case may be.

26. Liability Limits.

A. Anything contained in this Lease to the contrary notwithstanding, if Lessor, or any successor in interest, shall be a corporation, individual, joint venture, tenancy in common, firm or partnership, general or limited, or other legal entity, it is specifically understood and agreed that there shall be no personal liability on the stockholders or directors of such corporation or on such individual or the members of such firm, partnership, tenancy in common joint venture or upon such corporation, firm, partnership, tenancy in common joint venture, or other legal entity, in respect to any of the covenants or conditions of this Lease; and

the Lessee shall look solely to the equity of the interest of Lessor in the Property for the satisfaction of the remedies of the Lessee in the event of a breach by the Lessor of any of the terms, covenants and conditions of this Lease to be performed by Lessor, and no other property or assets of such Lessor shall be subject to levy, execution or other enforcement procedure for the satisfaction of Lessee's remedies.

B. With respect to any provision of this Lease which provides, in effect, that Lessor shall not unreasonably withhold or unreasonably delay any consent or any approval, Lessee shall not be entitled to make, nor shall Lessee make, any claim for, and Lessee hereby waives any claim for money damages by way of setoff, counterclaim or defense, based upon any claim or assertion by Lessee that Lessor has unreasonably withheld or unreasonably delayed any consent or approval; but Lessee's sole remedy shall be an action or proceeding for specific performance, injunction or declaratory judgment. In the event it is ever found in a court of competent jurisdiction that Lessor acted to withhold or delay consent to willfully damage Lessee and Lessee seeks damages therefore, then the parties agree that the amount of such damages shall be limited to actual damages, and shall not include punitive damages.

C. Anything contained in this Lease to the contrary notwithstanding, if Lessee, or any successor in interest, shall be a corporation, individual, joint venture, tenancy in common, firm or partnership, general or limited, or other legal entity, it is specifically understood and agreed that there shall be no personal liability on the stockholders or directors of such corporation or on such individual or the members of such firm, partnership, tenancy in common joint venture or upon such corporation, firm, partnership, tenancy in common joint venture, or other legal entity, in respect to any of the covenants or conditions of this Lease; and the Lessor shall look solely to the equity of the interest of Lessee in the Property for the satisfaction of the remedies of the Lessee in the event of a breach by the Lessee of any of the terms, covenants and conditions of this Lease to be performed by Lessee, and no other property or assets of such Lessee shall be subject to levy, execution or other enforcement procedure for the satisfaction of Lessor's remedies.

27. Miscellaneous. This Lease contains the entire agreement between the parties respecting the matters herein set forth and supersedes all prior agreements between the parties hereto respecting such matters. The covenants and agreements of this Lease cannot be altered, changed, modified or added to, except in writing signed by Lessor and Lessee. This Lease may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute but one agreement. The paragraph headings herein contained are for purposes of identification only and shall not be considered in construing this Lease.

If any party obtains a judgment or decree against any other party by reason of this Lease, reasonable attorneys' fees, as fixed by the court, shall be included in such judgment or decree.

No waiver by Lessor of any default of Lessee or of any event, circumstance or condition permitting Lessor to terminate this Lease shall be implied or inferred and no written waiver thereof shall constitute a waiver of any other default of Lessee or of any other event, circumstance or condition permitting such termination, whether of the same or of any other nature or type and whether preceding, concurrent or succeeding; and no failure on the part of Lessor to exercise any right it may have by the terms hereof or by law upon the default of Lessee, and no delay in the exercise of such right, shall prevent the exercise thereof by Lessor at any time when Lessee shall continue to be so in default and no such failure or delay and no waiver of default shall operate as a wavier of any other default, or as a modification in any respect of the provisions of this Lease. The subsequent acceptance of any payment or performance pursuant to this Lease (including, but not limited to, the acceptance of Rent pursuant to this Lease) shall not constitute a waiver of any previous default by Lessee or of any previous event, circumstance or condition or of any right of Lessor to terminate this Lease on account of such default, event, circumstance or condition, other than the default in the payment of the particular payment or the performance of the particular matter so accepted, regardless of Lessor's knowledge of the previous default or the previous event, circumstance or condition, at the time of accepting such payment or

performance, nor shall Lessor's acceptance of such payment or performance after termination constitute a reinstatement, extension or renewal of this Lease or revocation of any notice or other act by Lessor. No remedy conferred upon Lessor in this Lease is intended to be exclusive of any other remedy given hereunder or now or hereafter existing at law or in equity or by statute. Every power or remedy given by this Lease to Lessor or to which Lessor may otherwise be entitled, including actions in equity for injunctive relief, may be exercised concurrently or independently, from time to time and as often as may be deemed expedient by Lessor, and Lessor may pursue inconsistent remedies.

As used herein, "Lessor" means the person(s), partnership(s), corporation(s) or entity(ies) who is or are the owner or owners of the Premises at the time in question, whether singular or plural in number and whether named in this Lease as Lessor or having become the successor or successors in interest of the same. In the event Lessor conveys its interest in the Premises in accordance with the provisions of this Lease, then it shall thereupon be automatically freed and relieved from all obligations under this Lease which arise or accrue after the date of such conveyance. "Lessee" as used herein means the party, whether singular or plural in number; provided, however, that Lessee does not include any person, partnership, corporation or entity claiming under any assignment or other transfer prohibited by this Lease and this definition does not alter the provisions of the Lease relating to assignment or subletting. If there shall be more than one person constituting Lessee, their obligations shall be joint and several, and any notice required or permitted by the terms of this Lease may be given by or to any one thereof, and shall have the same force and effect as if given by or to all thereof.

The Lease shall be construed and enforced in accordance with the laws of the State of Tennessee. Each obligation of Lessee under this Lease constitutes both a covenant and a condition to its rights under this Lease. Neither this Lease nor anything contained herein shall be deemed to make Lessor in any way or for any purpose a partner, joint venturer or associate in any relationship with Lessee other than that of landlord and tenant, nor shall this Lease or any provisions thereof be construed to authorize either to act as agent for the other except as expressly provided in this Lease. The consent or approval by Lessor to or of any act by the Lessee requiring the Lessor's consent to approval shall not be deemed to waive or render unnecessary Lessor's consent or approval to or of any subsequent similar acts by the Lessee.

The locative adverbs "herein", "hereunder", "hereto", "hereby", "hereinafter", and like words wherever the same appear herein, mean and refer to this Lease in its entirety and not to any specific paragraph or subparagraph hereof unless otherwise expressly designated in context. Reference in this Lease to the "obligations" of Lessee, and words of like import, shall mean the covenants to pay Rent under this Lease and all other covenants, agreements, terms, conditions, limitations, restrictions and reservations contained in this Lease applicable to Lessee. The term "Lessee's obligations hereunder" and words of like import shall mean all obligations to this Lease which are to be performed, observed or kept by Lessee. The term "include", "including" and similar terms shall be construed as if followed by the phrase "without being limited to". Wherever in this Lease there is a reference to a cost being at Lessee's sole cost and expense, or words of similar import, such phrase shall be construed to mean that Lessee shall pay the costs so referred to or, if applicable, reimburse Lessor for the costs referred to and, in the latter case, within ten (10) days of demand by Lessor. The term "will not unreasonably withhold" and words of like import shall mean "will not unreasonably withhold or delay."

Any provision or provisions of this Lease which shall be to any extent in violation of any law or ordinance or which shall prove to be to any extent unenforceable, invalid, void or illegal, shall in no way affect, impair or invalidate any other provisions hereof, and the remaining provisions hereof, except those provisions which are made subject to or conditioned upon such unenforceable, invalid, void or illegal provision or provisions, shall nevertheless remain in full force and effect. No surrender to Lessor of this Lease or of the Premises, or any part thereof or of any interest therein, shall be valid or effective unless provided for in this Lease or otherwise agreed to and accepted in writing by Lessor and no act by Lessor or any representative or agent of Lessor,

other than such a written acceptance by Lessor, shall constitute an acceptance of any such surrender. No payment by Lessee or receipt by Lessor of a lesser amount than the monthly rent herein stipulated shall be deemed to be other than on account of the earliest stipulated rent, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as rent be deemed or any letter accompanying any check or payment as rent be deemed an accord and satisfaction, and Lessor may accept such check or payment without prejudice to Lessor's right to recover the balance of such rent or pursue any other remedy provided in this Lease. To the extent this Lease requires Lessee to submit payments for items other than the Rent and in the event Lessee submits a payment of less than the total combined amount of all of said payments, then the Lessor shall have the option to credit said payment towards any of said items it so desires, notwithstanding any specification of Lessee.

This Lease shall not be placed of record. Lessor and Lessee agree to execute a short form of this Lease in form appropriate for recording setting forth such provisions hereof as either party may reasonably request except that the provisions relating to Rent, Taxes and other charges shall not be disclosed in said short form.

Lessee agrees that as to Lessor, Lessee shall not have any right to sue for or collect, and Lessor shall never have any liability or responsibility whatsoever for, any consequential or indirect damages whether proximately or remotely related to any default of Lessor under this Lease, and Lessee hereby waives any and all such rights.

28. Merger. If both Lessor's and Lessee's estates in the Premises or the Improvements or both become vested in the same owner while the Premises or the Improvements or the estate of Lessor or Lessee therein shall be subject to one or more mortgages or deeds of trust, this Lease shall nevertheless not be destroyed by the application of the doctrine of merger except at the election of the mortgagee or beneficiaries under all such mortgages and deeds of trust.

29. Notices. Any notice, demand or document which any party is required or may desire to give to the other party shall be in writing, and may be personally delivered or given or made by United States registered or certified mail, return receipt requested, or by Federal Express or comparable express delivery service, addressed as follows:

To Lessee: Middle Tennessee Imaging, LLC
28 White Bridge Road, STE 316
Nashville, Tennessee 37215
Attn: General Counsel

To Lessor: Old Hickory Partners, LLC
1163 Saddle Springs Drive
Thompson Station, TN 37179

Subject to the right of either party to designate a different address for itself by notice similarly given. Any notice, demand or document so given by United States mail shall be deemed to have been given on the fifth day after the same is deposited in the United States mail as registered or certified matter, addressed as above provided, with postage thereon fully prepaid, except that any payments of Rent shall be deemed to have been made only when actually received by Lessor. Any such notice, demand or document not given by registered or certified mail as aforesaid shall be deemed to be given, delivered or made only upon receipt of the same by the party or parties to whom the same is to be given, delivered, or made. Notice to any other office, person, or department of Lessor shall not constitute notice under this Lease.

30. Estoppel Certificates Any party hereto shall deliver to any other party hereto, within fifteen (15) days after receipt of a written request therefore, an estoppel certificate stating the date to which Rent has been paid, the amount of any prepaid Rent, and stating whether such party has any actual knowledge that this Lease is not in full force and effect, whether such party of any other party is in default hereunder, and whether this Lease has been modified or amended.

31. Attorneys' Fees. In the event that either Lessor or Lessee fails to perform any of its obligations under this Lease or in the event a dispute arises concerning the meaning or interpretation of any provision of this Lease, the defaulting party or the party not prevailing in such dispute, as the case may be, shall pay any and all costs and expenses incurred by either party in enforcing or establishing its rights hereunder, including, without limitation, court costs and reasonable counsel fees. The right of Lessor or Lessee, as the case may be, to all costs and expenses incurred by it in enforcing or establishing its right hereunder pursuant to the provisions of this Paragraph 31 shall include, without limitation, all costs and expenses incurred by Lessor and Lessee, as the case may be (including, without limitation, court costs and reasonable counsel fees) in the enforcement of all obligations of Lessee or Lessor, as the case may be, under this Lease or otherwise with respect to the Premises, whether or not legal action was commenced, and including all such costs and expenses incurred in an action or participation in, or in connection with, a case or proceeding under Chapter 7 or 11 of the Bankruptcy Code, or any successor statute thereto.

32. Character of Lessee. The Lessee hereby acknowledges that the character of those comprising the managers, officers, directors and major shareholders (hereinafter called Principals) of Lessee affect reputation of Lessor. Accordingly, by signing this agreement on behalf of the Lessee, Lessee's executive officer personally represents to his or her best knowledge and belief (i) no Principals are, or have been, in any way related to, or affiliated with, organized crime, (ii) none has been convicted of a crime except for minor traffic violations and misdemeanors and (iii) they are all considered of good standing and good moral character within the community. Lessee covenants that it (i) will require each prospective Principal to certify in writing that he or she is not now, nor at any time has been, affiliated with organized crime, and that he or she has not been convicted of a crime except for minor traffic violations and misdemeanors, and (ii) will not admit any such person as a Principal knowing that such certification is false.

33. Public Relations. Lessor shall have the right to approve all press releases and other statements to the newspapers, radio, television, and other media made by Lessee and the tenants or occupants of the Improvements, relating to this transaction, the occupancy of the Improvements, and present and future leasing transactions in connection with the Improvements.

34. Broker. The parties hereto covenant, warrant and represent that there was no broker instrumental in consummating this Lease and that no conversations or prior negotiations were had with any broker concerning the renting of the Premises. Lessor and Lessee agree to indemnify and hold each other harmless against any claims for brokerage commission and other costs arising out of any conversations or negotiations had by the other party with any broker. The provisions of this paragraph shall survive expiration and termination of this Lease.

35. Escrow of Taxes and Insurance. In the event that Lessor escrows real estate taxes and assessments or insurance as provided in Paragraphs 7 and 8 above, such escrow shall be paid monthly to Lessor at the same time as the monthly rent is paid to Lessor. The amount to be paid monthly to Lessor shall be one-twelfth (1/12) of Lessor's reasonable estimate of the annual amount to be paid by Lessor for said real estate taxes and assessments or insurance, as the case may be. Such amounts shall be held by the Lessor without interest and applied to the payment of the items in respect to which such amounts were paid or, at the option of the Lessor, to the payment of said items in such order or priority as the Lessor shall reasonably determine, on or before the respective dates on which the same or any of them would become delinquent. If, one month prior

to the due date of the aforementioned amounts, the amount then on deposit therefore shall be insufficient for the payment of such item in full, the Lessee, within ten (10) days after demand, shall deposit the amount of the deficiency with the Lessor. Nothing in this Paragraph 36 shall be deemed to limit any other right or remedy that Lessor may have under the provisions of this Lease regarding Lessee's failure to pay real estate taxes and assessments or insurance.

IN WITNESS WHEREOF, the parties have executed this Lease as of the day and year first above written.

Lessor:

Old Hickory Partners, LLC

By: _____
Name: _____
Title: _____

Lessee:

Middle Tennessee Imaging, LLC
d/b/a Premier Radiology

By: _____
Name: _____
Title: _____

ACKNOWLEDGEMENT TAKEN IN TENNESSEE

State of Tennessee County of Davidson, ss:

On the ____ day of _____, in the year 2014, before me the undersigned, personally appeared _____ personally known to me or proved to me on the basis of satisfactory evidence, to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that (he) (she) (they) executed the same in (his) (her) (their) capacity(ies), and that by (his) (her) (their) signature(s) on the instrument, the individual(s) or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

EXHIBIT A TO GROUND LEASE - LEGAL DESCRIPTION

ALL THAT TRACT OR PARCEL OF LAND situate in Lot 1 Highlands of Brentwood, Resub of Sec 3,791 Old Hickory Blvd., Brentwood, TN 37027, State of Tennessee, County of Davidson, being bounded and described as follows:

TOGETHER WITH all appurtenances and improvements thereon.

SUBJECT TO utility easements and right's-of-way of record.

RESERVING nonetheless, to the Lessor such future easements and rights of way for passage of utility lines and pedestrian walkways over the above-described premises, including temporary easements for construction thereof, to serve other lands of the Lessor or Lessor's successors and assigns. The locations of any such future easements and rights of way shall not interfere with improvements on Lessee's premises, Lessor and Lessee shall agree upon the specific locations of such easements and rights of way, and Lessor shall restore the premises to their original condition following construction in any such easement or right of way.

EXHIBIT B

UNLIMITED CONTINUING GUARANTY

WHEREAS, **Middle Tennessee Imaging, LLC, a Tennessee limited liability company**, (hereinafter "Guaranteed") desires now and hereinafter to enter into a ground lease and engage in various transactions with **Old Hickory Partners, LLC, a Tennessee limited liability company**, and its successors and assigns (hereinafter "Landlord") and from time to time to renew and extend credits now or hereinafter existing; and

WHEREAS, Landlord is willing to extend credit to Guaranteed to such extent as Landlord may from time to time deem advisable, but only upon the guaranty by the undersigned Saint Thomas Health (hereinafter individually "Guarantor") of payment and performance of the Obligations, as hereinafter defined.

NOW, THEREFORE, in consideration of the recitals, and to enable Guaranteed to lease the real property referenced above and obtain other forms of credit from Landlord and to have transactions with Guaranteed, the undersigned Guarantor agrees with Landlord as follows:

1. Guarantor guarantees the prompt and punctual payment and performance of the following obligations, undertakings and liabilities of Guaranteed to Landlord (hereinafter individually an "Obligation", and collectively the "Obligations"):

All obligations, undertakings and liabilities arising from the ground lease dated _____ granted by Landlord to Guaranteed contemporaneously or substantially contemporaneously with, or upon the condition or assurance of, the execution and delivery of this continuing guaranty, and any extensions and/or renewals thereof.

2. Upon request from Landlord, Guarantor will promptly pay to and perform for Landlord all Obligations together with all costs, including reasonable attorneys' fees incurred in enforcing this Continuing Guaranty. Any verbal request made for written request delivered or deposited in the mail, postage prepaid and properly addressed, to Guarantor shall be conclusively presumed to be an immediately effective and sufficient request as to such Guarantor. Guarantor shall pay and perform each Obligation at the location at which Guaranteed was obligated to make payment or render performance thereof.

3. Guarantor hereby waives demand, notice, presentment and protest with respect to each and every Obligation, and Guarantor hereby waives diligence on the part of Landlord in making collection against Guaranteed or against any other party or entity for whom Guaranteed may be secondarily liable. All Obligations and undertakings of any other person or persons for whom Guaranteed may be secondarily liable may be renewed, extended or altered in whole or in part from time to time without notice to Guarantor, and without impairing the liability of Guarantor hereunder. Guarantor shall have no right to assert any defense to any Obligation that Guaranteed could not make in person.

4. This instrument shall be in full force and effect when delivered to Landlord as to all existing and future Obligations. This instrument may be delivered by Guaranteed as the agent of Guarantor or by Guarantor or by any other person, and Landlord shall not be charged with giving notice of any kind to Guarantor of the delivery of this instrument, or of the acceptance of this instrument. Such notices of delivery and acceptance are hereby waived by Guarantor. Guarantor shall not have any right to defend liability under this instrument after its receipt by Landlord for any irregularity in its procurement, signatures or delivery, or for any other reason whatsoever other than full payment, performance or expressed written discharge of the Obligations.

5. Payment of less than the full amount due on, or performance of less than all of the Obligations by any other guarantor shall not relieve the undersigned from liability for full payment and full performance of all remaining Obligations. If for any reason any payment by, or undertaking of, Guaranteed to Landlord shall be determined at any time to be a voidable preference or otherwise shall be set aside or required to be returned or repaid, this guaranty, nevertheless, shall remain in effect and shall be fully enforceable against Guarantor for the full undertaking or payment thus set aside, returned or repaid, as well as any Obligations still outstanding, together with all costs and attorneys' fees incurred by Landlord in connection with such determination.

6. In the event Landlord transfers or assigns any Obligation to another, Landlord may make an assignment of part or *all* of the benefits of this Guaranty, in which event this Guaranty shall continue to apply to such assigned Obligation as well as to

all other Obligations and, to the extent provided in such assignment, shall be enforceable by the assignee or any subsequent assignee in such assignee's or subassignee's name.

7. Landlord shall be under no duty to obtain or retain Security (as hereinafter defined) for any Obligation but may do so if Landlord so elects. "Security", as used herein, shall include collateral of every kind as well as the liability of any person or entity arising from co-signature, endorsement, guaranty, the issuance or confirmation of letters of credit, or any other form of suretyship or assurance. The liability of any Guarantor hereunder shall not in any way be impaired by Landlord's acceptance of Security for the payment and performance of any Obligation or any liability of any Guarantor, or by any failure, neglect or omission on the part of Landlord or its agents to proceed against, realized upon, retained, preserved, protect or perfect or maintain the perfection of a lien on, or security interest in, any Security or to proceed against any person or to enforce any Obligation. In the event of any default by Guaranteed, the Landlord, at its election, may proceed directly against Guaranteed or against any Security or against Guarantor; and may proceed against Guaranteed, any Security, or any and all Guarantors in such order as Landlord shall elect; and Landlord shall be under no duty to make demand on, file claim against, or pursue remedies either against Guaranteed or against any Security before, or as a condition for, proceeding against Guarantor. Guarantor hereby specifically waives any right to require that an action be brought against Guaranteed under the provisions of Title 47, Chapter 12, Tennessee Code Annotated, as amended from time to time.

8. Landlord may extend, renew, compromise, compound or otherwise change the terms of any Obligation or any liability of one of more guarantors in such a way as it may deem best; and no change, release, composition or settlement with Guaranteed or with any Guarantor, or with respect to any Security, shall discharge or impair the ability of any Guarantor hereunder whom Landlord does not specifically and expressly release in writing, Guarantors expressly waive any subrogation or other rights against any Security or against proceeds thereof or against Guaranteed, until all Obligations of Guarantor and Guaranteed to Landlord have been satisfied in full; and expressly subordinated all liabilities of Guaranteed to Guarantor to all Obligations. Guarantor shall have no claim (as such term is defined in 11 U.S.C. §101) against Guaranteed on account of any payment or grant of Security by Guarantors hereunder or in connection herewith, unless Guarantor's possession of such claim would in no circumstance render a payment or grant of Security, hypothetical or otherwise, by Guaranteed to Landlord subject to avoidance, turnover or nullification. Execution and delivery of this instrument shall create independent undertakings by Guarantor and is not to be construed as making Guarantor a "party" to instruments of indebtedness not in fact signed by Guarantor.

9. This Continuing Guaranty is continuing, absolute and unconditional until all Obligations have been fully paid and performed. Guarantor's undertakings hereunder shall continue in full force and effect as to all Obligations in existence at the time of Landlord's receipt of such notice, as to all extensions and renewals of such Obligations, made thereunder, and as to any future Obligations arising out of loans or extensions of credit which Landlord, at the time of receipt of such notice, was legally committed, despite the notice, to make to Guaranteed. Such notice shall be effective only as to Obligations credited after its actual receipt, other than those specified in the preceding sentence. Unless and until such termination notice is received as provided in this paragraph, this Continuing Guaranty shall remain effective as to all Obligations, irrespective of whether at some time or times after execution of this Guaranty an interval may have existed during which Guaranteed was not obligated to the Landlord or Landlord was not under a duty to make any loan or extension of credit to Guaranteed. The death of Guarantor shall not terminate this instrument as to the deceased's estate. The undertakings of this Continuing Guaranty shall survive any merger or acquisition of any corporate Guarantor.

10. This Continuing Guaranty shall be governed by, and construed in accordance with, the internal laws of the State of Tennessee, and jurisdiction shall be appropriate in any court of competent jurisdiction in Davidson County, Tennessee. **All parties expressly waive the right to trial by jury in any action filed as a result of the obligations set forth in this instrument.**

Executed this _____ day of _____, 2013.

GUARANTOR:

SAINT THOMAS HEALTH

By_____

Printed name_____

Title_____

{{Notary}}

EXHIBIT C TO GROUND LEASE - IMPROVEMENTS TO BE CONSTRUCTED

Pending confirmation from the property authorities that a certificate of need is not required, or alternatively, pending the receipt by lessee of a Certificate of Need, a Free Standing Emergency Room similar to the architectural sketches provided to Lessor, as to be more fully described in the plans to be completed by Lesee's architects. Upon completion of such plans, Lessee will deliver to Lessor a full set of the plans. If it is determined that a certificate of need is required and a certificate of need for the free standing ER cannot be obtained, then Lessee shall have the right to use the Premises for another purpose, which is reasonably acceptable to Lessor.

IN WITNESS WHEREOF, the parties have executed this Lease as of the day and year first above written.

Lessor:

Old Hickory Partners, LLC

By: _____
Name: _____
Title: _____

Lessee:

Middle Tennessee Imaging, LLC
d/b/a Premier Radiology

By: _____
Name: Chad L. Calendine
Title: President

IN WITNESS WHEREOF, the parties have executed this Lease as of the day and year first above written.

Lessor:

Old Hickory Partners, LLC

By: _____
Name: C. Hugh Hicks
Title: Chief Manager

Lessee:

Middle Tennessee Imaging, LLC
d/b/a Premier Radiology

By: _____
Name: _____
Title: _____

STATE OF TENNESSEE
COUNTY OF DAVIDSON

Before me, Tamra Catt of the state and county mentioned, personally appeared Chad L. Calendine, M.D., with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged such person to be president (or other officer authorized to execute the instrument) of Middle Tennessee Imaging, LLC, the within named bargainor, a Tennessee limited liability company, and that such president or officer as such limited liability company, executed the foregoing instrument for the purpose therein contained, by personally signing the name of the limited liability company as President.

Witness my hand and seal, at office in Nashville, Tennessee, this 9th day of April, 2014.

Tamra Catt

Notary Public

Printed Name: TAMRA CATT

My Commission Expires:

3/7/17

Tamra Catt
State of Tennessee Notary Public
Davidson County
Comm. Exp. 3/7/17

STATE OF TENNESSEE
COUNTY OF DAVIDSON

Before me, Tamra Catt of the state and county mentioned, personally appeared Clinton Hugh Hicks, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged such person to be president (or other officer authorized to execute the instrument) of Old Hickory Partners, LLC, the within named bargainor, a Tennessee limited liability company, and that such president or officer as such limited liability company, executed the foregoing instrument for the purpose therein contained, by personally signing the name of the limited liability company as Chief Manager.

Witness my hand and seal, at office in Nashville, Tennessee, this 9th day of April, 2014.

Tamra Catt

Notary Public

Printed Name: TAMRA CATT

My Commission Expires:

3/7/17

Tamra Catt
State of Tennessee Notary Public
Davidson County
Comm. Exp. 3/7/17

Tab 6

Attachment A, 13

MCO/BHO Participation

Saint Thomas Midtown Hospital Managed Care Contracts List

Plan Name	Products/Network/Payor Name	Plan Type
Aetna / USHealthcare	Aetna HMO (Includes QPOS and US Access), Elect Choice (EPO), Managed Choice POS, Open Choice, Quality Point of Service (QPOS), US Access, National Advantage Plan, Aetna Select, Open Access Aetna Select, Aetna Open Access HMO, Aetna Open Access Elect Choice, Aetna Choice POS, Aetna Choice POS II, Aetna Open Access Managed Choice, Open Choice PPO, Traditional Choice, Aetna Affordable Health Choices PPO	HMO, EPO, POS, PPO, HMO/POS
	Aetna Golden Medicare Plan - HMO, Aetna Golden Choice Plan - PPO, Aetna Medicare Open Plan - Private FFS (PFFS)	Medicare Advantage
Aetna Institutes of Quality Bariatric Surgery Facility	IOQ Bariatric Surgery	Center of Excellence
Aetna Institutes of Quality Orthopedic Care	IOQ Joint Replacement	Center of Excellence
	IOQ Spine Surgery	Center of Excellence
Alive Hospice	Alive Hospice	Direct
Americhoice	Americhoice (aka United HealthCare Plan of the River Valley, Inc.) (Includes Dual Eligible Special Needs Plan - SNP)	TennCare HMO
AMERIGROUP Community Care	AMERIGROUP Community Care	TennCare HMO
	AMERIVANTAGE Medicare Advantage (Includes Dual Eligible Special Needs Plan - SNP)	Medicare Advantage
Avalon Hospice (formerly Trinity Hospice) (STH, MTMC and Hickman added eff. 2/1/10)	Trinity Hospice	Hospice (Inpatient services for Medicare and TennCare Patients)
Beech Street (A Viant Company) (formerly Concentra, Concentra Preferred Systems, Health Network Systems, PPONext, CapCare, MediChoice) *(Purchased by MultiPlan, but networks remain separate until further notice)*	Beech Street (Includes Beech Street Primary Network, Beech Street Complementary Network and Viant Supplemental Networks)	PPO
BC/BS of TN (BCBST)	BlueAdvantage and BlueAdvantage Plus (PFFS) *It is a unique program in that members may use any doctor, specialist or hospital that accepts the BlueAdvantage terms, conditions and payment rate. Prior to providing services to a BlueAdvantage member, providers must agree to the Terms and Conditions of Plan Payment. When Providers choose to extend services to a BlueAdvantage member, they are acknowledging their agreement and are "deemed" to have a contract with BlueCross BlueShield of Tennessee.*	Medicare Advantage Private Fee for Service (PFFS)
	BlueAdvantage Local PPO (effective 1/1/2009)	Medicare Advantage
	Medicare Advantage Regional PPO (effective 9/20/09)	Medicare Advantage
	BlueCoverTN / Blue Network V	PPO
	Access TN (uses BlueSelect / Network S)	PPO
	Cover Kids (uses Blue Select / Network S)	PPO
	Blue Preferred / Network P (includes Suitcase PPO Program/ BlueCard and Federal Employees Standard Option and Basic Option Programs)	PPO
	Blue Select / Network S (Includes Suitcase PPO Program/BlueCard)	PPO
CCN (National network owned by First Health)	CCN (consolidated under First Health Network as of 1/1/07)	PPO
Blue Distinction Center for Bariatric Surgery	Blue Distinction Center for Bariatric Surgery	Center of Excellence
Blue Distinction Center of Knee and Hip Replacement	Blue Distinction Center for Knee and Hip Replancement	Center of Excellence
Blue Distinction Center for Spine Surgery	Blue Distinction Center for Spine Surgery	Center of Excellence
Bluegrass Family Health	Bluegrass Family Health	HMO, PPO, POS, Consumer Directed Health, including HRA and HSA, Self Insured / TPA, Network Leasing
CenterCare Managed Care Programs	Center Care	PPO, POS
Cigna Healthplan	Cigna Healthplan PPO (Includes Starbridge Choice and Great West PPO)	PPO
	Cigna Healthplan HMO and Gatekeeper POS (Includes HMO Fully Insured, Open Access Plus and Network and Great West HMO and POS)	HMO / POS
	Cigna Medicare Access, Cigna Medicare Access Plus Rx (No provider networks or contracts. Members can visit any provider who accepts original Medicare payment and also Cigna's terms and conditions of payment.)	Medicare Private Fee For Service
CorVel Corporation	CorCare	WC
Coventry Health Care (formerly First Health Direct)	Coventry Health Care (formerly First Health Direct) (As of 1/1/07, this replaced the First Health Direct business. It is the directly administered commercial business	PPO
Division of Rehabilitation Services	Division of Rehabilitation Services	Direct
First Health	First Health (As of 1/1/07, this network is part of Coventy Health Care's rental network business, including group health and workers comp. The following networks will be consolidated under the First Health name: CCN, Healthcare Value Management (HCVM) and PPO Oklahoma)	Rental Network (PPO)
FOCUS Healthcare Management *(a wholly owned susidary of Concentra)*	FOCUS	WC
Great West (formerly known as One Health Plan)	Great West / One Health Plan / PPO *(As of 2/1/09, plan will access Cigna PPO)*	PPO
	Great West / One Health Plan / HMO *(As of 2/1/09, plan will acesss Cigna Managed Care)*	HMO
	Great West / One Plan /POS *(As of 2/1/2009, plan will acesss Cigna Managed Care)*	POS
	Great West / Open Access) *(As of 2/1/2009, plan will acesss Cigna Managed Care)*	POS
HealthMarkets Care Assured	Health Markets Care Assured PFFS *(No provider networks or contracts. Members can visit any doctor, specialist or facility who accepts Medicare and HealthMarkets Care Assured's policies)*	Medicare Advantage Private Fee for Service (PFFS)
Health Payors Organization, Ltd. / Interplan Healthgroup	HPO	PPO
HealthSpring (fka Healthnet Management Co.)	HealthSpring HMO, Inc. (Commercial Plans include Primary Plan, Advantage Plan, Freedom Plan, Direct Product Plan and Member Option Plan)	HMO, POS and EPO
	HealthSpring Medicare Advantage	Medicare Advantage
Humana Health Care Plans	Humana HMO, POS, PPO (Including Choice Care) (Includes CHA Prime Network for fully insured HMO, POS and PPO as of 1/1/2009)	HMO, POS PPO
	HumanaChoice PPO and Humana Gold Plus HMO	Medicare Advantage (Contracted)
	Humana Gold Choice Medicare Advantage PFFS *(No provider networks or contracts. Members can visit any doctor, specialist or facilitywho accepts Medicare and Humana's terms)*	Medicare Private Fee For Service

Plan Name	Products/Network/Payor Name	Plan Type
KY Medicaid	Operating 4 MCOs: WellCare, Coventry, Humana, Passport.	Medicaid
MultiPlan (includes BCE Emergis / ProAmerica) *(MultiPlan purchased PHCS and Beechstreet/Viant. Networks will remain separate until further notice)*	MultiPlan, BCE Emergis, ProAmerica, Up and Up, Formost	PPO
NovaNet	Nova Net	PPO
OccuComp *(*Only STHS Outpatient Rehabilitiation Services)*	OccuComp	WC
Odyssey Healthcare	Odyssey Healthcare	Hospice (Inpatient services for Medicare and TennCare Patients)
Prime Health (formerly known as Comp Plus)	Prime Health (formerly known as CompPlus)	
	Workers Compensation	WC
	Tier I Commmercial	PPO
	Tier II Commercial	PPO
Private Healthcare Systems, Ltd. *(Purchased by MultiPlan. Networks will remain separate until further notice)*	Private Healthcare Systems (PHCS)	PPO & PPO/POS
Pyramid Life - Today's Options	Today's Options Medicare Advantage Private Fee for Service (No provider networks or contracts. Members can visit any doctor, specialist or facility who accepts Medicare and Pyramid's terms)	Medicare Advantage Private Fee for Service (PFFS)
Signature Health Alliance *(BlueGrass purchased Signature Health Alliance. Effective 4/1/10, contracted under BlueGrass with two tiers of payment)*	Signature Health Alliance	PPO
Southern Benefit Administrators, Inc.	Southern Benefit Administrators, Inc.	TPA
Starbridge Choice *(Plan falls under Cigna PPO network)*	Starbridge Choice	PPO
Sterling Healthcare (Option 1) *(No contract required)*	Option I	Medicare Advantage, Private Fee for Service
TriCare for Life *(No contract required)*	TriCare for Life	Medicare Supplement for retired military
TRICARE North (HealthNet Federal Services)	TRICARE Standard, TRICARE Prime, TRICARE Prime Remote, TRICARE Extra, TRICARE Reserve Select	TRICARE
TRICARE South (Humana Military)	TRICARE Standard, TRICARE Prime, TRICARE Prime Remote, TRICARE Extra, TRICARE Reserve Select	TRICARE
United Healthcare	United Healthcare: Choice, Choice Plus, Select, Select Plus, Options PPO, Definity HRAs and HSAs	HMO, PPO, POS
	Secure Horizons (fka United Healthcare Medicare Complete)	Medicare Advantage
USA Managed Care Organization	PPO: Includes USA H&W and USA WIN (PPO includes Tennessee Healthcare Group Health)	PPO
	EPO: Includes USA SPAA and USA WIN SPAA (EPO includes Tennessee Healthcare Work Comp) (As of 9/20/2006, Tennessee Healthcare began accessing USA MCO with the exception of State of TN Public Employees (Work Comp) which will remain with Prime Health through 2007)	EPO
Windsor HealthCare	Windsor HealthCare Medicare Advantage	Medicare Advantage

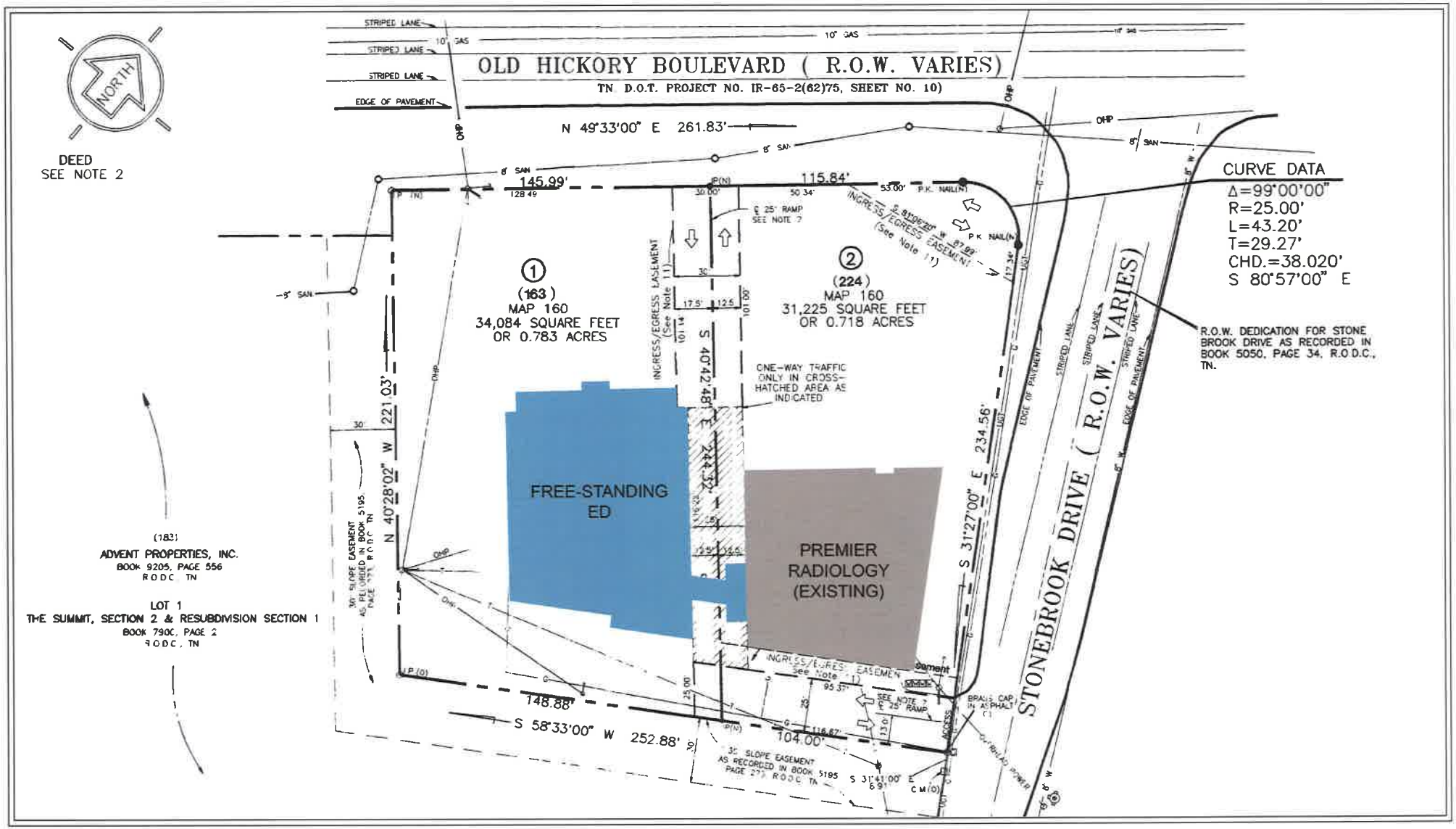
Attachment B

Plot Plan
Maps of Service Area Access
Schematics

Tab 7

Attachment B, III.(A)

Plot Plan



SAINT THOMAS HEALTH SERVICES
FREE-STANDING EMERGENCY DEPARTMENT - BRENTWOOD, TN

000116

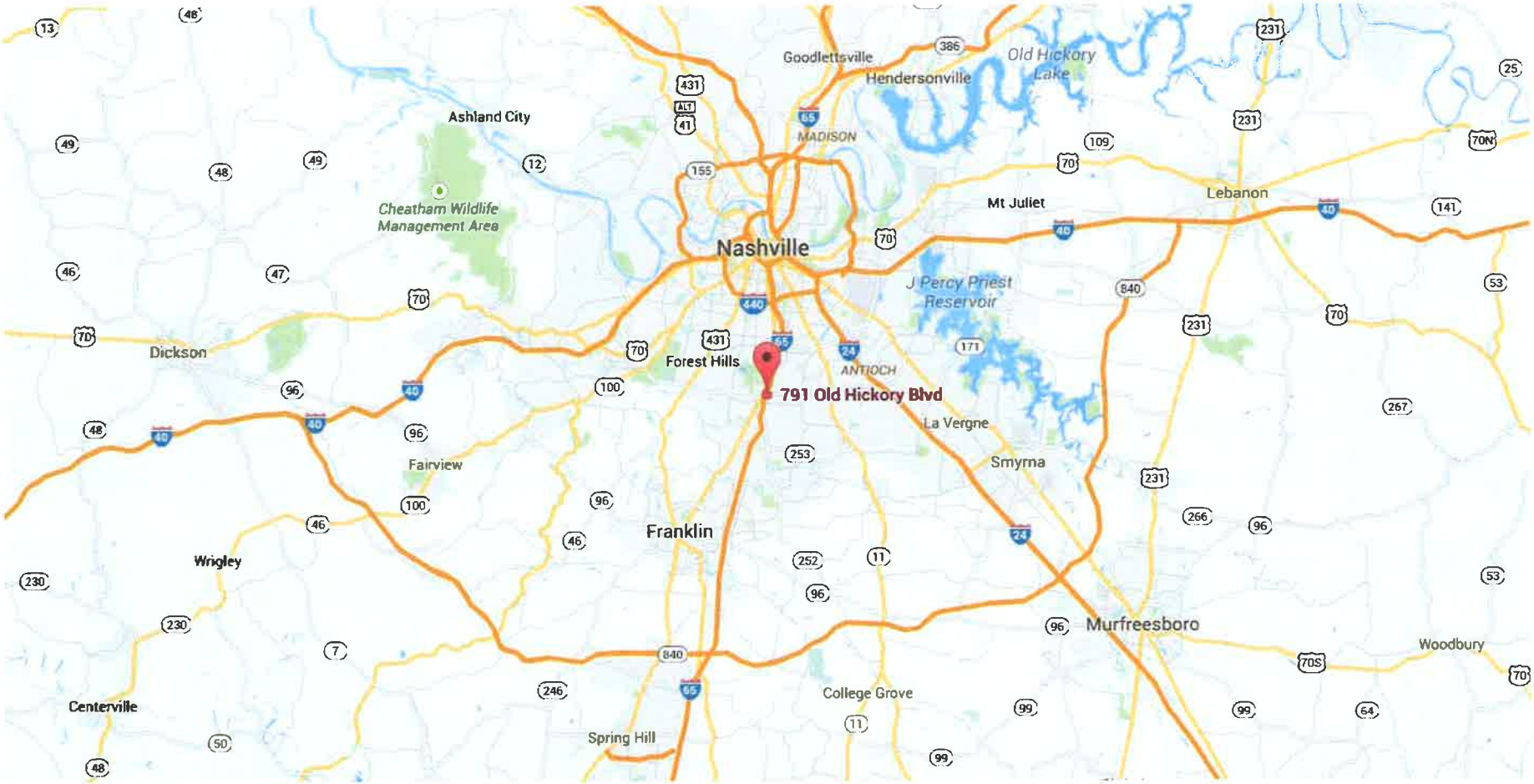
FreemanWhite

Tab 8

Attachment B, III.(B).1

Maps of Service Area Access

Access to Saint Thomas Midtown Satellite ED in Brentwood



Driving from Satellite ED in Brentwood to Saint Thomas Midtown Hospital

Tab 9

Attachment B, IV

Schematics

SAINT THOMAS HEALTH SERVICES
FREE-STANDING EMERGENCY DEPARTMENT - BRENTWOOD, TN

000123

FreemanWhite

Attachment C

Service Area Map
TennCare Population Data
Construction Costs Verification Letter
Verification of Funding
Balance Sheet and Income Statement
Audited Financials
Letters of Support
Performance Improvement Plan
Utilization Review Plan
Patient Bill of Rights
The Joint Commission Documentation
Hospital License
Inspection Report
Plan of Corrective Action

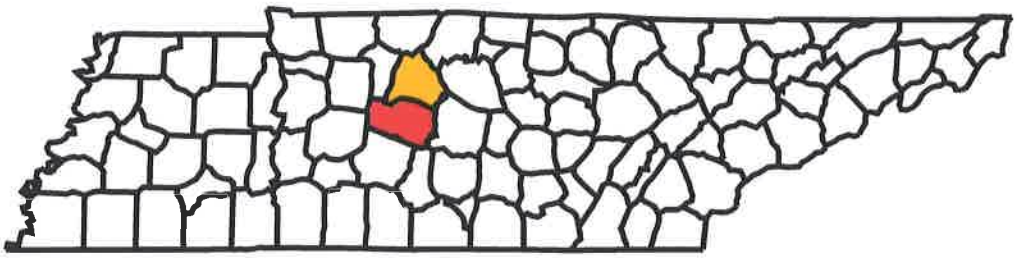
Tab 10

Attachment C
Need - 3

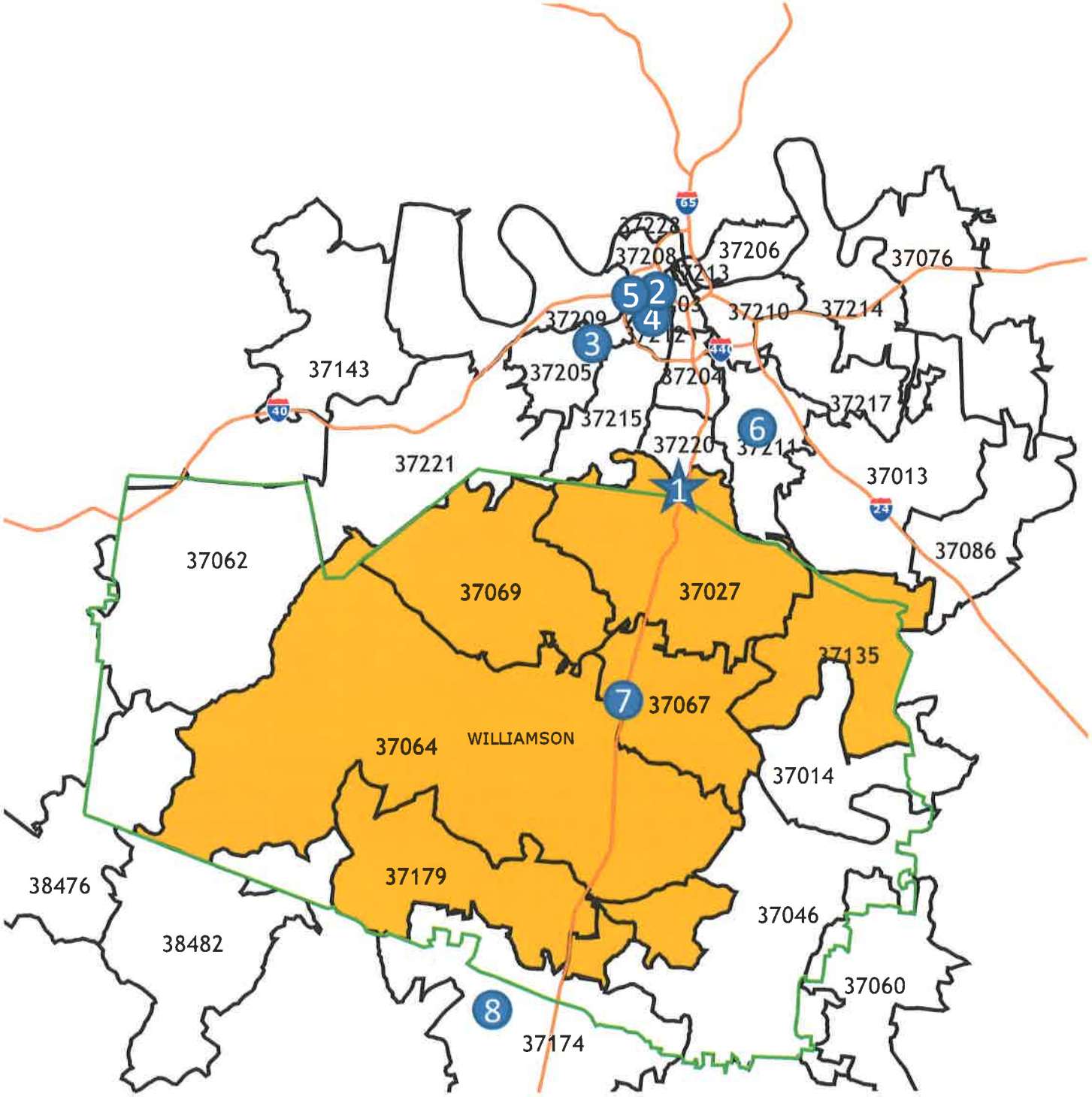
Service Area Map

Service Area Map

Primary Service Area Secondary Service Area



STH Satellite ED Map, by Zip Code



1. STH Satellite ED
2. Midtown Hospital
3. West Hospital
4. Vanderbilt
5. Centennial
6. Southern Hills
7. Williamson
8. TriStar ER Spring Hill

Tab 11

Attachment C
Need - 4

TennCare Population Data

Service Area TennCare Population
April 2014

Service Area Counties	TennCare Enrollees	2014 Population	% Enrolled
Williamson	9,214	216,691	4.3%
Davidson	124,103	709,211	17.5%
Total SA	**133,317**	**925,902**	**14.4%**
Tennessee	1,241,028	6,778,877	18.3%

Sources: Nielsen, Inc., Bureau of Tenncare

Tab 12

Attachment C
Economic Feasibility - 1

Construction Costs Verification Letter

FreemanWhite

December 8, 2014

Mrs. Karen Springer
Saint Thomas Health Services
102 Woodmont Boulevard, Suite #800
Nashville, Tennessee 37205

Reference: Saint Tho□ as Health Services – Satellite E□ ergency Depart□ ent – Brentwood□TN□ Conceptual Esti□ ate

Dear Mrs. Springer,

This letter is being issued as verification that the submitted estimate of cost for the proposed Saint Thomas Health Services Satellite Emergency Department in Brentwood, TN. is reasonable. The aggregate construction cost estimate of $2,685,808 (9,250SF @ $290 / BGSF) is based on comparative estimates of similar new construction and project scope types. In addition, the overall comprehensive project cost of $4,358,804, excluding land costs, is also comparable to similar projects.

I attest that the design and construction information submitted is consistent with the design and cost of similar facilities in the region. The physical environment will conform to the applicable federal, state, and local construction codes, standards, manufacturers' specifications and licensing agencies requirements, including the current 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

We hope this meets with your approval and stand ready to answer and questions that you may have. As always, we look forward to assisting in the development of this project. Please feel free to call me with any questions, clarifications, or comments.

Please feel free to call if you should have any additional questions.

Sincerely,

Brian Adams, AIA
Principal
FreemanWhite

Tab 13

Attachment C
Economic Feasibility - 2

Verification of Funding

Saint Thomas Health

December 5, 2014

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application - Saint Thomas Midtown Hospital

Dear Ms. Hill:

Saint Thomas Health has a centralized cash management program for managing and investing operating funds for all Saint Thomas Health hospitals, including Saint Thomas Midtown Hospital. This letter is to confirm that Saint Thomas Health has available more than sufficient resources to fund the projected CON cost of $6.8 million required to implement Midtown Hospital's project to construct a satellite emergency department.

Thank you for your attention to this matter.

Sincerely,

Craig Polkow
Chief Financial Officer

102 Woodmont Blvd., Suite 800
Woodmont Centre
Nashville, TN 37205
SaintThomasHealth.com

Tab 14

Attachment C
Economic Feasibility - 10

Balance Sheet and Income Statement

Saint Thomas Midtown Hospital
Balance Sheet
(Dollars in Thousands)

	June 30, 2014		June 30, 2014
ASSETS		**LIABILITIES AND NET ASSETS**	
CURRENT ASSETS:		**CURRENT LIABILITIES**	
Cash And Cash Equivalents	$2	Current Portion of Long-Term Debt	$3,458
Gross Patient Accounts Receivable	126,785	Accounts Payable	10,196
Less Allowances	(80,758)	AR Credit balances, net	1,465
Patient Accounts Receivable, Net	46,027	Accrued Liabilities	9,680
Estimated Settlements from Third-Party Payors	2,367	Estimated Settlements to Third Party Payors	6,591
Total Inventory	5,337	Current Portion Self-Insurance Liability	2,772
Total Other Current Assets	3,016	Total Other Current Liabilities	12,795
Total Current Assets	**$56,905**	**Total Current Liabilities**	**$46,958**
PROPERTY AND EQUIPMENT		**NONCURRENT LIABILITIES**	
Land and Improvements	$8,737	**Long-Term Debt:**	
Buildings	224,855	Centralized Debt Management System	$238,261
Equipment	134,348	**Net Long-Term Debt**	**$238,261**
Construction in Progress	3,301	**Other Long-Term Liabilities:**	
Less Accumulated Depreciation	(269,885)	Self-Insurance Liability	$1,237
Total Property and Equipment, (net)	**$101,355**	Pension and Other Post Retirement Benefits	1,572
Other Assets:		Other	4,314
Investments in Unconsolidated Entities	$938	**Total Noncurrent Liabilities**	**$245,384**
Other	8,684	**Total Liabilities**	**$292,342**
Total Other Assets	**$9,623**	**NET ASSETS**	
Total Assets	**$167,883**	Unrestricted Net Assets	$164,221
		Total Net Assets	**$164,221**
		Total Liabilities and Net Assets	**$167,883**

Saint Thomas Midtown Hospital
Statement of Operations
For The Twleve Months Ending June 30, 2014

GROSS PATIENT SERVICE REVENUE:	
Total Inpatient Routine Revenue	$184,819,831
Inpatient Ancillary Revenue	696,921,799
Outpatient Revenue	461,652,449
Total Gross Patient Service Revenue	**$1,343,394,079**
REVENUE DEDUCTIONS:	
Charity Care	$47,790,033
Medicare Deductions	390,943,365
Medicaid Deductions	114,698,900
Blue Cross Deductions	193,717,180
HMO/PPO Deductions	144,073,139
Bad Debts Deductions	9,069,349
Other Revenue and Contract Deductions	54,545,243
Total Revenue Deductions	**$954,837,209**
Net Patient Service Revenue	**$388,556,871**
OTHER REVENUE:	
Other Revenue	$18,396,279
Gain on Sale of Assets	113,413
Income from Unconsolidated Entities	1,787,067
Total Other Revenue	**$20,296,760**
Total Operating Revenue	**$408,853,631**
OPERATING EXPENSES:	
Salaries and Wages	$92,143,355
Employee Benefits	22,998,918
Purchased Services	34,624,503
Professional Fees	8,895,450
Supplies	77,182,805
Insurance	629,415
Interest	7,776,719
Income Tax	0
Depreciation	13,674,404
Amortization	2,914,926
Other Operating Expenses	106,091,394
Total Operating Expenses	**$366,931,889**
Income (Loss) From Recurring Operations	41,921,741
Recurring Op Inc before Non-reucrring Items	41,921,741
Total Impair Write-Dwn, Restruct, NonRec	542,820
Income (Loss) from Operations	$41,378,921
NONOPERATING GAINS (LOSSES):	
Other NonOperating Activity	(909,167)
Total NonOperating Gains (Losses), Net	**($909,167)**
Income(Loss) Before Oth NonOper. Items	**$40,469,755**
Net Income (Loss)	**$40,469,755**

Tab 15

Attachment C
Economic Feasibility - 10

Audited Financials

Consolidated Financial Statements and Supplementary Information

Ascension Health Alliance
d/b/a Ascension
Years Ended June 30, 2014 and 2013
With Reports of Independent Auditors

Ascension

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2014 and 2013

Contents

Report of Independent Auditors 1

Consolidated Financial Statements

Consolidated Balance Sheets 3
Consolidated Statements of Operations and Changes in Net Assets 5
Consolidated Statements of Cash Flows 7
Notes to Consolidated Financial Statements 9

Supplementary Information

Report of Independent Auditors on Supplementary Information 66
Schedule of Net Cost of Providing Care of Persons Living in Poverty and Other Community Benefit Programs 67
Credit Group Consolidated Balance Sheets as of June 30, 2014 and 2013 68
Credit Group Consolidated Statements of Operations and Changes in Net Assets for the Years Ended June 30, 2014 70
Schedule of Credit Group Cash and Investments 72
Schedule of Credit Group Statistical Information 73

Building a better working world

Ernst & Young LLP
The Plaza in Clayton
Suite 1300
190 Carondelet Plaza
St. Louis, MO 63105-3434

Tel: +1 314 290 1000
Fax: +1 314 290 1882
ey.com

Report of Independent Auditors

The 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, 2014 and 2013, and the related consolidated statements of operations and changes in net 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.

A member firm of Ernst & Young Global Limited

Building a better working world

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Ascension Health d/b/a Ascension at June 30, 2014 and 2013, 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 11, 2014

A member firm of Ernst & Young Global Limited

Ascension

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2014	June 30, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ **618,418**	$ 753,555
Short-term investments	**109,081**	113,825
Accounts receivable, less allowance for doubtful accounts ($1,260,407 and $1,297,609 at June 30, 2014 and 2013, respectively)	**2,419,616**	2,292,521
Inventories	**332,739**	297,233
Due from brokers *(see Notes 4 and 5)*	**343,757**	178,380
Estimated third-party payor settlements	**236,559**	119,379
Other *(see Notes 4 and 5)*	**562,367**	1,026,397
Total current assets	**4,622,537**	4,781,290
Long-term investments *(see Notes 4 and 5)*	**15,327,255**	14,156,447
Property and equipment, net	**8,410,629**	8,274,854
Other assets:		
Investment in unconsolidated entities	**649,888**	628,772
Capitalized software costs, net	**778,705**	718,122
Other	**1,509,849**	1,487,886
Total other assets	**2,938,442**	2,834,780
Total assets	$ **31,298,863**	$ 30,047,371

	June 30, 2014	June 30, 2013
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ **91,532**	$ 89,869
Long-term debt subject to short-term remarketing arrangements*	**1,345,530**	1,187,125
Accounts payable and accrued liabilities	**2,293,663**	2,278,242
Estimated third-party payor settlements	**450,054**	455,432
Due to brokers *(see Notes 4 and 5)*	**332,169**	493,420
Current portion of self-insurance liabilities	**226,856**	210,115
Other *(see Notes 4 and 5)*	**274,645**	639,566
Total current liabilities	**5,014,449**	5,353,769
Noncurrent liabilities:		
Long-term debt (senior and subordinated)	**4,994,913**	5,278,304
Self-insurance liabilities	**541,859**	553,706
Pension and other postretirement liabilities	**428,679**	554,368
Other *(see Notes 4 and 5)*	**1,343,826**	1,178,597
Total noncurrent liabilities	**7,309,277**	7,564,975
Total liabilities	**12,323,726**	12,918,744
Net assets:		
Unrestricted		
Controlling interest	**16,736,190**	14,986,302
Noncontrolling interests	**1,656,106**	1,592,356
Unrestricted net assets	**18,392,296**	16,578,658
Temporarily restricted	**391,226**	375,054
Permanently restricted	**191,615**	174,915
Total net assets	**18,975,137**	17,128,627
Total liabilities and net assets	$ **31,298,863**	$ 30,047,371

*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, 2015. 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, drawing upon the $1billion line of credit, and issuing commercial paper. The commercial paper program is supported by the $1billion line of credit.

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

Ascension

Consolidated Statements of Operations and Changes in Net Assets

(Dollars in Thousands)

	Year Ended June 30, 2014	Year Ended June 30, 2013
Operating revenue:		
Net patient service revenue	$ 19,193,307	$ 16,326,684
Less provision for doubtful accounts	1,273,354	1,124,409
Net patient service revenue, less provision for doubtful accounts	17,919,953	15,202,275
Other revenue	2,229,767	1,334,623
Total operating revenue	20,149,720	16,536,898
Operating expenses:		
Salaries and wages	8,202,294	6,974,951
Employee benefits	1,747,739	1,528,119
Purchased services	1,210,276	955,440
Professional fees	1,279,459	1,093,446
Supplies	2,822,102	2,334,427
Insurance	128,535	109,178
Interest	194,616	150,877
Depreciation and amortization	899,389	730,757
Other	2,901,859	2,140,182
Total operating expenses before impairment, restructuring and nonrecurring losses, net	19,386,269	16,017,377
Income from operations before self-insurance trust fund investment return and impairment, restructuring, and nonrecurring losses, net	763,451	519,521
Self-insurance trust fund investment return	66,174	34,985
Impairment, restructuring and nonrecurring losses, net	(223,834)	(103,344)
Income from operations	605,791	451,162
Nonoperating gains (losses):		
Investment return	1,515,819	736,300
Loss on extinguishment of debt	(1,605)	(4,079)
(Loss) gain on interest rate swaps	(6,020)	53,746
Income from unconsolidated entities	5,539	8,544
Contributions from business combinations, net	–	2,021,963
Other	(63,119)	(69,524)
Total nonoperating gains, net	1,450,614	2,746,950
Excess of revenues and gains over expenses and losses	2,056,405	3,198,112
Less noncontrolling interests	245,893	131,184
Excess of revenues and gains over expenses and losses attributable to controlling interest	1,810,512	3,066,928

Continued on next page.

Ascension

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

(Dollars in Thousands)

	Year Ended June 30, 2014	2013
Unrestricted net assets, controlling interest:		
Excess of revenues and gains over expenses and losses	**$ 1,810,512**	$ 3,066,928
Transfers to sponsors and other affiliates, net	**(6,566)**	(9,152)
Contributed net assets	**(1,534)**	(1,050)
Membership interest changes, net	**45,255**	–
Net assets released from restrictions for property acquisitions	**62,537**	65,706
Pension and other postretirement liability adjustments	**23,990**	76,483
Change in unconsolidated entities' net assets	**4,571**	23,295
Other	**(24,514)**	4,507
Increase in unrestricted net assets, controlling interest, before loss from discontinued operations	**1,914,251**	3,226,717
Loss from discontinued operations	**(164,363)**	(76,829)
Increase in unrestricted net assets, controlling interest	**1,749,888**	3,149,888
Unrestricted net assets, noncontrolling interests:		
Excess of revenues and gains over expenses and losses	**245,893**	131,184
Distributions of capital	**(531,159)**	(829,989)
Contributions of capital	**401,546**	1,579,187
Membership interest changes, net	**(52,530)**	–
Contributions from business combinations	–	64,738
Increase in unrestricted net assets, noncontrolling interests	**63,750**	945,120
Temporarily restricted net assets, controlling interest:		
Contributions and grants	**99,885**	88,841
Investment return	**31,292**	17,232
Net assets released from restrictions	**(115,353)**	(108,193)
Contributions from business combinations	–	44,201
Other	**348**	1,088
Increase in temporarily restricted net assets, controlling interest	**16,172**	43,169
Permanently restricted net assets, controlling interest:		
Contributions	**10,405**	2,664
Investment return	**7,942**	1,598
Contributions from business combinations	–	67,846
Other	**(1,647)**	(368)
Increase in permanently restricted net assets, controlling interest	**16,700**	71,740
Increase in net assets	**1,846,510**	4,209,917
Net assets, beginning of year	**17,128,627**	12,918,710
Net assets, end of year	**$ 18,975,137**	$ 17,128,627

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

Ascension

Consolidated Statements of Cash Flows

(Dollars in Thousands)

	Year Ended June 30, 2014	2013
Operating activities		
Increase in net assets	**$ 1,846,510**	$ 4,209,917
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	**899,389**	730,757
Amortization of bond premiums	**(22,497)**	(13,948)
Loss on extinguishment of debt	**1,605**	4,079
Provision for doubtful accounts	**1,275,961**	1,128,717
Pension and other postretirement liability adjustments	**(23,990)**	(76,483)
Contributed net assets	**1,534**	1,050
Contributions from business combinations	**–**	(1,742,900)
Interest, dividends, and net (gains) losses on investments	**(1,621,227)**	(790,115)
Change in market value of interest rate swaps	**1,880**	(61,349)
Deferred gain on interest rate swaps	**(303)**	(303)
Gain on sale of assets, net	**(25,556)**	(4,008)
Impairment and nonrecurring expenses	**30,353**	17,259
Transfers to sponsor and other affiliates, net	**6,566**	9,152
Restricted contributions, investment return, and other	**(122,232)**	(98,755)
Other restricted activity	**6,362**	15,965
Nonoperating depreciation expense	**234**	317
(Increase) decrease in:		
Short-term investments	**4,744**	212,624
Accounts receivable	**(1,393,667)**	(1,134,828)
Inventories and other current assets	**437,913**	(213,753)
Due from brokers	**(165,377)**	610,891
Investments classified as trading	**466,353**	(959,888)
Other assets	**(186,983)**	(182,693)
Increase (decrease) in:		
Accounts payable and accrued liabilities	**(685)**	(2,009)
Estimated third-party payor settlements, net	**(124,475)**	30,604
Due to brokers	**(161,251)**	(387,193)
Other current liabilities	**(357,167)**	91,435
Self-insurance liabilities	**4,894**	(15,342)
Other noncurrent liabilities	**60,731**	(153,420)
Net cash provided by continuing operating activities	**839,619**	1,225,780
Net cash provided by (used in) and adjustments to reconcile change in net assets for discontinued operations, including write-down of assets	**126,554**	(19,386)
Net cash provided by operating activities	**966,173**	1,206,394

Continued on next page.

Ascension

Consolidated Statements of Cash Flows (continued)

(Dollars in Thousands)

	Year Ended June 30, 2014	2013
Investing activities		
Property, equipment, and capitalized software additions, net	**$ (1,102,680)**	$ (871,203)
Proceeds from sale of property and equipment	**15,594**	26,321
Net cash used in investing activities	**(1,087,086)**	(844,882)
Financing activities		
Issuance of long-term debt	**512,231**	1,228,995
Repayment of long-term debt	**(606,502)**	(1,235,850)
(Increase) decrease in assets under bond indenture agreements	**(17,506)**	20,577
Transfers to sponsors and other affiliates, net	**(24,679)**	(26,112)
Restricted contributions, investment return, and other	**122,232**	98,755
Net cash (used in) provided by financing activities	**(14,224)**	86,365
Net (decrease) increase in cash and cash equivalents	**(135,137)**	447,877
Cash and cash equivalents at beginning of year	**753,555**	305,678
Cash and cash equivalents at end of year	**$ 618,418**	$ 753,555

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

Ascension

Notes to Consolidated Financial Statements
(Dollars in Thousands)

June 30, 2014

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 Health Ministries, located in 23 of the United States and the District of Columbia.

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

- AH Holdings, LLC, d/b/a Ascension Holdings, LLC
- AHV Holding Company, LLC, d/b/a AV Holding Company
- Ascension Health
- Ascension Health Clinical Holdings, d/b/a Ascension Clinical Holdings
- Ascension Health Global Mission, d/b/a Ascension Global Mission
- Ascension Health Insurance, Ltd. (AHIL)
- Ascension Health – IS. Inc., d/b/a Ascension Information Services
- Ascension Health Resource and Supply Management Group, LLC d/b/a The Resource Group
- Ascension Health Leadership Academy, d/b/a Ascension Leadership Academy
- Ascension Health Ventures, d/b/a Ascension Ventures
- Ascension Investment Management, LLC (AIM)
- Ascension Alpha Fund, LLC, f/k/a CHIMCO Alpha Fund, LLC (Alpha Fund)
- Ascension Risk Services, LLC

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

Effective July 15, 2013, Ascension Health Leadership Academy, LLC, Ascension Health Global Mission and Ascension Health Clinical Holdings began doing business as Ascension Leadership Academy, Ascension Global Mission and Ascension Clinical Holdings, respectively. On July 17, 2013, AH Holdings, LLC began doing business as Ascension Holdings. Effective October 14, 2013, CHIMCO Alpha Fund, LLC was renamed Ascension Alpha Fund, LLC.

1. Organization and Mission (continued)

Effective November 4, 2013, Ascension Health Ventures, LLC was renamed Ascension Ventures, LLC and AHV Holding Company, LLC began doing business as AV Holding Company. Effective December 12, 2013, Ascension Health – IS, Inc. began doing business as Ascension Information Services. Effective January 1, 2014, Catholic Healthcare Investment Management Company (CHIMCO) transferred all of its business and assets to AIM, a limited liability company wholly owned by Ascension and CHIMCO's successor in interest.

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. As more fully described in the Organizational Changes note, Marian Health System, which was previously sponsored by the Sisters of the Sorrowful Mother of the Third Order of St. Francis of Assisi – US/Caribbean Province, became part of Ascension Health on April 1, 2013.

Mission

The System directs its governance and management activities toward strong, vibrant, Catholic Health 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 Health Ministry 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.

1. Organization and Mission (continued)

- 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 patients, including those with the means to pay. Discounts provided to those patients who did not qualify for assistance under charity care guidelines 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.

The amount of traditional charity care provided, determined on the basis of cost, was $580,606 and $524,605 for the years ended June 30, 2014 and 2013, 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 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, 2014	Year Ended June 30, 2013
Other revenue	**$ 83,317**	$ 105,173
Nonoperating gains, net	**5,539**	8,544

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.

Fair Value of Financial Instruments

Carrying values of financial instruments classified as current assets and current liabilities approximate fair value. The fair values of other financial instruments 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.

2. Significant Accounting Policies (continued)

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.

Long-term investments include assets limited as to use of approximately $1,431,000 and $1,311,000, at June 30, 2014 and 2013, 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 on investments, 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.

2. Significant Accounting Policies (continued)

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, 2014 and 2013, is as follows:

	June 30, 2014	June 30, 2013
Land and improvements	**$ 880,352**	$ 822,885
Buildings and equipment	**14,933,470**	14,427,322
	15,813,822	15,250,207
Less accumulated depreciation	**7,987,988**	7,436,307
	7,825,834	7,813,900
Construction in progress	**584,795**	460,954
Total property and equipment, net	**$ 8,410,629**	$ 8,274,854

Depreciation is determined on a straight-line basis over the estimated useful lives of the related assets. Depreciation expense in 2014 and 2013 was $739,853 and $620,177, respectively.

Several capital projects have remaining construction and related equipment purchase commitments of approximately $301,000.

2. Significant Accounting Policies (continued)

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.

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 $125,451 and $99,048 at June 30, 2014 and 2013, respectively:

	June 30,	
	2014	**2013**
Capitalized software costs	**$ 1,557,302**	$ 1,388,880
Less accumulated amortization	**778,597**	670,758
Capitalized software costs, net	**778,705**	718,122
Goodwill	**181,490**	130,306
Other, net	**62,573**	71,440
Intangible assets included in other long-term assets	**244,063**	201,746
Total intangible assets, net	**$ 1,022,768**	$ 919,868

Intangible assets whose lives are indefinite, primarily goodwill, are not amortized and are evaluated for impairment at least annually, 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 2014 and 2013 was $157,150 and $108,633, respectively.

2. Significant Accounting Policies (continued)

The System is in the midst 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 2016. The project is anticipated to result in 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 $320,000 and $301,000 at June 30, 2014 and 2013, respectively, and are included in capitalized software costs in the preceding table. Certain costs of this project were also expensed. Beginning September 1, 2012, the software associated with Symphony was considered substantially complete and ready for its intended use and is amortized on a straight-line basis over its expected useful life. Accumulated amortization of Symphony was approximately $55,000 and $25,000 at June 30, 2014 and 2013, respectively. See the Impairment, Restructuring, and Nonrecurring Gains (Losses) discussion below for additional information about costs associated with Symphony.

Noncontrolling Interests

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

Temporarily and Permanently Restricted Net Assets

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

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

2. Significant Accounting Policies (continued)

Performance Indicator

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

Operating and Nonoperating Activities

The System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, long-term care, and other healthcare services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to the System's primary mission are considered to be nonoperating. Additionally, contributions recognized in conjunction with business combination transactions are also classified as 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 $95,591 and $55,340 for the years ended June 30, 2014 and 2013, respectively.

2. Significant Accounting Policies (continued)

The percentage of net patient service revenue, less provision for doubtful accounts earned by payor for the years ended June 30, 2014 and 2013, is as follows:

	June 30,	
	2014	**2013**
Medicare – traditional and managed	**36 %**	36 %
Medicaid – traditional and managed	**11**	11
Commercial and other managed care	**45**	45
Self-Pay and other	**8**	8
	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, 2014 and 2013, are as follows:

	June 30,	
	2014	**2013**
Medicare – traditional and managed	**22 %**	22 %
Medicaid – traditional and managed	**9**	8
Commercial and other managed care	**45**	43
Self-Pay and other	**24**	27
	100 %	100 %

2. Significant Accounting Policies (continued)

The provision for doubtful accounts is based upon management's assessment of expected net collections considering economic conditions, historical experience, 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. The System has not experienced material changes in write-off trends and has not materially changed its charity care policy in the current fiscal year.

Impairment, Restructuring, and Nonrecurring Gains (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.

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 establish a shared service center and develop a business intelligence data warehouse. Costs associated with product deployment are recorded as nonrecurring gains (losses), and costs associated with product support are recorded as recurring operating expenses.

2. Significant Accounting Policies (continued)

During the year ended June 30, 2014, the System recorded total impairment, restructuring, and nonrecurring losses, net of $223,834. This amount was comprised primarily of $163,293 of nonrecurring expenses associated with Symphony, one-time termination benefits and other restructuring expenses of $26,012, impairment expenses of $23,120, and other nonrecurring expenses of $11,409.

During the year ended June 30, 2013, the System recorded total impairment, restructuring, and nonrecurring losses, net of $103,344. This amount was comprised primarily of $113,193 of nonrecurring expenses associated with Symphony, one-time termination benefits and other restructuring expenses of $57,470, and impairment and other nonrecurring expenses of $4,998, partially offset by pension curtailment gains of $72,317, as discussed in the Retirement Plans note.

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, 2014.

At June 30, 2014, the System has deferred tax assets of approximately $326,000 for federal and state income tax purposes primarily related to net operating loss carryforwards. A valuation allowance of approximately $322,000 was recorded due to the uncertainty regarding use of the deferred tax assets.

2. Significant Accounting Policies (continued)

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 2013 accompanying consolidated financial statements to conform to the 2014 presentation.

Adoption of New Accounting Standards

In December 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-11, *Disclosures about Offsetting Assets and Liabilities,* an amendment to the accounting guidance for disclosures about offsetting assets and liabilities. In January 2013, the FASB issued ASU No. 2013-01, *Clarifying the Scope of Disclosures about Offsetting Assets and Liabilities.* These ASUs expand the disclosure requirements in that entities will be required to disclose both gross and net information about instruments and transactions eligible for offset in the balance sheet. Ascension adopted this collective guidance on July 1, 2013, which did not have a material impact on Ascension's consolidated financial statements for the year ended June 30, 2014. See the Derivative Instruments note for disclosures about offsetting assets and liabilities for the year ended June 30, 2014.

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 in the consolidated financial statements as of the Consolidated Balance Sheet date. For the year ended June 30, 2014, the System evaluated subsequent events through September 11, 2014, representing the date on which the accompanying audited consolidated financial statements were issued.

2. Significant Accounting Policies (continued)

In July 2014, the System signed two separate non-binding letters of intent to sell primarily all assets and liabilities and related operations of Ascension's operations in Kansas City, Missouri and Tucson, Arizona, as discussed in the Organizational Changes note.

In August 2014, Ascension Health signed an affiliation agreement to sell primarily all of the assets, liabilities and operations associated with Ascension's operations in Niagara Falls, New York to Catholic Health System, Inc. This transaction is intended to close during calendar year 2015, after obtaining all necessary approvals.

3. Organizational Changes

Business Combinations

Marian Health System

Effective April 1, 2013, Ascension Health, a subsidiary of the System, became the sole corporate member, through a non-cash business combination transaction, of three regional health systems that formerly comprised Marian Health System, Inc. (Marian Health System): Via Christi Health, Inc. (Via Christi Health), based in Wichita, Kansas; Ministry Health Care, Inc. (Ministry Health Care), based in Milwaukee, Wisconsin; and St. John Health System, Inc. (St. John Health), based in Tulsa, Oklahoma (collectively, the Marian Systems). Prior to this transaction, Marian Health System was the sole corporate member of Ministry Health Care and St. John Health, while Ascension Health and Marian Health System were the two corporate members of Via Christi Health.

Prior to April 1, 2013, the System accounted for its 50% interest in Via Christi Health under the equity method of accounting. The System's investment in Via Christi Health at March 31, 2013, was $545,018, which was reported in the Consolidated Balance Sheet at that date in investment in unconsolidated entities. For the year ended June 30, 2013, the System's excess of revenues and gains over expenses and losses included $34,141, representing the System's share of Via Christi Health's excess of revenues over expenses prior to the business combination transaction on April 1, 2013. The System's investment in Via Christi Health of $545,018 at March 31, 2013, was derecognized on April 1, 2013, in conjunction with the accounting for the business combination transaction.

3. Organizational Changes (continued)

The fair values of the Marian Systems' net assets, by major type, that were recognized in the System's Consolidated Balance Sheet on April 1, 2013, were as follows. The valuation of these net assets was finalized during the year ended June 30, 2014, resulting in no material adjustments.

Net working capital	$ 557,274
Intangible assets, including capitalized software	135,819
Property and equipment	1,950,739
Assets limited as to use	1,126,259
Investments and other long-term assets	1,125,652
Noncurrent liabilities assumed	(2,144,948)
Subtotal	2,750,795
Less: March 31, 2013 Investment in Via Christi Health	(545,018)
Fair value of net assets	$ 2,205,777

The fair value of net assets of $2,205,777 in the preceding table was recognized in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2013, as a nonoperating contribution from business combinations of $2,028,992; contributions of temporarily and permanently restricted net assets of $44,201 and $67,846, respectively; and contributions of noncontrolling interests of $64,738.

For the three months ended June 30, 2013, the System recognized revenues of the Marian Systems of $1,049,259, and an excess of revenues and gains over expenses and losses of the Marian Systems of $56,670, of which $55,542 was attributable to controlling interest, with the remaining attributable to noncontrolling interests. Additionally, for the three months ended June 30, 2013, the System recognized an increase in unrestricted net assets – controlling interests, excluding the excess of revenues and gains over expenses and losses of $56,670 above, of $53,801; an increase in unrestricted net assets – noncontrolling interests of $823; an increase in temporarily restricted net assets of $915; and a decrease in permanently restricted net assets of $56.

3. Organizational Changes (continued)

The following unaudited pro forma financial information presents the combined results of operations of the System and the Marian Systems for the year ended June 30, 2013, as though the April 1, 2013 business combination transaction had occurred on July 1, 2011. This pro forma financial information is not necessarily indicative of the results of operations that would have occurred had the System and the Marian Systems constituted a single entity during this period, nor is it necessarily indicative of future operating results.

	Year Ended June 30, 2013
Total operating revenue	$ 20,005,943
Excess of revenues and gains over expenses and losses	1,230,777
Increase in unrestricted net assets – controlling interest	1,307,542
Increase in unrestricted net assets – noncontrolling interests	879,585
Increase in temporarily restricted net assets	7,497
Increase in permanently restricted net assets	7,945

The excess of revenues and gains over expenses and losses and the increase in unrestricted net assets – controlling interest in the table above exclude the nonoperating contribution from the Marian Health System business combination of $2,028,992 included in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2013. The pro forma excess of revenues and gains over expenses and losses above includes certain adjustments attributable to the April 1, 2013, business combination transaction.

In addition, the increases in unrestricted net assets – controlling interest, temporarily restricted net assets, and permanently restricted net assets in the table above exclude the contributions from business combinations reflected in the contributions of noncontrolling interests, and temporarily and permanently restricted net assets of $64,738, $44,201, and $67,846, respectively.

3. Organizational Changes (continued)

Mercy Regional Health Center, Inc.

On February 27, 2014 (transaction date), Via Christi Health, a subsidiary of Ascension Health, became the sole corporate member of Mercy Regional Health Center, Inc. (MRHC) through a membership transfer agreement with Memorial Hospital Association (MHA). Prior to the transaction date, Via Christi Health held a 50% controlling interest in MRHC, which it consolidated, with a noncontrolling interest recognized for the portion of MRHC held by MHA. On the transaction date, Via Christi Health paid cash of approximately $7,300 to MHA in exchange for MHA's 50% interest valued at approximately $52,530, along with contingent consideration, paid in the event of a sale or future change in control of either MRHC or Via Christi Health, or the dissolution of MRHC. As such, this contingent liability had a value of zero at June 30, 2014 and through September 11, 2014, the date of issuance of Ascension's consolidated financial statements. This transaction was accounted for as a $45,255 increase in controlling interest and a corresponding $52,530 decrease in noncontrolling interest in Ascension's Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2014.

Divestitures and Discontinued Operations

As of June 30, 2014, and through September 11, 2014, the date of issuance of Ascension's consolidated financial statements, the System is in discussions, and has signed related non-binding letters of intent, with certain third parties for the sale of primarily all assets, liabilities and operations, excluding certain non-acute care entities, associated with Ascension's operations in Kansas City, Missouri; Tucson, Arizona; and Niagara Falls, New York (entities held for sale). A noncontrolling interest in the operations in Tucson, Arizona, subsequent to the sale is expected to be retained. Completion of these proposed transactions is subject to due diligence and execution of final definitive agreements, including obtaining all necessary approvals.

3. Organizational Changes (continued)

Assets and liabilities intended to be sold are designated as assets and liabilities held for sale, and included within other assets and other liabilities, respectively, in the System's Consolidated Balance Sheets. Assets held for sale were $431,404 and $571,350 at June 30, 2014 and 2013, respectively, while liabilities held for sale were $130,722 and $142,707 at June 30, 2014 and 2013, respectively. Revenues of the entities held for sale were $870,862 and $862,838 for the years ended June 30, 2014 and 2013, respectively. Losses of the entities held for sale included in the Loss from discontinued operations in the Consolidated Statement of Operations and Changes in Net Assets were $31,579 and $74,892 for the years ended June 30, 2014 and 2013, respectively. Primarily all of the remaining loss from discontinued operations for the year ended June 30, 2014, was comprised of the write-down of assets in Tucson, Arizona, and Niagara Falls, New York, in conjunction with being classified as held for sale.

Other

In June 2014, Alexian Brothers Health System, a subsidiary of Ascension Health, signed a non-binding letter of intent to form a joint operating company with Adventist Midwest Health. Completion of this proposed transaction is subject to due diligence and execution of final definitive agreements, including obtaining all necessary approvals.

4. Pooled Investment Fund

At June 30, 2014 and 2013, 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 assets continue to be held through the Ascension Legacy Portfolio, and subsequent to April 2012, the Ascension Legacy Portfolio no longer holds assets for unrelated entities. Additional System investments include those held and managed by the Health Ministries' and their consolidated foundations.

The Alpha Fund includes the investment interests of the System and other Alpha Fund members. AIM, a wholly owned subsidiary of the System, manages and 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.

4. Pooled Investment Fund (continued)

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 $1,490,082 and $1,450,580 at June 30, 2014 and 2013, 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 180 days. Due to redemption restrictions, investments in certain of these funds, whose fair value was $1,312,677 at June 30, 2014, 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.

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, 2014, contractual agreements of the Alpha Fund expire between July 2014 and December 2019. The remaining unfunded capital commitments of the Alpha Fund total approximately $1,459,000 for 95 individual funds as of June 30, 2014. 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, option, 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.

4. Pooled Investment Fund (continued)

At June 30, 2014 and 2013, the notional value of Alpha Fund derivatives outstanding was approximately $2,377,000 and $2,126,000, respectively. The fair value of Alpha Fund derivatives in an asset position was $61,234 and $35,404 at June 30, 2014 and 2013, respectively, while the fair value of Alpha Fund derivatives in a liability position was $3,478 and $84,249 at June 30, 2014 and 2013, respectively. These derivatives are included in long-term investments in the Consolidated Balance Sheets at June 30, 2014 and 2013.

The Alpha Fund also participates in a securities lending program, whereby a portion of the Alpha Fund's investments are loaned to selected established brokerage firms in return for cash and securities from the brokers as collateral for the investments loaned, usually on a short-term basis. The fair value of collateral held by the Alpha Fund associated with such lending agreements amounts to approximately $3,000 and $394,000 at June 30, 2014 and 2013, respectively, and is included in other current assets in the Consolidated Balance Sheets, while the liability associated with the obligation to repay such collateral is also approximately $3,000 and $394,000 at June 30, 2014 and 2013, respectively, and is included in other current liabilities in the Consolidated Balance Sheets. In addition, the Alpha Fund has liabilities for investments sold, not yet purchased, representing obligations of the Alpha Fund to purchase investments in the market at prevailing prices. The fair value of this Alpha Fund liability is approximately $179,000 and $7,000 at June 30, 2014 and 2013, respectively, and is included in other noncurrent liabilities in the Consolidated Balance Sheets.

Due from brokers and due to brokers on the Consolidated Balance Sheets at June 30, 2014 and 2013, represent the Alpha Fund's positions and amounts due from or to various brokers, primarily amounts for security transactions not yet settled, and cash held by brokers for securities sold, not yet purchased.

5. Cash and Investments

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

	June 30,	
	2014	**2013**
Cash and cash equivalents	**$ 618,418**	$ 753,555
Short-term investments	**109,081**	113,825
Long-term investments	**15,327,255**	14,156,447
Subtotal	**16,054,754**	15,023,827
Other Alpha Fund assets and liabilities:		
In other current assets	**30,671**	459,050
In other long-term assets	**2,641**	2,785
In accounts payable and other accrued liabilities	**(7,013)**	(5,680)
In other current liabilities	**(3,341)**	(394,763)
In other noncurrent liabilities	**(178,732)**	(6,622)
Due to brokers, net	**11,588**	(315,040)
Total cash and investments, net	**15,910,568**	14,763,557
Less noncontrolling interests of Alpha Fund	**1,490,082**	1,450,580
System cash and investments, including assets limited as to use	**14,420,486**	13,312,977
Less assets limited as to use:		
Under bond indenture agreement	**43,869**	33,955
Self-insurance trust funds	**759,388**	728,621
Temporarily or permanently restricted	**652,244**	561,802
Total assets limited as to use	**1,455,501**	1,324,378
System unrestricted cash and investments, net	**$ 12,964,985**	$ 11,988,599

5. Cash and Investments (continued)

At June 30, 2014 and 2013, 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, 2014	June 30, 2013
Cash and cash equivalents and short-term investments	**$ 828,020**	$ 1,113,823
Pooled short-term investment funds	**302,436**	311,027
U.S. government, state, municipal and agency obligations	**3,301,360**	3,447,500
Corporate and foreign fixed income securities	**1,660,267**	1,664,001
Asset-backed securities	**978,429**	1,196,168
Equity securities	**3,318,063**	2,695,483
Alternative investments and other investments:		
Private equity and real estate funds	**1,039,704**	809,341
Hedge funds	**3,303,800**	2,860,776
Commodities funds and other investments	**1,322,675**	925,708
Total alternative investments and other investments	**5,666,179**	4,595,825
Total cash and cash equivalents, short-term investments, and long-term investments	**$ 16,054,754**	$ 15,023,827

As of June 30, 2014 and 2013, the System's membership interest in the Alpha Fund totaled $12,500,448 and $11,251,590, respectively. As of June 30, 2014 and 2013, the noncontrolling interest (see Note 2) in the Alpha Fund, representing interests held by entities other than the System, totaled $1,490,082 and $1,450,580, respectively.

Investment return recognized by the System for the years ended June 30, 2014 and 2013, is summarized in the following table. Total investment return includes the System's return in the Ascension Legacy Portfolio and the investment return of the Alpha Fund. System investment return represents the System's total investment return, net of the investment return earned by the noncontrolling interests of other Alpha Fund members.

5. Cash and Investments (continued)

	Year Ended June 30, 2014	2013
Interest and dividends	**$ 203,975**	$ 169,797
Net gains on investments reported at fair value	**1,378,018**	601,488
Restricted investment return and unrealized gains, net	**39,234**	18,830
Total investment return	**1,621,227**	790,115
Less return earned by noncontrolling interests of Alpha Fund	**193,400**	106,039
System investment return	**$ 1,427,827**	$ 684,076

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.

There were no significant transfers between Levels 1 and 2 during the years ended June 30, 2014 and 2013.

As of June 30, 2014 and 2013, the assets and liabilities listed in the fair value hierarchy tables below use the following valuation techniques and inputs:

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.

6. Fair Value Measurements (continued)

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.

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.

6. Fair Value Measurements (continued)

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.

Securities Lending Collateral

The fair value of collateral received under the Alpha Fund's securities lending program is valued using the calculated net asset value for the commingled fund in which the collateral is invested. The underlying investments in the commingled fund are valued using techniques consistent with the market approach, which uses significant observable market inputs such as available trade, quotes, benchmark curves, sector groupings, and matrix pricing.

6. Fair Value Measurements (continued)

Benefit Plan Assets

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

Interest Rate Swap Assets and Liabilities

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

Investments Sold, Not Yet Purchased

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

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2014, 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, 2014				
Cash and cash equivalents	$ 351,934	$ 3,398	$ –	$ 355,332
Short-term investments	44,193	23,804	293	68,290
Pooled short-term investment funds	302,436	–	–	302,436
U.S. government, state, municipal and agency obligations	–	3,301,360	–	3,301,360
Corporate and foreign fixed income securities	–	1,429,694	230,573	1,660,267
Asset-backed securities	–	878,508	99,921	978,429
Equity securities	3,079,815	186,670	51,578	3,318,063
Alternative investments and other investments:				
Private equity and real estate funds	388	5,901	1,030,536	1,036,825
Hedge funds	–	–	3,303,800	3,303,800
Commodities funds and other investments	134	1,352	1,212,420	1,213,906
Assets not at fair value				516,046
Cash and investments				$ 16,054,754
Securities lending collateral, in other current assets	$ –	$ 3,341	$ –	$ 3,341
Benefit plan assets, in other noncurrent assets	235,991	–	40,749	276,740
Interest rate swaps, in other noncurrent assets	–	69,883	–	69,883
Investments sold, not yet purchased, in other noncurrent liabilities	–	178,732	–	178,732
Interest rate swaps, included in other noncurrent liabilities	–	189,659	–	189,659

6. Fair Value Measurements (continued)

For the year ended June 30, 2014, 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	U.S. Government, State, Municipal and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Hedge Funds	Commodities Funds and Other Investments	Benefit Plan Assets
Year Ended June 30, 2014									
Beginning balance	$ 238	$ 5,829	$ 391,287	$117,033	$ 2,163	$ 799,414	$2,857,114	$ 831,182	$ 35,662
Total realized and unrealized gains (losses):									
Included in income from operations	–	3	178	1	8,287	–	(11)	8	–
Included in nonoperating gains (losses)	55	(27)	19,138	35	(97)	103,975	267,740	413,774	–
Included in changes in net assets	–	–	–	–	–	44	577	17	–
Purchases	–	–	104,381	94,926	52,839	337,742	543,162	267,890	202,600
Settlements	–	–	–	–	–	(391)	–	–	–
Sales	–	(5,805)	(273,882)	(2,227)	(10,899)	(210,248)	(376,420)	(299,570)	(216,349)
Transfers into Level 3	–	–	–	–	–	–	11,640	–	77,763
Transfers out of Level 3	–	–	(10,529)	(109,847)	(715)	–	(2)	(881)	(58,927)
Ending balance	$ 293	$ –	$ 230,573	$ 99,921	$ 51,578	$1,030,536	$3,303,800	$ 1,212,420	$ 40,749
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, 2014	$ 56	$ –	$ 7,605	$ (239)	$ 7,394	$ 70,701	$ 241,386	$ 128,351	$ –

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

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2013, 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, 2013				
Cash and cash equivalents	$ 618,129	$ 14,277	$ –	$ 632,406
Short-term investments	21,821	45,258	238	67,317
Pooled short-term investment funds	311,027	–	–	311,027
U.S. government, state, municipal and agency obligations	–	3,441,671	5,829	3,447,500
Corporate and foreign fixed income securities	–	1,272,714	391,287	1,664,001
Asset-backed securities	–	1,079,135	117,033	1,196,168
Equity securities	2,656,950	36,370	2,163	2,695,483
Alternative investments and other investments:				
Private equity and real estate funds	529	3,752	799,414	803,695
Hedge funds	–	–	2,857,114	2,857,114
Commodities funds and other investments	5,762	(6,061)	831,182	830,883
Assets not at fair value				518,233
Cash and investments				$ 15,023,827
Securities lending collateral, in other current assets	$ –	$ 394,310	$ –	$ 394,310
Benefit plan assets, in other noncurrent assets	210,767	–	35,662	246,429
Interest rate swaps, in other noncurrent assets	–	76,650	–	76,650
Investments sold, not yet purchased, in other noncurrent liabilities	–	6,622	–	6,622
Interest rate swaps, included in other noncurrent liabilities	–	194,546	–	194,546

6. Fair Value Measurements (continued)

For the year ended June 30, 2013, 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	U.S. Government, State, Municipal and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Hedge Funds	Commodities Funds and Other Investments	Benefit Plan Assets
Year Ended June 30, 2013									
Beginning balance	$ –	$ 7,437	$ 120,418	$ 15,297	$ 13,118	$ 593,753	$1,887,407	$ 615,813	$ 35,373
Total realized and unrealized gains (losses):									
Included in income from operations	–	16	242	10	1,489	–	123	(45)	–
Included in nonoperating gains (losses)	3	445	1,059	(227)	170	83,975	220,887	80,222	–
Included in changes in net assets	–	–	–	–	–	–	293	27	–
Purchases	–	169	328,980	122,703	718	188,085	981,414	401,957	44,150
Settlements	–	–	–	–	–	(25)	–	–	(279)
Sales	–	(2,238)	(58,928)	(17,883)	(13,372)	(66,836)	(232,198)	(266,889)	(41,668)
Transfers into Level 3	235	–	2,962	–	40	927	3,271	139	12,485
Transfers out of Level 3	–	–	(3,446)	(2,867)	–	(465)	(4,083)	(42)	(14,399)
Ending balance	$ 238	$ 5,829	$ 391,287	$117,033	$ 2,163	$ 799,414	$2,857,114	$ 831,182	$ 35,662
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, 2013	$ 46	$ 342	$ (1,682)	$ (751)	$ 149	$ 39,300	$ 234,426	$ (28,407)	$ –

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

7. Long-Term Debt

Long-term debt at June 30, 2014 and 2013, 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, 2014	June 30, 2013
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 (0.12% at June 30, 2014) tied to a market index plus a spread	**$ 393,425**	$ 408,605
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2039; interest (0.06% June 30, 2014) set at prevailing market rates	**224,225**	225,665
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2033; interest (0.06% at June 30, 2014) set at prevailing market rates, swapped to fixed rates of 5.454% and 5.544%, respectively, through maturity	**307,300**	307,300
Indexed put bonds subject to weekly rate resets based on a taxable index, payable through November 2046; interest (2.036% at June 30, 2014) swapped to a variable rate tied to a tax-exempt market index plus a spread through November 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 (4.10% at June 30, 2014) swapped to a variable rate tied to a market index plus a spread through November 2016	**153,690**	153,690
Fixed rate serial and term bonds payable in installments through November 2051; interest at 3.00% to 5.25%	**1,154,320**	1,207,490
Fixed rate serial and term bonds payable in installments through November 2039; interest at 5.00% swapped to variable rates over the life of the bonds	**585,290**	587,360
Fixed rate serial mode bonds payable through 2047 with purchase dates ranging from August 2014 through June 2021; interest at 0.90% to 5.00% through the purchase dates	**1,221,920**	1,224,750

7. Long-Term Debt (continued)

	June 30, 2014	June 30, 2013
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 2027; interest (0.06% at June 30, 2014) set at prevailing market rates	**$ 55,100**	$ 56,060
Fixed rate serial mode bonds payable through 2027 with purchase dates through November 2019; interest at 0.32% to 5.00%	**445,435**	446,515
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 4.847%	**425,000**	425,000
Total hospital revenue bonds under Senior Master Trust Indenture and Subordinate Master Trust Indenture	**5,119,505**	5,196,235
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 3.50% to 5.50%	**153,710**	157,000
Total hospital revenue bonds under the Alexian Brothers Health System Master Trust Indenture	**153,710**	157,000
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 3.00% to 5.00%	**24,040**	25,060
Total hospital revenue bonds under the Mercy Regional Health Center, Inc. Master Trust Indenture	**24,040**	25,060
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%	**19,185**	20,040
Total hospital revenue bonds under The Howard Young Medical Center, Inc. Master Trust Indenture	**19,185**	20,040

7. Long-Term Debt (continued)

	June 30, 2014	June 30, 2013
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%	$ 407,550	$ 414,500
Total hospital revenue bonds under the St. John Health System Master Trust Indenture	407,550	414,500
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%	358,415	368,260
Total hospital revenue bonds under the Ministry Health Care Master Trust Indenture	358,415	368,260
Total hospital revenue bonds under the Ascension Health Alliance Senior Master Trust Indenture; Ascension Health Alliance Subordinate Master Trust Indenture; 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; St. John Health System Master Trust Indenture; and Ministry Health Care Master Trust Indenture	6,082,405	6,181,095
Other debt:		
Obligations under capital leases	30,623	41,957
Other	123,368	113,710
	6,236,396	6,336,762
Unamortized premium, net	195,579	218,536
Less current portion	(91,532)	(89,869)
Less long-term debt subject to short-term remarketing arrangements	(1,345,530)	(1,187,125)
Long-term debt, less current portion and long-term debt subject to short-term remarketing arrangements	$ 4,994,913	$ 5,278,304

7. Long-Term Debt (continued)

	June 30, 2014	June 30, 2013
Ascension Health Alliance Senior Master Trust Indenture long-term debt obligations, including unamortized premium, net	**$ 3,329,323**	$ 3,579,334
Ascension Health Alliance Subordinate Master Trust Indenture long-term debt obligations, including unamortized premium, net	**505,843**	511,009
Alexian Brothers Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	**160,965**	162,594
Mercy Regional Health Center, Inc. Master Trust Indenture long-term debt obligations, including unamortized premium, net	**25,498**	27,258
The Howard Young Medical Center, Inc. Master Trust Indenture long-term debt obligations, including unamortized premium, net	**19,942**	20,933
St. John Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	**429,154**	437,503
Ministry Health Care Master Trust Indenture long-term debt obligations, including unamortized premium, net	**381,144**	394,781
Other	**143,044**	144,892
Long-term debt, less current portion, and long-term debt subject to short-term remarketing arrangements	**$ 4,994,913**	$ 5,278,304

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, 2014, are as follows:

	Ascension Health Alliance MTIs	Alexian Brothers Health System MTI	Mercy Regional Health Center, Inc. MTI	The Howard Young Medical Center, Inc. MTI	St. John Health System MTI	Ministry Health Care MTI	Other Debt	Total
Year ending June 30:								
2015	$ 59,835	$ 340	$ 1,045	$ 875	$ 7,305	$ 11,185	$ 10,947	$ 91,532
2016	50,130	7,485	1,080	910	7,680	11,665	22,513	101,463
2017	65,945	13,130	1,125	945	8,070	12,185	9,200	110,600
2018	69,045	15,655	1,175	975	6,890	12,890	35,710	142,340
2019	85,230	5,735	1,230	1,000	7,230	12,265	8,908	121,598
Thereafter	4,789,320	111,365	18,385	14,480	370,375	298,225	66,713	5,668,863
Total	$ 5,119,505	$ 153,710	$ 24,040	$ 19,185	$ 407,550	$ 358,415	$ 153,991	$ 6,236,396

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, 2014 and 2013. During the years ended June 30, 2014 and 2013, interest paid was approximately $223,000 and $170,000, respectively. Capitalized interest was approximately $5,500 and $5,400 for the years ended June 30, 2014 and 2013, 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. The System may cause each subordinate designated affiliate to

7. Long-Term Debt (continued)

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, 2014, 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; the Master Trust Indenture dated October 1, 1984, by and between Ministry Health Care and the Ministry Health Care Master Trustee; the Master Trust Indenture dated August 15, 1993, between The Howard Young Medical Center, Inc., a subsidiary of Ministry Health Care, and The Howard Young Medical Center, Inc. Master

7. Long-Term Debt (continued)

Trustee; and the Master Trust Indenture dated January 15, 2013, between Mercy Regional Health Center, Inc. (a subsidiary of Via Christi Health) and the Mercy Regional Health Center, Inc. Master Trustee.

In June 2013, the System issued a total of $521,865 of tax-exempt bonds, Series 2013A and 2013B, through the Wisconsin issuing authority. In June 2013, the System also issued a total of $425,000 of taxable bonds, Series 2013A. The proceeds of the bonds, including original issue premium, were used to refinance debt and general corporate purposes.

Due to aggregate financing activity during the fiscal years ended June 30, 2014 and 2013, losses on extinguishment of debt of $1,605 and $4,079, respectively, were recorded, which are included in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

The System is a party to multiple interest rate swap agreements that convert the variable or fixed rates of certain debt issues to fixed or variable rates, respectively. See the Derivative Instruments note for a discussion of these derivatives.

As of June 30, 2014, the Senior Credit Group has a line of credit of $1,000,000 which may be used as a source of funding for unremarketed variable debt (including commercial paper) or for general corporate purposes, towards which bank commitments totaling $1,000,000 extend to November 9, 2014. As of June 30, 2014 and 2013, there were no borrowings under the line of credit.

As of June 30, 2014, the Senior Credit Group has a $75,000 revolving line of credit related to its letters of credit program toward which a bank commitment of $75,000 extends to November 26, 2014. 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 $75,000 revolving line of credit, letters of credit totaling $57,455 have been issued as of June 30, 2014. No borrowings were outstanding under the letters of credit as of June 30, 2014 and 2013.

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, 2014 and 2013, the notional values of outstanding interest rate swaps were as follows:

	June 30,	
	2014	**2013**
Ascension Health Alliance MTI	**$ 2,128,757**	$ 2,128,757
Alexian Brothers Health System MTI	**39,220**	47,220
Ministry Health Care MTI	**192,950**	270,880
St. John Health System MTI	**100,000**	125,000
Total	**$ 2,460,927**	$ 2,571,857

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, 2014		June 30, 2013	
	Asset	**Liability**	**Asset**	**Liability**
Ascension Health Alliance MTI	**$ 66,981**	**$ 169,031**	$ 73,846	$ 174,413
Alexian Brothers Health System MTI	**–**	**1,934**	–	2,685
Ministry Health Care MTI	**2,902**	**17,938**	2,804	16,492
St. John Health System MTI	**–**	**756**	–	956
Total	**$ 69,883**	**$ 189,659**	$ 76,650	$ 194,546

8. Derivative Instruments (continued)

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. Collateral and net fair value of interest rate swap agreements with credit-risk-related contingent features at June 30, 2014 and 2013, based upon the respective net liability positions and applicable credit ratings were as follows:

	June 30, 2014		June 30, 2013	
	Net Fair Value	Collateral Posted	Net Fair Value	Collateral Posted
Ascension Health Alliance MTI	**$ (102,050)**	**$ –**	$ (100,567)	$ –
Alexian Brothers Health System MTI	**(1,934)**	**–**	(2,685)	–
Ministry Health Care MTI	**(15,036)**	**16,218**	(13,688)	23,024
St. John Health System MTI	**(756)**	**–**	(956)	–
Total	**$ (119,776)**	**$ 16,218**	$ (117,896)	$ 23,024

Prior to July 1, 2006, the System designated certain of its interest rate swaps as cash flow hedges, for accounting purposes, and accordingly deferred gains or losses associated with those swaps in net assets. As of June 30, 2014, the deferred net gain associated with these interest rate swaps was $4,054. The portion of this gain that will be reclassified into nonoperating gains (losses) over the next 12 months is immaterial.

Beginning July 1, 2006, the System's previously designated cash flow hedging relationships were de-designated for accounting purposes. Accordingly, all changes in the fair value of interest rate swaps have been recognized in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets. A net nonoperating gain of $1,752 was recognized for the year ended June 30, 2014, while a net nonoperating loss of $61,651 was recognized for the year ended June 30, 2013.

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 covering substantially all eligible employees of certain System entities. 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 cash and cash equivalents, equity, fixed income funds, 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.

During previous fiscal years, the System approved and communicated to employees a redesign of associate retirement benefits, which affects certain System Plans, as well as provides an enhanced comprehensive defined contribution plan. This redesign resulted in the recognition of a curtailment gain of $73,198, for the year ended June 30, 2013, which was recognized in total impairment, restructuring, and nonrecurring losses, net for the year ended June 30, 2013. This redesign resulted in a decrease to the projected benefit obligation and is included in pension and other postretirement liabilities in the Consolidated Balance Sheets.

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

9. Retirement Plans (continued)

The following table sets forth the combined benefit obligations and assets of the System Plans at June 30, 2014 and 2013, 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, 2014	Year Ended June 30, 2013
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 7,201,780**	$ 6,437,246
Service Cost	**51,176**	119,018
Interest Cost	**343,781**	289,634
Amendments	**290**	(12,792)
Assumption change	**408,908**	(363,778)
Actuarial (gain) loss	**55,623**	(28,641)
Business combinations	**–**	1,137,270
Curtailment	**(4,193)**	(74,962)
Benefits paid	**(365,406)**	(301,215)
Projected benefit obligation at end of year	**7,691,959**	7,201,780
Accumulated benefit obligation at end of year	**7,649,965**	7,155,166
Change in plan assets:		
Fair value of plan assets at beginning of year	**6,742,384**	5,992,677
Actual return on plan assets	**1,046,540**	121,715
Employer contributions	**41,597**	54,541
Business combinations	**–**	874,666
Benefits paid	**(365,406)**	(301,215)
Fair value of plan assets at end of year	**7,465,115**	6,742,384
Net amount recognized at end of year and funded status	**$ (226,844)**	$ (459,396)

The System Plans' funded status as a percentage of the projected benefit obligation at June 30, 2014 and 2013, was 97.1% and 93.6%, respectively. The System Plans' funded status as a percentage of the accumulated benefit obligation at June 30, 2014 and 2013, was 97.6% and 94.2%, respectively.

9. Retirement Plans (continued)

Included in unrestricted net assets at June 30, 2014 and 2013, are the following amounts that have not yet been recognized in net periodic pension cost for the System Plans:

	Year Ended June 30, 2014	Year Ended June 30, 2013
Unrecognized prior service credit	$ (17,348)	$ (23,080)
Unrecognized actuarial loss	330,938	364,739
	$ 313,590	$ 341,659

Changes in plan assets and benefit obligations recognized in unrestricted net assets for System Plans during 2014 and 2013 include:

	Year Ended June 30, 2014	Year Ended June 30, 2013
Current year actuarial gain	$ (27,867)	$ (87,934)
Amortization of actuarial (gain) loss	(5,934)	19,725
Current year prior service cost (credit)	290	(12,792)
Amortization of prior service credit	5,442	5,944
	$ (28,069)	$ (75,057)

	Year Ended June 30, 2014	Year Ended June 30, 2013
Components of net periodic benefit cost		
Service cost	$ 51,176	$ 119,018
Interest cost	343,781	289,634
Expected return on plan assets	(558,335)	(500,497)
Amortization of prior service credit	(4,017)	(6,242)
Amortization of actuarial loss	7,709	53,783
Curtailment gain	(1,426)	(73,198)
Settlement gain	(1,774)	(12)
Net periodic benefit cost	$ (162,886)	$ (117,514)

9. Retirement Plans (continued)

The prior service credit and actuarial gain included in unrestricted net assets and expected to be recognized in net periodic pension cost during the year ending June 30, 2015, are $4,000 and $24,955, respectively.

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

	June 30,	
	2014	**2013**
Weighted-average discount rate	**4.35%**	4.88%
Weighted-average rate of compensation increase	**3.81%**	3.81%
Weighted-average expected long-term rate of return on plan assets	**8.30%**	8.30%

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

9. Retirement Plans (continued)

In accordance with the System Plans' asset diversification targets, as presented in the table that follows, the Trust holds certain alternative investments, consisting of various hedge funds, real asset funds, private equity funds, commodity funds, private credit funds, and certain other private funds. These investments do not have observable market values. As such, each of these investments is valued at net asset value as determined by each fund's investment manager, which approximates fair value. The fair value of the System Plans' alternative investments in the Trust as of June 30, 2014, is reported in the fair value measurement table that follows. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods ranging from 1 to 180 days. Due to redemption restrictions, investments of certain private funds, whose fair value was approximately $1,313,000 at June 30, 2014, cannot 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, 2014, investment periods expire between July 2014 and March 2018. The remaining unfunded capital commitments of the Trust total approximately $416,000 for 62 individual contracts as of June 30, 2014.

The weighted-average asset allocation for the System Plans in the Trust at the end of fiscal 2014 and 2013 and the target allocation for fiscal 2015, by asset category, are as follows:

	Target Allocation	Percentage of Plan Assets At Year-End	
Asset Category	**2015**	**2014**	**2013**
Growth	50%	**53%**	52%
Deflation	30	**29**	29
Inflation	20	**18**	19
Total	100%	**100%**	100%

9. Retirement Plans (continued)

The System Plans' assets in the Other Trusts are invested in portfolios designed to best serve the participants of the System Plans' through a long-term investment strategy designed to ensure that funds are available to pay benefits as they become due and to maximize the total return at a prudent level of investment risk. The System Plans' assets invested in the Other Trusts are diversified among various assets classes based upon established investment guidelines.

	Target Allocation	Percentage of Plan Assets At Year-End	
Asset Category	**2015**	**2014**	**2013**
Cash	1%	**1%**	6%
Growth	62	**67**	61
Income	32	**28**	25
Other	5	**4**	8
Total	100%	**100%**	100%

9. Retirement Plans (continued)

The following tables summarize fair value measurements at June 30, 2014 and 2013, 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, 2014				
Short-term investments	$ 191,495	$ 399	$ –	$ 191,894
Derivatives receivable	7	15,245	19,404	34,656
U.S. government, state, municipal and agency obligations	–	1,704,131	–	1,704,131
Corporate and foreign fixed income securities	–	673,696	47,850	721,546
Asset-backed securities	–	232,484	24,080	256,564
Equity securities	1,649,136	395,372	3,045	2,047,553
Alternative investments and other investments:				
Private equity and real estate funds	–	–	909,980	909,980
Hedge funds	–	–	1,448,274	1,448,274
Commodities funds and other investments	–	–	295,563	295,563
Assets not at fair value				154,023
Total				7,764,184
Derivatives payable	26	160,907	2,980	163,913
Investments sold, not yet purchased	1,555	–	–	1,555
Liabilities not at fair value				133,601
Total				299,069
Fair value of plan assets				$ 7,465,115

9. Retirement Plans (continued)

	Level 1	Level 2	Level 3	Total
June 30, 2013				
Short-term investments	$ 324,803	$ 20,331	$ –	$ 345,134
Derivatives receivable	1,078	337	21,059	22,474
U.S. government, state, municipal and agency obligations	–	1,671,493	1,266	1,672,759
Corporate and foreign fixed income securities	25,843	566,812	53,729	646,384
Asset-backed securities	–	226,920	22,838	249,758
Equity securities	1,317,933	18,741	2,936	1,339,610
Alternative investments and other investments:				
Private equity and real estate funds	–	–	747,864	747,864
Hedge funds	34,708	–	1,452,190	1,486,898
Commodities funds and other investments	–	316,971	271,282	588,253
Assets not at fair value				334,875
Total				7,434,009
Derivatives payable	68	300	248,988	249,356
Investments sold, not yet purchased	3,794	(71)	–	3,723
Liabilities not at fair value				438,546
Total				691,625
Fair value of plan assets				$ 6,742,384

9. Retirement Plans (continued)

For the years ended June 30, 2014 and 2013, the changes in the fair value of the System Plans' assets measured using significant unobservable inputs (Level 3) consisted of the following:

	Net Derivatives	U.S. Government, State, Municipal and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Hedge Funds	Commodities Funds and Other Investments
June 30, 2014								
Beginning balance	$ (227,929)	$ 1,266	$ 53,729	$ 22,838	$ 2,936	$ 747,864	$1,452,190	$ 271,282
Total actual return on assets	123,117	23	5,784	1,182	353	70,779	105,507	21,672
Purchases, issuances, and settlements	(108,811)	(1,289)	(9,038)	16,599	(351)	91,337	(109,423)	2,609
Transfers into (out of) Level 3	230,047	–	(2,625)	(16,539)	107	–	–	–
Ending balance	$ 16,424	$ –	$ 47,850	$ 24,080	$ 3,045	$ 909,980	$1,448,274	$ 295,563
Actual return on plan assets relating to plan assets still held at June 30, 2014	$ 16,515	$ –	$ 2,823	$ 869	$ 555	$ 56,528	$ 146,882	$ (20,343)

	Net Derivatives	U.S. Government, State, Municipal and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Hedge Funds	Commodities Funds and Other Investments
June 30, 2013								
Beginning balance	$ 8,174	$ 1,903	$ 28,308	$ 14,243	$ 1,514	$ 546,165	$1,187,124	$ 282,320
Acquisitions	–	–	–	–	–	37,048	–	9,994
Total actual return on assets	(154,133)	130	(171)	(89)	5	54,153	147,977	(21,032)
Purchases, issuances, and settlements	(122,486)	(767)	31,994	20,384	1,417	98,174	156,513	–
Transfers into (out of) Level 3	40,516	–	(6,402)	(11,700)	–	12,324	(39,424)	–
Ending balance	$ (227,929)	$ 1,266	$ 53,729	$ 22,838	$ 2,936	$ 747,864	$1,452,190	$ 271,282
Actual return on plan assets relating to plan assets still held at June 30, 2013	$ (280,606)	$ 59	$ (2,202)	$ (115)	$ 227	$ 54,968	$ 147,248	$ (21,024)

9. Retirement Plans (continued)

The Trust has entered into a series of interest rate swap agreements with a net notional amount of $2,958,450. 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.

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.

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

Expected employer contributions 2015	$ 41,714
Expected benefit payments:	
2015	502,046
2016	478,701
2017	494,566
2018	502,342
2019	506,546
2020-2024	2,499,041

The contribution amount above includes 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, 2014 and 2013, is $44,473 and $45,308, respectively. The net asset included in pension and other postretirement liabilities in the accompanying Consolidated Balance Sheets at June 30, 2014, is $756, while the net obligation included in pension and other postretirement liabilities in the accompanying Consolidated Balance Sheets at June 30, 2013, is $6,624. The change in the plans' assets and benefit obligations recognized in unrestricted net assets during the year ended June 30, 2014, was a decrease of $1,471.

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 $280,223 and $193,856 during 2014 and 2013, 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 2014 and 2013 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 AHIL.

The wholly owned onshore trust has a self-insured retention of $10,000 per occurrence with no aggregate. Excess coverage is provided through AHIL with limits up to $205,000. AHIL retains $5,000 per occurrence and $5,000 annual 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 Marian Health System joined the System. 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'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 were not renewed and are in run off.

10. Self-Insurance Programs (continued)

Self-insured entities in the states of Indiana, Kansas, Pennsylvania, and Wisconsin 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.

Included in operating expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets is professional and general liability expense of $99,568 and $68,437 for the years ended June 30, 2014 and 2013, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are professional and general liability loss reserves of $604,846 and $614,913 at June 30, 2014 and 2013, respectively.

AHIL also offers 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 and Illinois. Coverage is offered to physicians with limits ranging from $100 per claim to $1,000 per claim with various aggregate limits. Beginning October 1, 2013, AHIL offered similar coverage to employed physicians from Marian Health System in Kansas and Wisconsin.

Edessa Insurance Company Ltd. (Edessa) was acquired as part of the Alexian Brothers business combination effective January 1, 2012. Effective July 1, 2012, the self-insurance programs of Edessa were consolidated into AHIL, and Edessa ceased operations.

10. Self-Insurance Programs (continued)

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 Marian Health System was self-insured or commercially insured up to various limits and excess insurance against catastrophic loss was obtained through commercial insurers. As of October 1, 2013, the Marian Systems are provided coverage under the self-insured trust. Premium payments made to the trust are expensed and represent claims reported and claims incurred but not reported.

Included in operating expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets is workers' compensation expense of $42,052 and $41,699 for the years ended June 30, 2014 and 2013, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are workers' compensation loss reserves of $114,237 and $137,825 at June 30, 2014 and 2013, respectively.

11. Lease Commitments

Future minimum payments under noncancelable operating leases with terms of one year or more are as follows:

Year ending June 30:		
2015	$	188,138
2016		172,635
2017		138,931
2018		104,991
2019		75,410
Thereafter		209,295
Total	$	889,400

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.

11. Lease Commitments (continued)

The System's future minimum noncancelable payments associated with operating leases 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:			
2015	$ 188,138	$ 50,118	$ 138,020
2016	172,635	41,175	131,460
2017	138,931	32,104	106,827
2018	104,991	26,333	78,658
2019	75,410	20,626	54,784
Thereafter	209,295	300,833	(91,538)
Total	$ 889,400	$ 471,189	$ 418,211

Rental expense under operating leases amounted to $391,928 and $347,087 in 2014 and 2013, 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 March 2013, the System and some of its subsidiaries were named as defendants to litigation surrounding the Church Plan status of its System Plans. On May 9, 2014, the United States District Court, Eastern District of Michigan, Southern Division, issued its Decision and Order Granting Defendants' Motion to Dismiss, which effectively dismissed the case against the System. On June 11, 2014, the plaintiff in the case filed a Notice of Appeal, and the appeal is pending. Regardless of the outcome of such appeal, the System does not believe that this matter will have a material adverse effect on the System's financial position or results of operations.

12. Contingencies and Commitments (continued)

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. In connection with this nationwide review, identified System hospitals are reviewing applicable medical records and responding to the DOJ. The DOJ's investigation spans a time frame beginning in 2003 and extending through the present time. To date, four System hospitals have entered into settlements with the DOJ and the System is having settlement discussions with the DOJ regarding two other System hospitals subject to the ICD investigation.

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 $37,623 and $44,553 at June 30, 2014 and 2013, 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 $95,700.

The System entered into agreements with sponsors for support through January 2017. The System's obligation under these agreements totals $31,000 at June 30, 2014, and is included in other current and noncurrent liabilities in the accompanying Consolidated Balance Sheet.

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 $190,700.

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 26 years. The following represents the remaining guarantees and other commitments of the Senior and Subordinate Credit Groups at June 30, 2014:

Hospital de la Concepción 2000 Series A debt guarantee	**$ 29,240**
St. Vincent de Paul Series 2000A debt guarantee	**28,300**
Other guarantees and commitments	**36,200**

Supplementary Information

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Report of Independent Auditors on Supplementary Information

The Board of Directors
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 Community Benefit Programs, the Credit Group Consolidated Balance Sheets, the Credit Group Consolidated Statements of Operations and Changes in Net Assets, and the Schedule of Credit Group Cash and Investments are presented for purposes of additional analysis and is not a required part of the 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 financial statements. The information 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 is fairly stated, in all material respects, in relation to the financial statements as a whole.

Ernst + Young LLP

September 11, 2014

A member firm of Ernst & Young Global Limited

Ascension

Schedule of Net Cost of Providing Care of Persons Living in Poverty and Other Community Benefit Programs

(Dollars in Thousands)

Years Ended June 30, 2014 and 2013

The net cost of providing care to persons living in poverty and other community benefit programs is as follows:

	Year Ended June 30, 2014	2013
Traditional charity care provided	**$ 580,606**	$ 524,605
Unpaid cost of public programs for persons living in poverty	**641,981**	488,959
Other programs for persons living in poverty and other vulnerable persons	**117,990**	89,923
Community benefit programs	**480,866**	383,583
Care of persons living in poverty and other community benefit programs	**$ 1,821,443**	$ 1,487,070

Ascension

Credit Group[1] Financial Statements
Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2014	June 30, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 414,489	$ 413,891
Short-term investments	60,957	73,881
Accounts receivable, less allowance for doubtful accounts ($1,077,662 and $1,130,769 at June 30, 2014 and 2013, respectively)	1,979,167	1,887,031
Inventories	270,472	237,594
Due from brokers	343,757	178,380
Estimated third-party payor settlements	225,709	108,559
Other	617,517	1,009,996
Total current assets	3,912,068	3,909,332
Long-term investments	14,970,497	13,778,749
Property and equipment, net	6,297,972	6,227,296
Other assets:		
Investment in unconsolidated entities	539,394	532,483
Capitalized software costs, net	684,996	651,627
Due from affiliates	637,799	651,022
Other	1,353,604	1,341,384
Total other assets	3,215,793	3,176,516
Total assets	$ 28,396,330	$ 27,091,893

Continued on next page.

[1]The Credit Group Financial Statements are comprised of the System (see Note 1) excluding the System's investment in Via Christi Health, Inc. prior to March 31, 2013 and assets, liabilities and net assets of Alexian Brothers Health System (ABHS), St. John Health System, Inc. (St. John), and Ministry Health Care, Inc (Ministry). As discussed in Note 3, Ascension Health became the sole corporate member of Via Christi Health, Inc. on April 1, 2013, at which time Via Christi Health, Inc. became a member of the Credit Group. 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 $1,490,082, or approximately 10.7%, and $1,450,580, or approximately 12.9%, of the Alpha Fund's net assets as of June 30, 2014 and 2013, respectively. See Note 5 for further discussion of noncontrolling interests of the Alpha Fund.

Ascension

Credit Group[1] Financial Statements
Consolidated Balance Sheets (continued)
(Dollars in Thousands)

	June 30, 2014	June 30, 2013
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ **69,301**	$ 66,291
Long-term debt subject to short-term remarketing arrangements	**1,345,530**	1,187,125
Accounts payable and accrued liabilities	**1,926,657**	1,903,339
Estimated third-party payor settlements	**344,262**	352,343
Due to brokers	**332,169**	493,420
Current portion of self-insurance liabilities	**220,710**	202,113
Other	**154,472**	531,141
Total current liabilities	**4,393,101**	4,735,772
Noncurrent liabilities:		
Long-term debt (senior and subordinated)	**3,961,654**	4,221,758
Self-insurance liabilities	**517,691**	519,423
Pension and other postretirement liabilities	**319,808**	404,516
Other [2]	**2,658,030**	2,252,568
Total noncurrent liabilities	**7,457,183**	7,398,265
Total liabilities	**11,850,284**	12,134,037
Net assets:		
Unrestricted		
Controlling interest	**14,418,042**	12,919,514
Noncontrolling interests [3]	**1,655,092**	1,591,091
Unrestricted net assets	**16,073,134**	14,510,605
Temporarily restricted	**349,104**	334,201
Permanently restricted	**123,808**	113,050
Total net assets	**16,546,046**	14,957,856
Total liabilities and net assets	$ **28,396,330**	$ 27,091,893

[2]Includes $1,490,730 and $1,241,017 at June 30, 2014 and 2013, respectively, representing the amounts due to ABHS, St. John and Ministry from Ascension attributable to interests in investments held by Ascension.

[3]Includes $1,490,082 and $1,450,580 at June 30, 2014 and 2013, respectively, attributable to the Alpha Fund (see Notes 4 and 5).

Ascension

Credit Group Financial Statements
Consolidated Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

	Year Ended June 30, 2014	Year Ended June 30, 2013
Operating revenue:		
Net patient service revenue	$ 15,791,162	$ 14,730,194
Less provision for doubtful accounts	1,090,775	1,027,245
Net patient service revenue, less provision for doubtful accounts	14,700,387	13,702,949
Other revenue	1,307,373	1,090,380
Total operating revenue	16,007,760	14,793,329
Operating expenses:		
Salaries and wages	6,664,407	6,282,418
Employee benefits	1,402,949	1,372,742
Purchased services	880,836	798,329
Professional fees	1,112,707	1,012,804
Supplies	2,306,106	2,106,666
Insurance	102,453	88,747
Interest	132,946	126,307
Depreciation and amortization	712,801	651,391
Other	2,026,905	1,861,777
Total operating expenses before impairment, restructuring and nonrecurring losses, net	15,342,110	14,301,181
Income from operations before self-insurance trust fund investment return and impairment, restructuring and nonrecurring losses, net	665,650	492,148
Self-insurance trust fund investment return	66,174	34,985
Impairment, restructuring and nonrecurring losses, net	(218,279)	(168,937)
Income from operations	513,545	358,196
Nonoperating gains (losses):		
Investment return [4]	1,357,908	731,181
Loss on extinguishment of debt	(1,605)	(4,079)
(Loss) gain on interest rate swaps	(1,407)	53,746
Income from unconsolidated entities	5,016	8,137
Contributions from business combinations	–	982,018
Other	(56,771)	(73,497)
Total nonoperating gains, net	1,303,141	1,697,506
Excess of revenues and gains over expenses and losses	1,816,686	2,055,702
Less noncontrolling interests	246,390	131,380
Excess of revenues and gains over expenses and losses attributable to controlling interest	1,570,296	1,924,322

Continued on next page.

[4]Includes the investment return of $1,533,134 and $762,550 for the years ended June 30, 2014 and 2013, respectively, attributable to the Alpha Fund. Of the Alpha Fund's investment return, $193,400 and $106,039 for the years ended June 30, 2014 and 2013, respectively, is included in the noncontrolling interests.

Ascension

Credit Group Financial Statements
Consolidated Statement of Operations and Changes in Net Assets (continued)
(Dollars in Thousands)

	Year Ended June 30, 2014	2013
Unrestricted net assets, controlling interest:		
Excess of revenues and gains over expenses and losses	$ 1,570,296	$ 1,924,322
Transfers from (to) sponsors and other affiliates, net	9,815	(6,138)
Contributed net assets	(1,534)	(1,049)
Membership interest changes, net	45,255	–
Net assets released from restrictions for property acquisitions	54,869	60,084
Pension and other postretirement liability adjustments	(2,725)	31,469
Change in unconsolidated entities' net assets	4,571	5,523
Other	(17,656)	2,759
Increase in unrestricted net assets, controlling interest, before loss from discontinued operations	1,662,891	2,016,970
Loss from discontinued operations	(164,363)	(76,829)
Increase in unrestricted net assets, controlling interest	1,498,528	1,940,141
Unrestricted net assets, noncontrolling interest:		
Excess of revenues and gains over expenses and losses	246,390	131,380
Distributions of capital	(530,534)	(829,932)
Contributions of capital	400,675	1,578,371
Contributions from business combinations	–	63,757
Membership interest changes, net	(52,530)	–
Increase in unrestricted net assets, noncontrolling interest[5]	64,001	943,576
Temporarily restricted net assets, controlling interest:		
Contributions and grants	81,762	80,893
Investment return	27,264	17,524
Net assets released from restrictions	(96,232)	(97,345)
Contributions from business combinations	–	11,868
Other	2,109	3,040
Increase in temporarily restricted net assets, controlling interest	14,903	15,980
Permanently restricted net assets, controlling interest:		
Contributions	10,290	2,581
Investment return	635	1,744
Contributions from business combinations	–	6,717
Other	(167)	407
Increase in permanently restricted net assets, controlling interest	10,758	11,449
Increase in net assets	1,588,190	2,911,146
Net assets, beginning of period	14,957,856	12,046,710
Net assets, end of period	$ 16,546,046	$14,957,856

[5]Includes net distributions of $153,898, comprised of distributions of $487,564 and contributions of $333,666 for the year ended June 30, 2014 and net contributions of $755,906, comprised of contributions of $1,555,146 and distributions of $799,240 for the year ended June 30, 2013, attributable to the Alpha Fund.

Ascension

Schedule of Credit Group Cash and Investments
(Dollars in Thousands)

The Credit Group's cash and investments at June 30, 2014 and 2013, 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, 2014	June 30, 2013
Cash and cash equivalents	**$ 414,489**	$ 413,891
Short-term investments	**60,957**	73,881
Long-term investments	**14,970,497**	13,778,749
Subtotal	**15,445,943**	14,266,521
Other Alpha Fund and Ascension Legacy Portfolio assets and liabilities:		
In other current assets	**30,671**	459,050
In other long-term assets	**2,641**	2,785
In accounts payable and accrued liabilities	**(7,013)**	(5,680)
In other current liabilities	**(3,341)**	(394,763)
In other noncurrent liabilities	**(178,732)**	(6,622)
Due to brokers, net	**11,588**	(315,040)
Total cash and investments, net	**15,301,757**	14,006,251
Less noncontrolling interests of Alpha Fund	**1,490,082**	1,450,580
Less interest in investments held by Ascension on behalf of:		
Alexian Brothers Health System	**369,491**	347,403
St. John Health System	**417,881**	378,162
Ministry Health System	**703,358**	515,452
Credit Group cash and investments, net including assets limited as to use	**12,320,945**	11,314,654
Less assets limited as to use:		
Under bond indenture agreements	**10,079**	17,724
Self insurance trust funds	**758,775**	701,237
Temporarily or permanently restricted	**425,947**	390,959
Credit Group unrestricted cash and investments, net	**$11,126,144**	$ 10,204,734

Ascension

Schedule of Credit Group Statistical Information (unaudited)
(Dollars in Thousands)

	For the Year Ended June 30, 2014	2013
Total Available Beds	**18,634**	18,463
Total Patient Days	**4,263,264**	3,784,649
Total Discharges	**631,831**	616,603
Average Length of Stay	**6.75**	6.14
Total Outpatient Visits	**19,619,835**	18,520,894

The percentage of net patient service revenue, less provision for doubtful accounts, earned by payor for the years ended June 30, 2014 and 2013, are as follows:

	June 30, 2014	2013
Medicare – traditional and managed	**36%**	37%
Medicaid – traditional and managed	**12**	12
Commercial and other managed care	**43**	43
Self-Pay and other	**9**	8
	100%	100%

Significant concentrations of accounts receivable, less allowance for doubtful accounts, at June 30, 2014 and 2013, are as follows:

	June 30, 2014	2013
Medicare – traditional and managed	**22%**	22%
Medicaid – traditional and managed	**9**	8
Commercial and other managed care	**46**	43
Self-Pay and other	**23**	27
	100%	100%

Tab 16

Attachment C
Contribution to the Orderly Development of Health Care – 2

Letters of Support

Letters to be submitted separately

Tab 17

Attachment C
Contribution to the Orderly Development of Health Care – 5

Performance Improvement Plan

Saint Thomas Health
Quality and Patient Safety Improvement Plan
Fiscal Year 2014
(July 1, 2013 – June 30, 2014)

I. Introduction

The hospitals of Saint Thomas Health (STHe) are committed to the continuous improvement of the quality, reliability and safety of the care they provide. This plan serves as the supporting document for the organizational structures and functions that are the vehicles of safe, reliable, high-quality patient care.

The STHe governing board has the ultimate responsibility for the quality and safety of care provided throughout the system. Any changes or revisions to this plan are presented for approval to the STHe Clinical Quality Committee of the Board of Trustees annually and on an as-needed basis. Additional approval of this plan is required annually by the STHe Board of Directors.

All data used within the STHe quality and patient safety program is legally protected from discovery by TCA 63-6-219 and the Ascension Health Patient Safety Organization (PSO) as Patient Safety Work Product (PSWP).

II. About the Plan

This plan is based on the concepts of continuous improvement, collaboration and a cultural approach to patient safety and quality that strives to achieve the following:

- Creation of a just culture that is safe for patients, associates, physicians, volunteers and visitors and minimizes risk to system assets.
- Promotion of respect, sensitivity and caring in regard to our patients' individual needs and expectations.
- Efficient, effective, timely and safe use of available resources and ongoing process improvements.
- Responsible decision-making and priority-setting through interdisciplinary collaboration and by utilization of available data.
- Process and outcome monitoring that reliably measures the quality and safety of patient care.
- Comparative evaluation of organizational and system measurements against established benchmarks and industry norms.
- Ongoing integration of established best practices into our delivery of patient care.
- Internal and external recognition of our commitment to safe, reliable, high quality care.
- Utilization of common methodologies in the design, testing, implementation and evaluation of improvements.

- The goals set forth by Ascension Health's High Reliability Organization – Healing without Harm by 2014.
- The goals set forth by Ascension Health's participation in CMS's Healthcare Engagement Network (Partnership for Patients) grant.

For the purposes of prioritization of needs and evaluation of effectiveness in FY 14, the following factors have been identified in consideration of the quality and patient safety program:

Key Innovations

- *Successful* early-adoption of Ascension Health's High Reliability Organization for Healing without Harm by 2014 with observed 50% reduction in serious safety events across the STHe since 2008
- Addition of a STHe Process Improvement/LEAN effort with dedicated leadership and system-wide scope
- Deployment of CPOE at ST Rutherford Hospital and achievement of Stage 1 Meaningful Use
- Revision and expansion of STHe system-wide quality reporting and scorecards
- Establishment of the Ministry Collaborative Council (MCC) to effect system-wide clinically focused performance improvement initiatives to improve quality of care and patient safety as well as to meet AH HEN goals
- Reorganization of the facility-centric quality, safety and risk model into a consolidated system-level STHe Quality Department
- Establishment of a STHe Readmissions Avoidance Program (RAP) in partnership with Mission Point
- Inclusion of Infection Prevention into the STHe Quality Department in facilitate prevention of Healthcare Associated Infections (HACs)
- Deployment of a concurrent abstraction model for the abstraction of Core Measures is designed to improve clinical outcomes and compliance with CMS standards of care
- Unification of existing facility-centric HEN teams into STHe system teams.

Strengths and Accomplishments

- Senior leadership engagement in quality and safety, most notably the *HRH program and CMS HEN program*
- Medical staff championship of quality initiatives and the Healing Without Harm (HWH) program
- Associate-level engagement with the HWH program and the safety event reporting structure
- Strong quality and safety departmental leadership at each facility
- "Priority for Action" success within the Ascension Health System

- Proactive facility and medical staff leadership throughout the quality and patient safety committee structures
- Continued CMS Disease Specific Certification recognition for multiple clinical programs within STHe.
- Participation in the National Surgical Quality Improvement Program (NSQIP) at both ST West and Midtown Hospitals.
- Unification of the existing facility PSOs into a STHe system level PSO thus facilitating the sharing of vital patient safety information across STHe
- Implementation of a successful Safe Patient Handling initiative at Saint Thomas West Hospital (STWH) with reduction in employee injuries related to patient handling.
- Successful Process Improvement (PI) activities as each hospital; typically using LEAN methodologies.
- Participation in the Tennessee Initiative for Perinatal Quality (TIPQC) by Saint Thomas Midtown Hospital and Saint Thomas Rutherford Hospital.

Weaknesses

- Integration of process improvement and leadership expectations into daily work functions at the associate level
- Engagement of mid-level leadership and front-line staff in performance improvement due to real or perceived resource limitations and competing priorities
- Inadequate unit level managerial accountability for safe patient and associate practices
- Incomplete and unreliable sharing of patient safety and risk information between facilities
- Uncoordinated patient transitions between the inpatient and outpatient environments with resultant unacceptably high readmissions for our patients
- Inadequate education of front line staff in quality and safety standards effecting patient care
- Inconsistency in physician peer review processes and incorporation of quality and safety metrics performance data in credentialing and OPPE and FPPE efforts
- Incomplete documentation of processes and reporting of performance metrics for the Quality information Center internally
- Continued financial losses due to CMS mandated readmission penalties
- Fragmentation and incoordination in clinical data analytic processes and reporting
- Active cross-functional performance improvement teams driving PI and best practices across the system using LEAN methodologies
- Orientation to performance improvement for new leaders and associates
- Consistency in core measures performance
-

- Efficient and effective communication methods to provide timely feedback to front-line staff and physicians relating to quality and safety performance
- Integration of electronic and manual data management processes
- Failure to leverage our Cerner investment in order to drive clinical quality interventions via the EHR
- Lack of a quality reporting standard for all the hospitals in the system
- Lack of physician oversight and participation in collection and use of clinical quality data
- Lack of physician support for meeting national quality metrics unless there is compelling evidence of improved quality outcomes in association with interventions mandated by those metrics.

Opportunities

- Utilization of LEAN improvement methods to eliminate waste and add value to processes
- Leveraging of the relationship between quality and information technology to advance our ability to interface with clinical databases, maximize electronic resources and develop strategies for real-time abstraction of concurrent data
- Identification of common data sets and coalescence of data definitions with clinical workflow and extraction methods
- Further integration with the Human Resources Department in order to advance nursing and associate education to improve quality and safety performance
- Inadequate or non-existent patient and family representation on system quality and safety committees
- Inadequate external community reporting of STH quality and safety metrics for all facilities within STH
- Improvement in care coordination across STH in order to decrease readmissions
- Extension of Safe Patient Handling initiatives across STH
- Increased use of Cerner and our EHR platforms to prompt and drive clinical quality initiatives and interventions.
- Further reduction in patient harm by participation in Ascension Health's Healthcare Engagement Network
- Further partnership with the Tennessee Hospital Association's Center for Patient Safety to drive quality and patient safety behavior and programs

Threats

- Unfunded mandates and multiple external reporting priorities that require utilization of existing resources and the limitations those mandates create in our ability to focus on internal quality needs and opportunities
- Private Insurer Pay for Performance Plans
- Uncertainty regarding CMS and AHRQ public reporting of quality and safety indicators.

- Recovery audit contractors as related to quality outcomes and physician performance
- Reductions in revenue and patient service volumes
- Lack of alignment with independent physician practices
- Anticipated pay for performance initiatives from private insurers
- Capital budget restraints from Ascension Health
- CMS Value Base Purchasing which represents ongoing significant potential for loss of reimbursement if Core measure or HCAHPS performance does not improve.
- Significant financial penalties for failure to meet CMS readmission standards.

III. Approach to Performance Improvement

Principles and Key Terms

- Patient Focus – High reliability organizations and those with established quality reputations focus on exceeding patient expectations.
- Recovery-oriented – Services are characterized by a commitment to holistic, reverent care that promotes flexibility, choice and patient-defined treatment goals.
- Employee empowerment – Effective programs involve associates at all levels of the organization for the purpose of improving quality and increasing subsidiarity.
- Leadership commitment – Strong and proactive leadership throughout the organization maintains focus on quality and safety goals that are consistent with the organization's mission and strategic plan.
- Chartering – To achieve effective outcomes in an efficient and timely manner, performance improvement initiatives are chartered. Chartering encourages and sustains:
    - Setting of priorities
    - Strategic alignment of initiatives with the Mission, Vision and Values
    - Focus on scope, timeline and organizational relevance
    - Collaboration with and coordination of improvement efforts across the system
- Affiliate Physician Engagement – Physician involvement throughout quality and patient safety improvement processes greatly increases the potential success of those efforts.
- LEAN Process Improvement Methodology applied to the healthcare environment using the principles of the Toyota Production System.

IV. Strategic Goals Healing Without Harm and Patient Experience

Strategic Goal #1 – High Reliability Organization and Healing without Harm by 2014

STHe is pursuing four initiatives to build a high-reliability, safety-focused culture as follows:

1. Recognition of safety as an organizational imperative
2. Integration of error-prevention behaviors into all daily work processes
3. Focused efforts to simplify work processes
4. Event analysis which involves key stakeholders and focuses on communication of lessons-learned and proactive safety precepts
5. Integration of HRH and HWH data into physician credentialing (OPPE and FPPE)

The HWH program is the primary strategic quality initiative throughout STHe facilities and remains a top priority throughout STHe for FY 14. Metrics related to the HWH program that will be reported at both the facility and system board levels include:

- Serious Safety Event Rate per 10,000 Adjusted Patient Days
- Number of Serious Safety Events, Precursor Safety Events and Near-Miss Events
- Hospital-Acquired Conditions

In addition, metrics related to the HWH program that will be reported at the facility leadership level include:

- Number of "Red Rule" Violations
- Number of "Déjà vu" Events Resulting in Serious Safety Events

Strategic Goal #2 – Priorities for Action

Priorities for Action (PFA) are specific measures, defined by Ascension Health and reported at the facility, Saint Thomas Health and Ascension Health corporate levels. Priorities for Action for FY 14 include:

- Ventilator Associated Pneumonia in the ICU
- Rate of Central Line Sepsis in the ICU
- Facility-Acquired Pressure Ulcer Rate
- Rate of Falls with Serious Injury
- Rate of Birth Trauma
- Neonatal Mortality Resulting from a Serious Safety Event
- Overall Neonatal Mortality

- Risk-Adjusted Mortality
- Clean Surgical Site Infection Rate
- FY 14Obstetrical and Perinatal Care Measures

Strategic Goal #3 – Core Measures

All STHe facilities collect and report Core Measures for both internal and external (public-reporting) purposes as follows:

- Pneumonia
- Heart Failure
- Acute Myocardial Infarction
- Surgical Care Improvement Project
- IMM/IED
- Surgical HOP
- Medical HOP
- Early Elective Delivery
- VTE
- ED Throughput
- Stroke
- Hospital Acquired Conditions
- Hospital acquired Infections

Core measure compliance remains a top priority for FY 14 and into the foreseeable future in part due to the financial penalties tied to Value Based Purchasing (VBP) initiatives of CMS. At the facility level, core measures are reported at the leadership, Medical Executive Committee and board levels. Composite facility performance is also reported to the STHe Board of Trustees. (Attachment 2)Incidences of non-compliance are identified at the patient level for investigation and follow-up and unit-level performance data is analyzed for patterns, trends and process improvement opportunities. Every six months, physicians across STHe are evaluated to include their core measures results in addition to other key quality metrics as part of the FPPE/OPPE process.

Strategic Goal #4 – Exceptional Patient Experience

With direction from the Ascension Health Experience Team, the facilities of STHe strive to achieve the highest possible level of satisfaction as experienced by our patients, associates and physicians.

Patient satisfaction/experience and HCAHPS measurements are conducted regularly by Professional Research Consultants, Inc. to include a patient sampling of both inpatient and outpatient units with unit-level results available to hospital and medical staff leadership on a monthly basis.

As part of our commitment to the patient's experience of care within STHe facilities, the following strategies have been employed:

- Closed-loop feedback
- Patient rounding
- Support of associate engagement, empowerment and alignment
- Development of emotional and spiritual care
- Expectation of efficient workflow as evidenced by perceptions of improved coordination, communication and cooperation among all those involved in the patient's experience of care

Key metrics reported to the STHe Board of Trustees, System and Facility Leadership and Medical Staff include but not limited to the following:

- INPT NPS
- ED NPS
- OP NPS
- HCAHPS Overall

For FY 14, the Patient Experience goals for each facility are as follows:

Facility	IPNPS	EDNPS	OPNPS	HCAHPS (Overall)
Saint Thomas West Hospital	85	78.7	88	79.0
Saint Thomas Midtown Hospital	78	64.6	77	78.6
Saint Thomas Rutherford Hospital	68	51.6	74	79.3

Strategic Goal #5: Associate Safety:

STHe Senior Leaders support the Integration of Associate Safety into the Overall High Reliability Organization Initiative.

STHe continues to pursue four initiatives to build a high-reliability, safety-focused culture as follows:

1. Recognition of safety (both patient and associate) as an organizational imperative.

2. Integration of error-prevention behaviors into all daily work processes.

3. Focused efforts to simplify work processes.

4. Associate injury event apparent cause analysis (ACA) which involves key stakeholders and focuses on communication of lessons-learned and proactive safety precepts.

The HWW program is the primary strategic quality initiative throughout STHe facilities. Associate Safety will be incorporated into the HWH program in FY14 for all STHe facilities. Associate Safety specific metrics will be presented monthly to the Safety Coaches and in FY14 will be reported at the various STHe Management/leadership meetings (Organizational Update, Management Council, etc.).

Metrics related to the Associate Safety program that will be reported at the facility leadership meeting include:

- Overall Facility Injury Rate
- Overall Facility DART rate
- "Top 3" Injury/Event types
- # of Hazard Concern Reports for the month and presentation of the associate safety "Hazard Concern" reporting award

- Ensure all STHe facilities are below the National Average for Overall Associate Injury Rate

All of the STHe hospital facilities are required by law to have and maintain an OSHA injury log. Any associate injury event requiring more than first aid is considered to be OSHA Recordable and is added to the OSHA log for that facility.

- Ensure all STHe facilities are below the National Average for Associate Injury DART Rate

Any injury event that results in the associate incurring days away, restricted time or transfers (DART) from their normal working environment is counted towards that facilities DART rate.

- Spread OSHA VPP (Voluntary Protection Program)

Saint Thomas Midtown Hospital was the first and is still the only hospital in the State of Tennessee to receive VPP certification. VPP certification recognizes excellence in Health and Safety programs. In FY14, we will continue the "spread" of the lessons-learned and best health and safety practices across STHe.

- Support the various Hospital Engagement Networks (HEN) and teams

Associate safety plays a vital role in ensuring that the hospital environment is safe for patients to receive the highest quality care. Proper hand-washing and PPE usage plays a huge role in reducing central-line associated blood stream infections. Associates who follow the established patient handling and mobilization techniques reduce the skin "shearing" which can lead to pressure ulcers.

Strategic Goal #6: One Patient One Chart

The accelerated evolution of STHe into an integrated digital healthcare environment is paramount if STHe is to meet the challenges of the new health care landscape - delivery high quality and cost effective care, satisfaction of regulatory and payer mandates, and effectively delivery of population health management. This evolution will require:

- Clinical process re-engineering towards standardized digital workflows supported by modernized IT infrastructure
- Architecture and technologies that drive multidisciplinary care collaboration across care venues and provide a continuum, patient centric view of clinical data
- Technologies that seamlessly engage the consumer/patient across the spectrum of their interaction with STHe

Enterprise analytics platforms that facilitate not only insight into near real-time retrospective outcomes performance, but support the necessary migration to prescriptive, evidence based care delivery buttressed by predictive outcomes modeling.

STHe has codified the integrated, system-wide approach to address the requirements outlined above, in the single over-arching strategy - ***One Patient, One Chart (OPOC)***. The FY15 OPOC initiatives, that in aggregate comprise the FY14 Quality Goal #5, are outlined below.

Clinical process re-engineering

High reliability health care delivery is dependent upon reducing the complexity of the systems that deliver that care. The systematic replacement of clinical process variation with system-wide process standards based on clinical evidence and lean engineering methodology is the *sine qua non* for that reduction in complexity. A central consideration this approach is the ability of new processes to account for regulatory, payer and business mandates. Organizational structures that will

systematically delivery this transformation is requisite.

- *OPOC Initiative 1: Creation of a clinical process re-engineering group within the Quality Department with clearinghouse and prioritization authority relative to all clinical process re-engineering across STHe by 10/1/2013*
- *OPOC Initiative 2: Achievement of Meaningful Use Stage I (YR2) and Meaningful Use Stage II (YR1). ST-Midtown, ST-Rutherford, and ST-West have achieved Meaningful Use Stage 1 (YR1). These 3 campuses will achieve Meaningful Use Stage 1 (YR2) by 10/1/2013. In addition these 3 campuses will achieve the increased EHR adoption targets of Meaningful Use Stage II (YR1) by 7/1/2013.*

Re-engineering of clinical process to standard workflows that effectively use digital technology is absolutely dependent upon a robust underlying infrastructure that ultimately delivers "technology as a utility" - reliability, access and performance levels that strive to make the technology transparent to end-users. In FY13 major upgrades to the core infrastructure (switches, edge routers, fiber to clinical device) were completed, and the Managed Virtual Desktop (MVD) initiative was started. MVD is the migration from standalone clinical PCs to a centralized, server-based architecture that provides greater system performance management and allows for enhanced system access and reliability for end-users. MVD completion across the system is foundational to our migration to "technology as a utility".

- *OPOC Initiative 3: Completion of the Managed Virtual Desktop (MVD) clinical computing environment across STHe by 9/1/1013*

Architecture / technologies supporting collaborative patient-centric care

Population health management is the statistical result of the aggregated effects of a multitude of individual interactions between patients, providers, and healthcare systems. Patient specific, coordinated and collaborative health care delivered by a multidisciplinary team across the continuum of care is a hallmark of systems that successfully manage population health. The core technical requirement for this is the ability to deliver the right clinical dataset, at the right time, to the appropriate provider at the point of care, in a manner that integrates into the venue specific workflow. Attributes of systems that are successful in this regard include:

1) Consolidation of enterprise ambulatory EHRs to single integrated platforms,

2) Cross venue Health Information Exchange (HIE) between acute care EHRs, ambulatory EHRs and other clinical data sources, and

3) Effective communication tools between the disparate providers and venues of care that are collectively accountable for the health and wellbeing of an individual patient.

STHe will address each of these attributes under a specific OPOC FY14 initiative.

- *OPOC Initiative 4: STPS Ambulatory EHR Consolidation from 6 unique EHR domains to a single enterprise EHR domain by 7/1/2014*
- *OPOC Initiative 5: Expansion of OneChart, the proprietary STHe HIE. OneChart aggregates clinical data from the acute care Cerner EHR and the ambulatory NextGen EHRs to give providers a patient centric cross continuum view to clinical data. This initiative will aim to expand the number of end-users with access to OneChart from the current 15 pilot providers to a minimum of 100 providers 1/1/2014, and 250 providers by 7/1/2014.*
  OPOC Initiative 6: Implementation of Direct-Protocol secure provider-to-provider communication platform. This platform, deployed in coordination with MissionPoint Health Partners will enroll 500 providers by 7/1/2014.

Patient Engagement

Increasingly integrated health care delivery systems will distinguish themselves on the basis of the seamlessness with which they interact with patients, and their ability to engage with customers (both current and prospective) in a pro-active and contextually aware fashion. STHe has made significant investments in these capabilities through the implementation of the STHe Patient Portal, the STHe Consumer Portal and a sophisticated Customer Relationship Management (CRM) solution. However, at present these platforms are not integrated, and thus cannot realize their full potential as quality of care and business drivers. In addition the STPS ambulatory environment is not a component of the portal architecture. These needs will be addressed in

FY 14.

- *OPOC Initiative 7: Delivery of a seamless platform for patient interaction (viewing of clinical records, scheduling of appointments, communication to providers/practices, and participation in STHe condition specific or population wellness initiatives). This will be achieved by the integration of STHe patient portal, consumer portal and CRM platforms by 7/1/2014.*

- *OPOC Initiative 8: Expansion of STHe patient portal architecture to encompass STPS ambulatory practices/providers by 7/1/2014.*

Enterprise Analytics Platform

The currency of the new healthcare landscape is data. The ability to aggregate data from disparate sources (clinical and claims), semantically normalize that data, provide both retrospective and predictive analytics on a time scale that matches external demands, and present those analytics in a format that can be quickly understood by providers, will distinguish those healthcare systems that survive the turbulence of health care reform. Ascension Health has committed to the implementation of the Humedica Business Intelligence (BI) platform as the corporate standard; the AH pilot implementation of that platform at STHe was completed in Q3 FY13. The Humedica platform aggregates clinical data from the acute care Cerner EHR and the ambulatory NextGen EHRs, as well as payer claims data, and allows for both retrospective and predictive analytics for various population cohorts. STHe will expand the incorporation of Humedica derived retrospective and prospective analytics into clinical and business processes in FY14.

- *OPOC Initiative 9: As appropriate, based on timeliness requirements, the Humedica platform will be used for retrospective performance analytics for both the inpatient and ambulatory venues (NextGen practice subset of STPS). This incorporation will be ongoing throughout FY14.*
- *OPOC Initiative 10: The Ascension Heath Clinical Integration Council ambulatory provider metrics will be produced for STPS providers (NextGen practice subset) from Humedica on a retrospective quarterly basis beginning 10/1/2013.*
- *OPOC Initiative 11: STHe will begin the evaluation of Humedica based population specific predictive modeling as applied to the Congestive Heart Failure and Chronic Obstructive Disease cohorts. This will begin*

in Q1 FY14 and, if validated for the STHe population, will be utilized in prospective population management during Q3/Q4 of FY14.

V. Performance Improvement Structures

System Structure

The Ministry Collaborative Council (MCC) operates as a decision making body for STHe addressing performance improvement opportunities that impact clinical quality, patient and associate safety, regulatory compliance, and operational efficiency.
The goals and functions of the group include:

- Responsible for developing and approving performance improvement initiatives to impact clinical care in the following areas:
  - Patient care delivery
  - Patient Safety
  - Regulatory Compliance
  - Standardizing clinical processes across STHe venues of care by the elimination of care variation with introduction of standard processes and protocols.
- Assuring highly reliable clinical care within STHe
- Optimizing clinical use of the EHR to improve care and outcomes

The Medication Management Oversight Committee (MMOC) operates as a subcommittee of the MCC to analyze and address medication-process specific challenges as related to medication safety, medication ordering and administration and formulary development.

The goals and functions of this group include:

- Awareness and analysis of safety issues impacting bedside medication administration such as bar code technology, patient identification, smart pump integration, nursing-pharmacy communications, etc.
- Recommendations for capital planning related to medication delivery systems and IT integration
- Work toward building a common STHe medication formulary to facilitate cost containment and efficiency
- Oversight of the Ascension Health medication safety Priority for Action efforts.

The Saint Thomas Health (STHe) Clinical Foundation Suite (CFS) Governance Council (GC) is the primary group charged with setting the strategic goals, priorities and timelines for the implementation of the electronic health record. This multi-disciplinary group includes the CEO, CMO, CNO, IT Director as well as 5 physicians (including MEC members) from each campus.

This group is supported by the CIO, CMIO, Director of Pharmacy Informatics, Director of Nursing Informatics, Physician Network Executive and Corporate Compliance Officer. The STHe CFS GC meets every 6 weeks and provides multi-disciplinary input on HIT/EMR strategic direction, prioritization and budgeting recommendations relative to HIT initiatives, evaluation of HIT/EMR implementation progress, and oversight relative to HIT/EMR impact on clinical outcomes, quality and provider workflow. The STHe CFS GC interacts communicates with the STHe IT Shared Governance Council, the Quality / Patient Experience Council and the campus-specific MECs. It directs the STHe PIC relative to areas of focus regarding the technical aspects of HTI/EMR implementation. The majority of work for the STHe CFS GC in FY12 will focus on Meaningful Use qualification for BH, MTMC and STH and will consist of determination of the qualification period, evaluation of the implementation strategy and assessment of program resourcing.

The Information Management Council (IMC) is the group charged with translating the strategic direction set by STHe Senior Leadership into operationally appropriate projects at both the system and facility levels by managing project charters, setting Information Systems (IS) priorities, and directing Information Technology (IT) capital/OpEx spend in accordance with strategy. This group includes a multidisciplinary group chaired by the SVP of Operations, CMIO, CIO, VP Finance/Controller, STPS CMIO, Facility COO, Facility CNO, and ad hoc members deemed necessary.

Facility-Specific Structure and Interface with System Structure

Hospital structures supporting quality, patient safety and performance improvement report to the facility's Board of Trustees through its Medical Executive Committee and to the system level through the STHe Clinical Quality Committee of the Board of Trustees, the body responsible and accountable for all quality and patient safety functions throughout Saint Thomas Health.

The functional committees supporting quality and patient safety at each facility include:

- Infection Control Committee or equivalent group

- Pharmacy and Therapeutics Committee
- Medication Safety Committee or equivalent group
- Environment of Care Committee

Quality Council (Saint Thomas Midtown Hospital and Saint Thomas West Hospital) reports to the Medical Executive Committee of each facility and is comprised of executive, hospital and medical staff leadership. Quality Council is chaired by a physician and is the primary body for review of each hospital's Quality Scorecard, containing the key metrics listed in this plan.

Each facility's Quality Council:

- Promotes leadership participation in quality efforts
- Makes recommendations for quality and performance improvement efforts
- Addresses issues regarding Joint Commission accreditation and survey preparedness
- Identifies and oversees facility-specific improvement projects
- Tracks quality indicators and improvement projects
- Provides oversight of facility quality measures

Patient Safety Council (Saint Thomas Midtown Hospital and Saint Thomas West Hospital) reports error and event data to the Q/PE to affect positive change in each facility and throughout the system. Membership is comprised of senior executives, medical staff and clinical leadership under the direction of the Quality and Risk Management department. A physician chairman acts as facilitator of Patient Safety Council meetings.

Patient Safety Council functions to:

- Review safety events including serious safety events, precursor safety events and near misses as referred by the facility's Risk Manager
- Determine the occurrence of sentinel events and review resultant root cause analyses, making recommendations for additional corrective actions as indicated
- Ensure the completion of action plans completed in response to safety events
- Review Joint Commission's Sentinel Event Alerts and issue recommendations for addressing relevant concerns
- Review aggregate patient safety data, as provided by Ascension Health, for benchmarking purposes
- Assure the completion of "Culture of Safety" assessments and review findings
- Provide multidisciplinary oversight of all patient safety functions at the facility level

Quality/Patient Safety Council (Saint Thomas Rutherford Hospital) integrates

previously-defined functions and purposes of Quality Council and Patient Safety council into a single committee.

The Clinical Assessment Committee (Saint Thomas Midtown and Saint Thomas West Hospitals) or Physician Excellence Committee (Saint Thomas Rutherford Hospital) performs multidisciplinary physician peer review at each facility, reporting to the Medical Executive Committee. The work of this committee is legally protected by TCA 63-6-219. The groups are chaired by a physician and supported by each facility's Quality Department.

The Clinical Assessment or Physician Excellence Committee:

- Adjudicates cases in which there are questions regarding standards of care
- Identifies ways to improve the quality and safety of patient care
- Analyzes how hospital and medical staff processes can be improved to eliminate the risk of recurrent error
- Ensures that physicians who are found not meeting the standard of care have access to resources, support and oversight to avoid subsequent events

- Tracks and analyzes physician practice patterns that indicate opportunity for improvement
- Recommends actions to the Medical Executive Committee
- Provides peer coaching and counseling in response to individual physician performance variances

MEC Health Information Subcommittee: is one of the primary campus specific groups at each facility charged with technical assessment of HIT and EMR functionality and its impact on patient safety, clinical quality and provider workflow. The group consists of practicing physicians from a variety of subspecialties. The physician group is supported by administrative, pharmacy, clinical informatics and IT representatives. Each campus specific MEC HIT Subcommittee meets monthly and serves as a forum for physician input on HIT implementation and provides a direct mechanism for alignment of HIT initiatives with establish medical staff governance process. The campus specific MEC HIT Subcommittees meet collaboratively on a bi-monthly basis to address the impact of HIT implementation on the dissemination of best practices and evidence based therapies across the STHe network.

VI. Performance Improvement Models

LEAN Methodology

During FY 12-13, the facilities of Saint Thomas Health have been integrating LEAN methodology into the performance improvement structure to assist in the development of solutions to complicated organizational opportunities for improvement.

In order to advance the process improvement efforts for FY14, an executive director of performance improvement position has been approved and filled. The department is currently seeking directors of PI at St. Thomas-West and St. Thomas-Midtown; St. Thomas-Rutherford currently employs a director of process and systems improvement. These positions will help to ensure the continuation of LEAN process improvements and facilitate LEAN events as new priorities are identified.

Lean and A3 Structured Problem Solving

The primary methodology for performance improvement efforts throughout the facilities of STH is the Lean process improvement methodology. The goal of any Lean event or project is transformational process change that leads directly to breakthrough process performance. In order to achieve this we will continue to train and spread the use the nine block A3 format. . Its use will ensure that a systematic approach is applied to improvement at all levels of the organization. Fundamentally, it forces the discussion for the reason for *any* action, and, although very basic, when it is overlooked or ignored, can lead to a solution that does not address the root cause. An A3 provides a clear path from current state to the desired outcome. It also provides the "lessons learned" that can be deployed along with accelerating organizational learning. The A3 platform is the preferred method for problem solving in hospital systems with highly evolved Lean cultures; some of these would include: ThedaCare, Denver Health, and Virginia Mason to name a few.

The plan for FY14 is to align the process improvement efforts with the strategic goals of the system. We will do this by developing the Transformation Plan which will consist of the strategic initiatives that executive leadership agree the Process Improvement teams at each facility will need to focus on for the fiscal year. In addition to the Transformation Plan, we will develop an Employee Engagement strategy. This will involve communicating what we are doing with regard to process improvement, why we need to improve our processes, and how associates can get involved to help build a better tomorrow.

VII. Performance Improvement Tools

The facilities of Saint Thomas Health use tools and instruments common to quality improvement processes and include:

- Flow-charting
- Brainstorming
- Nominal group technique
- Multi-voting
- Affinity diagrams
- Cause-and-Effect diagrams
- Histograms
- Pareto charts
- Run charts
- Control charts
- Benchmarking
- Root cause analysis
- Apparent cause analysis
- Common cause analysis

A description of each of these tools and the manner in which they may be used if found in Addendum C of this plan.

VIII. Annual Evaluation of Quality and Patient Safety Plan

A comprehensive review of quality and patient safety activities is conducted annually at the system and facility level through review of quality scorecards as well as other reports, findings and audits that have been collected throughout the past twelve months.

New priorities, initiatives, goals and expected outcomes are identified as previously described in this plan.

Each facility is responsible for evaluating its internal quality and patient safety program, including intersects with contracted services.

Tab 18

Attachment C
Contribution to the Orderly Development of Health Care – 5

Utilization Review Plan

Midtown Hospital
Nashville, Tennessee

Title: Utilization Review Plan	**Policy #:**
Developed By: Richard A. Orland, M.D. Medical Advisor Care Management Program	**Date: April 26**, 2013
Approved By:	**Date:**
Reviewed:	**Revised:**
Scope: Hospital – Wide	**Written:**

I. AUTHORITY (Title 42 Code of Federal Regulations 456.105)

Ultimate responsibility for the quality, appropriateness and clinical necessity of admissions, continued stays, and supportive services rests with the Saint Thomas Health (STHe) Board of Directors. The STHe Board of Directors authorizes the Midtown Hospital Medical Staff and Hospital Administration to demonstrate and promote effective and efficient patient care through the implementation of a Utilization Review (UR) plan.

II. RESPONSIBILITY

The Board of Directors, Chief Executive Officer of Midtown Hospital, and the Chief of the Medical Staff assigns and empowers the Utilization Review Committee (URC) to implement the Utilization Management Plan to support the hospital's mission and vision through collection and review of data that assures the appropriate allocation of hospital resources.

III. PURPOSE

The purpose of this UR plan is:

A. To assure effective and efficient utilization of available hospital facilities and services consistent with patient needs and professionally recognized standards of healthcare.
B. To identify opportunities for changes needed to maintain high quality and appropriate patient care, as well as identify over and under utilization of resources, quality related issues, and/or risk related issues.
C. To assure that documentation in the medical record substantiates the quality and utilization of services needed in the management and progress of every patient.

IV. ORGANIZATION (42 CFR 456.105, 106, 112 & 113)

A utilization review committee (URC) shall be established at Midtown Hospital to carry out the utilization review plan. It may be titled differently, i.e., "Clinical Resource Committee." URC shall report all significant issues, findings and recommendations to the Medical Executive Committee at least annually, as evidenced in the Medical Executive Committee's minutes. It is the ultimate responsibility of the Board of Directors and Medical Staff to facilitate the efforts of the URC by providing assistance and direction in the process of implementing and/or maintaining

quality patient care.

A. Membership and Structure (A-0310 482.30, 217)

i. Either the Chief Medical Officer (CMO) or a physician committee member appointed by the CMO or Chief or Staff will serve as Chair of the URC. The Chair will make himself/herself available to facilitate and assist the Medical Advisor, Care Management, as need arises.

ii. Physician members who are part of the Midtown Hospital Medical Staff and who represent various medical staff departments shall be appointed by the CMO with assistance and input from the Chair and Medical Advisor. In addition to the Medical Advisor, a minimum of two practicing physicians shall serve on the URC. All Midtown Hospital Medical Staff physician members, including the Medical Advisor, will have voting privileges.

iii. Non-physician, non-voting members may include representatives from such areas as administration, care management, Clinical Integration, access/bed management, HIM, performance improvement, and Compliance. Other health care practitioners may be asked to serve as consultants to the committee and may be requested to attend meetings on an "as needed" basis.

iv. The Utilization Review Committee will meet as deemed necessary by the Chair, but at least four (4) times each calendar year. A quorum will be 33% of the URC physician membership.

v. The URC shall keep minutes of all meetings. The minutes shall summarize significant discussions, findings, and actions taken as a result of URC decisions or recommendations. Minutes, information, and data used by the URC will be maintained as peer review records including any findings or recommendations as required to assure confidentiality and compliance with all laws and regulations.

vi. The URC authorizes the Medical Affairs, Clinical Integration, Care Management, Finance, and HIM Departments to provide support services as needed for the performance of the URC.

vii. The URC recognizes the authority of the State QIO(s) in their role as to any assessment and monitoring of review activities.

viii. Per Tennessee Code Annotated (TCA) 63 – 6 – 219, data generated or utilized by the UR Committee will be maintained in confidence and secured to the fullest extent possible to protect from loss, defacement, tampering, or use by unauthorized persons. Information which identifies an individual or practitioner is considered privileged except for that information which is necessary to facilitate the review program by fiscal intermediaries and state agencies for payment of claims. Exceptions will be granted to other outside agencies only through signed, written agreements with the hospital or as required by law.

B. Condition of membership and conflict of interest (A-0310 482.30, section 3, 218)

i. All physician members of the committee shall serve renewable one-year memberships. Members are expected to attend at least 50% of scheduled meetings. The CMO, with the approval by the Chair of the URC, shall be responsible for appointing members to fill vacancies.

ii. No physician member shall have review responsibility for any case in which s/he had, has, or expects to have clinical involvement.

iii. No committee member shall have a direct financial interest, as defined by the Social Security Administration, in Midtown Hospital.

C. Responsibilities (A-0311 482.30)

i. To establish and carry out a review program in accordance with applicable state, federal and payer rules and requirements.

ii. To obtain, review and evaluate information generated by the hospital's Care Management program, Clinical Integration, and other departments. This may include information regarding:

a. Comparative data of physician specialties, services lines, DRGs, and individual physicians with respect to ALOS and charges/costs per case;
b. Denied days of care or denied costs of care received from third party payers specific to lack of precertification, medical necessity, or quality of care;
c. Average length of stay and Case Mix Index;
d. Numbers of cases that were sent to second-level physician review;
e. Case manager interventions related to days/costs saved
f. Avoidable days specific to obstacles that delay the progress of care or delivery of care and which may compromise the safety of patients and the quality of care
g. Other data and information pertaining to resource utilization and management as determined by the committee to be part of the agenda of each meeting.

Such information and measures will be reported to the URC during scheduled meetings.

iii. Along with Care Management Program staff, to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, and use of medical or hospital services, which may contribute to under- or over-utilization of services when indicated by the data.

iv. To review selected cases that with extended length of stay, extraordinarily high costs and/or excessive physician services as detected by Care Management Program staff as no longer meeting screening criteria for continued care at the inpatient level of care

v. To refer individual cases, where there is a concern regarding the quality of patient care, to the appropriate hospital or medical staff department.

vi. Participate in educational initiatives for physicians and other caregivers regarding the stewardship of healthcare resources.

vii. To adopt and modify review criteria and standards as needed and recommend changes in hospital procedures or medical staff practices that are identified by an analysis of review findings.

viii. To determine that point during any specific patient's hospitalization at which Medicare, Medicaid, and Title V Programs, and other third party payers should have no further financial

responsibility for the patient because of lack of medical need. The attending physician has the right to have the case reviewed by the URC and the QIO in the case of federally funded cases.

ix. To maintain liaison with the quality improvement and risk management functions in order to coordinate the findings of the program.

x. To provide utilization information, as requested, for credential review files.

xi. To review the Utilization Review plan annually and make recommendations regarding such to the CMO and URC Chair for revision.

V. METHODS AND TYPES OF REVIEW (42 CFR 456.121, 131)

Utilization review consists of a pre-admission and/or admission certification, appropriateness of continued stay and discharge readiness. These determinations, using standard criteria sets, physician documentation, observations, and/or conversations with the attending physician are performed by Care Management Program staff.

Reviews may be focused on certain selected diagnoses and procedures with identified or suspected utilization related problems, regardless of payer type. All reviews will address over- and under-utilization as well as ineffective use and scheduling of resources.

A. Preadmission review (42 CFR 456.127)

i. On selected occasions, review and final decision prior to the patient's admission may be accomplished for certain providers or categories of admission identified by the URC and/or Care Management Program staff as potential utilization issues. This may include patients accessing inpatient services through the emergency department, direct admits and/or transfers from other facilities.

ii. 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.

iii. If needed, the case is elevated 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 he/she is formally admitted to the hospital and the hospital has reason to believe the admission will not be covered by Medicare or other payer.

B. Admission review (42 CFR 456.60, 4565.121 - 126 & 129)

i. All inpatient admissions shall be reviewed for appropriateness for inpatient level of care by a two-level process. Initial first level case review will be at the screening level and is to be performed by Care Management Program staff for appropriate level of care and appropriate plan of care, based on screening criteria (such as InterQual).

ii. In cases of seemingly non-qualified admission, once the initial screening criteria are applied, the Medical Advisor or another physician will provide second-level medical/physician review. Such physicians may be other physicians on the URC, non-URC physicians on the medical staffs of hospitals in the STHe system, and/or

other non-URC physician advisors of external resources and vendors.

C. Continued stay (42 CFR 456.128 - 137)

i. Continued stay reviews are based on established guidelines, such as those developed by "Interqual" criteria.

ii. 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.

iii. If continued stay appears inappropriate, the utilization review specialist or case manager will consult with the Care Management Program staff and/or the attending physician and discuss discharge readiness and alternate levels of care and services. If necessary, the Medical Advisor of the Care Management Program or other designated physicians will be consulted and perform second-level review.

iv. If needed, the case is elevated to the attention of the applicable physician chief of service or the CMO; if necessary, a Hospital Issued Notice of Non-Coverage (HINN) letter is issued to the patient per direction of the URC.

D. Second Level Physician Review for Inpatient Level of Care

i. If the Care Management Program case management staff determine by first-level screening criteria that a patient's inpatient admission is not appropriate or continuing care is no longer consistent with medical management at the in-patient level, the case will be referred to the hospital's Utilization Review Committee or a subgroup thereof, which contains at least one (1) physician member of the URC, which may be the Medical Advisor of the Care Management Program. or other designated physicians and/or physician advisors.

Second level reviews performed by physicians who are not on the Utilization Review Committee will be considered as advisory in nature. A physician member of the URC must review and agree with all reviews performed by non-URC physician members. The judgment and recommendation of the URC member shall be the action taken.

In the latter event of such second-level physician review, if the physician performing second-level review has reason to believe the admission or continued stay is not necessary or no longer medically appropriate at the in-patient level, he/she will attempt to contact the attending physician and afford him/her an opportunity to discuss the case or situation in question. In such situations, the attending physician's judgment and opinion is given considerable weight. If the attending physician concurs that inpatient admission is not appropriate or medical necessity for continued stay does not exist, the attending physician will treat the patient at a lower level of care or discharge the patient. In the situations where inpatient admission is not appropriate, the Hospital shall follow the procedures applicable for Condition Code 44 or the applicable denial of benefits procedure.

ii. If, however, the attending physician does not concur with the determination made by the Medical Advisor or other physician member of the UR Committee, the case

will be referred to at least one other physician member of the Utilization Review Committee for case review. In such situations, the attending physician's judgment is once again 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.

If the two physician members determine that the patient's inpatient admission/stay is not medically necessary or appropriate, their determination becomes final, and the attending physician shall be informed of such; the Hospital follows the applicable denial of benefits procedure or the procedures applicable for Condition Code 44. The determination of the URC member(s) shall be documented in the patient's record.

It should be noted that in such situations, Hospital care is not being denied, however, the patient (and/or insured) will be informed of any potential financial liability for non-covered services. The Director of Care Management or designee will provide written notice of such to the patient and/or patient representative when the determination is made that the patient's care is not appropriate at the inpatient level. Copies will be distributed to the hospital, the state agency for Medicare patients (if applicable), the attending physician and any other appropriate reviewing organization no later than 2 days after such final decision.

E. Extended Stay Reviews

Cases of long length of stay and/or high cost will also be reviewed by a two-level process. Initial first level case review will be at the screening level and is to be performed by Care Management Program staff for appropriate level of care and appropriate plan of care, based on screening criteria (such as InterQual).

If continued stay appears inappropriate, the utilization review specialist or case manager will consult with the Care Management Program staff and/or the attending physician and discuss discharge readiness and alternate levels of care and services. If necessary, the Medical Advisor of the Care Management Program or other designated physicians will be consulted and perform second-level review.

The procedures for second-level physician review as specified in **V. D** above ("Second Level Physician Review for Inpatient Level of Care") shall apply for such extended stay reviews.

F. Discharge Readiness

i. Early discharge planning is 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 case manager is responsible for coordinating the efforts of the multidisciplinary team for planning a patient's discharge. 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 Case Manager and staff of the Care Management Program to assure that post-acute care needs have been addressed by the time discharge occurs.

VI. PATIENT INFORMATION REQUIRED FOR UTILIZATION REVIEW

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 or procedure; the justification of an emergency admission (when applicable); and other supporting documentation that the URC believes appropriate to be include for the determination process.

VII. ACCEPTANCE AND APPROVAL

_____ _____

Chairman, Medical Executive Committee

_____ _____

President, Chief Executive Officer

Reference: Code of Federal Regulations Title 42, Part 456 and Part 482

Written: March 6, 2007

Revised: May 20, 2007
June 22, 2007
July 11, 2007
April 23, 2009
July 27, 2009
February 19, 2012
March 26, 2012

April 26, 2013

Tab 19

Attachment C
Contribution to the Orderly Development of Health Care – 5

Patient Bill of Rights

Effective Date:	*04/2013*
Last Reviewed:	*04/2013*
Last Revised:	*04/2013*
Expiration Date:	*04/2016*
Owner:	*Thompson, Dr. Bill: Chief Quality Officer*
Section/Dept:	*Rights and Responsibilities of the Individual*
References:	
Applicability:	*Saint Thomas Health*

Patient Rights and Responsibilities

Hospital care is a special partnership between patients, their loved ones, physicians and hospital staff. We at Saint Thomas Health respect your rights, values and dignity, and we ask that you recognize the responsibilities that come with being a patient in our hospitals. Please review these rights and responsibilities and discuss them with your caregivers and your family.

PATIENT RIGHTS:

- You have the right to safe, high quality, compassionate healthcare, without fear of discrimination of any kind.
- You have the right to the most appropriate medical treatment available, delivered in a safe, considerate, and respectful manner.
- You have the right to have your illness, treatment, alternatives and outcomes explained in a manner and language you can understand, including the use of interpretation services as needed.
- You or your personal representative has the right to participate in the development and implementation of your plan of care.
- You have the right to make informed decisions about your care in collaboration with your physician and other caregivers. You have the right to accept or refuse medical care, including life sustaining and resuscitative treatment, to the extent permitted by law. You have the right to be informed of the medical consequences of your decisions.
- You have the right to receive professional assessment and management of your pain.
- You have the right to know the identity and professional status of persons caring for you, and the right to refuse to be treated by a student. You have a right to request a second opinion.
- You have the right to complete, ongoing information concerning your diagnosis, treatment, and any known prognosis. You have the right to information on post-discharge care needs and alternatives, including transfers to another facility.
- You have the right to assistance with and to participate in the consideration of ethical issues that may arise in the course of your care.
- You have the right to know what hospital rules and regulations apply to you as a patient
- You have the right to refuse experimental treatment or drugs.
- You have the right to private and confidential treatment/personal care, communications and medical records to the extent permitted by law.
- You have the right to have information regarding your medical treatment explained to your family member or other appropriate individual when you are unable to participate in decisions about your care.
- You have the right to receive information about and assistance with advance directives, (Living Will/ Advance Care Plan; Durable Power of Attorney for Healthcare/ Surrogate Decision Maker for Healthcare/ Physician Orders for Scope of Treatment), which may include delegation of the right to make decisions about your care to a personal representative, as well as designation of a support person. You have the

right to review and revise existing directives, and to have your advance directives respected within the limits of the law.

- You have the right to have your wishes regarding organ donation honored. You have the right to have your treatment preferences honored and to receive the same level of care whether or not you have written advance directives.
- You have the right to access the information in your medical records within a reasonable timeframe. You have the right to request amendments to your medical record. You have the right to receive an accounting of disclosures of your medical information, within the limits of the law.
- You have the right to examine an itemized copy of your hospital bill and to have it explained to you, regardless of source of payment. You also have the right to information concerning possible resources for financial assistance.
- You have the right to care that is provided in the least restrictive way, and to have restrictions such as restraints or seclusion explained and reviewed.
- You have the right to be free from all forms of abuse, neglect and exploitation, and the right to access protective or advocacy services when indicated or required.
- You (or your support person) have the right to be informed of your visitation rights including any clinical restrictions or limitations of our rights.
- You have the right to receive visitors designated by you, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.
- You have the right to visitation privileges that are not restricted, limited, or denied based upon race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. All your visitors shall enjoy full and equal visitation privileges.
- You have the right to the presence of a support individual of your choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be your surrogate decision maker or legally authorized representative.

PATIENT RESPONSIBILITIES:

- You are responsible for providing the hospital with all necessary information about your medical history, hospitalizations, medications, and other matters related to your health.
- You are responsible to communicate with those involved in your care, including asking questions if medical information or instructions are not clear to you.
- You are responsible for following your plan of care. If you are unable or unwilling to follow the plan of care, you are responsible for telling your care provider. Your care provider will explain the medical consequences of not following the recommended treatment. You are responsible for the outcomes of not following your plan of care.
- You are responsible to respect your caregivers' efforts to provide care and treatment to other patients.
- You are responsible for following the hospital's rules and regulations, to act in a manner that is respectful of other patients, staff and hospital property, and to ask that your visitors do the same.
- You are responsible to provide the hospital with a copy of your advance directive, and to inform your family or preferred decision maker about your wishes and the location of any advance directives.
- You are responsible to provide the hospital with financial and health insurance information necessary to process your bill, and to meet your financial obligations to this facility.

COMPLAINT RESOLUTION:

We want to hear from you. You and your family have the right to voice your compliments, concerns and complaints freely without fear of coercion, discrimination, reprisals, or unreasonable interruptions of care. Your concerns and complaints will be reviewed and resolved when possible, and grievances will be responded to within seven (7) working days. You may voice your concerns with your caregivers, or you may call one of the following Complaint Lines:

Saint Thomas Hickman Hospital (931) 729-4271
Saint Thomas Midtown Hospital (615) 284-4438
Saint Thomas Rutherford Hospital (615) 396-5934
Saint Thomas West Hospital (615) 222-6630

If you do not feel your complaint was handled properly, please call one of the following numbers:

Tennessee Department of Health, Health Facilities Complaint Hotline 1-877-287-0010
Joint Commission Complaint Hotline 1-800-994-6610

All revision dates:	04/2013
Attachments:	No Attachments

COPY

Tab 20

Attachment C
Contribution to the Orderly Development of Health Care - 7.(b)

The Joint Commission Documentation

Accreditation Quality Report

The Joint Commission

Welcome to the Joint Commission's Quality Report. We know how important reliable information is to you and your family when making health care decisions. This Quality Report will help you make the right decisions to meet your needs. Since 1951, the Joint Commission has been the national leader in setting standards for health care organizations. When a health care organization seeks accreditation, it demonstrates commitment to giving safe, high quality health care and to continually working to improve that care.

The Quality Report is only one way to determine whether a health care organization can meet your needs. Discuss this report with your doctor or with other professional acquaintances before making a care decision. In addition to the accreditation status of the organization, the Quality Report uses checks, pluses, and minuses in each of the following key areas to help you compare a health care organization with similar accredited organizations.

- National Patient Safety Goals - safety guidelines that target the prevention of medical errors such as surgery on the wrong side of the body and safe medication use.
- National Quality Improvement Goals - measures the care of patients with specific conditions such as heart failure or pregnancy.

Not all measures are relevant to or available for all types of health care organizations. The Joint Commission will add relevant measures of health care quality as more measures become available. Your comments are just as important to us. The content and format of the Quality Report will be updated from time to time based on changes in the health care industry and your suggestions. Please call Customer Service at 630-792-5800 or e-mail the Joint Commission at qualityreport@jointcommission.org with your comments and suggestions.

Mark R. Chassin

Mark R. Chassin, MD, MPP, MPH
President of the Joint Commission

Summary of Quality Information

Symbol Key

- This organization achieved the best possible results.
- This organization's performance is above the target range/value.
- This organization's performance is similar to the target range/value.
- This organization's performance is below the target range/value.
- This Measure is not applicable for this organization.
- Not displayed

Footnote Key

1. The Measure or Measure Set was not reported.
2. The Measure Set does not have an overall result.
3. The number of patients is not enough for comparison purposes.
4. The measure meets the Privacy Disclosure Threshold rule.
5. The organization scored above 90% but was below most other organizations.
6. The Measure results are not statistically valid.
7. The Measure results are based on a sample of patients.
8. The number of months with Measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Accreditation Programs	Accreditation Decision	Effective Date	Last Full Survey Date	Last On-Site Survey Date
Hospital	Accredited	3/29/2014	3/28/2014	3/28/2014

Accreditation programs recognized by the Centers for Medicare and Medicaid Services (CMS)

Hospital

Advanced Certification Programs	Certification Decision	Effective Date	Last Full Review Date	Last On-Site Review Date
Inpatient Diabetes	Certification	7/11/2014	7/10/2014	7/10/2014
Primary Stroke Center	Certification	7/24/2014	7/23/2014	7/23/2014

Certified Programs	Certification Decision	Effective Date	Last Full Review Date	Last On-Site Review Date
Joint Replacement - Hip	Certification	7/25/2014	7/24/2014	7/24/2014
Joint Replacement - Knee	Certification	7/25/2014	7/24/2014	7/24/2014

Special Quality Awards

2013 ACS National Surgical Quality Improvement Program

		Compared to other Joint Commission Accredited Organizations	
		Nationwide	Statewide
Hospital	**2014National Patient Safety Goals**	✓	N/A*

The Joint Commission only reports measures endorsed by the National Quality Forum.

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Saint Thomas Midtown Hospital

DBA: Saint Thomas Midtown Hospital,
2000 Church Street, Nashville, TN

Org ID: 7884

Summary of Quality Information

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Reporting Period: Apr 2013 - Mar 2014

National Quality Improvement Goals:	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
Heart Attack Care	⊕	⊕
Heart Failure Care	✓	✓
Perinatal Care	(N/A) 2	(N/A) 2
Pneumonia Care	✓	✓
Surgical Care Improvement Project (SCIP)		
SCIP - Cardiac SCIP - Infection Prevention *For All Reported Procedures:*	⊕	⊕
• Blood Vessel Surgery	✓	✓
• Colon/Large Intestine Surgery	✓	✓
• Coronary Artery Bypass Graft	⊕	⊕
• Hip Joint Replacement	⊕	⊕
• Hysterectomy	⊕	⊕
• Knee Replacement	⊕	⊕
• Open Heart Surgery	⊕	⊕
SCIP – Venous Thromboembolism (VTE)		

The Joint Commission only reports measures endorsed by the National Quality Forum.

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Locations of Care

* Primary Location

Locations of Care	Available Services
Craig Center for Advanced Wound Healing at Midtown Hospital 2000 Murphy Avenue Nashville, TN 37203	**Other Clinics/Practices located at this site:** • Midtown Hospital Diabetes Center **Services:** • Outpatient Clinics (Outpatient)

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Locations of Care

* Primary Location

Locations of Care	Available Services
Saint Thomas Midtown Hospital * 2000 Church Street Nashville, TN 37236	**Joint Commission Advanced Certification Programs:** • Inpatient Diabetes • Primary Stroke Center **Joint Commission Certified Programs:** • Joint Replacement - Hip • Joint Replacement - Knee **Other Clinics/Practices located at this site:** • Saint Thomas Heart Midtown OP Cardiac Imaging • Saint Thomas Sports Medicine-Plaza II, Nashville TN • UT Medical Resident's Clinic **Services:** • Brachytherapy (Imaging/Diagnostic Services) • Cardiac Catheterization Lab (Surgical Services) • Cardiac Surgery (Surgical Services) • Cardiothoracic Surgery (Surgical Services) • Cardiovascular Unit (Inpatient) • Coronary Care Unit (Inpatient) • CT Scanner (Imaging/Diagnostic Services) • Dialysis Unit (Inpatient) • Ear/Nose/Throat Surgery (Surgical Services) • EEG/EKG/EMG Lab (Imaging/Diagnostic Services) • Gastroenterology (Surgical Services) • GI or Endoscopy Lab (Imaging/Diagnostic Services) • Gynecological Surgery (Surgical Services) • Gynecology (Inpatient) • Hematology/Oncology Unit (Inpatient) • Inpatient Unit (Inpatient) • Interventional Radiology (Inpatient, Outpatient, Imaging/Diagnostic Services) • Labor & Delivery (Inpatient) • Magnetic Resonance Imaging (Imaging/Diagnostic Services) • Medical /Surgical Unit (Inpatient) • Neurosurgery (Surgical Services) • Normal Newborn Nursery (Inpatient) • Nuclear Medicine (Imaging/Diagnostic Services) • Ophthalmology (Surgical Services) • Orthopedic Surgery (Surgical Services) • Orthopedic/Spine Unit (Inpatient) • Outpatient Clinics (Outpatient) • Pediatric Emergency Medicine (Outpatient - Child/Youth) • Pediatric General Surgery (Inpatient - Child/Youth) (Outpatient - Child/Youth) • Pediatric Otolaryngology (Inpatient - Child/Youth) (Outpatient - Child/Youth) • Plastic Surgery (Surgical Services) • Post Anesthesia Care Unit (PACU) (Inpatient) • Radiation Oncology (Imaging/Diagnostic Services) • Rehabilitation Unit (Inpatient, 24-hour Acute Care/Crisis Stabilization) • Sleep Laboratory (Sleep Laboratory) • Surgical ICU (Intensive Care Unit) • Surgical Unit (Inpatient) • Thoracic Surgery (Surgical Services) • Ultrasound (Imaging/Diagnostic Services) • Urology (Surgical Services) • Vascular Surgery (Surgical Services)

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Locations of Care

* Primary Location

Locations of Care	Available Services
	• Medical ICU (Intensive Care Unit) • Neuro/Spine Unit (Inpatient)
Saint Thomas Midtown Hospital OP Cardiac Imaging 900 Conference Drive, Ste. 8 Goodlettsville, TN 37072	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Midtown Hospital OP Cardiac Imaging - Franklin 4323 North Carothers Suite 310 Franklin, TN 37067	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Midtown Hospital OP Cardiac Imaging Ctr 222 22nd Ave N STE 501 Nashville, TN 37203	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sport Medicine/Life Therapies - Cool Springs 101 International Blvd. Franklin, TN 37067	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sports Medicine 491 Sage Road White House, TN 37188	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sports Medicine - Antioch/Lavergne 3534 Murfreesboro Pike, Ste. 101 Antioch, TN 37013	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sports Medicine - Bellevue, Nashville TN 7640 Highway 70 South, Suite 104 Nashville, TN 37221	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sports Medicine - Rivergate 1777 Gallatin Pike, North Madison, TN 37115	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sports Medicine - South 6005 Nolensville Road Nashville, TN 37211	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sports Medicine-Dickson 7101 Ramsy Way, Dickson, TN 37055	**Services:** • Outpatient Clinics (Outpatient)

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Locations of Care

* Primary Location

Locations of Care	Available Services
Saint Thomas Sports Medicine-Green Hills 3810 BedfordAve. Suite 120 Nashville, TN 37215	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sports Medicine-Maryland Farms 5101 Maryland Way Brentwood, TN 37027	**Services:** • Outpatient Clinics (Outpatient)
Saint Thomas Sports Medicine-Murfreesboro 1203B Memorial Blvd. Murfreesboro, TN 37129	**Services:** • Outpatient Clinics (Outpatient)
UT Medical Clinic 316 22nd Avenue North Nashville, TN 37203	**Services:** • Outpatient Clinics (Outpatient)

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2014 National Patient Safety Goals

Symbol Key

- The organization has met the National Patient Safety Goal.
- The organization has not met the National Patient Safety Goal.
- The Goal is not applicable for this organization.

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Hospital

Safety Goals	Organizations Should	Implemented
Improve the accuracy of patient identification.	Use of Two Patient Identifiers	✓
	Eliminating Transfusion Errors	✓
Improve the effectiveness of communication among caregivers.	Timely Reporting of Critical Tests and Critical Results	✓
Improve the safety of using medications.	Labeling Medications	✓
	Reducing Harm from Anticoagulation Therapy	✓
	Reconciling Medication Information	✓
Use Alarms Safely	Use Alarms Safely on Medical Equipment	✓
Reduce the risk of health care-associated infections.	Meeting Hand Hygiene Guidelines	✓
	Preventing Multi-Drug Resistant Organism Infections	✓
	Preventing Central-Line Associated Blood Stream Infections	✓
	Preventing Surgical Site Infections	✓
	Preventing Catheter-Associated Urinary Tract Infection	✓
The organization identifies safety risks inherent in its patient population.	Identifying Individuals at Risk for Suicide	✓
Universal Protocol	Conducting a Pre-Procedure Verification Process	✓
	Marking the Procedure Site	✓
	Performing a Time-Out	✓

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National Quality Improvement Goals

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Reporting Period: April 2013 - March 2014

Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
Heart Attack Care	This category of evidence based measures assesses the overall quality of care provided to Heart Attack (AMI) patients.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
ACE inhibitor or ARB for LVSD*	Heart attack patients who receive either a prescription for a medicine called an "ACE inhibitor" or a medicine called an angiotensin receptor blocker (ARB) when they are discharged from the hospital. This measure reports what percent of heart attack patients who have problems with the heart pumping enough blood to the body were prescribed medicines to improve the heart's ability to pump blood.*	100% of 45 eligible Patients	100%	98%	100%	98%
Aspirin at arrival*	Heart attack patients receiving aspirin when arriving at the hospital. This measure reports what percent of heart attack patients receive aspirin within 24 hours before or after they arrive at the hospital. Aspirin is beneficial because it reduces the tendency of blood to clot in blood vessels of the heart and improves survival rates.*	99% of 257 eligible Patients	100%	99%	100%	99%
Aspirin prescribed at discharge*	Heart attack patients who receive a prescription for aspirin when being discharged from the hospital. This measure reports how often aspirin was prescribed to heart attack patients when they are leaving a hospital. Aspirin is beneficial because it reduces the tendency of blood to clot in blood vessels of the heart and improves survival rates.*	99% of 239 eligible Patients	100%	99%	100%	99%

NQF The Joint Commission only reports measures endorsed by the National Quality Forum.

* This information can also be viewed at www.hospitalcompare.hhs.gov

---- Null value or data not displayed.

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National Quality Improvement Goals

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Heart Attack Care	This category of evidence based measures assesses the overall quality of care provided to Heart Attack (AMI) patients.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Beta blocker prescribed at discharge*	Heart attack patients who have a medicine called a "beta blocker" prescribed when they are discharged from the hospital. This measure reports what percent of heart attack patients were prescribed a special type of medicine when leaving the hospital, that has been shown to reduce further heart damage.*	100% of 233 eligible Patients	100%	99%	100%	99%
Fibrinolytic therapy received within 30 minutes of hospital arrival*	Heart attack patients who receive a medicine that breaks up blood clots (fibrinolytic therapy) within 30 minutes of hospital arrival. This measure reports how quickly heart attack patients were given a medication that breaks up blood clots (fibrinolytic therapy). Breaking up blood clots increases blood flow to the heart. If blood flow is returned to the heart muscle quickly during a heart attack, the risk of death is decreased. The medicine that breaks up clots in the arteries and allows the return of normal blood flow is called fibrinolytic therapy and is used in certain types of heart attacks. It is important that this medicine be given quickly after a heart attack is diagnosed.*	[3] ---	100%	61%	---[3]	----[3]

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Reporting Period: April 2013 - March 2014

Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
Heart Attack Care	This category of evidence based measures assesses the overall quality of care provided to Heart Attack (AMI) patients.	⊕	⊕

Measure	Explanation	Hospital Results	Nationwide: Top 10% Scored at Least:	Nationwide: Average Rate:	Statewide: Top 10% Scored at Least:	Statewide: Average Rate:
Primary PCI received within 90 minutes of hospital arrival*	Heart attack patient with a clogged artery in the heart that is opened with a balloon therapy called PCI within 90 minutes of hospital arrival. This measure reports how quickly heart attack patients had a clogged artery in the heart opened with a balloon therapy called PCI to increase blood flow to the heart and reduce heart damage. Lack of blood supply to heart muscle can cause lasting heart damage. In certain types of heart attacks, a small balloon is threaded into a blood vessel in the heart to open up a clogged artery that keeps the blood from flowing to the heart muscle. It is important that this therapy be given quickly after a heart attack is diagnosed.*	N/D 3 95% of 22 eligible Patients[3]	100%	96%	100%	98%
Statin Prescribed at Discharge	Heart attack patients who receive a prescription for a statin medication at discharge. This measure reports what percentage of heart patients who have problems with high cholesterol were prescribed medications to help reduce their "bad" cholesterol.	⊕ 96% of 235 eligible Patients	100%	99%	100%	99%

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Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
Heart Failure Care	This category of evidence based measures assesses the overall quality of care provided to Heart Failure (HF) patients.	✓	✓

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
ACE inhibitor or ARB for LVSD*	Heart failure patients who receive either a prescription for a medicine called an "ACE inhibitor" or a medicine called an angiotensin receptor blocker (ARB) when they are discharged from the hospital. This measure reports what percent of heart failure patients who have problems with the heart pumping enough blood to the body were prescribed medicines to improve the heart's ability to pump blood.*	✓ 96% of 212 eligible Patients	100%	97%	100%	97%
LVF assessment*	Heart failure patients who have had the function of the main pumping chamber of the heart (i.e., left ventricle) checked during their hospitalization. This measure reports what percent of patients with heart failure receive an in-depth evaluation of heart muscle function in order to get the right treatment for their heart failure. Limitations of measure use - see Accreditation Quality Report User Guide.*	⊕ 99% of 629 eligible Patients	100%	100%	100%	100%

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Reporting Period: April 2013 - March 2014

Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
Perinatal Care	This category of evidenced based measures assesses the care of mothers and newborns.	N/D 2	N/D 2

Measure	Explanation	Hospital Results	Nationwide: Top 10% Scored at Least:	Nationwide: Average Rate:	Statewide: Top 10% Scored at Least:	Statewide: Average Rate:
Antenatal Steroids	This measure reports the overall number of mothers who were at risk of preterm delivery at 24-32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. Antenatal steroids are sterolds given before birth.	N/D 4 —	100%	89%	100%	93%
Elective Delivery	This measure reports the overall number of mothers who had elective vaginal deliveries or elective cesarean sections at equal to and greater than 37 weeks gestation to less than 39 weeks gestation. An elective delivery is the delivery of a newborn(s) when the mother was not in active labor or presented with spontaneous ruptured membranes prior to medical induction and/or cesarean section.	N/D 8 7% of 30 eligible Patients	0%	4%	0%	4%
Exclusive Breast Milk Feeding	This measure reports the overall number of newborns who are exclusively breast milk fed during the newborns entire hospitalization. Exclusive breast milk feeding is when a newborn receives only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.	N/D 8 49% of 111 eligible Patients	74%	49%	57%	37%
Exclusive Breast Milk Feeding Considering Mothers Choice	This measure reports the overall number of newborns who are exclusively breast milk fed during the newborns entire hospitalization not including those newborns whose mothers chose to not exclusively feed breast milk at the time of birth of the newborn.	N/D 8 49% of 111 eligible Patients	93%	64%	95%	57%

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Saint Thomas Midtown Hospital

DBA: Saint Thomas Midtown Hospital
2000 Church Street, Nashville, TN
Org ID: 7884

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Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
Pneumonia Care	This category of evidence based measures assesses the overall quality of care provided to Pneumonia patients.	✓	✓

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Blood cultures for pneumonia patients in intensive care units.	Pneumonia patients cared for in an intensive care unit that had a blood test for the presence of bacteria in their blood within 24 hours of hospital arrival. This measure reports the percent of pneumonia patients in intensive care units who had a blood culture within 24 hours prior to or after hospital arrival.	✓ 92% of 96 eligible Patients	100%	98%	100%	99%
Initial antibiotic selection for CAP in immunocompetent – ICU patient*	Patients in intensive care units who have community-acquired pneumonia who received the appropriate medicine (antibiotic) that has been shown to be effective for community-acquired pneumonia. This measure reports how often patients in intensive care units with community-acquired pneumonia were given the correct antibiotic within 24 hours of hospital arrival, based on recommendations from written guidelines, for the treatment of pneumonia.*	3 88% of 26 eligible Patients[3]	100%	93%	100%	91%
Initial antibiotic selection for CAP in immunocompetent – non ICU patient*	Patients not in intensive care units who have community-acquired pneumonia who received the appropriate medicine (antibiotic) that has been shown to be effective for community-acquired pneumonia. This measure reports how often patients with community-acquired pneumonia not cared for in intensive care units, were given the correct antibiotic within 24 hours of hospital arrival, based on recommendations from written guidelines, for the treatment of pneumonia.*	✓ 98% of 146 eligible Patients	100%	97%	100%	97%

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		Compared to other Joint Commission Accredited Organizations	
Measure Area	Explanation	Nationwide	Statewide
SCIP - Cardiac	This evidence based measure assesses continuation of beta-blocker therapy in selected surgical patients.		

		Compared to other Joint Commission Accredited Organizations				
			Nationwide		Statewide	
Measure	Explanation	Hospital Results	Top 10% Scored at Least:	Average Rate:	Top 10% Scored at Least:	Average Rate:
Surgery patients taking a Beta-Blocker before hospital admission who received a Beta-Blocker in the time frame of 24 hours before surgery through the time they were in the recovery room.	This measure reports the number of patients taking a Beta-Blocker medication before hospital admission who received a Beta-Blocker in the time frame of 24 hours before surgery through the time they were in the recovery room. Risk of complications is decreased when the Beta-Blocker is continued during the surgical time frame.	⊕ 99% of 204 eligible Patients	100%	98%	100%	97%

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Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
SCIP - Infection Prevention	This category of evidence based measures assesses the overall use of indicated antibiotics for surgical infection prevention.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients having a surgery who received medicine to prevent infection (an antibiotic) within one hour before the skin was surgically cut.*	This measure reports how often patients having surgery received medicine that prevents infection (an antibiotic) within one hour before the skin was surgically cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut. Note: Not every surgery requires antibiotics and this measure reports on those selected surgeries where evidence/experts have identified that antibiotics would be helpful.	⊕ 99% of 452 eligible Patients	100%	99%	100%	99%
Patients having surgery who received the appropriate medicine (antibiotic) which is shown to be effective for the type of surgery performed.*	This measure reports how often patients who had surgery were given the appropriate medicine (antibiotic) that prevents infection which is know to be effective for the type of surgery, based upon the recommendations of experts around the country. Note: Not every surgery requires antibiotics and this measure reports on those selected surgeries where evidence/experts have identified that antibiotics would be helpful.	⊕ 97% of 450 eligible Patients	100%	99%	100%	99%

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Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
SCIP - Infection Prevention	This category of evidence based measures assesses the overall use of indicated antibiotics for surgical infection prevention.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients who had surgery and received appropriate medicine that prevents infection (antibiotic) and the antibiotic was stopped within 24 hours after the surgery ended.*	This measure reports how often surgery patients whose medicine (an antibiotic) to prevent infection was stopped within 24 hours after the surgery ended. Giving medicine that prevents infection for more than 24 hours after the end of surgery is not helpful, unless there is a specific reason (for example, fever or other signs of infection). Note: Not every surgery requires antibiotics and this measure reports on those selected surgeries where evidence/experts have identified that antibiotics would be helpful.	⊕ 98% of 445 eligible Patients	100%	98%	100%	98%
Patients Having Blood Vessel Surgery*	Overall report of hospital's performance on Surgical Infection Prevention Measure for Blood Vessel Surgery.	✓ 93% of 123 eligible Patients	100%	98%	100%	98%
Patients having blood vessel surgery who received medicine to prevent infection (an antibiotic) within one hour before the skin was surgically cut.*	This measure reports how often patients having blood vessel surgery received medicine that prevents infection (an antibiotic) within one hour before the skin was surgically cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut.*	✓ 98% of 41 eligible Patients	100%	98%	100%	98%
Patients having blood vessel surgery who received the appropriate medicine (antibiotic) which is shown to be effective for this type of surgery.*	This measure reports how often patients who had blood vessel surgery were given the appropriate medicine (antibiotic) that prevents infection which is know to be effective for the type of surgery, based upon the recommendations of experts around the country.*	✓ 88% of 41 eligible Patients	100%	99%	100%	99%

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SCIP - Infection Prevention	This category of evidence based measures assesses the overall use of indicated antibiotics for surgical infection prevention.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients who had blood vessel surgery and received appropriate medicine that prevents infection (antibiotic) and the antibiotic was stopped within 24 hours after the surgery ended.*	This measure reports how often blood vessel surgery patients whose medicine (an antibiotic) to prevent infection was stopped within 24 hours after the surgery ended. Giving medicine that prevents infection for more than 24 hours after the end of surgery is not helpful, unless there is a specific reason (for example, fever or other signs of infection).*	✓ 95% of 41 eligible Patients	100%	96%	100%	96%
Patients Having Colon/Large Intestine Surgery*	Overall report of hospital's performance on Surgical Infection Prevention Measures for Colon/Large Intestine Surgery.	✓ 97% of 169 eligible Patients	100%	97%	100%	96%
Patients having colon/large intestine surgery who received medicine to prevent infection (an antibiotic) within one hour before the skin was surgically cut. *	This measure reports how often patients having colon/large intestine surgery received medicine that prevents infection (an antibiotic) within one hour before the skin was surgically cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut.*	✓ 98% of 57 eligible Patients	100%	98%	100%	98%
Patients having colon/large intestine surgery who received the appropriate medicine (antibiotic) which is shown to be effective for this type of surgery.*	This measure reports how often patients who had colon/large intestine surgery were given the appropriate medicine (antibiotic) that prevents infection which is know to be effective for the type of surgery, based upon the recommendations of experts around the country.*	✓ 93% of 57 eligible Patients	100%	96%	100%	95%

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SCIP - Infection Prevention	This category of evidence based measures assesses the overall use of indicated antibiotics for surgical infection prevention.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients who had colon/large intestine surgery and received appropriate medicine that prevents infection (antibiotic) and the antibiotic was stopped within 24 hours after the surgery ended.*	This measure reports how often colon/large intestine surgery patients whose medicine (an antibiotic) to prevent infection was stopped within 24 hours after the surgery ended. Giving medicine that prevents infection for more than 24 hours after the end of surgery is not helpful, unless there is a specific reason (for example, fever or other signs of infection).*	○ 100% of 55 eligible Patients	100%	96%	100%	96%
Patients Having Coronary Artery Bypass Graft Surgery*	Overall report of hospital's performance on Surgical Infection Prevention Measures for Coronary Artery Bypass Graft Surgery.	⊕ 100% of 228 eligible Patients	100%	99%	100%	99%
Patients having coronary artery bypass graft surgery who received medicine to prevent infection (an antibiotic) within one hour before the skin was surgically cut.*	This measure reports how often patients having coronary artery bypass graft surgery received medicine that prevents infection (an antibiotic) within one hour before the skin was surgically cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut.*	○ 100% of 77 eligible Patients	100%	99%	100%	98%
Patients having coronary artery bypass graft surgery who received the appropriate medicine (antibiotic) which is shown to be effective for this type of surgery.*	This measure reports how often patients who had coronary artery bypass graft surgery were given the appropriate medicine (antibiotic) that prevents infection which is know to be effective for the type of surgery, based upon the recommendations of experts around the country.*	○ 100% of 76 eligible Patients	100%	100%	100%	100%

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Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients who had coronary artery bypass graft surgery and received appropriate medicine that prevents infection (antibiotic) and the antibiotic was stopped within 48 hours after the surgery ended.*	This measure reports how often coronary artery bypass graft surgery patients whose medicine (an antibiotic) to prevent infection was stopped within 48 hours after the surgery ended. Giving medicine that prevents infection for more than 48 hours after the end of surgery is not helpful, unless there is a specific reason (for example, fever or other signs of infection).*	100% of 75 eligible Patients	100%	99%	100%	99%
Patients Having Hip Joint Replacement Surgery*	Overall report of hospital's performance on Surgical Infection Prevention Measures for Hip Joint Replacement Surgery.	99% of 241 eligible Patients	100%	99%	100%	99%
Patients having hip joint replacement surgery who received medicine to prevent infection (an antibiotic) within one hour before the skin was surgically cut.*	This measure reports how often patients having hip joint replacement surgery received medicine that prevents infection (an antibiotic) within one hour before the skin was surgically cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut.*	98% of 81 eligible Patients	100%	99%	100%	99%
Patients having hip joint replacement surgery who received the appropriate medicine (antibiotic) which is shown to be effective for this type of surgery.*	This measure reports how often patients who had hip joint replacement surgery were given the appropriate medicine (antibiotic) that prevents infection which is know to be effective for the type of surgery, based upon the recommendations of experts around the country.*	100% of 80 eligible Patients	100%	100%	100%	100%

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8. The number of months with Measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Reporting Period: April 2013 - March 2014

Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
SCIP - Infection Prevention	This category of evidence based measures assesses the overall use of indicated antibiotics for surgical infection prevention.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients who had hip joint replacement surgery and received appropriate medicine that prevents infection (antibiotic) and the antibiotic was stopped within 24 hours after the surgery ended.*	This measure reports how often hip joint replacement surgery patients whose medicine (an antibiotic) to prevent infection was stopped within 24 hours after the surgery ended. Giving medicine that prevents infection for more than 24 hours after the end of surgery is not helpful, unless there is a specific reason (for example, fever or other signs of infection).*	✓ 99% of 80 eligible Patients	100%	98%	100%	97%
Patients Having a Hysterectomy*	Overall report of hospital's performance on Surgical Infection Prevention Measure for Hysterectomy Surgery.	⊕ 98% of 212 eligible Patients	100%	98%	100%	98%
Patients having hysterectomy surgery who received medicine to prevent infection (an antibiotic) within one hour before the skin was surgically cut.*	This measure reports how often patients having hysterectomy surgery received medicine that prevents infection (an antibiotic) within one hour before the skin was surgically cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut.*	○ 100% of 71 eligible Patients	100%	99%	100%	99%
Patients having hysterectomy surgery who received the appropriate medicine (antibiotic) which is shown to be effective for this type of surgery.*	This measure reports how often patients who had hysterectomy surgery were given the appropriate medicine (antibiotic) that prevents infection which is know to be effective for the type of surgery, based upon the recommendations of experts around the country.*	✓ 96% of 71 eligible Patients	100%	98%	100%	98%

The Joint Commission only reports measures endorsed by the National Quality Forum.

* This information can also be viewed at www.hospitalcompare.hhs.gov

---- Null value or data not displayed.

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Saint Thomas Midtown Hospital

DBA: Saint Thomas Midtown Hospital,
2000 Church Street, Nashville, TN

Org ID: 7884

National Quality Improvement Goals

Reporting Period: April 2013 - March 2014

Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
SCIP - Infection Prevention	This category of evidence based measures assesses the overall use of indicated antibiotics for surgical infection prevention.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients who had hysterectomy surgery and received appropriate medicine that prevents infection (antibiotic) and the antibiotic was stopped within 24 hours after the surgery ended.*	This measure reports how often hysterectomy surgery patients whose medicine (an antibiotic) to prevent infection was stopped within 24 hours after the surgery ended. Giving medicine that prevents infection for more than 24 hours after the end of surgery is not helpful, unless there is a specific reason (for example, fever or other signs of infection).*	✓ 99% of 70 eligible Patients	100%	98%	100%	98%
Patients Having Knee Joint Replacement Surgery*	Overall report of hospital's performance on Surgical Infection Prevention Measures for Knee Joint Replacement Surgery.	⊕ 99% of 263 eligible Patients	100%	99%	100%	99%
Patients having knee joint replacement surgery who received medicine to prevent infection (an antibiotic) within one hour before the skin was surgically cut.*	This measure reports how often patients having knee joint replacement surgery received medicine that prevents infection (an antibiotic) within one hour before the skin was surgically cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut.*	○ 100% of 88 eligible Patients	100%	99%	100%	99%
Patients having knee joint replacement surgery who received the appropriate medicine (antibiotic) which is shown to be effective for this type of surgery.*	This measure reports how often patients who had knee joint replacement surgery were given the appropriate medicine (antibiotic) that prevents infection which is know to be effective for the type of surgery, based upon the recommendations of experts around the country.*	○ 100% of 88 eligible Patients	100%	100%	100%	100%

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* This information can also be viewed at www.hospitalcompare.hhs.gov

---- Null value or data not displayed.

Symbol Key

- ○ This organization achieved the best possible results
- ⊕ This organization's performance is above the target range/value.
- ✓ This organization's performance is similar to the target range/value.
- ⊖ This organization's performance is below the target range/value.
- ○ Not displayed

Footnote Key

1. The Measure or Measure Set was not reported.
2. The Measure Set does not have an overall result.
3. The number of patients is not enough for comparison purposes.
4. The measure meets the Privacy Disclosure Threshold rule.
5. The organization scored above 90% but was below most other organizations.
6. The Measure results are not statistically valid.
7. The Measure results are based on a sample of patients.
8. The number of months with Measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

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National Quality Improvement Goals

Reporting Period: April 2013 - March 2014

Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
SCIP - Infection Prevention	This category of evidence based measures assesses the overall use of indicated antibiotics for surgical infection prevention.	⊕	⊕

Measure	Explanation	Hospital Results	Nationwide: Top 10% Scored at Least:	Nationwide: Average Rate:	Statewide: Top 10% Scored at Least:	Statewide: Average Rate:
Patients who had knee joint replacement surgery and received appropriate medicine that prevents infection (antibiotic) and the antibiotic was stopped within 24 hours after the surgery ended.*	This measure reports how often knee joint replacement surgery patients whose medicine (an antibiotic) to prevent infection was stopped within 24 hours after the surgery ended. Giving medicine that prevents infection for more than 24 hours after the end of surgery is not helpful, unless there is a specific reason (for example, fever or other signs of infection).*	✓ 98% of 87 eligible Patients	100%	99%	100%	98%
Patients Having Open Heart Surgery other than Coronary Artery Bypass Graft*	Overall report of hospital's performance on Surgical Infection Prevention Measures for Open Heart Surgery.	⊕ 98% of 111 eligible Patients	100%	99%	100%	99%
Patients having open heart surgery other than coronary artery bypass graft who received medicine to prevent infection (an antibiotic) within one hour before the skin was surgically cut.*	This measure reports how often patients having open heart surgery other than coronary artery bypass graft received medicine that prevents infection (an antibiotic) within one hour before the skin was surgically cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut. *	✓ 97% of 37 eligible Patients	100%	99%	100%	99%
Patients having open heart surgery other than coronary artery bypass graft who received the appropriate medicine (antibiotic) which is shown to be effective for this type of surgery.*	This measure reports how often patients who had open heart surgery other than coronary artery bypass graft were given the appropriate medicine (antibiotic) that prevents infection which is know to be effective for the type of surgery, based upon the recommendations of experts around the country.*	○ 100% of 37 eligible Patients	100%	100%	100%	100%

The Joint Commission only reports measures endorsed by the National Quality Forum.

* This information can also be viewed at www.hospitalcompare.hhs.gov

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5. The organization scored above 90% but was below most other organizations.
6. The Measure results are not statistically valid.
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National Quality Improvement Goals

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Footnote Key

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Reporting Period: April 2013 - March 2014

Measure Area	Explanation	Compared to other Joint Commission Accredited Organizations: Nationwide	Statewide
SCIP - Infection Prevention	This category of evidence based measures assesses the overall use of indicated antibiotics for surgical infection prevention.	⊕	⊕

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients who had open heart surgery other than coronary artery bypass graft and received appropriate medicine that prevents infection (antibiotic) and the antibiotic was stopped within 48 hours after the surgery ended.*	This measure reports how often open heart surgery other than coronary artery bypass graft patients whose medicine (an antibiotic) to prevent infection was stopped within 48 hours after the surgery ended. Giving medicine that prevents infection for more than 48 hours after the end of surgery is not helpful, unless there is a specific reason (for example, fever or other signs of infection).*	✓ 97% of 37 eligible Patients	100%	99%	100%	99%
Heart surgery patients with controlled blood sugar after surgery.	This measure reports the number of heart surgery patients that had a blood sugar of less than 200 on day one and day two after surgery. Infection is lowest in both diabetic and nondiabetic patients when blood sugar is controlled immediately after surgery.	○ 100% of 125 eligible Patients	100%	96%	100%	95%
Surgery patients with proper hair removal.	This measure reports the number of surgical patients that have had hair at the site of the surgical cut removed properly. Infection is lowest when patients have hair removed with electrical clippers or hair removal cream.	⊕ 99% of 597 eligible Patients	100%	100%	100%	100%
Urinary Catheter Removed	This measure reports the number of surgery patients whose urinary catheter was removed by the end of the second day after surgery.	✓ 97% of 368 eligible Patients	100%	98%	100%	97%

NQF The Joint Commission only reports measures endorsed by the National Quality Forum.

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---- Null value or data not displayed.

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National Quality Improvement Goals

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Footnote Key

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2. The Measure Set does not have an overall result.
3. The number of patients is not enough for comparison purposes.
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5. The organization scored above 90% but was below most other organizations.
6. The Measure results are not statistically valid.
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8. The number of months with Measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

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Reporting Period: April 2013 - March 2014

Measure Area	Explanation
SCIP – Venous Thromboembolism (VTE)	This category of evidenced based measures assesses the use of indicated treatment for the prevention of blood clots in selected surgical patients

Measure	Explanation	Hospital Results	Compared to other Joint Commission Accredited Organizations: Nationwide Top 10% Scored at Least:	Nationwide Average Rate:	Statewide Top 10% Scored at Least:	Statewide Average Rate:
Patients having surgery who received the appropriate treatment to prevent blood clots which is shown to be effective for the type of surgery performed. Note: Treatment may be medication, stockings, or mechanical devices for exercising the legs.*	This measure reports how often patients who had surgery were given the appropriate treatment that prevents blood clots which is known to be effective for the type of surgery, based upon the recommendations of experts around the country. Note: Not every surgery requires treatment and this measure reports on those selected surgeries where evidence/experts have identified that treatment to prevent blood clots would be helpful.*	⊕ 98% of 362 eligible Patients	100%	99%	100%	99%

The Joint Commission only reports measures endorsed by the National Quality Forum.

* This information can also be viewed at www.hospitalcompare.hhs.gov

---- Null value or data not displayed.

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Tab 21

Attachment C
Contribution to the Orderly Development of Health Care - 7.(c)

Hospital License

Board for Licensing Health Care Facilities

State of Tennessee

0000000032

No. of Beds 0683

DEPARTMENT OF HEALTH

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

SAINT THOMAS MIDTOWN HOSPITAL *to conduct and maintain a*

Hospital SAINT THOMAS MIDTOWN HOSPITAL

Located at 2000 CHURCH STREET, NASHVILLE

County of DAVIDSON *, Tennessee.*

This license shall expire APRIL 30 *,* 2015 *, 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 30TH *day of* APRIL *,* 2014 *.*

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

DEC 15 '14 PM 1:01

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

By John J. Dreyzehner, MD
COMMISSIONER

000287

DCF011

Tab 22

Attachment C
Contribution to the Orderly Development of Health Care -7.(d)

Inspection Report

FAX TRANSMITTAL

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH CARE FACILITIES

TO: Bernard Sherry, Administrator

FACILITY: Baptist Hospital

FAX NUMBER: 615-284-1592 PHONE: 615-284-6851

FROM: Karen B. Kirby, Regional Administrator – HCF, ETRO by KG

FAX NUMBER: (865) 594-5739

DATE: September 12, 2012

NUMBER OF PAGES INCLUDING THIS ONE: 9

IF YOU HAVE ANY QUESTIONS, CALL (865) 588-5656

SUBJECT/MESSAGE: **COMPLAINT(S) # TN00030295**

Original to follow by mail. If you have any questions regarding your statement of deficiencies please call for a supervisor @ 865-588-5656.

CONFIDENTIALITY NOTICE: The information contained in this message is confidential and is intended solely for the use of the person or entity named above. This message may contain individually identifiable information that must remain confidential and is protected by state and federal law. If the reader of this message is not the intended recipient, the reader is hereby notified that any dissemination, distribution or reproduction of this message is strictly prohibited. If you have received this message in error, please immediately notify the sender by telephone and destroy the original message. We regret any inconvenience and appreciate your cooperation.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

September 12, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

Provider Number: 44-0133

Dear Mr.Sherry:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Baptist Hospital on **September 4, 2012.** You are requested to submit a Plan of Correction by **September 22, 2012** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to **October 19, 2012.** Please notify this office when these deficiencies are corrected.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Please submit the Plan of Correction (POC), by **September 22, 2012:**

Office of Health Licensure and Regulation
Lakeshore Park, Bldg. One
5904 Lyons View Pike
Knoxville, TN 37919

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice.
- How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction State Form.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If you have any questions, please contact this office at (865) 588-5656 or by facsimile at (865) 594-5739.

Sincerely,

Karen B. Kirby/mad

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

Enclosure: CMS-2567

TN00030295

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	440133		C 09/04/2012

NAME OF PROVIDER OR SUPPLIER: BAPTIST HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the nursing staff educated patients adequately before discharge for one (#3) of five patients reviewed. The findings included: Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID	A 395		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	440133		C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	Continued From page 1 (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4,	A 395		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	440133	A. BUILDING ____ B. WING ____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

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A 395	Continued From page 2 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 395		
A 820	482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan. (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an appropriate discharge plan to meet the needs of patients for one (#3) of five patients reviewed. Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units	A 820		

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A 820	Continued From page 3 each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin	A 820		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 820	Continued From page 4 administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4, 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 820		

PRINTED: 09/07/2012
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53132	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 09/04/2012
NAME OF PROVIDER OR SUPPLIER BAPTIST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 CHURCH ST NASHVILLE, TN 37236		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-1 Initial During complaint investigation of #30296, conducted on September 4, 2012, at Baptist Hospital, no deficiencies were cited in relation to the complaint under 1200-8-1, Standards for Hospitals.	H 001		

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 Q1PI11 If continuation sheet 1 of 1

Tab 23

DEC 15 '16 PM 1:01

Attachment C
Contribution to the Orderly Development of Health Care -7.(d)

Plan of Corrective Action

FAX TRANSMITTAL

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH CARE FACILITIES

TO: Bernard Sherry, Administrator

FACILITY: Baptist Hospital

FAX NUMBER: 615-284-1592 PHONE: 615-284-6851

FROM: Karen B. Kirby, Regional Administrator – HCF, ETRO by KG

FAX NUMBER: (865) 594-5739

DATE: September 12, 2012

NUMBER OF PAGES INCLUDING THIS ONE: 9

IF YOU HAVE ANY QUESTIONS, CALL (865) 588-5656

SUBJECT/MESSAGE: **COMPLAINT(S) # TN00030295**

Original to follow by mail. If you have any questions regarding your statement of deficiencies please call for a supervisor @ 865-588-5656.

CONFIDENTIALITY NOTICE: The information contained in this message is confidential and is intended solely for the use of the person or entity named above. This message may contain individually identifiable information that must remain confidential and is protected by state and federal law. If the reader of this message is not the intended recipient, the reader is hereby notified that any dissemination, distribution or reproduction of this message is strictly prohibited. If you have received this message in error, please immediately notify the sender by telephone and destroy the original message. We regret any inconvenience and appreciate your cooperation.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

September 12, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

Provider Number: 44-0133

Dear Mr.Sherry:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Baptist Hospital on **September 4, 2012.** You are requested to submit a Plan of Correction by **September 22, 2012** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to **October 19, 2012.** Please notify this office when these deficiencies are corrected.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Please submit the Plan of Correction (POC), by **September 22, 2012:**

Office of Health Licensure and Regulation
Lakeshore Park, Bldg. One
5904 Lyons View Pike
Knoxville, TN 37919

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice.
- How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction State Form.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If you have any questions, please contact this office at (865) 588-5656 or by facsimile at (865) 594-5739.

Sincerely,

Karen B. Kirby/mad

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

Enclosure: CMS-2567

TN00030295

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	440133		C 09/04/2012

NAME OF PROVIDER OR SUPPLIER: BAPTIST HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the nursing staff educated patients adequately before discharge for one (#3) of five patients reviewed. The findings included: Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID	A 395	For current and future patients new triggers have been added to our computerized medical record system which triggers an individualized care plan to include diabetes education and insulin education based on individual experience with insulin use. As for patients that may have been affected in the past, a random audit of known diabetics over the past six months will be conducted seeking patients who have been discharged with new prescriptions of insulin. Five per month will be examined unless the total new insulin patients is less then 5 in a given month. If documented education is not found, patients will be given appointments with the Diabetes Center for education at no charge. Education for all nurses regarding individualizing care plans for diabetics is in process (began 9/28/12) with extended deadline to cover nurses who may be on leave of absence.	9/25/12 10/19/12 11/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	440133		C 09/04/2012

NAME OF PROVIDER OR SUPPLIER: BAPTIST HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	Continued From page 1 (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4,	A 395	Concurrent audits of diabetic patients by the Diabetes center nurses for a period of six months. Audits will include monitoring care plans, will be reviewed monthly by Kathie Hirsch, CNO and Deborah Roberts, Director, Quality/Risk. Discharge planning for patients regarding diabetes will be initiated with admission assessment and will be incorporated within the care plan including insulin teaching for the patient, significant others, and home caregivers. This will include return demonstrations. Depart process includes triggers for education of patients and significant others regarding injectable insulin including return demonstration and written materials to take home. The Diabetes Center nurses are also available to assist.	10/8/12 - 4/8/2013 9/25/12 9/25/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	440133		C 09/04/2012

NAME OF PROVIDER OR SUPPLIER: BAPTIST HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 2000 CHURCH ST, NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	Continued From page 2 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 395		
A 820	482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan. (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an appropriate discharge plan to meet the needs of patients for one (#3) of five patients reviewed. Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...", Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units	A 820	Education for all nurses regarding diabetic patient discharge instructions, return demonstration of insulin administration by patient and significant other is currently in process and will be extended to allow for nurses on leave of absence. Concurrent audits by Diabetes Center nurses regarding depart diabetes education, return demonstration if going home with new injectable insulin prescriptions for a period of 6 months. Will be reviewed monthly by Kathie Hirsch, CNO and Deborah Roberts, Director, Quality/Risk.	11/30/12 10/8/12 - 4/8/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
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	440133	A. BUILDING B. WING	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 820	Continued From page 3 each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin	A 820		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING B. WING	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER
BAPTIST HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE
2000 CHURCH ST
NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 820	Continued From page 4 administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4, 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 820	Diabetes Center was not asked to consult on this patient. Normal triggers for diabetes educators include blood sugars >180 and A1C >8. Neither applied in this situation. The electronic medical record system will now include a prompt for nursing to consult Diabetes Educator if necessary to ensure all patients are evaluated and educated.	

PRINTED: 09/07/2012
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53132	A. BUILDING B. WING	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-1 Initial During complaint investigation of #30295, conducted on September 4, 2012, at Baptist Hospital, no deficiencies were cited in relation to the complaint under 1200-8-1, Standards for Hospitals.	H 001		

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

October 31, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

RE: 44-0133

Dear Mr. Sherry:

The East Tennessee Region of Health Care Facilities conducted a complaint investigation on September 4, 2012. A desk review was conducted, based on that review; we are accepting your plan of correction and are assuming that your facility is in compliance with all participation requirements as of October 19, 2012.

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-588-5656 or by fax: 865-594-5739.

Sincerely,

Karen B. Kirby/kg

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

TN00030295

Attachment D

Copy of Published Public Notice
Letter of Intent

Tab 24

Attachment D

Copy of Published Public Notice

Public Notices

0000215594

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Saint Thomas Midtown Hospital, an existing acute care hospital, owned by Saint Thomas Midtown Hospital with an ownership type of not-for-profit and to be managed by Saint Thomas Midtown Hospital intends to file an application for a Certificate of Need for a full service, 24-hour-per-day/7-day-per-week satellite emergency department facility for patients who require care on an emergency basis. The project will be located at 791 Old Hickory Blvd., Brentwood, Davidson County, TN 37027. The project will be a satellite of the main emergency department at Saint Thomas Midtown Hospital and will be under the sole administrative control of Saint Thomas Midtown Hospital. The project will be physically connected to Premier Radiology Brentwood, located at 789 Old Hickory Blvd., Brentwood, Davidson County, TN 37027. The total number of treatment rooms will be eight. New construction will total 9,250 square feet of space. The total project costs are estimated to be $6,757,172.

Saint Thomas Midtown Hospital in Nashville is licensed by the Board for Licensing Healthcare Facilities as a 683-bed acute care hospital. The proposed satellite emergency department facility will provide the same full emergency diagnostic and treatment services as at the main hospital, but will utilize the adjacent Premier Radiology Brentwood imaging center for diagnostic services such as CT and MRI. The project does not contain major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements. The anticipated date of filing the application is: December 15, 2014. The contact person for this project is Blake Estes, Executive Director of Strategy & Planning, who may be reached at Saint Thomas Health, 102 Woodmont Blvd., Suite 800, Nashville, Tennessee, 37205, 615-284-3990.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 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 25

Attachment D

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

DEC 15 '14 PM 1:01

LETTER OF INTENT

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before 12/10 (Month / day), 2014 (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 Midtown Hospital (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

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

and to be managed by: Saint Thomas Midtown Hospital intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: a full service, 24-hour-per-day/7-day-per-week satellite emergency department facility for patients who require care on an emergency basis. The project will be located at 791 Old Hickory Blvd., Brentwood, Davidson County, TN 37027. The project will be a satellite of the main emergency department at Saint Thomas Midtown Hospital and will be under the sole administrative control of Saint Thomas Midtown Hospital. The project will be physically connected to Premier Radiology Brentwood, located at 789 Old Hickory Blvd., Brentwood, Davidson County, TN 37027. The total number of treatment rooms will be eight. New construction will total 9,250 square feet of space. The total project costs are estimated to be $6,757,172. Saint Thomas Midtown Hospital in Nashville is licensed by the Board for Licensing Healthcare Facilities as a 683-bed acute care hospital. The proposed satellite emergency department facility will provide the same full emergency diagnostic and treatment services as at the main hospital, but will utilize the adjacent Premier Radiology Brentwood imaging center for diagnostic services such as CT and MRI. The project does not contain major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements.

The anticipated date of filing the application is: December 15, 2014

The contact person for this project is Blake Estes (Contact Name) Executive Director of Strategy & Planning (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 / 284-3990 (Area Code / Phone Number)

(Signature) 12/9/2014 (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.

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

Revised letter

January 2, 2015

Blake Estes, Executive Director of Strategy & Planning
Saint Thomas Health
102 Woodmont Blvd., Suite 800
Nashville, TN 37205

RE: Certificate of Need Application -- Saint Thomas Midtown Hospital (Emergency Department at Brentwood) - CN1412-049
The establishment of a satellite emergency department physically with 8 treatment rooms at 718 Old Hickory Boulevard in Brentwood (Davidson County). The facility will be physically connected to Premier Radiology. The estimated project cost is $6,757,172.00. [NOTE: This application will be heard as a simultaneous review with TriStar Southern Hills Emergency Department at I-65 - CN1412-050.]

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 complete by this office. Your application is being forwarded to the Tennessee Department of Health for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on January 1, 2015. The first sixty (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 sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on March 25, 2015.

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, CON Director, Division of Health Statistics

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: January 2, 2015

RE: Certificate of Need Application
Saint Thomas Midtown Hospital (Emergency Department at Brentwood) - CN1412-049

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 January 1, 2015 and end on March 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Blake Estes, Executive Director of Strategy & Planning

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 Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before 12/10 (Month / day), 2014 (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 Midtown Hospital (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

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

and to be managed by: Saint Thomas Midtown Hospital intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: a full service, 24-hour-per-day/7-day-per-week satellite emergency department facility for patients who require care on an emergency basis. The project will be located at 791 Old Hickory Blvd., Brentwood, Davidson County, TN 37027. The project will be a satellite of the main emergency department at Saint Thomas Midtown Hospital and will be under the sole administrative control of Saint Thomas Midtown Hospital. The project will be physically connected to Premier Radiology Brentwood, located at 789 Old Hickory Blvd., Brentwood, Davidson County, TN 37027. The total number of treatment rooms will be eight. New construction will total 9,250 square feet of space. The total project costs are estimated to be $6,757,172. Saint Thomas Midtown Hospital in Nashville is licensed by the Board for Licensing Healthcare Facilities as a 683-bed acute care hospital. The proposed satellite emergency department facility will provide the same full emergency diagnostic and treatment services as at the main hospital, but will utilize the adjacent Premier Radiology Brentwood imaging center for diagnostic services such as CT and MRI. The project does not contain major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements.

The anticipated date of filing the application is: December 15, 2014

The contact person for this project is Blake Estes (Contact Name) Executive Director of Strategy & Planning (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 / 284-3990 (Area Code / Phone Number)

(Signature) 12/10/2014 (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.

Additional Information Supplemental #1 -Original-

ST Thomas Midtown Hospital (Emergency Department at Brentwood)

CN1412-049

SUPPLEMENTAL #1
December 29, 2014
2:50 pm

Saint Thomas Health

December 29, 2014

Via Hand Delivery

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application CN1412-049
Saint Thomas Midtown Hospital (Emergency Department at Brentwood)

Dear Mr. Earhart:

This is the second set of supplemental responses for the project referenced above. The first set was submitted to the Agency earlier today, before noon. Once again, **our responses are provided in triplicate.**

For ease of reference, question numbers below are from the original Agency request dated December 22, 2014. Responses to parts of four questions are addressed.

---

3. **Section A., Applicant Profile, Item 6**

The provided lease appears to be between Old Hickory Partners, LLC and Middle Tennessee Imaging, LLC d/b/a Premier Radiology. The Agency will need a deed, a purchase agreement, lease agreement, option to lease or other legal document which demonstrates the applicant has a legitimate legal interest in the property on which to locate the project. A fully executed (signed by both parties) Option to Purchase must at least include the expected purchase price, a description of the property with address and the anticipated date of closing. A fully executed Option to Lease must at least include the expected term of the lease and the anticipated lease payments.

102 Woodmont Blvd., Suite 800
Woodmont Centre
Nashville, TN 37205
SaintThomasHealth.com

Response: A fully executed Lease Assignment document from Middle Tennessee Imaging, LLC to the applicant is provided here in **Attachment A** at the same lease terms and payments as the original lease.

13. **Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)**

    c. Please provide a projected data chart for the proposed Satellite Emergency Room only.

    Response: Due to scheduling constraints over the holidays, the projected data chart submitted earlier today failed to account for an annual increase in gross charges per visit. Net charges per visit were correct, requiring adjustments here to deductions as well. Please see **Attachment B**.

14. **Section C, Economic Feasibility, Item 5 and 6**

The average gross charge, average deduction from operating revenue, and average net charge is noted. However, there is no Projected Data Chart for the proposed Emergency room to verify the charges. A request to provide a projected data chart for the proposed satellite emergency room has been requested; please check the charges against the requested Projected Data Chart. If needed, please revise charges on pages 34 and 39.

Response: Charge revisions to pages 34 and 39 are provided below.

Page 34 – Based on Year 2 projections (FY2018), the average gross patient charge per emergency department visit is $2,482. The average deduction from gross patient charges, based on contractual allowances and allowances for charity care and bad debt, is approximately 80%, resulting in average net revenue per visit of approximately $484.

Page 39 – Midtown Hospital presents the current and projected charges for an emergency department visit in Exhibit 20. An annual increase of 3% between FY2014 and Year 1 of the project, FY2017, is projected. Afterwards, the hospital assumes that charges will increase by 3% annually.

EXHIBIT 20

MIDTOWN HOSPITAL EMERGENCY DEPARTMENT, HOSPITAL-BASED AND SATELLITE AVERAGE GROSS CHARGE PER VISIT, CURRENT AND PROJECTED

	Current	FY2017	FY2018
Gross Charge	$2,205	$2,410	$2,482
Adjustment	$1,818	$1,926	$1,998
Net Revenue	$387	$484	$484

17. **Section C, Economic Feasibility, Item 9**

a. The participation of Mid-Town Hospital in state and federal programs is noted. However, please address the question specific to the proposed satellite emergency room project.

Response: Midtown's satellite ER will be licensed as part of Midtown Hospital and will follow Midtown Hospital's existing payor contracts.

Like Midtown Hospital, the satellite ER also will participate in both the Medicare and TennCare/Medicaid programs and will provide patient care regardless of payor source. Based on Year One projected data, Midtown's satellite ER will have an estimated payor mix (based on gross charges) of 36.8% Medicare, 6.0% Medicaid/TennCare and 10.1% self pay. In addition, Midtown satellite ER proposes to provide $592,869 in charity care in Year 1 and $843,252 in Year 2.

We hope these additional responses are sufficient to deem this CON application complete. A notarized affidavit is provided in **Attachment C**.

Given the holiday timing, I may be reached by cell at 615.504.8761 or by email at Blake.Estes@sth.org to clarify any other matters.

Sincerely,

Blake Estes
Executive Director, Strategy & Planning

attachments

SUPPLEMENTAL #1

December 29, 2014
2:50 pm

Attachment A

SUPPLEMENTAL #1
December 29, 2014
2:50 pm

This instrument was prepared by and upon
recordation should be returned to:

Berry Holt, Esq.
Bradley Arant Boult Cummings LLP
1600 Division Street, Suite 700
Nashville, Tennessee 37203

ASSIGNMENT AND ASSUMPTION OF GROUND LEASE

THIS ASSIGNMENT AND ASSUMPTION OF GROUND LEASE (the "Agreement") is made and entered into effective as of the 29th day of December, 2014 (the "Effective Date"), by and between MIDDLE TENNESSEE IMAGING, LLC, a Tennessee limited liability company ("Assignor"), SAINT THOMAS MIDTOWN HOSPITAL, a Tennessee non-profit corporation ("Assignee"), and OLD HICKORY PARTNERS, LLC, a Tennessee limited liability company ("Landlord").

WITNESSETH:

WHEREAS, Assignor and Landlord are parties to that certain Ground Lease, executed April 9, 2014 (the "Ground Lease"), pursuant to which Ground Lessor leases to Assignor certain real property located in Brentwood, Davidson County, Tennessee;

WHEREAS, Assignor now desires to assign the Ground Lease to Assignee, subject to the terms hereof; and

WHEREAS, Landlord is the landlord under the Ground Lease and desires to consent to the foregoing and the terms of this Agreement.

NOW, THEREFORE, for the covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Assignor, Assignee and Landlord hereby agree as follows:

1. Agreement. Assignor hereby sells, transfers, assigns, delivers and conveys to Assignee, its successors and assigns, all right, title and interest of Assignor in, to and under the Ground Lease.

2. Assumption. Assignee hereby assumes all of the obligations and duties of Assignor under the Ground Lease.

3. Indemnity. Assignor agrees to indemnify, defend (with counsel reasonably satisfactory to Assignee) and hold harmless Assignee for, from and against all third party claims and associated lawsuits, damages, costs and expenses arising out of or resulting from (i) any default by Assignor under the Ground Lease that occurred prior to the Effective Date or (ii) Assignor's failure to pay any amounts due under the Ground Lease allocable to periods prior to the Effective Date or perform any obligations of Assignor arising under the Ground Lease prior to the Effective Date or as a result of any matter occurring prior to the Effective Date.

4. Consent. Landlord hereby consents to this Agreement and the assignment of the Ground Lease pursuant hereto.

5. Certifications. Landlord and Assignor each hereby represents and warrants to Assignee that, as of the Effective Date: (i) it has not previously assigned its interest in the Ground Lease and has the

right, power and authority to enter into this Agreement, without obtaining the consent of any person or entity; (ii) a true, accurate and complete copy of the Ground Lease is attached hereto as Exhibit A, and (iii) to its actual knowledge, neither Assignor nor Landlord is in default under the Ground Lease and no matter exists that with the giving of notice, the passage of time or both would constitute such a default.

6. Reimbursement of Rent and Other Costs. Within thirty (30) days after the Effective Date, Assignee shall reimburse Assignor for (i) all monthly Rent (as defined in the Ground Lease) paid to Landlord by Assignor under the Ground Lease prior the Effective Date; and (ii) all other costs and expenses that Assignor has paid relating to the real property leased pursuant to the Ground Lease, as provided to Assignee in an itemized statement.

7. Re-Assignment Option.

(a) Assignor and Assignee acknowledge that Assignee has submitted an application for a certificate of need to permit the operation of a free standing emergency room on the Premises (the "CON"). In the event Assignee has not received the CON by January 1, 2016, then Assignor shall have the option to have Assignee re-assign all of its right, title and interest under the Ground Lease to Assignor (the "Re-Assignment Option"). In the event Assignor desires to exercise the Re-Assignment Option, it shall notify Assignee, in writing, on or before March 30, 2016 (the "Option Expiration Date"). If Assignor does not exercise the Re-Assignment Option prior to the Option Expiration Date, then the Re-Assignment Option shall terminate automatically and be of no further force or effect.

(b) If Assignor exercises the Re-Assignment Option, then Assignor, Assignee and Landlord agree that: (i) Assignor and Assignee shall promptly enter into a written agreement pursuant to which Assignee shall assign to Assignor all of Assignee's right, title and interest in, to and under the Ground Lease; (ii) Assignor shall reassume all its obligations and duties under the Ground Lease; (iii) Assignee shall be released from its obligations and liabilities under the Ground Lease and this Agreement; and (iv) Saint Thomas Health ("STH") shall be released from all of its obligations and liabilities under that certain Unlimited Continuing Guaranty executed by STH, dated December 29TH, 2014, pursuant to which STH guaranteed the satisfaction of certain of Assignee's obligations and liabilities under the Ground Lease. Landlord hereby consents to and agrees to be bound by the Re-Assignment Option and the terms of this Section 7.

8. Miscellaneous. This Agreement shall be governed by and construed under the laws of the State of Tennessee. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns. All exhibits referenced in this Agreement are incorporated herein. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original, and all such counterparts together shall constitute one and the same instrument. The prevailing party in any lawsuit arising out of or related to this Agreement shall be entitled to recover the reasonable attorneys' fees, court costs and litigation expenses it incurs in connection with such lawsuit from the non-prevailing party therein.

[SIGNATURES ON FOLLOWING PAGE]

SUPPLEMENTAL #1

December 29, 2014
2:50 pm

IN WITNESS WHEREOF, Assignor, Assignee and Landlord have executed this Agreement as of the day and year first above written.

ASSIGNOR:

MIDDLE TENNESSEE IMAGING, LLC

By: _____
Name: Ryan Brown
Title: General Counsel

ASSIGNEE:

SAINT THOMAS MIDTOWN HOSPITAL

By: _____
Name: CRAIG POLKOW
Title: CFO

LANDLORD:

OLD HICKORY PARTNERS, LLC

By: _____
Name: Arthur Hicks
Title: Chief Manager

Saint Thomas Health is signing below for internal approval purposes only. It is not a party to this Agreement.

SAINT THOMAS HEALTH

By: _____
Name: CRAIG POLKOW
Title: CFO

SUPPLEMENTAL #1
December 29, 2014
2:50 pm

STATE OF TN)
)
COUNTY OF DAVIDSON)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared RYAN BROWN, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the GENERAL COUNSEL of MIDDLE TENNESSEE IMAGING, LLC, the within named bargainor, a Tennessee limited liability company, and that he/she as such GENERAL COUNSEL, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the company by himself/herself as such GENERAL COUNSEL.

WITNESS my hand and seal at office in Nashville, Tennessee, on this the 29 day of DEC, 2014.

Diane Franklin
NOTARY PUBLIC

My Commission Expires: 1/9/2018

DIANE FRANKLIN
NOTARY PUBLIC AT LARGE
DAVIDSON COUNTY, TENN.

STATE OF TN)
)
COUNTY OF DAVIDSON)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared CRAIG POLKOW, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the CFO of SAINT THOMAS MIDTOWN HOSPITAL, the within named bargainor, a Tennessee not-for-profit corporation, and that he/she as such CFO, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself/herself as such CFO.

WITNESS my hand and seal at office in Nashville, Tennessee, on this the 29 day of DEC, 2014.

Diane Franklin
NOTARY PUBLIC

My Commission Expires: 1/9/2018

DIANE FRANKLIN
NOTARY PUBLIC AT LARGE
DAVIDSON COUNTY, TENN.

SUPPLEMENTAL #1
December 29, 2014
2:50 pm

STATE OF TN)
)
COUNTY OF DAVIDSON)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared _____, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the _____ of OLD HICKORY PARTNERS, LLC, the within named bargainor, a Tennessee limited liability company, and that he/she as such _____, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the company by himself/herself as such _____.

WITNESS my hand and seal at office in Nashville, Tennessee, on this the 29 day of Dec, 2014.

NOTARY PUBLIC

My Commission Expires: 1/9/2018

DIANE FRANKLIN
DAVIDSON COUNTY

SUPPLEMENTAL #1

December 29, 2014
2:50 pm

Attachment B

SUPPLEMENTAL #1
December 29, 2014
2:50 pm

PROJECTED DATA CHART - Midtwon Satellite ED

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

		Fiscal Yr 2017	Fiscal Yr 2018
A.	Utilization Data (ER Visits)	6,155	8,439
B.	Revenue from Services to Patients		
1.	Inpatient Services		
2.	Outpatient Services		
3.	Emergency Services	$14,833,550	$20,945,598
4.	Other Operating Revenue (Specify)		
	Gross Operating Revenue	$14,833,550	$20,945,598
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$11,039,222	$15,701,344
2.	Provision for Charity Care	$592,869	$843,252
3.	Provisions for Bad Debt	$225,290	$320,436
	Total Deductions	$11,857,381	$16,865,031
NET OPERATING REVENUE		$2,976,169	$4,080,567
D.	Operating Expenses		
1.	Salaries and Wages	$1,624,920	$2,223,957
2.	Physician's Salaries and Wages		
3.	Supplies	$474,477	$650,546
4.	Taxes		
5.	Depreciation	$205,745	$209,860
6.	Rent	144,000	144,000

SUPPLEMENTAL #1
December 29, 2014
2:50 pm

7. Interest, other than Capital		
8. Management Fees:		
a. Fees to Affiliates	0	0
b. Fees to Non-Affiliates	0	0
9. Other Expenses (See details below)	$609,680	$742,884
Total Operating Expenses	$3,058,822	$3,971,248
E. Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)	($82,653)	$109,319
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	($82,653)	$109,319

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Fiscal Yr 2017	Fiscal Yr 2018
1. Purchased Services	$344,680	$472,584
2. Technology Expense	$50,000	$51,000
3. Miscellaneous	$215,000	$219,300
4.		
5.		
6.		
7.		
Total Other Expenses	**$609,680**	**$742,884**

SUPPLEMENTAL #1

December 29, 2014
2:50 pm

Attachment C

SUPPLEMENTAL #1

December 29, 2014
2:50 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SAINT THOMAS MIDTOWN HOSPITAL

I, S. 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, STRATEGY & PLANNING
(Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 29 day of Dec, 2014, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires Jan 9, 2018.

DIANE FRANKLIN
NOTARY PUBLIC AT LARGE
DAVIDSON COUNTY, TENN.

HF-0043

Revised 7/02

Saint Thomas Health

DEC 11 PM 4:27

December 11, 2014

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

Re: Request for Simultaneous Review
Saint Thomas Midtown Hospital Satellite Emergency Department

Dear Ms. Hill:

Saint Thomas Midtown Hospital is requesting simultaneous review of its certificate of need application for an eight treatment room satellite emergency department located in Brentwood, Tennessee with an application for a similar project filed by TriStar Southern Hills.

Saint Thomas Midtown Hospital's Letter of Intent was filed on December 10, 2014, and TriStar Southern Hill's Letter of Intent was filed December 8, 2014.

An affidavit verifying that Saint Thomas Midtown Hospital has complied with all procedural requirements for simultaneous review and a stamped copy of the Letter of Intent are attached hereto.

Sincerely,

Blake Estes

Enclosures
cc: John Wellborn, Development Support Group

102 Woodmont Blvd., Suite 800
Woodmont Centre
Nashville, TN 37205
SaintThomasHealth.com

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

Blake Estes, being first duly sworn, says that he is the Executive Director, Strategy and Planning for Saint Thomas Health, and the contact person for Saint Thomas Midtown Hospital, which is seeking to establish a satellite emergency department in Brentwood, Tennessee.

Affiant states that the Letter of Intent for the project was filed with the Health Services and Development Agency and simultaneously published in a newspaper of general circulation on December 10, 2014, and that he was advised at that time that a Letter of Intent for a similar project had been filed by TriStar Southern Hills on December 8, 2014.

Affiant further states that a copy of the Letter of Intent for the Saint Thomas Midtown Hospital project has been hand delivered to John Wellborn, contact person for the other applicant.

Affiant further states that he is submitting this verified statement to establish that Saint Thomas Midtown Hospital has complied with all procedural requirements for simultaneous review.

S. BLAKE ESTES

Sworn to and subscribed before me this 11th day of December, 2014, a Notary Public, in and for the County/State of Tennessee.

Sonja Rene' Ward

NOTARY PUBLIC

My commission expires: March 8, 2016

(Month/Day) (Year)

SONJA RENE' WARD STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TENN.

My Commission Expires MAR. 8, 2016

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

DEC 11 '14 AM 1:27

LETTER OF INTENT

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before 12/10 (Month / day), 2014 (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 Midtown Hospital (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

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

and to be managed by: Saint Thomas Midtown Hospital intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: a full service, 24-hour-per-day/7-day-per-week satellite emergency department facility for patients who require care on an emergency basis. The project will be located at 791 Old Hickory Blvd., Brentwood, Davidson County, TN 37027. The project will be a satellite of the main emergency department at Saint Thomas Midtown Hospital and will be under the sole administrative control of Saint Thomas Midtown Hospital. The project will be physically connected to Premier Radiology Brentwood, located at 789 Old Hickory Blvd., Brentwood, Davidson County, TN 37027. The total number of treatment rooms will be eight. New construction will total 9,250 square feet of space. The total project costs are estimated to be $6,757,172. Saint Thomas Midtown Hospital in Nashville is licensed by the Board for Licensing Healthcare Facilities as a 683-bed acute care hospital. The proposed satellite emergency department facility will provide the same full emergency diagnostic and treatment services as at the main hospital, but will utilize the adjacent Premier Radiology Brentwood imaging center for diagnostic services such as CT and MRI. The project does not contain major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements.

The anticipated date of filing the application is: December 15, 2014

The contact person for this project is Blake Estes (Contact Name) Executive Director of Strategy & Planning (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 / 284-3990 (Area Code / Phone Number)

(Signature) 12/10/2014 (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
-Original-

ST Thomas Midtown Hospital (Emergency Department at Brentwood)

CN1412-049

SUPPLEMENTAL #1
December 29, 2014
11:48 am

December 29, 2014

Via Hand Delivery

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application CN1412-049
Saint Thomas Midtown Hospital (Emergency Department at Brentwood)

Dear Mr. Earhart:

Thank you for acknowledging receipt of our December 15, 2014 application for a Certificate of Need to establish a full service, 24 hour per day/7 day per week satellite emergency department to be located at 791 Old Hickory Blvd., Brentwood (Davidson County), TN 37027.

We received your request for supplemental information on December 23rd. **Our responses, below, are provided in triplicate by the deadline of 12:00 noon, Monday December 29, 2014.**

---

1. **Section A., Applicant Profile, Item 2**

   The email contact address of the applicant is listed as blake.estes@sth.org in the letter of intent and the application lists the email address as blake.estes@stthomas.org. Please clarify.

   Response: Due to an update of email systems, the correct email contact address of the applicant is blake.estes@sth.org. A replacement page is provided in **Attachment 1.**

2. **Section A., Applicant Profile, Item 5**

   Please indicate if the proposed emergency department satellite will be operated by a management/operating entity.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Response: The emergency department will be under the sole administrative control of Saint Thomas Midtown Hospital. No management entity is planned.

3. **Section A., Applicant Profile, Item 6**

The provided lease appears to be between Old Hickory Partners, LLC and Middle Tennessee Imaging, LLC d/b/a Premier Radiology. The Agency will need a deed, a purchase agreement, lease agreement, option to lease or other legal document which demonstrates the applicant has a legitimate legal interest in the property on which to locate the project. A fully executed (signed by both parties) Option to Purchase must at least include the expected purchase price, a description of the property with address and the anticipated date of closing. A fully executed Option to Lease must at least include the expected term of the lease and the anticipated lease payments.

Response: A fully executed Option to Sublease is provided in **Attachment 2,** at the same lease terms and payments as the original lease.

4. **Section B, Project Description, Item I.**

a. What is the distance between the applicant's proposed satellite emergency room and TriStar's simultaneously proposed satellite emergency room located at the NE intersection of Old Hickory Boulevard and American Way, Brentwood, TN 37250?

Response: The distance between the two sites is 0.4 miles according to Google Maps.

b. In light of the fact that this is one of two simultaneous review applications does the applicant believe there is a need for two satellite ERs in essentially the same location?

Response: Although located less than a mile apart, both proposed projects share only one defined zip code – 37027, Brentwood/ Nashville. As described in the original CON application (page 19), population growth alone is projected to generate demand in Davidson and Williamson counties for 15 additional treatment rooms excluding planned room closures at West Hospital and TriStar Centennial Medical Center.

c. What will the applicant do if this application is denied?

Response: Saint Thomas Midtown Hospital remains confident that its proposed project demonstrates need, financial feasibility, and will contribute to the orderly development of healthcare, and thus, does not anticipate a denial of the satellite emergency department.

However, in the event of a denial, Saint Thomas Health will re-assess the medical needs of South Davidson county and Williamson county and

SUPPLEMENTAL #1
December 29, 2014
11:48 am

respond in the most responsible, effective way possible in its effort to improve the health of the communities it serves.

d. Please indicate the distance from the proposed satellite emergency room to hospitals in the two county service area.

Response: There are 10 hospital emergency departments in the two county (Davidson and Williamson) service area if one also includes the TriStar Centennial Spring Hill satellite emergency department in adjacent Maury County. Of these 10 sites,

- the nearest are TriStar Southern Hills Medical Center at 6.5 miles and Williamson Medical Center at 9.7 miles
- the furthest are TriStar Spring Hill ER at 26.0 miles, TriStar Summit Medical Center at 18.1 miles and TriStar Skyline Medical Center at 17.4 miles
- while affiliated Saint Thomas Midtown Hospital and Saint Thomas West Hospital are 10.3 and 10.9 miles away, respectively.

A profile of driving distances from zip code 37027, where the proposed site is located, to all 11 facilities is provided in the response to question 5.c below. All distances are based on driving estimates from Google Maps.

e. Please provide an overview of the applicant's experience in operating a satellite emergency room.

Response: Saint Thomas Health operates four successful emergency departments in Middle Tennessee that provided more than 167,000 visits in fiscal year 2014. Emergency medicine requires the same resources and expertise, regardless of its location and adjacency to full-service hospitals. The applicant expects no change in the level of service and care for its patients in its satellite emergency department.

Additionally, there are four satellite emergency departments within Ascension Health and two more in the implementation phases in other markets. The applicant, along with its local and national resources, remains confident that it can serve the service area's communities in a safe and qualitative manner.

f. It is noted the applicant states both Midtown and West Hospital emergency have high utilization rates. However, what are the plans of the hospital if the proposed satellite ER does not have an impact on the ER utilization at the main campus and ER visits continue to increase with capacity issues at the main ER?

Response: As successful healthcare planners familiar with the facility operations and services area needs, a shift of patients from the hospital-based ERs to the satellite ER is fully expected. If volumes continue to increase at the hospital-based ERs, for whatever reasons, Saint Thomas

Health will evaluate additional options including other satellite emergency department locations.

g. Please indicate if the applicant will be contracting with a physician group to provide physician services in the proposed satellite ER. If so, please provide a brief overview of the Emergency Physician Group that will be staffing the ER.

Response: Yes, Midtown Hospital will contract with its existing hospital-based ER physician groups to provide physician services in the proposed satellite ER. This will help extend quality and continuity of patient care from the hospital-based ERs to the satellite ER.

As described in the CON application, this project will be staffed with the assistance of the 39 existing board-certified emergency medicine physicians in two groups now providing services at Midtown Hospital and West Hospital. Profiles of these physicians are provided in **Attachment 3.** Final operational details are pending CON approval.

h. What happens if a patient who should have gone to an acute care hospital goes to/is brought to a satellite ER?

Response: With only two exceptions, many patients are at least 10 miles from any type of ER and perhaps even farther from a hospital with heart surgery. The question of which patients "should have gone" to an acute care hospital initially is difficult to determine. When every minute counts in a true emergency, the most appropriate ER may in fact be the one without hospital beds.

The Midtown Satellite ER will be fully staffed, equipped and licensed like a hospital-based ER. Patients requiring a hospital bed or other services available only at a full-service hospital will be triaged and stabilized at the satellite ER then transported by ambulance to a Saint Thomas hospital for appropriate follow up care.

i. It is noted the applicant is planning to provide MRI services at the proposed satellite ER. What are the advantages of having an MRI available in an ER?

Response: MRI is typically not required on an emergent basis but MRI services are already available at the proposed site. Thus, MRI may be considered a "value added" service when required for joint and spinal conditions, chronic pain, etc.

j. Please clarify if the proposed satellite ER will include a helipad.

Response: Due to site limitations, the proposed satellite ER will not have a helipad provided. A helipad is not required for licensure, and this was clarified with the State of Tennessee Department of Health prior to

application. However, the project will have 24/7 ambulance service on-site for expedited transports of acute care patients.

k. Please describe the proposed "flex" psychiatric room. Please clarify if it will be secured.

Response: The "flex" psychiatric exam room will be equipped with all psychiatric security provisions required by all authorities having jurisdiction and applicable codes. The use of sliding wall panels, for example, allows for quick conversion to a standard exam room as the patient mix requires.

l. Please describe the trauma room.

Response: The trauma room is designed as a multiple-bay trauma room as defined within the 2010 AIA Guidelines for Healthcare facilities.

m. Please clarify if mobile crisis staff will have access to conduct assessments. If so, where? Where will law enforcement be located?

Response: Yes, Mobile Crisis staff will have access to conduct an assessment in the patient care area and/or the patient treatment room. If law enforcement agencies are accompanying a patient or needs to interact with the patient, accommodations will be made in the patient care area and/or treatment room.

n. Many times emergency room copays are waived if the patient is admitted inpatient. Please clarify if this arrangement is possible at the proposed satellite ER.

Response: Yes, such arrangements are possible at the satellite ER if they are offered at a traditional hospital-based ER. The Midtown Satellite ER will be licensed and operated as part of Midtown Hospital. All hospital-based billing arrangements, including co-pays and indigent/charity care policies, are applicable to the satellite ER.

o. On Monday December 15, 2014, Tennessee Gov. Bill Haslam unveiled his Insure Tennessee plan, a two year pilot program to provide health care coverage to Tennesseans who currently don't have access to health insurance or have limited options. The program rewards healthy behaviors, prepares members to transition to private coverage, promotes personal responsibility and incentivizes choosing preventative and routine care instead of unnecessary use of emergency rooms. What will the impact of Insure TN have on the applicant's volume projection?

Response: First, Saint Thomas Health's services and facilities are offered to all patients in need of care regardless of payor source. Second, it is widely accepted that uninsured populations are underserved because they pursue as little healthcare as possible due to high costs. Therefore, Saint

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Thomas Health seeks to provide the right care at the right time in the right place. The MissionPoint accountable care organization (ACO) is designed to link patients to primary care physicians and a medical home, thus avoiding the use of the ED as a primary care or urgent care clinic. Based on preliminary information available so far, the Insure Tennessee plan is expected to have a minimal impact on Midtown Hospital's Satellite ER volume projections.

p. Please clarify if an ambulance will be stationed at the satellite ED 24 hours/day, 7days/week, 365 days/year for life-threatening transports to full service hospitals.

Response: The proposed satellite ED will have dedicated ambulance service 24/7, provided by Saint Thomas Emergency Medical Services (STEMS), to expedite urgent and emergent transfers to full-service hospitals.

q. The applicant mentions $208,125 in related site work. Please describe the related site work and clarify if it is reflected in the Project Cost Chart.

Response: The related site work includes such items as reworked site grading, site utilities, site lighting, site paving, curbing, etc. This number is included within the Project Cost Chart provided within the initial application.

5. **Section B, Project Description, Item III.B.1**

a. Please clarify why the applicant expects patients to not access the proposed emergency room via public transportation.

Response: The Satellite ER is not intended to be a primary care or urgent care clinic. Saint Thomas Health seeks to provide the right care at the right time in the right place. This is done two ways. First, the MissionPoint accountable care organization (ACO) is designed to link patients to primary care physicians and a medical home. Second, population health initiatives focus on quality and accessible care. Both strive to avoid using the ER as a primary care or urgent care clinic. Those patients who initially might arrive at the Satellite ER by public transportation (i.e., bus) will be connected with primary care physicians and a medical home to avoid future unnecessary ER utilization.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

b. Is the proposed site served by public transportation? If so, please briefly describe.

Response: The proposed site is served by Nashville MTA buses, providing both express and local service to downtown Nashville and connecting with other routes throughout the area. Two bus routes are profiled in **Attachment 4.**

c. Please complete the following table that shows distance to existing ERs for the applicant's primary service area zip codes:

Response: Please see the tables below for driving distances and times to existing ERs in the Midtown Hospital Satellite ER's primary service area zip codes. Based on Google maps, the average driving distance is 23.6 miles and the average driving time is 32.3 minutes.

As reported previously, select point-to-point measures from the Midtown Hospital Satellite ER are:

- the nearest - TriStar Southern Hills Medical Center at 6.5 miles and Williamson Medical Center at 9.7 miles
- the furthest - TriStar Spring Hill ER at 26.0 miles, TriStar Summit Medical Center at 18.1 miles and TriStar Skyline Medical Center at 17.4 miles
- affiliated Saint Thomas Midtown Hospital and Saint Thomas West Hospital - 10.3 and 10.9 miles, respectively.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Driving Distance (in Miles) to Existing ERs
Primary Service Area Zip Codes

	37069 Franklin	37027 Brentwood/ Nashville	37067 Franklin	37135 Nolensville	37064 Franklin	37179 Thompson's Station
Vanderbilt University Medical Center	12.8	16.3	23.0	26.8	22.5	32.9
Saint Thomas West Hospital	11.6	16.6	23.3	27.1	21.4	33.2
Saint Thomas Midtown Hospital	13.7	16.0	22.7	26.5	27.6	32.6
TriStar Centennial Medical Center	14.2	17.2	23.9	27.7	23.9	33.8
Metropolitan Nashville General Hospital	15.7	16.8	23.4	27.2	28.4	33.4
TriStar Skyline Medical Center	22.5	23.2	29.8	29.7	34.8	39.8
TriStar Southern Hills Medical Center	15.7	8.7	19.0	11.3	23.9	28.9
TriStar Summit Medical Center	25.5	23.8	30.5	28.5	35.4	40.4
Williamson Medical Center	11.9	7.9	3.8	9.8	9.5	14.5
TriStar Spring Hill ER	28.1	24.1	20.5	29.0	17.4	7.4

Note: Zip code 37024 includes PO boxes in zip code 37027
Note: Zip code 37065 includes PO boxes in zip code 37064
Note: Zip code 37068 includes PO boxes in zip code 37064
Source: Google Maps

Driving Time (in Minutes) to Existing ERs
Primary Service Area Zip Codes

	37069 Franklin	37027 Brentwood/ Nashville	37067 Franklin	37135 Nolensville	37064 Franklin	37179 Thompson's Station
Vanderbilt University Medical Center	28	23	28	34	40	39
Saint Thomas West Hospital	23	22	26	33	35	37
Saint Thomas Midtown Hospital	31	22	26	32	39	37
TriStar Centennial Medical Center	30	25	30	36	42	40
Metropolitan Nashville General Hospital	29	24	28	35	41	39
TriStar Skyline Medical Center	40	35	35	39	47	45
TriStar Southern Hills Medical Center	30	18	25	24	38	36
TriStar Summit Medical Center	38	29	33	35	46	44
Williamson Medical Center	23	14	7	16	22	21
TriStar Spring Hill ER	36	28	23	31	27	19

Note: Zip code 37024 includes PO boxes in zip code 37027
Note: Zip code 37065 includes PO boxes in zip code 37064
Note: Zip code 37068 includes PO boxes in zip code 37064
Source: Google Maps

6. **Section B, Project Description, Item IV**

   The floor plan of the proposed satellite is noted. However, please indicate why the applicant believes waiting room with a capacity of 14 is adequate to serve an 8 treatment room emergency room.

   Response: While there are no governing codes dictating the number of waiting chairs within a Satellite ER, a standard department of this size is typically programmed at 1.5 chairs per exam room. This Satellite ER waiting room has been sized appropriately to allow for 1-2 family members within the treatment space.

7. **Section C, Need. Item 1 (Project Specific Criteria) Construction, Renovation, Item 3.a**

   How were these standards developed (Industry 1500 and HCA 1800)? Did they consider factors such as average minutes per room, average minutes per level of care and room occupancy differences between 7-3, 3-11, and 11-7 shifts? If yes, how so?

   Response: A search of literature from the American College of Emergency Physicians (ACEP) did not reveal any recent articles on the development of the 1,500 visits per treatment room per year standard. However, an August 14, 2014 article in ACEP *Now* titled, "Emergency Department Benchmarking Alliance Reports on Data Survey for Next Generation ED Design," cites 1,368 "patients seen per ED bed" as the 2013 survey result for Adult EDs.

   Midtown Hospital cannot respond to the HCA 1800 benchmark.

8. **Section C, Need. Item 1 (Project Specific Criteria) Construction, Renovation, Item 3.b**

   The applicant states 2 emergency department rooms are being lost to provide space for a CT scanner at the West Hospital. Please clarify the reason why the applicant chose to lose two emergency rooms at the West hospital while the applicant states ER utilization is high at the West hospital. Were there any other alternatives in choosing the site of the CT scanner other than in the 2 ER rooms?

   Response: The CT was needed for streamlining quality and timely patient care. Due to space limitations in and around the West ED, the only viable option was to locate the CT where existing treatment rooms were. This was not a desirable option, but the only one available. This decision has improved patient care but stressed throughput.

9. **Section C, Need, Item 4. A and B**

   a. Population projections in Exhibits 8-14 are noted. However, please revise to reflect 2014 and 2018 population projections.

      Response: Revised pages for Exhibits 8-14 and accompanying text are provided in **Attachment 5**.

   b. Please provide population projections for the ZIP Codes in the proposed service area.

      Response: ZIP Code level pages, similar to Exhibits 8-14 above, and accompanying text are provided in **Attachment 6**.

10. **Section C, Need, Item 5.**

   a. It is noted in Exhibit 15 Saint Thomas West is the only hospital in the service area to experience a decline in ED utilization from 2011-2013. Please provide factors that have influenced the decline.

      Response: Both Saint Thomas West Hospital and Saint Thomas Midtown Hospital are consolidating services across both campuses in order to achieve operational efficiencies and provide higher quality patient outcomes. As healthcare reimbursement transitions from volume-based to value-based, Saint Thomas Health seeks to provide the right care at the right time in the right place. The MissionPoint accountable care organization (ACO) is designed to link patients to primary care physicians and a medical home, thus avoiding the use of the ED as a primary care or urgent care clinic.

      While West Hospital's ED visits declined an average of 0.9% annually from 2011 to 2013, ED visits at Midtown Hospital increased an average of 1.6% annually. In this context, ED visits across the health system actually increased. More important than the trend at a single hospital is the trend in demand for ED services in the proposed nine zip code service area, where ED visits increased 2.0% annually. Please refer to data presented in the original CON application, Exhibit 3, page 16.

   b. Also, what percentage ER patients typically are admitted as inpatients and what percentage of ER patients are typically admitted for observation. Please discuss the pros and cons of these patients going to an ER at a

hospital versus going to a satellite ER that would require a transfer by ambulance.

Response: In fiscal year 2014, approximately 16% of Saint Thomas Midtown Hospital emergency department patients were admitted as an inpatient and approximately 7% were admitted as an observation patient.

As these data indicate, more than three quarters of ER patients do not require a bed of any type, be it a regular inpatient bed or an observation bed. For the vast majority of ER patients, care at a satellite ER can be delivered more quickly, closer to home, with less travel time to downtown Nashville.

For the minority of ER patients who do require a bed of some type for at least a few hours, care at a satellite ER also can be delivered more quickly, closer to home and with less travel time to downtown Nashville. Every minute counts in a true emergency. An ambulance transfer is a minor inconvenience compared to more quickly stabilizing a patient in an emergent and potentially life threatening condition.

c. It appears that ER visits both Midtown and West combined only increased 1.1% between 2011 and 2013. Please explain the need to add ER capacity at all.

Response: Based upon industry standards for ER utilization, existing treatment rooms at both Midtown and West are at capacity. Please refer to data presented in the original CON application, Exhibit 16, page 28. In 2013, Midtown's ER operated at 95.6% capacity while West's ED was at 75.9% capacity. Combined, both facilities were at 86.8% capacity and West is slated to lose two ED treatment rooms to provide space for a much needed ED CT scanner. It is very difficult to expand further when already at capacity.

11. **Section C, Need, Item 6.**

a. Please provide ER trends for all hospitals in service area, including a sub-total for all Tri-Star hospitals and for all Saint Thomas hospitals.

Response: Data are presented below, as requested, from the Joint Annual Reports for hospitals. Of particular note is the increased reporting of patients who left area ERs without being seen.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

	Presented in ER		
Hospital ER	**2011**	**2012**	**2013**
Saint Thomas Midtown Hosp	50,050	52,064	51,643
Saint Thomas West Hosp	33,973	34,174	33,400
Subtotal STH	**84,023**	**86,238**	**85,043**
TriStar Centennial Med Cntr	34,534	38,774	48,146
TriStar Skyline Med Cntr	52,637	56,707	54,922
TriStar Southern Hills Med Cntr	36,633	41,520	42,383
TriStar Summit Med Cntr	47,191	52,870	51,552
Subtotal HCA	**170,995**	**189,871**	**197,003**
Nashville Gen Hosp	33,199	34,214	36,536
Vanderbilt Univ Hosps	109,987	114,051	128,136
Williamson Med Cntr	35,961	37,946	36,184
Total	**434,165**	**462,320**	**482,902**

	Treated in ER		
Hospital ER	**2011**	**2012**	**2013**
Saint Thomas Midtown Hosp	50,050	52,064	51,643
Saint Thomas West Hosp	33,637	33,490	33,006
Subtotal STH	**83,687**	**85,554**	**84,649**
TriStar Centennial Med Cntr	34,534	38,774	48,146
TriStar Skyline Med Cntr	50,749	54,742	54,598
TriStar Southern Hills Med Cntr	36,083	40,632	41,495
TriStar Summit Med Cntr	47,981	52,862	50,834
Subtotal HCA	**169,347**	**187,010**	**195,073**
Nashville Gen Hosp	33,199	34,214	36,536
Vanderbilt Univ Hosps	109,987	114,051	119,225
Williamson Med Cntr	35,396	37,716	36,176
Total	**431,616**	**458,545**	**471,659**

	ER Patients Presented then Left		
Hospital ER	**2011**	**2012**	**2013**
Saint Thomas Midtown Hosp	0	0	0
Saint Thomas West Hosp	336	684	394
Subtotal STH	**336**	**684**	**394**
TriStar Centennial Med Cntr	0	0	0
TriStar Skyline Med Cntr	1,888	1,965	324
TriStar Southern Hills Med Cntr	550	888	888
TriStar Summit Med Cntr	-790	8	718
Subtotal HCA	**1,648**	**2,861**	**1,930**
Nashville Gen Hosp	0	0	0
Vanderbilt Univ Hosps	0	0	8,911
Williamson Med Cntr	565	230	8
Total	**2,549**	**3,775**	**11,243**

Source: TN Joint Annual Reports

b. Historical ER visits in application don't match with JAR. Please explain. If needed, please revise and resubmit historical ER visit data.

Response: ER visits are reported in the JARs two ways – as patients presenting and as patients treated. Not all patients presenting in the ER are eventually treated in the ER. When using JAR data, Midtown's application focused on the lower and more conservative numbers of patients treated as opposed to patients presenting.

A second data source is the Tennessee Hospital Association's ER patient origin data. While there are some discrepancies between the THA and JAR data, this is not unusual and does not materially alter the conclusions of need for additional ED capacity in Midtown's proposed service area.

c. If a Davidson County health care provider opened an urgent care close to the proposed satellite ER site, what impact would that cause on the projected utilization? Are there existing urgent care centers in the applicant's service area?

Response: As indicated below, five urgent care centers have been identified in Midtown's proposed service area. As indicated in the map in **Attachment 7,** one is already very close to Midtown's proposed site. This

is not a concern for Midtown's proposed 24/7 satellite ER as most urgent care centers are open fewer hours and serve patients with lesser acuity.

Local Urgent Care Centers

Facility	Zip Code
CareSpot Urgent Care	37027
Fast Pace Urgent Care Clinic	37027
Physicians Urgent Care	37027
CareSpot Urgent Care	37067
Concentra	37067

Source: Google

d. Please clarify if there is a shortage of primary care physicians in the applicant's service area that would force patients to go to an emergency room for routine treatment.

Response: There is a shortage of primary care physicians nationwide and Midtown's service area is no different. At the same time, healthcare reimbursement for both providers and patients is transitioning from volume-based to value-based. Saint Thomas Health seeks to provide the right care at the right time in the right place. The MissionPoint accountable care organization (ACO) is designed to link patients to primary care physicians and a medical home, thus avoiding the use of the ED as a primary care or urgent care clinic. MissionPoint was the first ACO in the Nashville area and, with approximately 110,000 covered lives, is the largest in Middle Tennessee.

e. Please complete the following table for ER patient origin by zip code for CY 2014 (January-October Annualized) for zip codes with patient origin over 0.15%.

Response: Please refer to **Attachment 8** for requested data for Midtown Hospital.

f. Please complete the following table for Mid-Town Hospital Patients Presenting 2012-2018 by level Acuity.

Response: Requested data are presented below.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Mid-Town Hospital Emergency Department Patients Presenting 2012-2-18 By Level of Acuity							
						Satellite Yr 1	Satellite Yr 2
	2012	2013	2014	2015	2016	2017	2018
Main ED							
Level I	3,431	3,407	3,221	3,367	3,468	3,536	3,603
Level II	9,497	9,432	8,916	9,321	9,601	9,787	9,974
Level III	13,291	13,201	12,479	13,046	13,437	13,698	13,959
Level IV	19,342	19,210	18,160	18,984	19,554	19,933	20,313
Level V	6,425	6,381	6,032	6,306	6,495	6,621	6,747
Subtotal	51,985	51,630	48,808	51,024	52,555	53,575	54,596
Satellite ED							
Level I						406	557
Level II						1,125	1,542
Level III						1,574	2,158
Level IV						2,290	3,140
Level V						761	1,043
Subtotal						6,155	8,439
Total Combined ED's	51,985	51,630	48,808	51,024	52,555	59,730	63,035

g. Please define levels I-V in the above chart.

Response: Descriptions are provided below.

Level 1 - Non-urgent: needs treatment when time permits
Level 2 - Semi-urgent: not life threatening
Level 3 - Urgent: not life threatening
Level 4 - Emergency: could become life threatening
Level 5 - Immediate: life threatening

h. Please complete the following chart for patient projection by Zip code in Yr. One of the proposed satellite ED project (2017) for zip codes with patient origin over 0.15%.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Response: Year Two patient projections down to 0.15% equals just 13 patients and are not feasible for individual zip codes. Patient locations which we feel can be projected with some basis of accuracy are presented below, based on population distribution among the zip codes.

Patient Zip Code	Patient City	Patient County	Total	Cumulative Patients	% by Zip Code	Cumulative %	Projected Patients 2017
37024/37027	Brent./Nash.	D/W	2,383	2,383	28.2%	28.2%	2,383
37064/37065, 068	Franklin	W	2,239	4,622	26.5%	54.8%	2,239
37067	Franklin	W	1,150	5,772	13.6%	68.4%	1,150
37069	Franklin	W	907	6,679	10.7%	79.1%	907
37135	Nolensville	W	466	7,145	5.5%	84.7%	466
37179	Thomp. Sta.	W	527	7,672	6.2%	90.9%	527
Subtotal			7,672	7,672	90.9%	90.9%	7,672
Other Davidson	Various	D	256	7,928	3.0%	93.9%	256
Other Williamson	Various	W	256	8,184	3.0%	96.9%	256
Other	Various	n/a	256	8,440	3.0%	99.9%	256
Total			8,439				8,439

i. Please provide patient destination by ZIP Code in proposed ZIP Code service area for 2013 in the table below.

Response: Requested data are presented below.

	Zip Codes									
Hospital ER	**37024**	**37027**	**37064**	**37065**	**37067**	**37068**	**37069**	**37135**	**37179**	**Total**
Saint Thomas Midtown Hosp	11	485	201	1	107	3	105	78	35	1,026
Saint Thomas West Hosp	17	610	314	7	116	5	348	40	44	1,501
Subtotal STH	**28**	**1,095**	**515**	**8**	**223**	**8**	**453**	**118**	**79**	**2,527**
TriStar Centennial ED Spring Hill		9	130	1	11		8	2	583	744
TriStar Centennial Med Cntr	5	563	280	4	185	3	113	99	77	1,329
TriStar Skyline Med Cntr	3	67	40	1	22		15	8	5	161
TriStar Southern Hills Med Cntr	10	673	130		68	2	27	212	22	1,144
TriStar Summit Med Cntr	5	76	56		25		13	20	13	208
Subtotal HCA	**23**	**1,388**	**636**	**6**	**311**	**5**	**176**	**341**	**700**	**3,586**
Nashville Gen Hosp	4	66	47		10		14	24	7	172
Vanderbilt Univ Hosps	32	2,018	1,553	9	705	36	703	385	303	5,744
Williamson Med Cntr	21	3,091	9,554	28	3,708	42	1,429	621	1,487	19,981
All Other Facilities	20	497	559	9	212	27	138	570	189	2,221
Total	**128**	**8,155**	**12,864**	**60**	**5,169**	**118**	**2,913**	**2,059**	**2,765**	**34,231**

Source: THA Market IQ

SUPPLEMENTAL #1
December 29, 2014
11:48 am

12. **Section C. Economic Feasibility Item 1 (Project Cost Chart) and Item 3**

    It is noted the applicant lists construction costs as $2,477,683 in the Project Costs Chart. Please clarify why the construction costs are listed as $2,685,808 in a construction letter dated December 8, 2014 located in Attachment C.

    Response: The architect's construction letter cites "aggregate" construction costs, which are a combination of construction of $2,477,683 plus site preparation of $208,125 for a total of $2,685,808.

13. **Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)**

    a. The applicant reported figures in the Historical and Projected Data Chart in the thousands. Please revise these charts to reflect the actual figures and resubmit.

       Response: The values reported in the Historical and Projected Data Chart, rounded to the nearest thousand dollars, are consistent with the financial audit presentation prepared by Ernst & Young and provided in Tab 15, Attachment C of the original CON application. With annual historical revenues at Midtown well in excess of $1.3 billion dollars, the extra detail "missing" in an amount of even $999.99 represents a "rounding error" of less than 0.00007%, or seven one-hundred-thousands of one percent. We respectfully ask the Agency to evaluate the data provided, as provided, which conforms to public accounting standards. This format is also consistent with information provided by Midtown in previous CON applications and previously accepted by the Agency.

    b. Please provide a historical data chart for Mid-Town Hospital's Emergency Department.

       Response: Please see **Attachment 9**.

    c. Please provide a projected data chart for the proposed Satellite Emergency Room only.

       Response: Please see **Attachment 10**.

d. The Historical and Projected Data Charts are noted. However, please clarify what services are represented in the charts. Are the charts for the West and Mid-town Hospital combined? Please label the charts with which hospital or services are reflected in the charts.

Response: The Historical and Projected Data Charts are presented for the applicant only, Midtown Hospital. All services at Midtown Hospital are included. Re-labeled charts are presented in **Attachment 11**.

14. **Section C, Economic Feasibility, Item 5 and 6**

The average gross charge, average deduction from operating revenue, and average net charge is noted. However, there is no Projected Data Chart for the proposed Emergency room to verify the charges. A request to provide a projected data chart for the proposed satellite emergency room has been requested; please check the charges against the requested Projected Data Chart. If needed, please revise charges on pages 34 and 39.

Response: Requested information has been provided. Charge revisions on pages 34 and 39 are not required.

15. **Section C, Economic Feasibility, Item 6B**

Exhibit 21 is noted. However, please explain the "service mix index" and the "Service Mix Average charge to 1.00".

Response: The service mix index is a measure of patient acuity used by CMS for Medicare patients to differentiate levels of patient care required. The higher the index value, the greater the patient's needs and the greater the provider's reimbursement.

To compare charges from one facility to another, one must first adjust for different levels of patient acuity at each facility. This is accomplished by dividing the facility average charge by the facility service mix index, or comparing charges at all facilities as if they had a common service mix index equal to 1.00.

16. **Section C, Economic Feasibility, Item 8**

A projected data chart has been requested from the applicant for the proposed Satellite Emergency room. If the requested Projected Data Chart shows losses in

the first two years of the proposed project, when does the applicant expect to break even with this project?

Response: Midtown's project is expected to be profitable in Year Two.

17. **Section C, Economic Feasibility, Item 9**

a. The participation of Mid-Town Hospital in state and federal programs is noted. However, please address the question specific to the proposed satellite emergency room project.

Response: Midtown's satellite ER will be licensed as part of Midtown Hospital and will follow Midtown Hospital's existing payor contracts.

Like Midtown Hospital, the satellite ER also will participate in both the Medicare and TennCare/Medicaid programs and will provide patient care regardless of payor source. Based on Year One projected data, Midtown's satellite ER will have an estimated payor mix (based on gross charges) of 36.8% Medicare, 6.0% Medicaid/TennCare and 10.1% self pay. In addition, Midtown satellite ER proposes to provide $532,571 in charity care in Year 1 and $730,198 in Year 2.

b. What is the payor mix of ERs in the service area?

Response: 2013 data from the Tennessee Hospital Association are presented below.

ER Visits by Payor, 9 Zip Service Area, 2013

Payer Group	Total	Percentage
BC/BS & BC Managed Care	9,187	26.8%
Medicare	8,600	25.1%
Comm & Comm Managed Care	7,833	22.9%
Self-Pay	3,701	10.8%
TennCare	3,699	10.8%
All Other	862	2.5%
Cover Tennessee	282	0.8%
Indigent / Free Care	47	0.1%
Medicaid (not Tenncare)	22	0.1%
Unknown	1	0.0%
Total	**34,234**	**100.0%**

Source: THA Market IQ

18. Section C, Economic Feasibility, Item 10

The Acension Consolidated Balance Sheet ending June 30, 2014 list current total liabilities in the amount of $5,014,449,000 and total current assets in the amount of $4,622,537,000. Please clarify the financial feasibility of the project when current liabilities exceed current assets by $391,912,000. If needed, please provide additional Financial Statements that demonstrates financial feasibility.

Response: Concern of the financial feasibility of the project is surprising. Construction cost for the proposed project is less than $5 million. The same balance sheet referenced indicates over $618 million in cash and equivalents, so the expenditures represent less than 1% of cash on hand. The project possesses full support of Saint Thomas Health and Ascension, and additional debt or any other financing is not required for the project. The applicant, along with its parent company Saint Thomas Health, is investing hundreds of millions of dollars into improving healthcare delivery in Middle Tennessee, and this project represents a minute expense in the company's overall investment into its health system.

For reference, a Saint Thomas Health balance sheet for the period ended November 30, 2014, represented in thousands of dollars, is provided in **Attachment 12**.

19. Section C, Orderly Development, Item 1.

a. What is the closest hospital to the proposed satellite emergency room? Is there a transfer agreement with that hospital? If not, why?

Response: The nearest hospitals are TriStar Southern Hills Medical Center at 6.5 miles and Williamson Medical Center at 9.7 miles. While the proposed Midtown Satellite ED does not have a transfer agreement with these two facilities, affiliated Saint Thomas Midtown Hospital and Saint Thomas West Hospital are only 10.3 and 10.9 miles away, respectively. Given a common patient registration system, medical record and physician staffing, ED patients are expected to be transferred within the Saint Thomas Heath system to promote continuity and quality of patient care. Furthermore, a STEMS ambulance and crew will be based at the satellite ED 24/7.

b. Please define the Emergency Medical Treatment and Labor Act (EMTALA).

Response: The CMS.gov web site, opening paragraph, defines EMTALA this way, "In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented." Like the hospital ED, the Midtown Satellite ED will also comply with EMTALA regulations.

c. Please indicate where emergency OB patients will be referred for treatment from the proposed satellite ER. Also, please clarify if the OB patients would be admitted directly to the receiving facility, or would need to admit through the receiving hospital's ER.

Response: Like other patients described above, OB patients will be transferred to Midtown Hospital. Midtown has an OB triage area and satellite ED patients will be registered already at Midtown through the Satellite ED admission and intake processes.

20. Section C, Orderly Development, Item 2.

a. Please explain the difference between an Urgent Care Clinic and a Satellite ER. Please include hours of operation, the patient costs (including copay) for each service, and any CPT code overlap.

Response: The Physician Urgent Care Clinic, for example, is only open 9:00 a.m. to 9:00 p.m., 7 days, whereas the Satellite ED is a 24/7 facility including all holidays. Midtown's Satellite ED will have the same payment policies as its hospital ED. While a freestanding ED is probably more costly than an urgent care center, Midtown's Satellite ED will be accessible to TennCare and indigent/charity care patients.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

b. Please complete the following chart indicating if the following conditions can be treated at an urgent care, hospital emergency room, or satellite ER.

Response: Though we have attempted to comply by completing the chart, the categories provided by the Agency are very generic and extremely broad. For example, a "broken bone" can refer to a fractured finger or a fractured femur, each requiring vastly differently levels of care.

Condition/Need	Urgent Care	Saint Thomas Midtown ER	Proposed Satellite ER
Broken Bones	X	X	X
Basic Lab Services	X	X	X
Complex Lab Services		X	X
Basic Radiological Services	X	X	X
Complex Radiological Services		X	
Fevers/Rashes	X	X	X
Sore Throat/ Ear Infections	X	X	X
Orthopedic Care Requiring an MRI		X	X
Prescriptions Written	X	X	X
Migraines	X	X	X
Minor Burns	X	X	X
Respiratory Infections	X	X	X
X-Rays		X	X
Advanced Life Support		X	X
Severe Chest Pain		X	X
Deep Puncture Wounds		X	X
Traumatic Injuries		X	X
Dizziness	X	X	X
Patients in Labor with medical problems		X	X
Patients requiring surgery		X	X
The Flu	X	X	X
Back Pain	X	X	X
Sprains	X	X	X
Toothache	X	X	X

SUPPLEMENTAL #1
December 29, 2014
11:48 am

21. Section C, Orderly Development, Item 3.

a. Since the proposed service is a 24/7 service. Please complete the following chart:

Response: Staffing in any clinical hospital department, including a satellite ER, is fluid and changes often, depending on the volume trends of the department. Below is an estimate of staffing trends based on expected volumes by shift, but is subject to change as we respond to the changing volumes and clinical needs at the emergency department.

Position	7-3 # FTEs	3-11 # FTEs	11-7 # FTEs
RN	4.4	6.4	3.8
EVS Tech	1.4	2.1	1.2
Lab Tech	1.4	2.1	1.2
Registration	1.4	2.1	1.2
Pharmacy	0.4	0.6	0.3
Total	9.1	13.3	7.9

b. Please clarify if there will be security available at the proposed satellite ER. If so, why is it not included in the staffing?

Response: Adequate security coverage is planned for the site. It is anticipated to be a contacted service, so it is included in the "Other Expenses" category.

22. Section C, Orderly Development, Item 7.

The general Joint Commission Accreditation Quality Report is noted. Please provide a copy of the most recent Joint Commission survey that was issued to Midtown.

Response: The most recent Joint Commission survey is provided in **Attachment 13**.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

23. Project Forecast Completion Chart

The applicant has indicated the Agency initial decision date as December 2014 in the Project Forecast Completion Chart. The earliest this application will be heard by the agency is March 2015. Please revise and resubmit.

Response: A clerical error is noted in top line only. A revised page is included in **Attachment 14.**

We hope these responses are sufficient to deem this CON application complete. A notarized affidavit is provided in **Attachment 15**.

Given the holiday timing, I may be reached by cell at 615.504.8761 or by email at Blake.Estes@sth.org to clarify any other matters.

Sincerely,

Blake Estes
Executive Director, Strategy & Planning

attachments

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 1

SUPPLEMENTAL #1

December 29, 2014
11:48 am

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

Saint Thomas Midtown Hospital (Emergency Department at Brentwood)
Name

791 Old Hickory Boulevard	Davidson	
Street or Route	County	
Brentwood	Tennessee	37027
City	State	Zip Code

2. ***Contact Person Available for Responses to Questions***

Blake Estes		Executive Director, Strategy & Planning	
Name		Title	
Saint Thomas Health		Blake.Estes@sth.org	
Company Name		Email address	
102 Woodmont Boulevard, Suite 800	Nashville	Tennessee	37205
Street or Route	City	State	Zip Code
Exec. Director, Strategy & Planning		615-284-3990	615-284-7403
Association with Owner		Phone Number	Fax Number

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

Saint Thomas Midtown Hospital		615-284-6869
Name		Phone Number
102 Woodmont Blvd, Suite 800		Davidson
Street or Route		County
Nashville	Tennessee	37205
City	State	Zip Code

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

A. Sole Proprietorship	_____	F. Governmental (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	_____	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 2

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 3

SUPPLEMENTAL #1

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11/19/2014
07:49:15AM

BIOGRAPHICAL WORKSHEET

December 29, 2014
11:48 am

Allen, Brady W. MD

ID Number: 1548395320

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 11/2008
End Date: 12/2018
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 08/07/2012

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Virginia -Charlottesville	Medical School	Medicine		05/2004	Y	05/14/2007
Univ. of Virginia -Charlottesville	RESIDENCY	Emergency Medicine	06/2004	06/2007	Y	05/10/2007

SUPPLEMENTAL #1

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

December 29, 2014
11:48 am

Anderson II, Stephen D. MD

ID Number: 1770625972

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 892425
Exam Date:
Specialty in Directory: N
Start Date: 06/2009
End Date: 12/2019
Re Cert Start:
Re Cert End: 12/2019
Verified: Y
Date Verified: 09/04/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Quillen East Tennessee State Univ	Medical School	Medicine		05/2005	Y	06/13/2008
Univ. of Louisville-Medical School Student Affairs Office	RESIDENCY	Emergency Medicine	07/2005	05/2008	Y	06/09/2008

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

December 29, 2014
11:48 am

Beier, Kevin H. MD

ID Number: 1790738839

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 00960661
Exam Date:
Specialty in Directory: N
Start Date: 11/1997
End Date: 12/2017
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 01/10/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Virginia -Charlottesville	Medical School	Medicine		05/1993	Y	12/22/2009
Hennepin County Medical Center	RESIDENCY	Emergency Medicine	06/1993	06/1996	Y	01/04/2005

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Bollinger, Allison D. MD

ID Number: 1376719286

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/2012
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 04/19/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
University of Texas at Houston	Medical School	Medicine	08/2004	06/2008	Y	06/02/2011
Vanderbilt Univ Med Ctr	Internship / Residency	Emergency Medicine	07/2008	06/2011	Y	09/19/2011

SUPPLEMENTAL #1

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11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

December 29, 2014
11:48 am

Bonner, Kevin J. MD

ID Number: 1437186087

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 10/1986
End Date: 12/2016
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 11/26/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Dalhousie University	Medical School	Medicine	07/1974	06/1978	Y	06/18/2001
Dalhousie University	INTERNSHIP	Rotating	07/1978	06/1979	Y	03/12/2001

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11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Boutros, Nabil MD

ID Number: 1962493676

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 11/2001
End Date: 12/2021
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 12/12/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
University of Michigan School of Medicine	Medical School	Medicine		06/1997	Y	01/22/2007
Wright State Univ. School of Medicine	RESIDENCY	Emergency Medicine	07/1997	06/2000	Y	02/01/2007

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11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Brown, Mary Jane MD

ID Number: 1114953080

Board Certifications

Board: AM Board of Family Medicine
Certification: Family Medicine (General Cert)
Status: Expired
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 07/1984
End Date:
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 07/07/2010

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 11362
Exam Date:
Specialty in Directory: N
Start Date: 10/1989
End Date: 12/2019
Re Cert Start:
Re Cert End: 12/2019
Verified: Y
Date Verified: 12/23/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Missouri, Columbia	Medical School	Medicine		01/1980	Y	06/11/1993
Naval Hospital (Pendleton)	INTERNSHIP	Family Medicine	06/1980	06/1981	Y	07/12/1993
Naval Hospital (Pendleton)	RESIDENCY	Family Medicine	06/1982	06/1984	Y	07/12/1993

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Bruno, Eric C. MD

ID Number: 1619956539

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 11/2003
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 06/04/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Drexel University College of Medicine (Registrar)	Medical School			05/1999	Y	11/01/2010
Drexel University College of Medicine (Emergency Medicine)	Internship / Residency	Emergency Medicine	06/1999	06/2002	Y	11/12/2010

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Dovgalyuk, Jacqueline M. MD

ID Number: 1366645020

Board Certifications

Board:	AM Board of Emergency Medicine	**Status:**	Certified	**Start Date:**	11/2011	**Verified:**	Y
Certification:	Emergency Medicine (General Cert)	**Certification #:**		**End Date:**	12/2021	**Date Verified:**	01/23/2014
		Exam Date:		**Re Cert Start:**			
		Specialty in Directory:	N	**Re Cert End:**			

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Virginia -Charlottesville	Medical School	Medicine	08/2002	05/2007	Y	05/11/2010
Univ. of Virginia -Charlottesville	RESIDENCY	Emergency Medicine	07/2007	06/2010	Y	08/19/2010

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11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Fengler, Brian T. MD

ID Number: 1497968564

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 892295
Exam Date:
Specialty in Directory: Y
Start Date: 12/2009
End Date: 12/2019
Re Cert Start:
Re Cert End: 12/2019
Verified: Y
Date Verified: 09/04/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
State University of New York-Syracuse	Medical School	Medicine		05/2005	Y	02/12/2008
Univ. of Virginia -Charlottesville	INTERNSHIP	Emergency Medicine	07/2005	06/2006	Y	04/07/2008
Univ. of Virginia -Charlottesville	RESIDENCY	Emergency Medicine	07/2006	06/2008	Y	04/07/2008

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11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Fredericks, Charles E. MD

ID Number: 1104861624

Board Certifications

Board: AM Board of Family Medicine
Certification: Family Medicine (General Cert)
Status: Expired
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 07/1983
End Date:
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 03/20/2012

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 370172
Exam Date:
Specialty in Directory: N
Start Date: 02/1989
End Date: 12/2019
Re Cert Start:
Re Cert End: 12/2019
Verified: Y
Date Verified: 03/10/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Brown Univ	Medical School	Medicine		06/1980	Y	05/09/1997
Provenant Mercy Medical Center	RESIDENCY	Family Medicine	06/1980	06/1983	Y	07/17/1997

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11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Galloway, Russell E. MD

ID Number: 1265469936

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 15854
Exam Date: 10/24/2008
Specialty in Directory: Y
Start Date: 10/1988
End Date: 12/2018
Re Cert Start:
Re Cert End: 12/2018
Verified: Y
Date Verified: 03/19/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Vanderbilt University School of Medicine-Registrar	Medical School	Medicine		05/1984	Y	
Jacksonville Medical Center	INTERNSHIP	Internal Medicine	07/1984	06/1985	Y	07/03/1989
Jacksonville Medical Center	RESIDENCY	Emergency Medicine	07/1985	06/1987	Y	06/22/1993

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11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Hines, Bruce E. MD

ID Number: 1841226792

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 27826
Exam Date:
Specialty in Directory: Y
Start Date: 11/1999
End Date: 12/2019
Re Cert Start:
Re Cert End: 12/2019
Verified: Y
Date Verified: 03/24/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Marshall Univ	Medical School	Medicine	07/1991	05/1995	Y	12/18/2000
Univ. of Louisville-Medical School Student Affairs Office	INTERNSHIP	Emergency Medicine	07/1995	07/1996	Y	12/08/2000
Univ. of Louisville-Medical School Student Affairs Office	RESIDENCY	Emergency Medicine	07/1996	06/1998	Y	12/08/2000

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Hutton, Robert M. MD

ID Number: 1902836307

Board Certifications

Board:	AM Board of Emergency Medicine	**Status:**	Certified	**Start Date:**	01/1987	**Verified:**	Y
Certification:	Emergency Medicine (General Cert)	**Certification #:**	176484	**End Date:**	12/2016	**Date Verified:**	02/10/2014
		Exam Date:		**Re Cert Start:**			
		Specialty in Directory:	Y	**Re Cert End:**	12/2016		

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
West Virginia University	Medical School			05/1976	Y	07/07/1988
West Virginia University Hospital	INTERNSHIP	Psychiatry	07/1976	06/1977	Y	07/07/1988

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Koons, Donald C. MD

ID Number: 1558418418

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/2010
End Date: 12/2020
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 03/26/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Eastern Virginia Medical School	Medical School	Medicine	06/2002	06/2006	Y	05/12/2009
Vanderbilt University School of Medicine-Registrar	RESIDENCY	Emergency Medicine	07/2006	06/2009	Y	04/27/2009

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Lee, David G. MD

ID Number: 1760419196

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 12868
Exam Date:
Specialty in Directory: N
Start Date: 10/1989
End Date: 12/2018
Re Cert Start:
Re Cert End: 12/2018
Verified: Y
Date Verified: 02/27/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Tennessee College of Medicine	Medical School	Medicine		01/1972	Y	09/15/1978
Regional Medical Center at Memphis	INTERNSHIP	Internal Medicine	06/1973	06/1974	Y	10/23/1978
Regional Medical Center at Memphis	FELLOWSHIP	Internal Medicine	07/1974	06/1975	Y	10/23/1978

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Meers, Stanley D. MD

ID Number: 1962439224

Board Certifications

Board: AM Board of Internal Medicine
Status: Lifetime Certification
Start Date: 09/1982
Verified: Y
End Date:
Date Verified: 03/12/2014
Certification #:
Re Cert Start:
Certification: Internal Medicine (General Cert)
Exam Date:
Re Cert End:
Specialty in Directory: N

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Emory Univ School of Medicine	Medical School			01/1979	Y	06/21/1993
Keesler AFB Medical Center-IM Residency	INTERNSHIP	Internal Medicine	07/1979	06/1980	Y	08/31/1993
Keesler AFB Medical Center-IM Residency	RESIDENCY	Internal Medicine	07/1980	06/1982	Y	08/31/1993

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Reiter, Mark H. MD

ID Number: 1508969825

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/2007
End Date: 12/2017
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 10/15/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
UMDNJ Robert Wood Johnson Medical School	Medical School			05/2003	Y	07/26/2012
University of North Carolina Hospital	RESIDENCY	Emergency Medicine	06/2003	06/2006	Y	08/15/2012

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Robinson Jr., Robert Willard MD

ID Number: 1447287081

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Grandfathered
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 01/1990
End Date:
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 01/01/1990

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Tennessee College of Medicine	Medical School	Medicine		01/1983	Y	07/11/1988
Baptist Hospital	INTERNSHIP	Surgery, General	07/1983	06/1984	Y	11/23/1984

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Rosen, Jessica L. MD

ID Number: 1912170226

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/2012
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 12/09/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
University of Virginia School of Medicine	Medical School	Medicine	08/2004	05/2008	Y	03/22/2012
Vanderbilt Univ Med Ctr	Internship / Residency	Emergency Medicine	07/2008	06/2011	Y	03/13/2012

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Rubino, Jason M. DO

ID Number: 1952456527

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/2012
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 12/03/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Philadelphia College of Osteopathic Medicine	Medical School	Medicine	08/1999	06/2003	Y	07/14/2013
Naval Medical Center (Va)	INTERNSHIP	Transitional	06/2003	06/2004	Y	07/26/2013
St. Lukes University Hospital / Health Network	RESIDENCY	Emergency Medicine	07/2008	06/2011	Y	07/26/2013

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Russell, Brad W. MD

ID Number: 1245387109

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 891069
Exam Date:
Specialty in Directory: Y
Start Date: 12/2009
End Date: 12/2019
Re Cert Start:
Re Cert End: 12/2019
Verified: Y
Date Verified: 09/09/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Texas Southwestern Medical School at Dallas	Medical School	Medicine		06/2005	Y	06/25/2008
Vanderbilt University Medical Center	INTERNSHIP	Emergency Medicine	07/2005	06/2006	Y	06/20/2008
Vanderbilt University Medical Center	RESIDENCY	Emergency Medicine	07/2006	06/2008	Y	06/20/2008

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

St. Amant, Jeffrey S. MD

ID Number: 1366656597

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 11/2010
End Date: 12/2020
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 05/23/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
University of Alabama	Medical School	Medicine	06/2002	06/2006	Y	08/21/2012
University of Virginia School of Medicine	RESIDENCY	Emergency Medicine	06/2006	06/2009	Y	09/05/2012

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Tanner, Jenifer L. MD

ID Number: 1316094204

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 11/2008
End Date: 12/2018
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 05/29/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Morehouse School of Medicine	Medical School	Medicine		05/2004	Y	08/22/2007
Vanderbilt University Medical Center	RESIDENCY	Emergency Medicine	07/2004	08/2007	Y	08/22/2007

MIDAS+ Seeker
11/19/2014
07:52:23AM

BIOGRAPHICAL WORKSHEET

Taylor, Lauren L. MD

ID Number: 1265645303

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/2009
End Date: 06/2019
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 04/09/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
University of TN - Memphis	Medical School	Medicine	08/2001	05/2005	Y	09/19/2011
University of Virginia School of Medicine	RESIDENCY	Emergency Medicine	06/2005	06/2008	Y	09/21/2011

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Whetstone, David R. MD

ID Number: 1316155757

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 868726
Exam Date:
Specialty in Directory: N
Start Date: 11/2008
End Date: 12/2018
Re Cert Start:
Re Cert End: 12/2018
Verified: Y
Date Verified: 09/04/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
East Carolina University	Medical School	Medicine		05/2004	Y	07/10/2008
Univ. of Virginia -Charlottesville	RESIDENCY	Emergency Medicine	06/2004	06/2007	Y	07/18/2008

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Wilbert, Christopher D. MD

ID Number: 1982900437

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 05/2014
End Date: 12/2024
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 09/08/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Florida State University	Medical School	Medicine	05/2006	05/2010	Y	03/28/2014
New York Methodist Hospital	RESIDENCY	Emergency Medicine	05/2010	06/2013	Y	03/25/2014
Palmetto Health/University of South Carolina	FELLOWSHIP	Ultrasound	07/2013	06/2014	Y	09/04/2014

MIDAS+ Seeker
11/19/2014
07:49:18AM

BIOGRAPHICAL WORKSHEET

Woods III, Dexter L. MD

ID Number: 1497785992

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/2002
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 11/21/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Tennessee College of Medicine	Medical School	Medicine		06/1996	Y	10/11/2002
Wake Forest University School of Medicine	INTERNSHIP	Rotating	07/1996	06/1997	Y	10/14/2002
Wake Forest University School of Medicine	RESIDENCY	Radiology, Diagnostic	07/1997	06/1998	Y	10/14/2002
Wake Forest University School of Medicine	INTERNSHIP	Emergency Medicine	07/1998	06/1999	Y	10/14/2002
Wake Forest University School of Medicine	RESIDENCY	Emergency Medicine	07/1999	06/2001	Y	10/14/2002

SUPPLEMENTAL #1

MIDAS+ Seeker
11/18/2014
12:26:35PM

BIOGRAPHICAL WORKSHEET

December 29, 2014
11:48 am

Anderson III, Ansel Glen MD

ID Number: 1538112602

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 11/1994
End Date: 12/2014
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 08/28/2009

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Mississippi Medical Center-Dept Orthopaedic	Medical School	Medicine	08/1984	05/1988	Y	09/14/2005
Univ. of Mississippi Medical Center-Dept Orthopaedic	INTERNSHIP	Medicine	07/1988	07/1989	Y	09/14/2005
Univ. of Mississippi Medical Center-Dept Orthopaedic	RESIDENCY	Emergency Medicine	07/1989	06/1992	Y	09/14/2005
University of Alabama-Birmingham-Plastic Surg	FELLOWSHIP	Occupational Medicine	07/1995	06/1996	Y	09/14/2005

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Bergeron, Paul MD

ID Number: 1235182429

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/1994
End Date: 12/2014
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 07/06/2009

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Mississippi Medical Center-Dept Orthopaedic	Medical School	Medicine		05/1988	Y	04/30/1993
Univ. of Mississippi Medical Center School of Medicine	INTERNSHIP	Internal Medicine	07/1988	06/1989	Y	04/30/1993
Univ. of Mississippi Medical Center-Dept Orthopaedic	RESIDENCY	Internal Medicine	07/1989	06/1990	Y	04/30/1993
Univ. of Mississippi Medical Center-Dept Orthopaedic	RESIDENCY	Emergency Medicine	07/1990	06/1993	Y	04/30/1993

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Carpenter, George K. MD

ID Number: 1487632857

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 11/1997
End Date: 12/2017
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 01/18/2010

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Tennessee/Knoxville	Medical School	Medicine		06/1992	Y	04/19/2006
University of Cincinnati College of Medicine	INTERNSHIP	Emergency Medicine	06/1992	06/1993	Y	04/24/2006
University of Cincinnati College of Medicine	RESIDENCY	Emergency Medicine	07/1993	06/1996	Y	04/24/2006

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Caudill, Paul H. MD

ID Number: 1104083757

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 968553
Exam Date:
Specialty in Directory: N
Start Date: 06/2012
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 01/17/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
University of Louisville School of Medicine	Medical School	Medicine	08/2004	05/2008	Y	02/21/2013
East Carolina University	Internship / Residency	Emergency Medicine	07/2008	06/2011	Y	02/26/2013

MIDAS+ Seeker
11/18/2014
12:26:36PM

BIOGRAPHICAL WORKSHEET

Damp, Peter H. MD

ID Number: 1376594143

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 718172
Exam Date:
Specialty in Directory: N
Start Date: 06/2002
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 07/02/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Medical College of Georgia	Medical School	Medicine		06/1998	Y	04/09/2001
Vanderbilt School of Medicine	INTERNSHIP	Emergency Medicine	07/1998	06/1999	Y	04/13/2001
Vanderbilt School of Medicine	RESIDENCY	Emergency Medicine	07/1999	06/2001	Y	04/13/2001

MIDAS+ Seeker
11/18/2014
12:26:36PM

BIOGRAPHICAL WORKSHEET

Kaiser, Rachel T. MD

ID Number: 1376595900

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 07/1996
End Date: 12/2015
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 08/27/2009

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Tufts Univ School of Dental Medicine	Medical School	Medicine		05/1989	Y	05/31/1994
Univ of Chicago Hospitals	INTERNSHIP	Surgery, General	07/1989	06/1990	Y	05/16/1994
Univ of Chicago Hospitals	RESIDENCY	Emergency Medicine	07/1991	06/1994	Y	06/30/1994

MIDAS+ Seeker
11/18/2014
12:26:36PM

BIOGRAPHICAL WORKSHEET

McVie, Andrew K. MD

ID Number: 1518919224

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 06/2002
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 05/20/2013

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Louisiana State Univ School of Med-New Orleans	Medical School	Medicine		05/1998	Y	01/23/2002
Vanderbilt School of Medicine	INTERNSHIP	Emergency Medicine	06/1998	06/1999	Y	01/23/2002
Vanderbilt School of Medicine	RESIDENCY	Emergency Medicine	06/1999	06/2002	Y	01/23/2002

MIDAS+ Seeker
11/18/2014
12:26:36PM

BIOGRAPHICAL WORKSHEET

Motyka, Tracy MD

ID Number: 1104811843

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 11/2004
End Date: 12/2014
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 08/24/2009

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Vanderbilt University School of Medicine-Registrar	Medical School	Medicine	08/1996	05/2000	Y	09/02/2009
University of North Carolina Hospital	RESIDENCY	Emergency Medicine	06/2000	06/2003	Y	09/01/2009

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Myers, Timothy P. MD

ID Number: 1104879352

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #: 770757
Exam Date:
Specialty in Directory: N
Start Date: 06/2004
End Date: 12/2014
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 09/08/2014

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Univ. of Missouri, Columbia	Medical School	Medicine		06/2000	Y	10/31/2003
Vanderbilt School of Medicine	INTERNSHIP	Emergency Medicine	06/2000	06/2001	Y	10/17/2003
Vanderbilt School of Medicine	RESIDENCY	Emergency Medicine	07/2001	06/2003	Y	11/07/2003

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Pasto-Crosby, Douglas J. MD

ID Number: 1538110317

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 04/1992
End Date: 12/2022
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 05/20/2013

Board: AM Board of Family Medicine
Certification: Family Medicine (General Cert)
Status: Certified
Certification #:
Exam Date:
Specialty in Directory: N
Start Date: 07/1983
End Date: 12/2014
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified: 07/06/2009

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Suny Health Science Center	Medical School	Medicine		05/1980	Y	04/12/1991
Wilson Hospital	INTERNSHIP	Family Medicine	06/1980	06/1981	Y	04/12/1991
Wilson Hospital	RESIDENCY	Family Medicine	07/1981	06/1983	Y	04/12/1991

BIOGRAPHICAL WORKSHEET

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Roque Jr., Pedro J. MD

ID Number: 1316197775

Board Certifications

Board: AM Board of Emergency Medicine
Certification: Emergency Medicine (General Cert)
Status: Eligible
Certification #:
Exam Date:
Specialty in Directory: N
Start Date:
End Date:
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified:

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
Harvard Medical School	Medical School	Medicine	08/2004	06/2008	Y	04/10/2014
Albany Medical Center - Dept. of Orthopaedics	Internship / Residency	Orthopedic Surgery	07/2008	07/2010	Y	04/09/2014
Maricopa Medical Center	Internship / Residency	Emergency Medicine	07/2011	06/2014	Y	04/14/2014

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 4

MTA Schedule Displays Around Town

Andrew Johnson Building, 710 James Robertson Parkway
Anthem Career College, 560 Royal Parkway
Belmont University, 1900 Belmont Boulevard
Bridgestone Arena, 501 Broadway
City Hall & Metro Courts, 1 Public Square
Daymar Institute, 340 Plus Park Boulevard
Davy Crockett Building, 500 James Robertson Parkway
Justice A.A. Birch Building, 408 2nd Avenue North
Lincoln College of Technology, 1524 Gallatin Road
Looby Center and Library, 2301 Rosa L. Parks Boulevard
Metro Board of Education, 2601 Bransford Avenue
Metro General Hospital, 1818 Albion Street
MTA Madison Headquarters, 430 Myatt Drive
Music City Central, 400 Charlotte Avenue
Nashville Downtown Library, 615 Church Street
Peabody College Post Office, 230 Appleton Place
Riverfront Regional Rail Station, 108 1st Avenue North
Tennessee Dept. of Human Services, 1000 2nd Avenue North
Tennessee Performing Arts Center, 505 Deaderick Street
Tennessee State University, 3500 John A. Merritt Boulevard
Vanderbilt University Post Office, 2301 Vanderbilt Place
Watkins College of Art, Design & Film, 2298 Rosa L. Parks Boulevard
William R. Snodgrass Tennessee Tower, 311 7th Avenue North

For a list of other locations for specific areas, please call MTA Customer Care at **(615) 862-5950.**

Bus Stops

Most MTA bus stops are marked with a blue-and-white sign. If no bus stops are visible in the area where you wish to board, please go to the nearest intersection of the street traveled by your bus and flag the bus down when it comes into view.

Music City Central

The main transfer station is located at Music City Central (400 Charlotte Avenue).

Destination Signs

Every MTA bus is marked with a route number as well as the destination name or area. All express routes are designated by an "X" following the route number. If you have questions about where a bus is going, please ask the driver as you board.

Park & Ride

Several bus routes provide Park & Ride service, which allows you to park your car at no charge and ride an MTA bus. MTA passengers are permitted to use Park & Ride lots as complimentary services by owners of the lots.

Snow Route Detours

Be prepared for winter weather and pick up your MTA snow route detours brochure today. Snow route information may be found at MTA displays around town, on MTA buses, online at **nashvillemta.org**, or by calling Customer Care at **(615) 862-5950.**

Holiday Service

On the following major holidays, MTA operates service on a Sunday/Holiday schedule:
• New Year's Day • Memorial Day • Independence Day • Labor Day • Thanksgiving • Christmas
On Martin Luther King Jr. Day, MTA operates service on a Saturday schedule.

MTA Office Hours

Customer Care Call Center: **(615) 862-5950**
6:30 a.m. to 6:30 p.m. – Monday-Friday
8:00 a.m. to 5:00 p.m. – Saturday
10:30 a.m. to 2:30 p.m. – Sunday
Closed holidays

Ticket Sales and Information at Music City Central
400 Charlotte Avenue
6:00 a.m. to 6:30 p.m. – Monday-Friday
8:00 a.m. to 5:00 p.m. – Saturday
10:30 a.m. to 2:30 p.m. – Sunday
Closed holidays

Music City Central – Hours of Operation
400 Charlotte Avenue
5:15 a.m. to 11:15 p.m. – Monday-Friday
6:00 a.m. to 10:15 p.m. – Saturday
6:00 a.m. to 9:15 p.m. – Sundays and holidays

Administrative Offices: **(615) 862-5969**
430 Myatt Drive, Nashville, TN 37115
8:00 a.m. to 4:30 p.m. – Monday-Friday
Closed weekends and holidays

Metropolitan Transit Authority
430 Myatt Drive, Nashville, TN 37115

designed by CHK America – chkamerica.com

EasyRide Commuter Benefits

Adult – Local, Airport & BRT Lite Services $1.70
Express Service $2.25
Senior ..... $ .85
(ages 65 and older, please show driver proof of age before depositing fare)
People with Disabilities and Medicare Cardholders ..... $ .85
(please show driver special identification card before depositing fare)
Youth Fare $1.00
(ages 19 and younger, please alert driver before depositing fare and be prepared to show proof of age upon request)
Children ages 4 and younger ..... No Charge

Fares

Benefits to employers

- Saves tax dollars
- On-site parking becomes a non-issue
- Less-stressed employees

Benefits to employees

- Cuts taxable income
- Reduces car expenses
- Arrive at work relaxed

For more information, contact MTA at **(615) 862-5969** *or ask your Human Resources Director about commuter benefits.*

EasyRide
MTA-RTA COMMUTER PROGRAM

Services for Medicare Cardholders, Seniors, or People with Disabilities

Medicare cardholders, who are not elderly or disabled, qualify for a reduced MTA fare of 85 cents on MTA buses with their Medicare ID.

Seniors age 65 and older and people with disabilities qualify for a reduced MTA fare of 85 cents on MTA buses with one of the following ID cards: Medicare, Seniors-MTA Golden Age, or drivers license; Disabled-Medicare, MTA Special Service, or other transit ID card for the disabled.

Passengers whose disabilities prevent them from using the large MTA buses may qualify for special door-to-door van service through the MTA AccessRide Program. Please call the MTA AccessRide Office at **(615) 880-3970** for more information or visit the MTA website at **nashvillemta.org.**

MTA Passes

For your convenience, passes are available for purchase at Music City Central (400 Charlotte Avenue), online at **nashvillemta.org**, or by phone at (615) 862-5950. In addition, passes may be requested via mail by sending the request to the MTA Administrative Office address.

All-Day Pass	$5.25	7-Day Pass	$24.00
All-Day		31-Day Pass	$84.00
Discounted Pass	$3.25	31-Day	
All-Day Youth Pass	$3.50	Discounted Pass	$44.00
20-Ride Local	$32.00	Quest 7-Day	
20-Ride Express	$42.00	Youth Pass	$16.00
20-Ride		Quest 31-Day	
Discounted Pass	$17.00	Youth Pass	$58.50

Cash, checks, money orders, and credit cards are accepted for these purchases. A shipping fee will be applied to all mail, phone and online orders.

Express Upgrades: Deposit an extra 50 cents to use a 20-Ride Local Pass on an express bus.

For more information, please call MTA Customer Care at **(615) 862-5950** *or visit our website at* **nashvillemta.org.**

All MTA buses are accessible and equipped with bike racks.

Thank you for riding with the Nashville MTA

We appreciate your business!

Nashville MTA

SUPPLEMENTAL #1

Tusculum/ McMurray Express

December 29, 2014
1:48 am

Customer Care & ADA Coordinator
(615) 862-5950
Accessride
(615) 880-3970
nashvillemta.org

37X

Cole Elementary School
Dollar General Park & Ride
Four Points by Sheraton
Music City Central - **Bay 21**
Nippers Corner

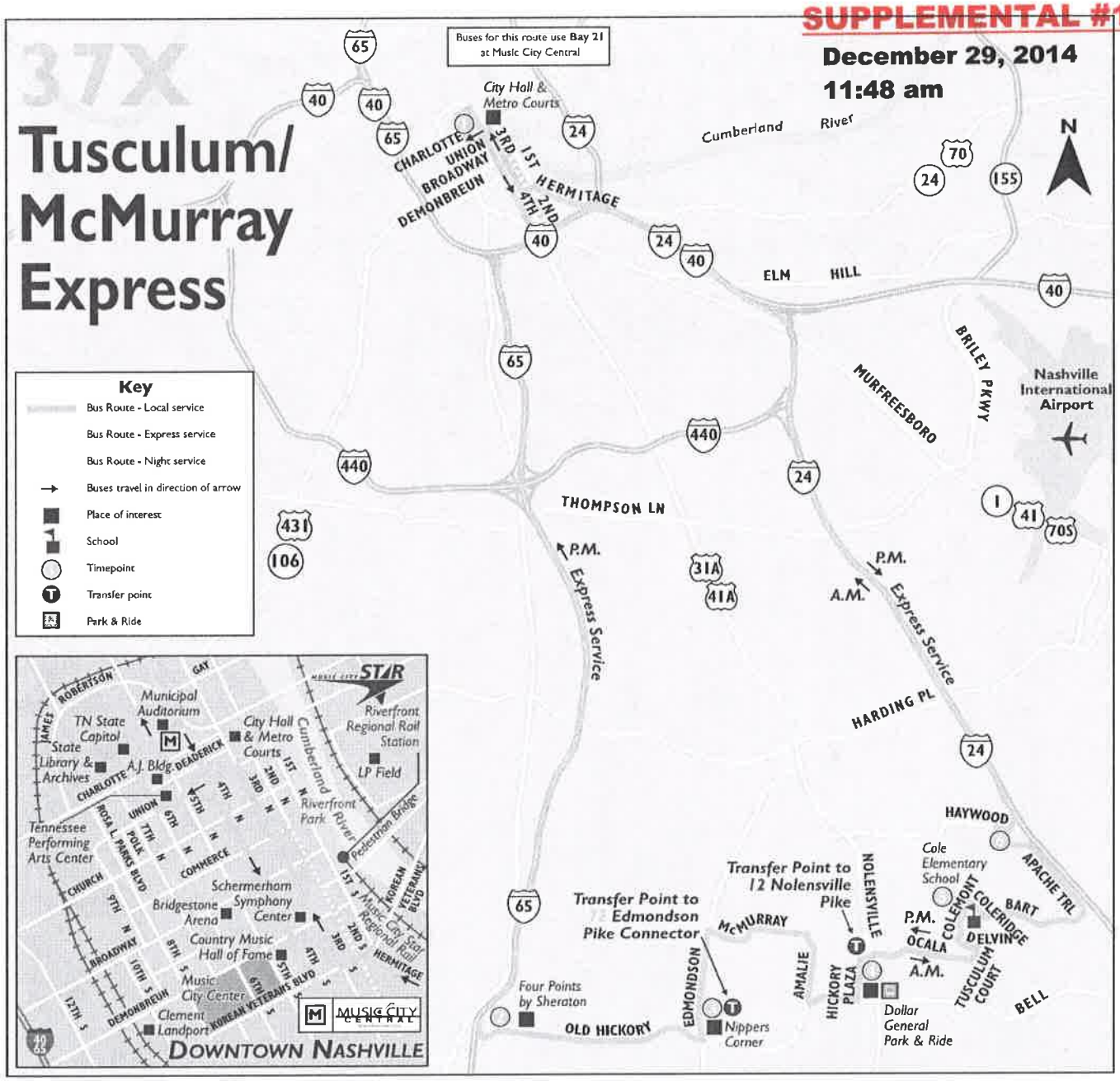
Nashville MTA

Effective September 28, 2014

SUPPLEMENTAL #1

December 29, 2014
11:48 am

37X Tusculum/ McMurray Express



WEEKDAYS — to Downtown

Four Points by Sheraton	Nippers Corner	Dollar General Park & Ride	Cole Elementary School	Apache & Haywood	Music City Central
6:17	6:24	6:35	6:40	6:50	7:15
6:38	6:47	6:59	7:06	7:15	7:45
4:40#		EXPRESS			5:35
5:39		EXPRESS			6:07

This bus travels to downtown via Route 35X - Rivergate Express.

NO SERVICE SATURDAYS, SUNDAYS OR HOLIDAYS

a.m. trips p.m. trips

WEEKDAYS — from Downtown

Music City Central Bay 21	Apache & Haywood	Cole Elementary School	Dollar General Park & Ride	Nippers Corner	Four Points by Sheraton	Music City Central
3:40•	4:03	4:11	4:19	4:30	4:40#	5:35
4:38	5:08	5:15	5:22	5:32	5:39	6:07

- On school days only, this bus begins service at Martin Luther King Jr. Magnet School at 3:20 p.m. and travels directly to Music City Central.

This bus travels to downtown via Route 35X - Rivergate Express.

On school early dismissal days only, a midday bus begins service at Martin Luther King Jr. Magnet School at 11:50 a.m. and travels directly to Music City Central.

MTA Schedule Displays Around Town

Andrew Johnson Building, 710 James Robertson Parkway
Anthem Career College, 560 Royal Parkway
Belmont University, 1900 Belmont Boulevard
Bridgestone Arena, 501 Broadway
City Hall & Metro Courts, 1 Public Square
Daymar Institute, 340 Plus Park Boulevard
Davy Crockett Building, 500 James Robertson Parkway
Justice A.A. Birch Building, 408 2nd Avenue North
Lincoln College of Technology, 1524 Gallatin Road
Lobby Center and Library, 2301 Rosa L. Parks Boulevard
Metro Board of Education, 2601 Bransford Avenue
Metro General Hospital, 1818 Albion Street
MTA Madison Headquarters, 430 Myatt Drive
Music City Central, 400 Charlotte Avenue
Nashville Downtown Library, 615 Church Street
Peabody College Post Office, 230 Appleton Place
Riverfront Regional Rail Station, 108 1st Avenue North
Tennessee Dept. of Human Services, 1000 2nd Avenue North
Tennessee Performing Arts Center, 505 Deaderick Street
Tennessee State University, 3500 John A. Merritt Boulevard
Vanderbilt University Post Office, 2301 Vanderbilt Place
Watkins College of Art, Design & Film, 2298 Rosa L. Parks Boulevard
William R. Snodgrass Tennessee Tower, 311 7th Avenue North

For a list of other locations for specific areas, please call MTA Customer Care at **(615) 862-5950.**

Bus Stops

Most MTA bus stops are marked with a blue-and-white sign. If no bus stops are visible in the area where you wish to board, please go to the nearest intersection of the street traveled by your bus and flag the bus down when it comes into view.

Music City Central

The main transfer station is located at Music City Central (400 Charlotte Avenue).

Destination Signs

Every MTA bus is marked with a route number as well as the destination name or area. All express routes are designated by an "X" following the route number. If you have questions about where a bus is going, please ask the driver as you board.

Park & Ride

Several bus routes provide Park & Ride service, which allows you to park your car at no charge and ride an MTA bus. MTA passengers are permitted to use Park & Ride lots as complimentary services by owners of the lots.

Snow Route Detours

Be prepared for winter weather and pick up your MTA snow route detours brochure today. Snow route information may be found at MTA displays around town, on MTA buses, online at **nashvillemta.org**, or by calling Customer Care at **(615) 862-5950.**

Holiday Service

On the following major holidays, MTA operates service on a Sunday/Holiday schedule:
• New Year's Day • Memorial Day • Independence Day • Labor Day • Thanksgiving • Christmas
On Martin Luther King Jr. Day, MTA operates service on a Saturday schedule.

MTA Office Hours

Customer Care Call Center: **(615) 862-5950**
6:30 a.m. to 6:30 p.m. – Monday-Friday
8:00 a.m. to 5:00 p.m. – Saturday
10:30 a.m. to 2:30 p.m. – Sunday
Closed holidays

Ticket Sales and Information at Music City Central
400 Charlotte Avenue
6:00 a.m. to 6:30 p.m. – Monday-Friday
8:00 a.m. to 5:00 p.m. – Saturday
10:30 a.m. to 2:30 p.m. – Sunday
Closed holidays

Music City Central – Hours of Operation
400 Charlotte Avenue
5:15 a.m. to 11:15 p.m. – Monday-Friday
6:00 a.m. to 10:15 p.m. – Saturday
6:00 a.m. to 9:15 p.m. – Sundays and holidays

Administrative Offices: **(615) 862-5969**
430 Myatt Drive, Nashville, TN 37115
8:00 a.m. to 4:30 p.m. – Monday-Friday
Closed weekends and holidays

Metropolitan Transit Authority
430 Myatt Drive, Nashville, TN 37115

designed by CHK America – chkamerica.com

Fares

Adult – Local, Airport & BRT lite Services	$1.70
Express Service	$2.25
Senior *(ages 65 and older, please show driver proof of age before depositing fare)*	$ .85
People with Disabilities and Medicare Cardholders *(please show driver special identification card before depositing fare)*	$ .85
Youth Fare *(ages 19 and younger, please alert driver before depositing fare and be prepared to show proof of age upon request)*	$1.00
Children ages 4 and younger	No Charge

Services for Medicare Cardholders, Seniors, or People with Disabilities

Medicare cardholders, who are not elderly or disabled, qualify for a reduced MTA fare of 85 cents on MTA buses with their Medicare ID.

Seniors age 65 and older and people with disabilities qualify for a reduced MTA fare of 85 cents on MTA buses with one of the following ID cards: Medicare, Seniors-MTA Golden Age, or driver's license; Disabled-Medicare, MTA Special Service, or other transit ID card for the disabled.

Passengers whose disabilities prevent them from using the large MTA buses may qualify for special door-to-door van service through the MTA AccessRide Program. Please call the MTA AccessRide Office at **(615) 880-3970** for more information or visit the MTA website at nashvillemta.org.

MTA Passes

For your convenience, passes are available for purchase at Music City Central (400 Charlotte Avenue), online at **nashvillemta.org**, or by phone at (615) 862-5950. In addition, passes may be requested via mail by sending the request to the MTA Administrative Office address.

All-Day Pass	$5.25	7-Day Pass	$24.00
All-Day Discounted Pass	$3.25	31-Day Pass	$84.00
All-Day Youth Pass	$3.50	31-Day Discounted Pass	$44.00
20-Ride Local	$32.00	Quest 7-Day Youth Pass	$16.00
20-Ride Express	$42.00	Quest 31-Day Youth Pass	$58.50
20-Ride Discounted Pass	$17.00		

Cash, checks, money orders, and credit cards are accepted for these purchases. A shipping fee will be applied to all mail, phone and online orders.

Express Upgrades: Deposit an extra 50 cents to use a 20-Ride Local Pass on an express bus.

For more information, please call MTA Customer Care at **(615) 862-5950** *or visit our website at* **nashvillemta.org.**

♿ *All MTA buses are accessible and equipped with bike racks.*

EasyRide Commuter Benefits

Benefits to employers
- *Saves tax dollars*
- *On-site parking becomes a non-issue*
- *Less-stressed employees*

Benefits to employees
- *Cuts taxable income*
- *Reduces car expenses*
- *Arrive at work relaxed*

For more information, contact MTA at **(615) 862-5969** *or ask your Human Resources Director about commuter benefits.*

EasyRide!
MTA-RTA COMMUTER PROGRAM

Thank you for riding with the Nashville MTA

We appreciate your business!

Nashville MTA

Edmondson Pike Connector

SUPPLEMENTAL #1

December 29, 2014

11:48 am

72

Edmondson Pike Library
Metroplex Office Complex
Nippers Corner
Sheriff's Correctional Complex
Walmart

LIMITED SERVICE

Customer Care & ADA Complaints
(615) 862-5950
Administrative
(615) 880-3970
nashvillemta.org

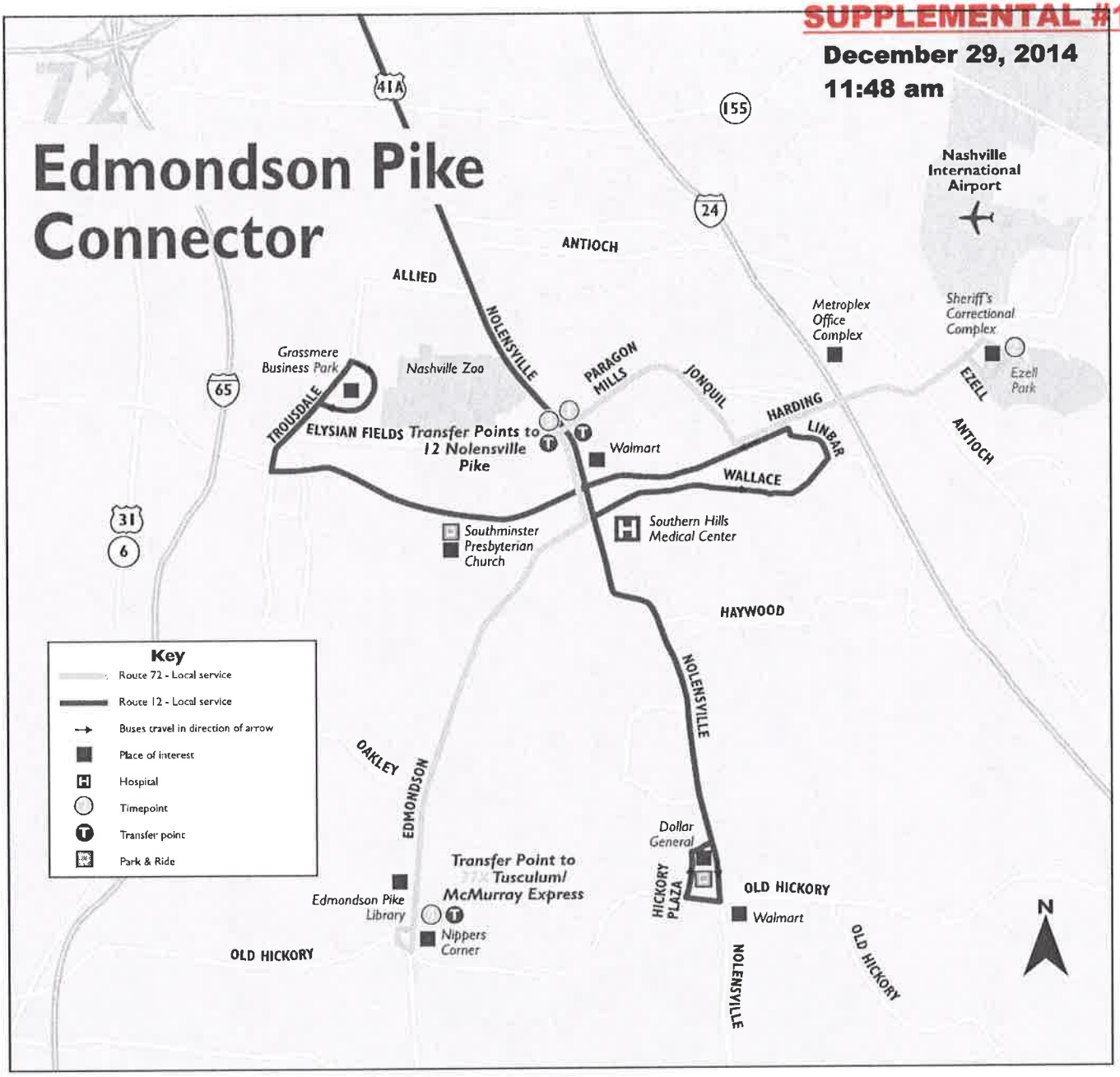
Nashville MTA

Effective September 28, 2014

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Edmondson Pike Connector



WEEKDAYS — via Harding Place

Walmart	Sheriff's Correctional Complex	Nolensville & Welshwood	Walmart
	5:55	6:08	
6:43	6:55	7:08	
7:41	7:55	8:10	
8:43	8:55	9:08	
9:45	10:00		10:10
11:20	11:32	11:45	
12:25	12:37	12:50	
1:30	1:42		1:52
4:40	4:55	5:10	
5:50	6:02	6:15	
6:46	6:58		7:08

WEEKDAYS — via Edmondson Pike

Nolensville & Welshwood	Edmondson & Nippers Corner	Walmart
6:10	6:28	6:39
7:10	7:28	7:41
8:10	8:28	8:41
9:10	9:28	9:41
11:50	12:08	12:21
12:55	1:13	1:26
4:05	4:23	4:36
5:15	5:33	5:46
6:15	6:33	6:46

NO SERVICE SATURDAYS, SUNDAYS OR HOLIDAYS

a.m. trips p.m. trips

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 5

Midtown Hospital and West Hospital also draw 29.7% of their Williamson County ED patients from another four zip codes in the Williamson County area – 37014, 37046, 37062 and 38476. However, due to location and road access, these zip codes are not expected to result in many visits to the proposed Brentwood Satellite ED.

Accounting for patient in-migration, approximately 10% of patients served are expected to reside outside the nine zip codes identified.

Please see **Attachment C, Need – 3 (Tab 10)** for county and zip code maps related to the service area.

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE: Midtown Hospital's Satellite ED service area is comprised of nine zip codes primarily within Davidson and Williamson counties.

Between 2014 and 2018, the population of the service area is projected to increase by 5.7%, or by 49,069 residents. This represents an annual growth rate of 1.4% and is greater than the projected growth rate of the state within that same four-year period, which is 0.7% annually, or 3.0% total growth, and twice the rate of growth of the United States as a whole. Please see **EXHIBIT 8,** which illustrates the projected changes in population of the service area between 2014 and 2018 and denotes population growth within the state of Tennessee, and the United States.

EXHIBIT 8
TOTAL POPULATION PROJECTIONS

	Total Population				
	2014	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	664,655	700,067	35,412	1.3%	5.3%
Williamson	199,481	213,134	13,653	1.7%	6.8%
Total Service Area	**864,136**	**913,205**	**49,069**	**1.4%**	**5.7%**
Tennessee	6,531,577	6,728,679	197,102	0.7%	3.0%
United States	317,199,353	326,056,739	8,857,386	0.7%	2.8%

SOURCE: NIELSEN, INC.

The anticipated growth in the 65 and older population within the service area is much greater; nearly four times that of the total growth. Between 2014 and 2018, projections indicate that the senior population will increase 21.7%, or by 21,458 residents. For Tennessee, projections are that the total four-year growth within this age cohort will be 15.2%, for the United States, 14.1%. Because seniors are among the highest users of healthcare services, such an explosive growth rate foretells the need for Midtown Hospital to anticipate increasing demand for services as result of this growth as well as that of the general population. Please see **EXHIBIT 9**.

EXHIBIT 9
65 AND OLDER POPULATION PROJECTIONS

	65+ Population				
	2014	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	75,873	90,910	15,037	4.6%	19.8%
Williamson	22,885	29,295	6,410	6.4%	28.0%
Total Service Area	**98,758**	**120,216**	**21,458**	**5.0%**	**21.7%**
Tennessee	968,443	1,115,625	147,182	3.6%	15.2%
United States	45,157,410	51,545,199	6,387,789	3.4%	14.1%

SOURCE: NIELSEN, INC.

B. 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: Midtown Hospital has a history of providing high quality healthcare that is accessible to all segments of the community. It provides services without regard to gender, race, socio-economic status, or ability to pay, and participates in the Medicare and TennCare programs.

In 2014, the 65 and older population will account for 11.4% of the total population in the service area. As a major demographic subgroup of Midtown Hospital's patient base, seniors will continue to expect of Midtown Hospital the same level of service while becoming an increasingly larger segment of the total service area population, with 2018 projections placing the 65 and older population at 13.2% of the total service area population.

The female population will represent 51.4% of the total population in the service area by 2018. As shown in **EXHIBIT 10**, the female population is expected to grow at the same annual rate for both sexes in service area, 1.4% per year.

EXHIBIT 10
FEMALE POPULATION PROJECTIONS

	Female Population				
	2014	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	342,524	360,026	17,502	1.3%	5.1%
Williamson	102,093	109,123	7,030	1.7%	6.9%
Total Service Area	**444,617**	**469,152**	**24,535**	**1.4%**	**5.5%**
Tennessee	3,345,908	3,443,698	97,790	0.7%	2.9%

SOURCE: NIELSEN, INC.

EXHIBITS 11-13 illustrate the racial composition of the Midtown Hospital service area. By 2018, the white population will comprise 67.4% of the total population of the service area, while the black population will account for 21.6% and other races, 11.0%.

EXHIBIT 11
WHITE POPULATION PROJECTIONS

	White Population				
	2014	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	408,515	430,440	21,925	1.3%	5.4%
Williamson	175,644	184,638	8,994	1.3%	5.1%
Total Service Area	**584,159**	**615,078**	**30,919**	**1.3%**	**5.3%**
Tennessee	5,008,888	5,100,159	91,271	0.5%	1.8%
United States	226,254,684	228,884,154	2,629,470	0.3%	1.2%

SOURCE: NIELSEN, INC.

EXHIBIT 12
BLACK POPULATION PROJECTIONS

	Black Population				
	2014	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	179,871	184,511	4,640	0.6%	2.6%
Williamson	10,334	12,926	2,592	5.8%	25.1%
Total Service Area	**190,205**	**197,494**	**7,289**	**0.9%**	**3.8%**
Tennessee	1,102,940	1,151,022	48,082	1.1%	4.4%
United States	40,263,108	41,673,503	1,410,395	0.9%	3.5%

SOURCE: NIELSEN, INC.

EXHIBIT 13
"OTHER" POPULATION PROJECTIONS

	Other Population				
	2014	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
Davidson	76,269	85,065	8,796	2.8%	11.5%
Williamson	13,503	15,516	2,013	3.5%	14.9%
Total Service Area	**89,772**	**100,582**	**10,810**	**2.9%**	**12.0%**
Tennessee	419,749	476,831	57,082	3.2%	13.6%
United States	50,681,561	55,464,705	4,783,144	2.3%	9.4%

SOURCE: NIELSEN, INC.

The service area counties as a whole have a Median Household Incomes higher than the state of Tennessee. Likewise, the annual growth in median household income is higher than that of the state, which remains flat over the period. Please see **EXHIBIT 14.**

EXHIBIT 14
SERVICE AREA MEDIAN HOUSEHOLD INCOME

	Median Household Income	
	2014	**2018**
Davidson	$44,608	$46,804
Williamson	$86,706	$92,785
Total Service Area	**$65,657**	**$69,795**
Tennessee	$43,390	$43,182

SOURCE: NIELSEN, INC.

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 6

Midtown Hospital and West Hospital also draw 29.7% of their Williamson County ED patients from another four zip codes in the Williamson County area – 37014, 37046, 37062 and 38476. However, due to location and road access, these zip codes are not expected to result in many visits to the proposed Brentwood Satellite ED.

Accounting for patient in-migration, approximately 10% of patients served are expected to reside outside the nine zip codes identified.

Please see **Attachment C, Need – 3 (Tab 10)** for county and zip code maps related to the service area.

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE: Midtown Hospital's Satellite ED service area is comprised of nine zip codes primarily within Davidson and Williamson counties.

Between 2014 and 2018, the population of the proposed zip code service area is projected to increase by 6.7%, or by 11,770 residents. This represents an annual growth rate of 1.6% and is greater than the projected growth rate of the state within that same four-year period, which is 0.7% annually, or 3.0% total growth, and twice the rate of growth of the United States as a whole. Please see **EXHIBIT 8,** which illustrates the projected changes in population of the service area between 2014 and 2018 and denotes population growth within the state of Tennessee, and the United States.

EXHIBIT 8
TOTAL POPULATION PROJECTIONS

	Total Population				
Zip Code	**2014**	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
37027	54,603	58,251	3,648	1.6%	6.7%
37064	51,305	53,957	2,652	1.3%	5.2%
37067	26,341	28,448	2,107	1.9%	8.0%
37069	20,784	21,879	1,095	1.3%	5.3%
37135	10,669	11,816	1,147	2.6%	10.7%
37179	12,081	13,203	1,122	2.2%	9.3%
Total	**175,783**	**187,553**	**11,770**	**1.6%**	**6.7%**
Tennessee	6,531,577	6,728,679	197,102	0.7%	3.0%
United States	317,199,353	326,056,739	8,857,386	0.7%	2.8%

SOURCE: NIELSEN, INC.

The anticipated growth in the 65 and older population within the proposed zip code service area is much greater; nearly four times that of the total growth. Between 2014 and 2018, projections indicate that the senior population will increase 27.7%, or by 5,891 residents. For Tennessee, projections are that the total four-year growth within this age cohort will be 15.2%, for the United States, 14.1%. Because seniors are among the highest users of healthcare services, such an explosive growth rate foretells the need for Midtown Hospital to anticipate increasing demand for services as result of this growth as well as that of the general population. Please see **EXHIBIT 9**.

EXHIBIT 9
65 AND OLDER POPULATION PROJECTIONS

	65+ Population				
Zip Code	**2014**	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
37027	7,715	9,808	2,093	6.2%	27.1%
37064	6,634	8,128	1,494	5.2%	22.5%
37067	2,755	3,647	892	7.3%	32.4%
37069	2,405	3,165	760	7.1%	31.6%
37135	878	1,183	305	7.7%	34.7%
37179	877	1,224	347	8.7%	39.6%
Total	**21,264**	**27,155**	**5,891**	**6.3%**	**27.7%**
Tennessee	968,443	1,115,625	147,182	3.6%	15.2%
United States	45,157,410	51,545,199	6,387,789	3.4%	14.1%

SOURCE: NIELSEN, INC.

B. 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: Midtown Hospital has a history of providing high quality healthcare that is accessible to all segments of the community. It provides services without regard to gender, race, socio-economic status, or ability to pay, and participates in the Medicare and TennCare programs.

In 2014, the 65 and older population will account for 12.1% of the total population in the proposed zip code service area. As a major demographic subgroup of Midtown Hospital's patient base, seniors will continue to expect of Midtown Hospital the same level of service while becoming an increasingly larger segment of the total service area population, with 2018 projections placing the 65 and older population at 14.5% of the total proposed zip code service area population.

The female population will represent 51.4% of the total population in the proposed zip code service area by 2018. As shown in **EXHIBIT 10**, the female population is expected to grow at the same annual rate for both sexes in service area, 1.4% per year.

EXHIBIT 10
FEMALE POPULATION PROJECTIONS

	Female Population				
Zip Code	**2014**	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
37027	28,136	30,059	1,923	1.7%	6.8%
37064	26,264	27,600	1,336	1.2%	5.1%
37067	13,659	14,754	1,095	1.9%	8.0%
37069	10,651	11,226	575	1.3%	5.4%
37135	5,394	5,981	587	2.6%	10.9%
37179	6,113	6,690	577	2.3%	9.4%
Total	**90,217**	**96,311**	**6,094**	**1.6%**	**6.8%**
Tennessee	3,345,908	3,443,698	97,790	0.7%	2.9%

SOURCE: NIELSEN, INC.

EXHIBITS 11-13 illustrate the racial composition of the Midtown Hospital service area. By 2018, the white population will comprise 85.4% of the total population of the proposed zip code service area, while the black population will account for 6.5% and other races, 8.0%.

EXHIBIT 11
WHITE POPULATION PROJECTIONS

	White Population				
Zip Code	**2014**	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
37027	47,774	50,139	2,365	1.2%	4.9%
37064	43,329	44,665	1,336	0.8%	3.1%
37067	22,344	23,733	1,389	1.5%	6.2%
37069	19,366	20,173	807	1.0%	4.2%
37135	8,869	9,571	702	1.9%	7.9%
37179	11,020	11,957	937	2.1%	8.5%
Total	**152,702**	**160,237**	**7,535**	**1.2%**	**4.9%**
Tennessee	5,008,888	5,100,159	91,271	0.5%	1.8%
United States	226,254,684	228,884,154	2,629,470	0.3%	1.2%

SOURCE: NIELSEN, INC.

EXHIBIT 12
BLACK POPULATION PROJECTIONS

	Black Population				
Zip Code	**2014**	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
37027	2,540	3,238	698	6.3%	27.5%
37064	4,248	4,957	709	3.9%	16.7%
37067	1,249	1,594	345	6.3%	27.6%
37069	546	720	174	7.1%	31.8%
37135	852	1,087	235	6.3%	27.6%
37179	538	650	112	4.8%	20.8%
Total	**9,973**	**12,244**	**2,271**	**5.3%**	**22.8%**
Tennessee	1,102,940	1,151,022	48,082	1.1%	4.4%
United States	40,263,108	41,673,503	1,410,395	0.9%	3.5%

SOURCE: NIELSEN, INC.

EXHIBIT 13
"OTHER" POPULATION PROJECTIONS

	Other Population				
Zip Code	**2014**	**2018**	**Abs Chg**	**Ann % Chg**	**Abs % Chg**
37027	4,289	4,858	569	3.2%	13.3%
37064	3,728	4,321	593	3.8%	15.9%
37067	2,748	3,114	366	3.2%	13.3%
37069	872	982	110	3.0%	12.6%
37135	948	1,153	205	5.0%	21.6%
37179	523	595	72	3.3%	13.8%
Total	**13,108**	**15,024**	**1,916**	**3.5%**	**14.6%**
Tennessee	419,749	476,831	57,082	3.2%	13.6%
United States	50,681,561	55,464,705	4,783,144	2.3%	9.4%

SOURCE: NIELSEN, INC.

The service area counties as a whole have a Median Household Incomes higher than the state of Tennessee. Likewise, the annual growth in median household income is higher than that of the state, which remains flat over the period. Please see **EXHIBIT 14.**

EXHIBIT 14
SERVICE AREA MEDIAN HOUSEHOLD INCOME

	Median Household Income	
Zip Code	**2014**	**2018**
37027	$106,099	$114,318
37064	$72,892	$78,137
37067	$86,882	$93,404
37069	$99,461	$107,495
37135	$96,875	$106,229
37179	$88,804	$96,560
Total	**$91,836**	**$99,357**
Tennessee	$43,390	$43,182

SOURCE: NIELSEN, INC.

SUPPLEMENTAL #1

December 29, 2014
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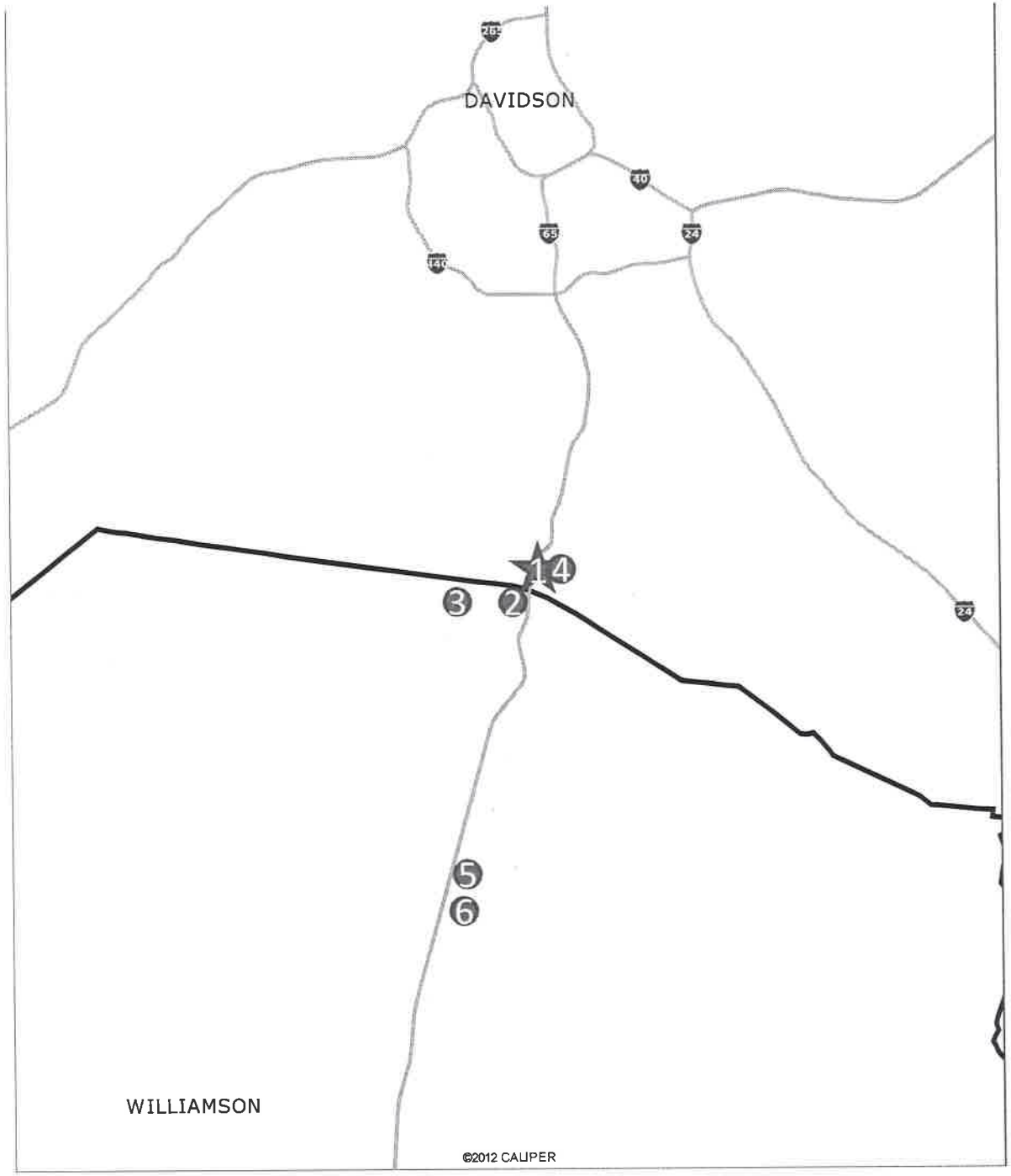
Attachment 7



Urgent Care Centers

1. Midtown Satellite ED
2. CareSpot Urgent Care
3. Fast Place Urgent Care
4. Physicians Urgent Care
5. CareSpot Urgent Care
6. Concentra

SUPPLEMENTAL #1
December 29, 2014
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SUPPLEMENTAL #1

December 29, 2014
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Attachment 8

SUPPLEMENTAL #1

December 29, 2014
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Midtown Hospital ER Patient Origin by Zip Code
CY 2014 (January-October, Annualized)
Zip Codes with Patient Origin Over 0.15%

Patient Zip Code	Patient City	Patient County	Total	Cumulative Patients	% by Zip Code	Cumulative %	Annualized Patients 2014
37207	NASHVILLE	Davidson	4,074	4,074	10.25%	10.25%	4,889
37208	NASHVILLE	Davidson	3,300	7,374	8.31%	18.56%	3,960
37206	NASHVILLE	Davidson	2,991	10,365	7.53%	26.09%	3,589
37203	NASHVILLE	Davidson	2,473	12,838	6.22%	32.31%	2,968
37209	NASHVILLE	Davidson	2,108	14,946	5.31%	37.62%	2,530
37218	NASHVILLE	Davidson	1,829	16,775	4.60%	42.22%	2,195
37210	NASHVILLE	Davidson	1,647	18,422	4.15%	46.37%	1,976
37013	ANTIOCH	Davidson	1,600	20,022	4.03%	50.40%	1,920
37115	MADISON	Davidson	1,565	21,587	3.94%	54.34%	1,878
37211	NASHVILLE	Davidson	1,520	23,107	3.83%	58.16%	1,824
37236	NASHVILLE	Davidson	1,121	24,228	2.82%	60.98%	1,345
37216	NASHVILLE	Davidson	1,085	25,313	2.73%	63.72%	1,302
37217	NASHVILLE	Davidson	1,014	26,327	2.55%	66.27%	1,217
37072	GOODLETTSVILLE	Davidson	699	27,026	1.76%	68.03%	839
37221	NASHVILLE	Davidson	597	27,623	1.50%	69.53%	716
37214	NASHVILLE	Davidson	558	28,181	1.40%	70.93%	670
37075	HENDERSONVILLE	Sumner	469	28,650	1.18%	72.12%	563
37076	HERMITAGE	Davidson	465	29,115	1.17%	73.29%	558
37204	NASHVILLE	Davidson	455	29,570	1.15%	74.43%	546
37027	BRENTWOOD	Williamson	396	29,966	1.00%	75.43%	475

SUPPLEMENTAL #1

December 29, 2014

11:48 am

37015	ASHLANDCITY	Cheatham	394	30,360	0.99%	76.42%	473
37212	NASHVILLE	Davidson	394	30,754	0.99%	77.41%	473
37122	MOUNTJULIET	Wilson	369	31,123	0.93%	78.34%	443
37138	OLDHICKORY	Davidson	315	31,438	0.79%	79.13%	378
37205	NASHVILLE	Davidson	288	31,726	0.72%	79.86%	346
37215	NASHVILLE	Davidson	285	32,011	0.72%	80.58%	342
37080	JOELTON	Davidson	257	32,268	0.65%	81.22%	308
37086	LAVERGNE	Rutherford	251	32,519	0.63%	81.85%	301
37228	NASHVILLE	Davidson	210	32,729	0.53%	82.38%	252
37167	SMYRNA	Rutherford	196	32,925	0.49%	82.88%	235
37055	DICKSON	Dickson	190	33,115	0.48%	83.35%	228
37066	GALLATIN	Sumner	180	33,295	0.45%	83.81%	216
37087	LEBANON	Wilson	173	33,468	0.44%	84.24%	208
37172	SPRINGFIELD	Robertson	173	33,641	0.44%	84.68%	208
37188	WHITEHOUSE	Sumner	171	33,812	0.43%	85.11%	205
37189	WHITESCREEK	Davidson	170	33,982	0.43%	85.54%	204
37082	KINGSTONSPRINGS	Cheatham	158	34,140	0.40%	85.93%	190
37064	FRANKLIN	Williamson	144	34,284	0.36%	86.30%	173
37043	CLARKSVILLE	Montgomery	140	34,424	0.35%	86.65%	168
37073	GREENBRIER	Robertson	135	34,559	0.34%	86.99%	162
37129	MURFREESBORO	Rutherford	131	34,690	0.33%	87.32%	157
37062	FAIRVIEW	Williamson	130	34,820	0.33%	87.65%	156
37146	PLEASANTVIEW	Cheatham	121	34,941	0.30%	87.95%	145
37143	PEGRAM	Cheatham			0.28%	88.23%	

SUPPLEMENTAL #1
December 29, 2014
11:48 am

			111	35,052			133
37219	NASHVILLE	Davidson	103	35,155	0.26%	88.49%	124
37130	MURFREESBORO	Rutherford	100	35,255	0.25%	88.74%	120
37148	PORTLAND	Sumner	99	35,354	0.25%	88.99%	119
37220	NASHVILLE	Davidson	99	35,453	0.25%	89.24%	119
37187	WHITEBLUFF	Dickson	93	35,546	0.23%	89.47%	112
37069	FRANKLIN	Williamson	87	35,633	0.22%	89.69%	104
37201	NASHVILLE	Davidson	82	35,715	0.21%	89.90%	98
37042	CLARKSVILLE	Montgomery	78	35,793	0.20%	90.10%	94
37067	FRANKLIN	Williamson	77	35,870	0.19%	90.29%	92
37040	CLARKSVILLE	Montgomery	75	35,945	0.19%	90.48%	90
38401	COLUMBIA	Maury	72	36,017	0.18%	90.66%	86
37090	LEBANON	Wilson	69	36,086	0.17%	90.83%	83
37025	BONAQUA	Hickman	67	36,153	0.17%	91.00%	80
37128	MURFREESBORO	Rutherford	63	36,216	0.16%	91.16%	76
37213	NASHVILLE	Davidson	63	36,279	0.16%	91.32%	76
37035	CHAPMANSBORO	Cheatham	62	36,341	0.16%	91.47%	74
37174	SPRINGHILL	Maury	59	36,400	0.15%	91.62%	71
37033	CENTERVILLE	Hickman	55	36,455	0.14%	91.76%	66
37135	NOLENSVILLE	Williamson	55	36,510	0.14%	91.90%	66
37036	CHARLOTTE	Dickson	54	36,564	0.14%	92.04%	65
37202	NASHVILLE	Davidson	53	36,617	0.13%	92.17%	64

Source: Internal records

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 9

SUPPLEMENTAL #1

December 29, 2014
11:48 am

HISTORICAL DATA CHART - Midtown Hospital, ED Only

Give us information for the last three (3) years for which complete are available for the facility or agency. The fiscal year begins in July. (Dollars reported in thousands)

			FY 2012	FY 2013	FY 2014
A.	Utilization Data (ER Visits)		51,980	51,625	48,803
B.	Revenue from Services to Patients				
	1.	Inpatient Services	$278,959,727	$277,054,558	$237,528,651
	2.	Outpatient Services	$36,599,395	36,349,438	37,944,093
	3.	Emergency Services	$82,508,108	81,944,615	78,073,928
	4.	Other Operating Revenue (Specify)			
		Gross Operating Revenue	$398,067,231	$395,348,611	$353,546,672
C.	Deductions from Gross Operating Revenue				
	1.	Contractual Adjustments	$268,095,776	$266,264,803	$239,954,098
	2.	Provision for Charity Care	$14,421,762	$14,323,268	$12,907,928
	3.	Provisions for Bad Debt	$5,626,960	$5,588,530	$5,036,305
		Total Deductions	$288,144,498	$286,176,601	$257,898,330
NET OPERATING REVENUE			$109,922,733	$109,172,010	$95,648,342
D.	Operating Expenses				
	1.	Salaries and Wages	$34,180,978	$33,947,538	$29,296,907
	2.	Physician's Salaries and Wages			
	3.	Supplies	$20,542,417	$20,402,122	$17,607,141
	4.	Taxes			
	5.	Depreciation	$3,639,480	$3,614,624	$3,119,440
	6.	Rent			
	7.	Interest, other than Capital			
	8.	Other Expenses (Specify: Lab, Pharmacy, Other)	$39,297,062	$39,028,681	$33,681,961
		Total Operating Expenses	$97,659,938	$96,992,965	$83,705,449

SUPPLEMENTAL #1

December 29, 2014
11:48 am

E. Other Revenue (Expenses) – Net (Specify)			
NET OPERATING INCOME (LOSS)	$12,262,794	$12,179,045	$11,942,893
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures			
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$12,262,794	$12,179,045	$11,942,893

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 10

SUPPLEMENTAL #1
December 29, 2014
11:48 am

PROJECTED DATA CHART

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

		Fiscal Yr 2017	Fiscal Yr 2018
A.	Utilization Data (ER Visits)	6,155	8,439
B.	Revenue from Services to Patients		
1.	Inpatient Services		
2.	Outpatient Services		
3.	Emergency Services	$13,627,594	$18,684,527
4.	Other Operating Revenue (Specify)		
	Gross Operating Revenue	$13,627,594	$18,684,527
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$9,916,476	$13,596,287
2.	Provision for Charity Care	$532,571	$730,198
3.	Provisions for Bad Debt	$202,377	$277,475
	Total Deductions	$10,651,425	$14,603,960
NET OPERATING REVENUE		$2,976,169	$4,080,567
D.	Operating Expenses		
1.	Salaries and Wages	$1,624,920	$2,223,957
2.	Physician's Salaries and Wages		
3.	Supplies	$474,477	$650,546
4.	Taxes		
5.	Depreciation	$205,745	$209,860
6.	Rent	144,000	144,000

SUPPLEMENTAL #1
December 29, 2014
11:48 am

7. Interest, other than Capital		
8. Management Fees:		
a. Fees to Affiliates	0	0
b. Fees to Non-Affiliates	0	0
9. Other Expenses (See details below)	$609,680	$742,884
Total Operating Expenses	$3,058,822	$3,971,248
E. Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)	($82,653)	$109,319
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	($82,653)	$109,319

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Fiscal Yr 2017	Fiscal Yr 2018
1. Purchased Services	$344,680	$472,584
2. Technology Expense	$50,000	$51,000
3. Miscellaneous	$215,000	$219,300
4.		
5.		
6.		
7.		
Total Other Expenses	**$609,680**	**$742,884**

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 11

HISTORICAL DATA CHART - Midtown, All Services

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July. (Dollars reported in thousands, entire hospital)

		Fiscal Yr 2012	Fiscal Yr 2013	Fiscal Yr 2014
A.	Utilization Data (Patient Days)	112,163	110,408	100,820
B.	Revenue from Services to Patients			
1.	Inpatient Services	$780,339	$862,034	$881,742
2.	Outpatient Services	408,992	399,432	379,702
3.	Emergency Services	71,046	69,385	81,950
4.	Other Operating Revenue (Specify) - Misc.	29,405	27,821	20,297
	Gross Operating Revenue	$1,289,782	$1,358,672	$1,363,691
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$806,267	$883,666	$897,978
2.	Provision for Charity Care	53,683	36,117	47,790
3.	Provisions for Bad Debt	9,962	21,308	9,069
	Total Deductions	$869,913	$941,090	$954,837
NET OPERATING REVENUE		$419,869	$417,582	$408,854
D.	Operating Expenses			
1.	Salaries and Wages	$133,380	$127,496	$115,142
2.	Physician's Salaries and Wages	0	0	0
3.	Supplies	74,598	77,106	77,183
4.	Taxes	0	0	0
5.	Depreciation	16,425	16,627	13,674
6.	Rent	0	0	0

7. Interest, other than Capital	9,195	8,524	7,777
8. Management Fees:			
a. Fees to Affiliates	0	0	0
b. Fees to Non-Affiliates	0	0	0
9. Other Expenses (See details below)	152,984	150,771	153,156
Total Operating Expenses	$386,582	$380,524	$366,932
E. Other Revenue (Expenses) - Net (Specify)	$0	$0	$0
NET OPERATING INCOME (LOSS)	$33,286	$37,058	$41,922
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	$0	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$33,286	$37,058	$41,922

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Fiscal Yr 2012	Fiscal Yr 2013	Fiscal Yr 2014
1. Purchased Services	$34,902	$34,181	$34,625
2. Professional Fees	10,955	9,588	8,895
3. Miscellaneous	107,127	107,002	109,636
4.			
5.			
6.			
7.			
Total Other Expenses	**$152,984**	**$150,771**	**$153,156**

PROJECTED DATA CHART - Midtown, All Services

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in July. (Dollars reported in thousands)

		Fiscal Yr 2017	Fiscal Yr 2018
A.	Utilization Data (Patient Days)	101,021	101,171
B.	Revenue from Services to Patients		
1.	Inpatient Services	$1,000,893	$1,002,379
2.	Outpatient Services	$408,997	$409,604
3.	Emergency Services	$91,021	$91,526
4.	Other Operating Revenue (Specify)	$22,209	$22,242
	Gross Operating Revenue	$1,523,120	$1,525,751
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$1,020,434	$1,022,029
2.	Provision for Charity Care	$36,612	$36,664
3.	Provisions for Bad Debt	$26,286	$26,325
	Total Deductions	$1,083,333	$1,085,018
NET OPERATING REVENUE		$439,787	$440,733
D.	Operating Expenses		
1.	Salaries and Wages	$133,243	$133,468
2.	Physician's Salaries and Wages		
3.	Supplies	$83,330	$83,461
4.	Taxes		
5.	Depreciation	$17,799	$17,829
6.	Rent		

7. Interest, other than Capital	$9,287	$9,301
8. Management Fees:		
a. Fees to Affiliates	0	0
b. Fees to Non-Affiliates	0	0
9. Other Expenses (See details below)	$152,644	$153,125
Total Operating Expenses	$396,304	$397,184
E. Other Revenue (Expenses) -- Net (Specify)	$0	$0
NET OPERATING INCOME (LOSS)	$43,483	$43,549
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$43,483	$43,549

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Fiscal Yr 2017	Fiscal Yr 2018
1. Purchased Services	$32,208	$32,616
2. Professional Fees	$9,464	$9,341
3. Miscellaneous	$110,973	$111,168
4.		
5.		
6.		
7.		
Total Other Expenses	**$152,644**	**$153,125**

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 12

Saint Thomas Health Balance Sheet
November 30, 2014
(Dollars in Thousands)

	November 30, 2014	June 30, 2014
ASSETS:		
Cash and investments	$ 23,926	$ 19,328
Patient accounts receivable	388,430	404,664
Less allowances	(260,326)	(262,373)
Net Accounts Receivable	128,104	142,291
Estimated settlements from 3rd party payors	14,361	13,615
Current portion of assets limited to use	433	491
Inventory	19,841	18,863
Other current assets	29,501	26,831
Total Current Assets	216,166	221,419
Trusteed assets	25,683	31,042
Assets Limited to Use	25,683	31,042
Other Long-Term Investments	729,312	697,216
Property, plant, equipment cost	1,237,918	1,227,093
Construction in progress	30,759	22,019
Less accumulated depreciation	(802,666)	(779,082)
Total Property, Plant & Equipment	466,011	470,030
Investment in unconsolidated entities	35,957	37,176
Assets held for sale		-
Advances to affiliated entities, net	5	2
Other miscellaneous assets	95,894	85,277
Total Other Assets	131,856	122,454
TOTAL ASSETS	$ 1,569,028	$ 1,542,159

	November 30, 2014	June 30, 2014
LIABILITIES:		
Current maturities of long-term debt	$ 5,498	$ 6,629
Accounts payable	40,040	38,758
Accrued liabilities	45,526	49,845
Estimated third party payor settlement	20,505	16,713
Current portion of self-insurance liability	9,482	10,118
Other current liabilities	44,270	25,292
Total Current Liabilities	165,321	147,354
Long-term Debt	396,299	401,396
Self-insurance liability	2,944	2,997
Other non-current liabilities	28,130	34,812
Other Non-Current Liabilities	31,074	37,809
TOTAL LIABILITIES	592,694	586,560
NET ASSETS:		
Unrestricted net assets	937,401	916,688
Unrestricted net assets noncontrolling interest	7,117	7,379
Temporarily restricted net assets	28,904	29,231
Permanently restricted net assets	2,912	2,301
TOTAL NET ASSETS	976,334	955,599
TOTAL LIABILITES AND NET ASSETS	$ 1,569,028	$ 1,542,159

SUPPLEMENTAL #1
December 29, 2014
11:48 am

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 13

The Joint Commission

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Saint Thomas Midtown Hospital
2000 Church Street
Nashville, TN 37236

Organization Identification Number: 7884

Program(s)
Hospital Accreditation

Survey Date(s)
03/25/2014-03/28/2014

Executive Summary

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.

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:	IC.02.02.01	EP2,EP4
	LS.01.02.01	EP1
	LS.02.01.20	EP1,EP13,EP30
	MM.05.01.01	EP8
	PC.01.02.07	EP3
	PC.02.01.03	EP1
	PC.02.01.11	EP2
	PC.03.01.03	EP1,EP8
	RI.01.03.01	EP7
	UP.01.03.01	EP2,EP4

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.02.02.01	EP5
	EC.02.05.01	EP8
	EC.02.06.01	EP1,EP26
	IC.01.05.01	EP1
	LD.04.01.05	EP1
	LS.02.01.35	EP5,EP6
	LS.02.01.50	EP9
	PC.01.02.03	EP5
	PC.01.02.05	EP1
	RC.01.01.01	EP19
	TS.03.01.01	EP2,EP7

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(b)(2)	A-0131	HAP - RI.01.03.01/EP7	Standard

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.01.02.05/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(c)(2)	A-0724	HAP - EC.02.06.01/EP26	Standard
§482.41(a)	A-0701	HAP - EC.02.06.01/EP26	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP1, EP13, EP30, LS.02.01.35/EP5, EP6, LS.02.01.50/EP9	Standard

---

CoP: §482.42 **Tag:** A-0747 **Deficiency:** Standard

Corresponds to: HAP - IC.02.02.01/EP4

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.

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)(1)(ii)	A-0952	HAP - PC.01.02.03/EP5	Standard
§482.51(b)	A-0951	HAP - IC.02.02.01/EP2, EP4, IC.01.05.01/EP1	Standard

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CoP: §482.52 **Tag:** A-1000 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.52 Condition of Participation: Anesthesia Services

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.52(b)(1)	A-1003	HAP - PC.03.01.03/EP8	Standard

CoP: §482.57 **Tag:** A-1151 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.57 Condition of Participation: Respiratory Care Services

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care services.

CoP Standard	Tag	Corresponds to	Deficiency
§482.57(b)(3)	A-1163	HAP - PC.02.01.03/EP1	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01 ESC 60 days

Standard Text: The hospital manages risks related to hazardous materials and waste.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals. 4

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
Observed in Tracer Visit at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
During a tour of the Labor and Delivery area, an observation was made of a cleaning cart in the hallway. There were hazardous cleaning solutions on the top of the cart that was left unattended.

Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
An observation was made of a cleaning cart in the hallway outside of the NICU where the hazardous cleaning solutions were stored on top of the cart and left unattended.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.01 ESC 60 days

Standard Text: The hospital manages risks associated with its utility systems.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

8. The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 8
Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
The kitchen used natural gas for cooking. There were 2 shutoff controls to facilitate a partial shutdown. Existing policy empowered staff to shut off the gas if there was a need to do so. The controls were not labeled.

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.

Primary Priority Focus Area: Physical Environment

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

26. The hospital keeps furnishings and equipment safe and in good repair.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
The bathroom in the Blue Pod of the ER had a lock that needed a special square key. Security had a key and nursing stated there was a key ring somewhere on the unit, however the keys were not in a designated location. The door was locked and staff was asked to open the door as quickly as possible simulating that a patient in the bathroom pulled the emergency cord. Security took over 2 minutes to respond as they were on a one to one in the with a psych patient at the time. Nursing did not locate the key ring until several minutes after the exercise. The lock needed to be a common unlocking mechanism or the special key needed to be available near the door.

Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
The bathroom in the Red Pod of the ER had a lock that needed a special square key. Security had a key and nursing stated there was a key ring somewhere on the unit, however the keys were not in a designated location. The door was locked and staff was asked to open the door as quickly as possible simulating that a patient in the bathroom pulled the emergency cord. Security took over 2 minutes to respond as they were on a one to one in the with a psych patient at the time. Nursing did not locate the key ring until several minutes after the exercise. The lock needed to be a common unlocking mechanism or the special key needed to be available near the door.

Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
The bathroom in the Purple Pod of the ER had a lock that needed a special square key. Security had a key and nursing stated there was a key ring somewhere on the unit, however the keys were not in a designated location. The door was locked and staff was asked to open the door as quickly as possible simulating that a patient in the bathroom pulled the emergency cord. Security took over 2 minutes to respond as they were on a one to one in the with a psych patient at the time. Nursing did not locate the key ring until several minutes after the exercise. The lock needed to be a common unlocking mechanism or the special key needed to be available near the door.

Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
There was an unsecured H size Argon tank in the ER basement tank storage room

EP 26
§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 Tracer Activities at UT Medical Clinic (316 22nd Avenue North, Nashville, TN) site for the Hospital deemed service.
While conducting survey activity within the medicine clinic's draw station, the surveyor observed that the blood draw chair's arm had multiple tears.

Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
During a tour of the Labor and Delivery area, an observation was made at the Nurses' Station of 2 synthetic leather chairs that had extensive cracks in the seats.

§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 Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
An observation was made of a torn chair seat at the Nurses' Station in the Newborn Nursery

Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
During a tour of the Pre-admission Testing Unit, it was noted that a synthetic leather chair in at least one exam room had extensive cracks on the arms of the chair. Staff stated a work order had been submitted, however the chair was not removed from the care area. The surface of the chair could not be adequately

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.01.05.01

ESC 60 days

Standard Text: The hospital has an infection prevention and control plan.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

1. When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
While observing a time out, it was noted that the cardiologist performing the procedure was not wearing his mask properly. His nose was not covered, but no one pointed this out to the practitioner.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

ESC 45 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring
Category : A
Score : Insufficient Compliance

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring
Category : C
Score : Insufficient Compliance

Observation(s):

EP 2
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Tracer Visit at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The staff advised the surveyor that biopsy instruments were washed in soap and water and ultimately placed aside and delivered to central sterile supply later in the day for sterilization. When the staff was queried about the use of an enzymatic cleanser, the surveyor was told that only a plain soap and water was used. Upon review of the organization's policy 23.6a related to cleaning and decontamination, an enzymatic cleaner was to be implemented.

EP 4
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Tracer Visit at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
While conducting tracer activity within the breast center the surveyor observed that there were seven expired breast tissue markers stored within the clinic that had expiration dates of 5/2013 (6) and 01/14 (1) .

Observed in Tracer Visit at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
While conducting tracer activity within the breast center the surveyor observed that there were 1.5 boxes of expired probe guides dated 07/13.

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Tracer Activities at UT Medical Clinic (316 22nd Avenue North, Nashville, TN) site for the Hospital deemed service.
While conducting tracer activity within the medicine clinic, the surveyor observed that there were urinals and urine specimen containers stored underneath the sink's cabinet. The hospital prohibited the storage of supplies for patient use in this area.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.01.05

ESC 60 days

Standard Text: The hospital effectively manages its programs, services, sites, or departments.

Primary Priority Focus Area: Organizational Structure

Element(s) of Performance:

1. Leaders of the program, service, site, or department oversee operations.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While tracing patient's through the Endoscopy Lab, it was discovered that nurses were completing the Endoscopy Standing Order form for at least one physician on a routine basis. Staff nurses stated they filled out the physician order form as they "routinely knew what the physicians wanted" and would select and implement such orders as "Admit to the Endoscopy Lab, NPO, have consent signed and start IV Lock, start IV with NS or D5W @ 50 ml/hr" and implement these actions prior to getting a either telephone order or the physician actually signing the Endoscopy Physician Order form. Staff stated the physician would then sign the order form(once completed by the nurse) either before or after the procedure. Hospital leaders were not aware of this practice and when made aware, immediately changed these processes.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.01.02.01 ESC 45 days

Standard Text: The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.

Primary Priority Focus Area: Communication

Element(s) of Performance:

1. The hospital notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm or sprinkler system is out of service more than 4 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text and any exceptions, refer to NFPA 101-2000: 9.6.1.8 and 9.7.6.1) (See also LS.01.01.01, EP 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Document Review at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
The annual fire inspection conducted in 12/12 reported that 5 visual devices in the 5th floor Central Surgery area failed the inspection. A purchase order was initiated and work was completed in 2/13. There was no evaluation conducted to determine the need for ILSM measures during this period. No ILSM measures were implemented to compensate for the failed devices.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20 ESC 45 days

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Doors in a means of egress are unlocked in the direction of egress. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)

Scoring Category : A
Score : Insufficient Compliance

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)

Scoring Category : C
Score : Partial Compliance

30. Signs reading 'No Exit' are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text and any exceptions, refer to NFPA 101-2000: 7.10.8.1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§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 Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The two sets of sliding glass doors at the main doors of the Kidd Building Horseshoe exit were fitted with operable dead bolt thumb latches.When engaged, the dead bolt latches prevented the doors from "breaking out" as designed. Signs on the door stated "in emergency push to open". This was observed and then corrected at the time of survey.

EP 13
§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:
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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 Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
In the ER there was equipment stored in the egress corridor across from rooms 12 and 13. This corridor was not identified as a suite on the current prints.

Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
In the ER there were dirty linen carts stored in the egress corridor across from rooms 19 and 20. This corridor was not identified as a suite on the current prints.

EP 30
§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.

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This Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The elevator equipment room door in the Kidd wing penthouse may have been mistaken for an exit. There was not a "No Exit" sign on the door. This was observed and corrected at the time of survey.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

ESC 60 days

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

4

Scoring Category : C
Score : Partial Compliance

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)

4

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
§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 Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
There were several sprinkler heads in the food prep area, in the main kitchen, that had an excessive amount of foreign materials on the heads.

Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
There were several sprinkler heads in the food prep area, in the dishwashing area, that had an excessive amount of foreign materials on the heads.

EP 6
§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 Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
There was not 18 inches or more of open space maintained below the sprinkler deflector to the top of storage in the Pharmacy. This was observed and corrected at the time of survey.

Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
There was not 18 inches or more of open space maintained below the sprinkler deflector to the top of storage in Central Supply. This was observed and corrected at the time of survey.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.50 ESC 60 days

Standard Text: The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

9. All linen and waste chute inlet and discharge service doors have both self-closing and positive latching devices.
Note: Discharge doors may be held open with fusible links or electrical hold-open devices. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.4.1 and 8.2.3.2.3.1; NFPA 82-1999: 3-2.2.9)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 9
§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 Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The positive latching device was removed from the laundry chute door of the 8th floor collection room in the Springfield building. This was observed and then corrected at the time of survey.

Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The positive latching device was removed from the laundry chute door of the 6th floor collection room in the Springfield building. This was observed and then corrected at the time of survey.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.01

ESC 45 days

Standard Text: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

Primary Priority Focus Area: Medication Management

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Element(s) of Performance:

8. All medication orders are reviewed for the following: Therapeutic duplication.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 8
Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
An observation was made od therapeutic duplication in a post C-Section patient. There was not distinction as to when to administer Zofran vs Phenergan.

Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While tracing an orthopedic total joint patient, it was noted that the "Post Op Comfort Meds" order set included two medications for constipation; Magnesium hydroxide (Milk of Magnesia) 30 ml, suspension, PO, QDay, PRN Constipation and bisacodyl (Ducolax Laxative), 5 mg, ER Tablet, PO QDay, PRN Constipation. The medication orders did not include instructions for which medication to use as a first-line or second-line approach to care, allowing the nurses to chose the medication they felt would best address the patient's current issue related to constipation.

Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While tracing a second orthopedic total joint patient, it was noted that the "Post Op Comfort Meds" order set included two medications for constipation; Magnesium hydroxide (Milk of Magnesia) 30 ml, suspension, PO, QDay, PRN Constipation and bisacodyl (Ducolax Laxative), 5 mg, ER Tablet, PO QDay, PRN Constipation. The medication orders did not include instructions for which medication to use as a first-line or second-line approach to care, allowing the nurses to chose the medication they felt would best address the patient's current issue related to constipation.

Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
Review of a patient's record revealed two medications ordered for the same indication without clear guidelines as to which to use first. The orders were not clarified before the medications were dispensed.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: UP.01.03.01

ESC 45 days

Standard Text: A time-out is performed before the procedure.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

2. The time-out has the following characteristics:
- It is standardized, as defined by the hospital.
- It is initiated by a designated member of the team.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

Scoring Category : A
Score : Insufficient Compliance

4. During the time-out, the team members agree, at a minimum, on the following:
- Correct patient identity
- The correct site
- The procedure to be done

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
During a time-out, the practitioner was not actively participating, since he was donning his gown and gloves during the time out.

EP 4
Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While observing the time-out prior to and EGD it was noted that, although the physician and technician listened to the nurse correctly identify the patient and the procedure to be done, there was no verbal agreement between the team members as part of the time-out as required by hospital policy.

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.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

Scoring
Category : C
Score : Insufficient Compliance

Observation(s):

EP 5
§482.51(b)(1)(ii) - (A-0952) - (ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
During tracer of a post operative vascular surgery patient, it was noted that although there was an update to the H and P, the update did not include a re-examination of the patient, nor was it dated and timed as required. In accordance with policy, the update should include Time, Date, a review of the H and P and attestation that there are no changes and that the patient was re-examined.

Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The history and physical performed before a surgical procedure was performed before the patient presented to the organization for the procedure. There was no evidence of an update before the procedure.

Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The history and physical performed before a procedure involving moderate sedation was performed before the patient presented to the organization for the procedure. There was no evidence of an update before the procedure.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.05 ESC 60 days

Standard Text: Qualified staff or licensed independent practitioners assess and reassess the patient.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. Based on the initial assessment, a registered nurse determines the patient's need for nursing care, as required by hospital policy and law and regulation.

Scoring Category : A
Score : Insufficient 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 UT Medical Clinic (316 22nd Avenue North, Nashville, TN) site for the Hospital deemed service.
The surveyor traced the care of a patient who was admitted and also seen within the medicine clinic. Within the medicine clinic there was no documentation noted to support that there was a complete initial assessment . The areas related to primary language, learning assessments, education and psycho-social factors were noted to be blank within the system's electronic database. The patient was noted to be Hispanic. In speaking with staff it was determined that the patient could only speak Spanish. The residents and the Rn in the setting did not complete the initial assessment of the patient as observed per documentation within the medical record.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.07 ESC 45 days

Standard Text: The hospital assesses and manages the patient's pain.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While reviewing the Physical Therapy Evaluation for a post operative Total Knee Arthroplasty patient, it was noted that the pain assessment did not include the numerical pain scale assessment as required by organization policy. The assessment of pain stated the pain level was "as expected"

Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While reviewing the Physical Therapy Evaluation for a post operative Total Hip Arthroplasty patient, it was noted that although a comprehensive evaluation of the patient's pain was include in the evaluation, the pain assessment did not include a numerical pain scale assessment as required by organization policy.

The Joint Commission Findings

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.

Primary Priority Focus Area: Credentialed Practitioners

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. *
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
§482.57(b)(3) - (A-1163) - (3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
While tracing a patient having an EGD, it was noted that the standing Endoscopy Orders were dated and timed 3/26/14 at 1000. The orders on the overprinted form that were circled were to; admit to Endoscopy Lab as Short Stay Patient, NPO, have consent signed for EGD, and start IV Lock. The orders were noted as taken off by the nurse at 1020, however the physician signature on the form was timed at 1130. When asked who filled out the physician orders, the staff stated, "we select the appropriate actions to be completed on the order form for the patient because we generally know what the physician wants, for example for an EGD we would select 'IV Lock' versus NS @ 50 ml/hr because that's what we would do for a colonoscopy patient". I asked when the physician actually signed the orders and staff explained "sometimes before the procedure or after the procedure". In this instance the nurse filled out the physician orders, and started the IV lock without having written orders or telephone orders from the physician. When asked if the nurses filled out the physician orders as a general rule, they said "yes, for some physicians".

Observed in Record Review at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
While reviewing a second medical record of a patient having an EGD on 3/26/2014, it was also noted that the physician orders to admit to Endoscopy Lab, NPO, Have consent signed for EGD, and Start IV Lock were circled and dated 3/26/2014 at 0900 and noted by the nurse at 0930. The IV lock was started by the nurse without a physician signature. The physician orders were signed and dated on 3/26/2014 at 0930. The nurses stated they completed the orders and implemented the care for the physician and he signed them after the fact. Staff again stated "they did not obtain a telephone order and routinely filled out the Endoscopy Orders form for some physicians and they sign the orders when they can, either before the procedure or after".

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.11 ESC 45 days

Standard Text: Resuscitation services are available throughout the hospital.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served.
Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EPs 2 and 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While tracing patients in the Post Anesthesia Care Unit, it was noted that although the staff were testing and checking the adult and pediatric crash carts on a daily basis on the week days when the unit was open, the carts are not tested and checked on weekends when emergency surgery is performed. Policy states the carts should be checked daily when patients are cared for on the unit.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.01.03 ESC 45 days

Standard Text: The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2)

Scoring Category : A
Score : Insufficient Compliance

8. The hospital reevaluates the patient immediately before administering moderate or deep sedation or anesthesia. (See also RC.02.01.01, EP 2)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Record Review at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While reviewing the medical record for a patient who had a Coronary Artery By-pass Graft on 3/21/14, it was noted that page 2 of 3 of the Anesthesia Peri-operative Record, 'Anesthesiologist's Pre-Anesthesia History, Evaluation and Plan' was blank. None of the entries on page 2 were completed. The medical history, anesthesia history, Anesthesia exam, airway assessment, Dental assessment, ASA Class, and Plan were blank.

EP 8
§482.52(b)(1) - (A-1003) - [The policies must ensure that the following are provided for each patient:]

(1) A pre-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
An observation was made in a patient's medical record where there was no documentation of an immediate pre-induction assessment prior to the patient receiving anesthesia.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

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 Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
An observation was made in the Labor and Delivery area where there was no documentation of time on a Release of Information form that was in the patient's medical record.

Observed in Tracer Activities at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
An observation was made where there was no documentation of time noted on a Physician's History and Physical which was in the patient's medical record.

Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
It was noted that a progress note dated 3/25/2014 was not timed as required.

Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The H and P for a patient having an EGD on 3/26/2014 was not timed.

Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
The H and P for a patient having a Colonoscopy on 3/26/2014 was not timed.

Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
While tracing a patient in the Post Anesthesia Care Unit, it was noted the H and P for this patient dated, however it was not time as required. Additionally, the Immediate post operative note for the same patient was note dated or timed as required.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01 ESC 45 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Primary Priority Focus Area: Rights & Ethics

Element(s) of Performance:

7. The informed consent process includes a discussion about the patient's proposed care, treatment, and services.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7
§482.13(b)(2) - (A-0131) - (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site for the Hospital deemed service.
During tracer activities in the Labor and Delivery area, an observation was made of an incomplete informed consent for a patient that had a vaginal delivery. In the space provided on the form for the type of anesthesia to be given to the patient, there was no documentation of the anesthesia plan.

Chapter: Transplant Safety

Program: Hospital Accreditation

Standard: TS.03.01.01

Standard Text: The hospital uses standardized procedures for managing tissues.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

2. The hospital develops and maintains standardized written procedures for the acquisition, receipt, storage, and issuance of tissues. (See also TS.03.02.01, EP 5)

Scoring
Category : A
Score : Insufficient Compliance

7. The hospital verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. (See also TS.03.02.01, EP 6)
Note 1: If the distributor uses validated shipping containers, then the receiver may document that the shipping container was received undamaged and within the stated time frame.
Note 2: Tissues requiring no greater control than 'ambient temperature' (generally defined as the temperature of the immediate environment) for transport and storage would not need to have the temperature verified on receipt.

Scoring
Category : C
Score : Partial Compliance

Observation(s):

EP 2
Observed in Tracer Visit at Craig Center for Advanced Wound Healing at Midtown Hospital (2000 Murphy Avenue, Nashville, TN) site.
The surveyor observed while reviewing the organization's tissue log, that a receiver, time of receipt, staff preparing the product, and the date and time the physician applied the Apilgraf was not documented as required within the log per hospital policy.

Observed in Tracer Visit at Craig Center for Advanced Wound Healing at Midtown Hospital (2000 Murphy Avenue, Nashville, TN) site.
The surveyor observed while reviewing the organization's tissue log, that a receiver, time of receipt, staff preparing the product, and the date and time the physician applied the Apilgraf was not documented as required within the log per hospital policy.

Observed in Tracer Visit at Craig Center for Advanced Wound Healing at Midtown Hospital (2000 Murphy Avenue, Nashville, TN) site.
The surveyor observed that there was no patient name or medical record documented within the tissue log that identified who the tissue was administered to as required by hospital policy. The tissue was documented as applied on 6//13/13 with no patient identifying information. The organization retrospectively corrected the observation onsite during the survey.

EP 7
Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While reviewing the the implant/tissue log for surgical services, it was noted that although the organization documents when tissue was received, the log does not include any notation that the package integrity was met and transport temperature range was controlled for Allomax.

Observed in Individual Tracer at Saint Thomas Midtown Hospital (2000 Church Street, Nashville, TN) site.
While reviewing the the implant/tissue log for surgical services, it was noted that although the organization documents when tissue was received, the log does not include any notation that the package integrity was met for implanted tissues such as Patella Wedge bone and other tissues. It was observed the log does not include documentation that the package integrity for all tissues received. Policy currently does not require documentation of package integrity or temperature range control as required.

SUPPLEMENTAL #1
December 29, 2014
11:48 am

Attachment 14

SUPPLEMENTAL #1
December 29, 2014
11:48 am

PROJECT FORECAST COMPLETION CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c March, 2015

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	0	Mar-15
2. Construction documents approved by the Tennessee Department of Health	120	Jul-15
3. Construction contract signed	150	Aug-15
4. Building permit secured	150	Aug-15
5. Site preparation completed	180	Sep-15
6. Building construction commenced	180	Sep-15
7. Construction 40% complete	270	Dec-15
8. Construction 80% complete	390	Apr-16
9. Construction 100% complete (approved for occupancy)	450	Jun-16
10. *Issuance of license	480	Jul-16
11. *Initiation of service	480	Jul-16
12. Final Architectural Certification of Payment	480	Jul-16
13. Final Project Report Form (HF0055)	480	Jul-16

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

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

SUPPLEMENTAL #1

December 29, 2014
11:48 am

Attachment 15

SUPPLEMENTAL #1
December 29, 2014
11:48 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SAINT THOMAS MIDTOWN HOSPITAL

I, S. 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, STRATEGY & PLANNING
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 29 day of DEC, 2014, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires JAN. 9, 2018.

DIANE FRANKLIN
NOTARY PUBLIC AT LARGE
DAVIDSON COUNTY, TENN.

HF-0043

Revised 7/02

Supplemental #2
-Original-

ST Thomas Midtown Hospital (Emergency Department at Brentwood)

CN1412-049

SUPPLEMENTAL

December 30, 2014

Via Hand Delivery

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application CN1412-049
Saint Thomas Midtown Hospital (Emergency Department at Brentwood)

Dear Mr. Earhart:

For background and filing purposes, this is the third set of supplemental responses for the project referenced above. The first two sets were submitted to the Agency yesterday, December 29th. Once again, **our responses are provided in triplicate.**

---

1. **Section C., Need, Item 4.A.**

   Your response to this item is noted. Please complete the following chart using population projections provided by the Department of Health and US Census:

   Response: The chart has been completed as requested. Please refer to **Attachment A**.

2. **Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)**

   The historical data chart for Mid-Town Hospital's Emergency Department is noted. However, the chart indicates the dollars are reported in thousands which appears to be in error. Please revise and resubmit.

   Response: The historical data chart for Mid-Town Hospital's Emergency Department submitted yesterday, December 29th, as Attachment 9 has been revised to delete the reference to "dollars are reported in thousands." Please refer to **Attachment B** here.

SUPPLEMENTAL

3. **Section C, Economic Feasibility, Item 5 and 6**

   The revised average gross charge, average deduction from operating revenue, and average net charge is noted in the Projected Data Chart for the proposed Satellite ER. However, the project's average gross charge, average deduction form operating revenue, and average net charge do not match responses on page 34 of the original application. Please revise charges on pages 34 and 39 and submit replacement pages.

   Response: These changes were made and submitted to the Agency yesterday afternoon, December 29th, with narrative excerpts. Full replacement pages are provided here. Please refer to **Attachment C**.

We hope these additional responses are sufficient to deem this CON application complete. A notarized affidavit is provided in **Attachment D**.

Given the holiday timing, I may be reached by cell at 615.504.8761 or by email at Blake.Estes@sth.org to clarify these matters.

Sincerely,

Blake Estes
Executive Director, Strategy & Planning

attachments

SUPPLEMENTAL

Attachment A

Midtown Hospital Satellite ED - Supplemental Demographic Analysis

Demographic Data	Davidson County	Williamson County	Service Area Total	State of TN Total
Total Population - 2014	656,385	202,923	859,308	6,588,698
Total Population - 2018	682,330	223,333	905,663	6,833,509
Total Population % Change	4.0%	10.1%	5.4%	3.7%
65+ Pop. - 2014	74,375	23,028	97,403	981,984
65+ Pop. - 2018	85,594	27,729	113,323	1,102,413
65+ Population % Change	15.1%	20.4%	16.3%	12.3%
65+ Population % of Total Population - 2014	11.3%	11.3%	11.3%	14.9%
Median Age	34	39	36.5	38
Median Household Income	$47,335	$89,779	$68,557	$44,298
TennCare Enrollees	124,103	9,214	133,317	1,241,028
TennCare Enrollees as % of Total Population	17.5%	4.3%	14.4%	18.3%
Persons Below Poverty Level	112,795	10,919	123,714	1,128,618
% of Total Population below Poverty Level	17.8%	5.5%	14.9%	17.8%

Source: Tennessee Department of Health and US Census

SUPPLEMENTAL

Attachment B

SUPPLEMENTAL

HISTORICAL DATA CHART - Midtown Hospital, ED Only

Give us information for the last three (3) years for which complete are available for the facility or agency. The fiscal year begins in July.

		FY 2012	FY 2013	FY 2014
A.	Utilization Data (ER Visits)	51,980	51,625	48,803
B.	Revenue from Services to Patients			
	1. Inpatient Services	$278,959,727	$277,054,558	$237,528,651
	2. Outpatient Services	$36,599,395	36,349,438	37,944,093
	3. Emergency Services	$82,508,108	81,944,615	78,073,928
	4. Other Operating Revenue (Specify)			
	Gross Operating Revenue	$398,067,231	$395,348,611	$353,546,672
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$268,095,776	$266,264,803	$239,954,098
	2. Provision for Charity Care	$14,421,762	$14,323,268	$12,907,928
	3. Provisions for Bad Debt	$5,626,960	$5,588,530	$5,036,305
	Total Deductions	$288,144,498	$286,176,601	$257,898,330
NET OPERATING REVENUE		$109,922,733	$109,172,010	$95,648,342
D.	Operating Expenses			
	1. Salaries and Wages	$34,180,978	$33,947,538	$29,296,907
	2. Physician's Salaries and Wages			
	3. Supplies	$20,542,417	$20,402,122	$17,607,141
	4. Taxes			
	5. Depreciation	$3,639,480	$3,614,624	$3,119,440
	6. Rent			
	7. Interest, other than Capital			
	8. Other Expenses (Specify: Lab, Pharmacy, Other)	$39,297,062	$39,028,681	$33,681,961
	Total Operating Expenses	$97,659,938	$96,992,965	$83,705,449

E. Other Revenue (Expenses) -- Net (Specify)			
NET OPERATING INCOME (LOSS)	$12,262,794	$12,179,045	$11,942,893
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures			
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$12,262,794	$12,179,045	$11,942,893

SUPPLEMENTAL

Attachment C

4. Complete Historical and Projected 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 for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. 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).

   RESPONSE: Please refer to the completed hospital-wide charts on the four following pages.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

   RESPONSE: Based on Year 2 projections (FY2018), the average gross patient charge per emergency department visit is $2,482. The average deduction from gross patient charges, based on contractual allowances and allowances for charity care and bad debt, is approximately 80%, resulting in average net revenue per visit of approximately $484.

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

RESPONSE: Midtown Hospital presents the current and projected charges for an emergency department visit in **Exhibit 20**. An annual increase of 3% between FY2014 and Year 1 of the project, FY2017, is projected. Afterwards, the hospital assumes that charges will increase by 3% annually. As demonstrated in **Exhibit 21**, Midtown Hospital's emergency department charges compare favorably with other providers in Nashville.

EXHIBIT 20
MIDTOWN HOSPITAL EMERGENCY DEPARTMENT, HOSPITAL-BASED AND SATELLITE
AVERAGE GROSS CHARGE PER VISIT, CURRENT AND PROJECTED

	Current	FY2017	FY2018
Gross Charge	$2,205	$2,410	$2,482
Adjustment	$1,818	$1,926	$1,998
Net Revenue	$387	$484	$484

B. 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: Comparison charge data for emergency department visits is very limited. To compare its charges with similar facilities, Midtown Hospital relied upon Medicare data from the American Hospital Directory (AHD) or ahd.com, as a source. Midtown Hospital profiled six area hospitals serving Davidson and Williamson counties from the AHD database.

Average charges per visit ranged from a low of $478 to a high of $1,443 with Midtown Hospital at $1,144. However, service mix indexes, a measure of patient severity, ranged from a low of 2.09 to a high of 4.64 with Midtown Hospital at 3.91. Adjusting the average charge by the service mix index resulted in a range of charges from a low of $155 to a high of $318 with Midtown Hospital at $293. Please see **Exhibit 21**, which profiles the emergency department average charge data for the area hospitals.

SUPPLEMENTAL

Attachment D

SUPPLEMENTAL

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SAINT THOMAS MIDTOWN HOSPITAL

I, S. 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, STRATEGY & PLANNING

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 30 day of DEC., 2014, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires 1/9, 2018.

HF-0043

Revised 7/02

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

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:615/532-9940

December 29, 2014

Blake Estes
Saint Thomas Health
102 Woodmont Blvd., Suite 800
Nashville, Tennessee 37205

RE: Certificate of Need Application CN1412-049
Saint Thomas Midtown Hospital (Emergency Department at Brentwood)

Dear Mr. Estes:

This will acknowledge our December 29, 2014 receipt of your supplemental response for a Certificate of Need to establish a full service, 24 hour per day/7 day per week satellite emergency department to be located at 791 Old Hickory Blvd., Brentwood (Davidson County), TN 37027.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Tuesday December 30, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section C., Need, Item 4.A.**

   Your response to this item is noted. Please complete the following chart using population projections provided by the Department of Health and US Census:

Demographic Data	Davidson County	Williamson County	Service Area Total	State of TN Total
Total 2014 Population				
Total Population-				
Total 2014 Population % Change				
65+ Pop. - 2014				
65+ Pop. - 2018				
65+ Population % Change				
65+ Population % of Total Population				
Median Age				
Median Household Income				
TennCare Enrollees				
TennCare Enrollees as % of Total Population				
Persons Below Poverty Level				
% of Total Population below Poverty Level				

2. **Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)**

   The historical data chart for Mid-Town Hospital's Emergency Department is noted. However, the chart indicates the dollars are reported in thousands which appears to be in error. Please revise and resubmit.

3. **Section C, Economic Feasibility, Item 5 and 6**

   The revised average gross charge, average deduction from operating revenue, and average net charge is noted in the Projected Data Chart for the proposed Satellite ER. However, the project's average gross charge, average deduction form operating revenue, and average net charge do not match responses on page 34 of the original application. Please revise charges on pages 34 and 39 and submit replacement pages.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application, the sixtieth (60th) day after written Notification is Friday, February 20, 2015. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Resubmittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior

to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. э 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 any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart
Health Services Development Examiner

PME

Enclosure

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:615/532-9940

December 22, 2014

Blake Estes
Saint Thomas Health
102 Woodmont Blvd., Suite 800
Nashville, Tennessee 37205

RE: Certificate of Need Application CN1412-049
Saint Thomas Midtown Hospital (Emergency Department at Brentwood)

Dear Mr. Estes:

This will acknowledge our December 15, 2014 receipt of your application for a Certificate of Need to establish a full service, 24 hour per day/7 day per week satellite emergency department to be located at 791 Old Hickory Blvd., Brentwood (Davidson County), TN 37027.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Monday December 29, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section A., Applicant Profile, Item 2**

   The email contact address of the applicant is listed as blake.estes@sth.org in the letter of intent and the application lists the email address as blake.estes@stthomas.org. Please clarify.

2. **Section A., Applicant Profile, Item 5**

   Please indicate if the proposed emergency department satellite will be operated by a management/operating entity.

3. **Section A., Applicant Profile, Item 6**

   The provided lease appears to be between Old Hickory Partners, LLC and Middle Tennessee Imaging, LLC d/b/a Premier Radiology. The Agency will need a deed, a purchase agreement, lease agreement, option to lease or other legal document which demonstrates the applicant has a legitimate legal interest in the property on which to locate the project. A fully executed (signed by both parties) Option to Purchase must at least include the expected purchase price, a description of the property with address and the anticipated date of closing. A fully executed Option to Lease must at least include the expected term of the lease and the anticipated lease payments.

4. **Section B, Project Description, Item I.**

   What is the distance between the applicant's proposed satellite emergency room and TriStar's simultaneously proposed satellite emergency room located at the NE intersection of Old Hickory Boulevard and American Way, Brentwood, TN 37250?

   In light of the fact that this is one of two simultaneous review applications does the applicant believe there is a need for two satellite ERs in essentially the same location?

   What will the applicant do if this application is denied?

   Please indicate the distance from the proposed satellite emergency room to hospitals in the two county service area.

   Please provide an overview of the applicant's experience in operating a satellite emergency room.

   It is noted the applicant states both Midtown and West Hospital emergency have high utilization rates. However, what are the plans of the hospital if the proposed satellite ER does not have an impact on the ER utilization at the main campus and ER visits continue to increase with capacity issues at the main ER?

   Please indicate if the applicant will be contracting with a physician group to provide physician services in the proposed satellite ER. If so, please provide a brief overview of the Emergency Physician Group that will be staffing the ER.

   What happens if a patient who should have gone to an acute care hospital goes to/is brought to a satellite ER?

   It is noted the applicant is planning to provide MRI services at the proposed satellite ER. What are the advantages of having an MRI available in an ER?

   Please clarify if the proposed satellite ER will include a helipad.

   Please describe the proposed "flex" psychiatric room. Please clarify if it will be secured.

   Please describe the trauma room.

Please clarify if mobile crisis staff will have access to conduct assessments. If so, where? Where will law enforcement be located?

Many times emergency room copays are waived if the patient is admitted inpatient. Please clarify if this arrangement is possible at the proposed satellite ER.

On Monday December 15, 2014, Tennessee Gov. Bill Haslam unveiled his Insure Tennessee plan, a two year pilot program to provide health care coverage to Tennesseans who currently don't have access to health insurance or have limited options. The program rewards healthy behaviors, prepares members to transition to private coverage, promotes personal responsibility and incentivizes choosing preventative and routine care instead of unnecessary use of emergency rooms. What will the impact of Insure TN have on the applicant's volume projection?

Please clarify if an ambulance will be stationed at the satellite ED 24 hours/day, 7days/week, 365 days/year for life-threatening transports to full service hospitals.

The applicant mentions $208,125 in related site work. Please describe the related site work and clarify if it is reflected in the Project Cost Chart.

5. **Section B, Project Description, Item III.B.1**

Please clarify why the applicant expects patients to not access the proposed emergency room via public transportation.

Is the proposed site served by public transportation? If so, please briefly describe.

Please complete the following table that shows distance to existing ER's for the applicant's primary service area zip codes:

Zip Code	Hospital Emergency Dept.	County	Distance in miles	Drive time in minutes

6. **Section B, Project Description, Item IV**

The floor plan of the proposed satellite is noted. However, please indicate why the applicant believes waiting room with a capacity of 14 is adequate to serve an 8 treatment room emergency room.

7. **Section C, Need. Item 1 (Project Specific Criteria) Construction, Renovation, Item 3.a**

   How were these standards developed (Industry 1500 and HCA 1800)? Did they consider factors such as average minutes per room, average minutes per level of care and room occupancy differences between 7-3, 3-11, and 11-7 shifts? If yes, how so?

8. **Section C, Need. Item 1 (Project Specific Criteria) Construction, Renovation, Item 3.b**

   The applicant states 2 emergency department rooms are being lost to provide space for a CT scanner at the West Hospital. Please clarify the reason why the applicant chose to lose two emergency rooms at the West hospital while the applicant states ER utilization is high at the West hospital. Were there any other alternatives in choosing the site of the CT scanner other than in the 2 ER rooms?

9. **Section C, Need, Item 4. A and B**

   Population projections in Exhibits 8-14 are noted. However, please revise to reflect 2014 and 2018 population projections.

   Please provide population projections for the ZIP Codes in the proposed service area.

10. **Section C, Need, Item 5.**

    It is noted in Exhibit 15 Saint Thomas West is the only hospital in the service area to experience a decline in ED utilization from 2011-2013. Please provide factors that have influenced the decline.

    Also, what percentage ER patients typically are admitted as inpatients and what percentage of ER patients are typically admitted for observation. Please discuss the pros and cons of these patients going to an ER at a hospital versus going to a satellite ER that would require a transfer by ambulance.

    It appears that ER visits both Midtown and West combined only increased 1.1% between 2011 and 2013. Please explain the need to add ER capacity at all.

11. **Section C, Need, Item 6.**

Please provide ER trends for all hospitals in service area, including a sub-total for all Tri-Star hospitals and for all ST. Thomas hospitals.

Historical ER visits in application don't match with JAR. Please explain. If needed, please revise and resubmit historical ER visit data.

If a Davidson County health care provider opened an urgent care close to the proposed satellite ER site, what impact would that cause on the projected utilization? Are there existing urgent care centers in the applicant's service area?

Please clarify if there is a shortage of primary care physicians in the applicant's service area that would force patients to go to an emergency room for routine treatment.

Please complete the following table for ER patient origin by zip code for CY 2014 (January-October Annualized) for zip codes with patient origin over 0.15%.

Patient Zip Code	Patient City	Patient County	Total	Cumulative Patients	% by Zip Code	Cumulative %	Annualized Patients 2014

Please complete the following table for Mid-Town Hospital Patients Presenting 2012-2018 by level Acuity

Mid-Town Hospital Emergency Department Patients Presenting 2012-2-18 By Level of Acuity							
						Satellite Yr 1	Satellite Yr 2
	2012	2013	2014	2015	2016	2017	2018
Main							
ED							
Level I							
Level II							
Level III							
Level IV							
Level V							
Satellite ED							
Level I							
Level II							
Level III							
Level IV							
Level V							
Subtotal							
Total Combined ED's							

Please define levels I-V in the above chart.

Please complete the following chart for patient projection by Zip code in Yr. One of the proposed satellite ED project (2017) for zip codes with patient origin over 0.15%.

Patient Zip Code	Patient City	Patient County	Total	Cumulative Patients	% by Zip Code	Cumulative %	Projected Patients 2017

Please provide patient destination by ZIP Code in proposed ZIP Code service area for 2013 in the table below.

Hospital ER	Zip Codes								
	37024	37065	37069	37027	37067	37135	37064	37068	37179
Total									

12. **Section C. Economic Feasibility Item 1 (Project Cost Chart) and Item 3**

    It is noted the applicant lists construction costs as $2,477,683 in the Project Costs Chart. Please clarify why the construction costs are listed as $2,685,808 in a construction letter dated December 8, 2014 located in Attachment C.

13. **Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)**

    The applicant reported figures in the Historical and Projected Data Chart in the thousands. Please revise these charts to reflect the actual figures and resubmit.

    Please provide a historical data chart for Mid-Town Hospital's Emergency Department.

    Please provide a projected data chart for the proposed Satellite Emergency Room only.

    The Historical and Projected Data Charts are noted. However, please clarify what services are represented in the charts. Are the charts for the West and Mid-town Hospital combined? Please label the charts with which hospital or services are reflected in the charts.

14. **Section C, Economic Feasibility, Item 5 and 6**

The average gross charge, average deduction from operating revenue, and average net charge is noted. However, there is no Projected Data Chart for the proposed Emergency room to verify the charges. A request to provide a projected data chart for the proposed satellite emergency room has been requested; please check the charges against the requested Projected Data Chart. If needed, please revise charges on pages 34 and 39.

15. **Section C, Economic Feasibility, Item 6B**

Exhibit 21 is noted. However, please explain the "service mix index" and the "Service Mix Average charge to 1.00".

16. **Section C, Economic Feasibility, Item 8**

A projected data chart has been requested from the applicant for the proposed Satellite Emergency room. If the requested Projected Data Chart shows losses in the first two years of the proposed project, when does the applicant expect to break even with this project?

17. **Section C, Economic Feasibility, Item 9**

The participation of Mid-Town Hospital in state and federal programs is noted. However, please address the question specific to the proposed satellite emergency room project.

What is the payor mix of ERs in the service area?

18. **Section C, Economic Feasibility, Item 10**

The Acension Consolidated Balance Sheet ending June 30, 2014 list current total liabilities in the amount of $5,014,449,000 and total current assets in the amount of $4,622,537,000. Please clarify the financial feasibility of the project when current liabilities exceed current assets by $391,912,000. If needed, please provide additional Financial Statements that demonstrates financial feasibility.

19. **Section C, Orderly Development, Item 1.**

What is the closest hospital to the proposed satellite emergency room? Is there a transfer agreement with that hospital? If not, why?

Please define the Emergency Medical Treatment and Labor Act (EMTALA).

Please indicate where emergency OB patients will be referred for treatment from the proposed satellite ER. Also, please clarify if the OB patients would be admitted directly to the receiving facility, or would need to admit through the receiving hospital's ER.

20. Section C, Orderly Development, Item 2.

Please explain the difference between an Urgent Care Clinic and a Satellite ER. Please include hours of operation, the patient costs (including copay) for each service, and any CPT code overlap.

Please complete the following chart indicating if the following conditions can be treated at an urgent care, hospital emergency room, or satellite ER.

Condition/Need	Urgent Care	Saint Thomas Midtown ER	Proposed Satellite ER
Broken Bones			
Basic Lab Services			
Complex Lab Services			
Basic Radiological Services			
Complex Radiological Services			
Fevers/Rashes			
Sore Throat/ Ear Infections			
Orthopedic Care Requiring an MRI			
Prescriptions Written			
Migraines			
Minor Burns			
Respiratory Infections			
X-Rays			
Advanced Life Support			
Severe Chest Pain			
Deep Puncture Wounds			
Traumatic Injuries			
Dizziness			
Patients in Labor with medical problems			
Patients requiring surgery			
The Flu			

Back Pain			
Sprains			
Toothache			

21. Section C, Orderly Development, Item 3.

Since the proposed service is a 24/7 service. Please complete the following chart:

Position	7-3 # FTEs	3-11 # FTEs	11-7 # FTEs
RN			
EVS Tech			
Lab Tech			
Registration			
Pharmacy			
Total			

Please clarify if there will be security available at the proposed satellite ER. If so, why is it not included in the staffing?

22. Section C, Orderly Development, Item 7.

The general Joint Commission Accreditation Quality Report is noted. Please provide a copy of the most recent Joint Commission survey that was issued to Midtown.

23. Project Forecast Completion Chart

The applicant has indicated the Agency initial decision date as December 2014 in the Project Forecast Completion Chart. The earliest this application will be heard by the agency is March 2015. Please revise and resubmit.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application, the sixtieth (60th) day after written Notification is Friday, February 20, 2015. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Resubmittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental

information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. э 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 any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart
Health Services Development Examiner

PME

Enclosure