# AGENDA

## HEALTH SERVICES AND DEVELOPMENT AGENCY

Legislative Plaza
Room 12
Sixth Avenue North & Union Street
Nashville, TN

Wednesday, September 26, 2012

8:30 a.m. CDT

I. CALL TO ORDER

II. DIRECTOR'S ANNOUNCEMENTS

III. STATE HEALTH PLAN UPDATE

A. Update: Jeff Ockerman, Director of Health Planning, Department of Health

IV. CERTIFICATE OF NEED APPLICATIONS

A. Baptist Memorial Hospital - Huntingdon, Huntingdon (Carroll County), TN ─ CN1205-021
The initiation of psychiatric services by the conversion of twelve (12) acute care beds to geriatric psychiatric beds. The hospital proposes to initiate a geriatric psychiatric service to be managed by Psychiatric Resource Partners. The project involves the renovation of approximately 4,600 square feet. There are no additional services, major medical equipment, or additional beds involved. There will be no change in the hospital licensed total bed count of 70 beds.
$ 727,000.00
**Opposition:** Henry County Medical Center; Behavioral Healthcare Center at Martin
**DEFERRED FROM THE AUGUST MEETING**

B. The Pavilion-THS, Lebanon (Wilson County), TN ─ CN1204-016
The addition of *twenty-four (24) skilled nursing beds that will be dually certified for Medicare and Medicaid and the construction of an addition to the existing sixty (60) licensed bed nursing home. The expanded facility will have a total of eighty-four (84) licensed beds that will be dually certified for Medicare and Medicaid.
*These beds are subject to the 2011-2012 Nursing Home Bed Pool.
$ 1,823,093.00
**Opposition:** Quality Care Health Center; Mt. Juliet Health Care Center; SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center

C. Southern Sports Surgery Center, Hendersonville (Sumner County), TN ─ CN1204-019
Relocation of an approved but unimplemented certificate of need for the establishment of an ambulatory surgical treatment center (ASTC) and expansion of the designated use of its previously approved single-specialty ASTC (CN1104-013A) to multi-specialty services. The proposed project will relocate from 1163 Nashville Pike, Gallatin (Sumner County), TN 37066 to Lot 38 (Indian Lake Village), Saundersville Road, Hendersonville (Sumner County), TN 37075. The center will contain approximately 6,200 square feet of space including two (2) operating rooms, one (1) procedure room, pre/post holding area and support space. The project does not contain any major medical equipment and will not initiate or discontinue any other health service. If granted, the applicant will surrender CN1104-013A.
$ 3,355,533.00

**(Continued on next page)**

**Opposition:** Hendersonville Medical Center; Board Members of Hendersonville Medical Center: Charles Lea, Kelli Fischer, Tracy Callister, M.D., Nell Nestor, M.D., Ken Wilber; Brett Branson, M.D.; Randy Howard, M.D.; Duane Harrison, M.D.; Brent Nason, M.D.; Don Russo, M.D.; Jill Steier, M.D.; William Norris, M.D.; Steven Dickerson, M.D; Tamie Babb, M.D.; Brandon Riggan, M.D.; Jeffrey Jones, M.D.; Chad Swan, M.D.; Kenneth Lanyon, M.D.; Tom Taylor, M.D.; Patrick Meacham, M.D.; William Davis, M.D.; Clyde Southwell, M.D.; Stanley Embree, DPM; Robert Fogolin, M.D.; Webb Earthman, M.D.

D. Coram Alternate Site Services, Inc. d/b/a Coram Specialty Infusion Services, Inc., an Apria Healthcare Company, Nashville (Davidson County), TN ─ CN1205-020
The establishment of a home health agency providing and administering home infusion products and related infusion nursing services ancillary to Coram's pharmacy services. By way of example and not limitation, related infusion nursing services include: line maintenance, phlebotomy services, infusion equipment repair and replacement, and dressing changes on central lines and external access ports within the following Tennessee counties: Bedford, Bledsoe, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Franklin, Giles, Grundy, Hamilton, Hickman, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marion, Marshall, Maury, Montgomery, Monroe, Overton, Putnam, Rhea, Robertson, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, and Wilson, from its current licensed home infusion pharmacy located at 2970 Sidco Drive, Nashville (Davidson County), Tennessee 37207.
$ 63,000.00
**Opposition:** NHC HomeCare, Athens; NHC HomeCare, Columbia; NHC HomeCare, Chattanooga; NHC HomeCare, Murfreesboro; NHC HomeCare, Springfield; SunCrest Helathcare, Inc.

E. Metro Knoxville HMA, LLC d/b/a Tennova Healthcare--North Knoxville Medical Center, Powell (Knox County), TN ─ CN1206-027
The initiation of mobile positron emission tomography/computerized tomography (PET/CT) services at Tennova Healthcare – North Knoxville Medical Center (NKMC). Mobile services are being proposed for one (1) day per week. No other services will be initiated and no inpatient beds are involved with this project.
$ 1,309,471.00

F. Summit Medical Center, Hermitage (Davidson County), TN ─ CN1206-029
The initiation of inpatient rehabilitation services and conversions of twenty (20) adult psychiatric beds to inpatient rehabilitation beds. The adult psychiatric patients will be transferred to the existing adult inpatient psychiatric program at Skyline Medical Center, Madison, a sister facility. Summit Medical Center is a 188 licensed bed general hospital facility. The project will not change its licensed bed complement or initiate any other health service or include any major medical equipment.
$ 2,500,000.00
**Opposition:** Hon. Mark A. Pody, State Representative; Thomas Scott Baker, M.D.; University Medical Center; Saint Thomas Health and Baptist Hospital

G. Sycamore Shoals Hospital, Elizabethton (Carter County), TN ─ CN1206-030
The discontinuance of obstetrical services. This project will not involve any major medical equipment, will not initiate nor discontinue any other type of health service, and will not change the licensed total bed count of 121 beds at the facility.
$ 14,000.00
**Opposition:** Tina Gregg

V. GENERAL COUNSEL'S REPORT

A. Memphis Long Term Care Specialty Hospital, Memphis (Shelby County), TN ─ CN0908-046A
Request for change of control of an approved but unimplemented certificate of need. Shelby County Health Care Corporation d/b/a The MED proposes to acquire all of the issued and outstanding equity in Memphis Long Term Care Specialty Hospital, LLC to which the referenced certificate of need was issued. This project was approved at November 18, 2009 Agency meeting for the relocation and replacement of the twenty-four (24) bed long term acute care hospital to a new facility to be constructed. The project cost was $7,617,100.
**DEFERRED FROM THE AUGUST MEETING**

B. Erlanger East, Chattanooga (Hamilton County), TN ─ CN0405-047A
Request for extension of expiration date for twenty-four (24) months from December 1, 2012 to December 1, 2014. Two twenty-four (24) month extensions of the expiration date have been granted prior to this request; the first was approved on June 25, 2008 and the second was approved on June 23, 2010. This project was originally approved at the October 27, 2004 Agency meeting for the construction of new four (4) story patient tower and other ancillary space; transfer of seventy-nine (79) beds from the main campus to the east campus; initiation of cardiac catheterization and the acquisition of a magnetic resonance imaging (MRI) scanner. This project decreased the main campus beds from 703 to 624 licensed beds and increased the east campus beds from 28 to 107 licensed beds. The project cost was $68,725,321.

C. Vanderbilt University Hospital, Nashville (Davidson County), TN ─ CN0606-037A
Request for a thirty-two (32) month extension of the expiration date from November 1, 2012 to July 1, 2015. This project was approved unanimously by the Agency on September 27, 2006 for the renovation and expansion of the current hospital, to include: the addition of a third bed tower, the addition of one hundred forty-one (141) acute care beds, including six (6) neonatal intensive care unit (NICU) beds, the renovation and expansion of cardiac catheterization labs and hybrid operating rooms (ORs), and the addition of fourteen (14) newly constructed OR suites. The approved project cost is $234,421, 471.00. A six (6) year expiration date was granted: November 12, 2012.

D. Contested Case Update

VI. OTHER BUSINESS

VII. MINUTES

VIII. ADJOURNMENT

**HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING**
**AUGUST 22, 2012**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | Baptist Memorial Hospital- Huntingdon |
| PROJECT NUMBER: | CN1205-021 |
| ADDRESS: | 631 R.B. Wilson Drive<br>Huntingdon (Carroll County), TN 38344 |
| LEGAL OWNER: | Baptist Memorial Hospital- Huntingdon<br>631 R.B. Wilson Drive<br>Huntingdon (Carroll County), TN 38344 |
| OPERATING ENTITY: | Psychiatric Resource Partners, Inc.<br>830 Crescent Center Drive<br>Franklin (Williamson County), TN 37067 |
| CONTACT PERSON: | Arthur Maples<br>(901) 227-4137 |
| DATE FILED: | May 14, 2012 |
| PROJECT COST: | $727,000.00 |
| FINANCING: | Cash Reserves from Parent Company, Baptist Memorial Health Care and affiliated entities |
| REASON FOR FILING: | Initiation of Adult Inpatient Psychiatric Services and conversion of twelve (12) currently licensed medical surgical beds to twelve (12) geriatric psychiatric beds |

DESCRIPTION:

Baptist Memorial Hospital-Huntingdon (BMH-H) is seeking approval for the initiation of adult psychiatric services and conversion of twelve (12) currently licensed medical-surgical beds to twelve (12) geriatric psychiatric beds at its seventy (70) bed acute care hospital located at 631 R.B. Wilson Drive in Huntingdon (Carroll County), TN. The proposed project will involve renovation

of 4,611 square feet of a medical surgical nursing unit on the first floor of the hospital. The remodeling will involve creation of 4 private rooms and 4 semi-private rooms, a central nursing station, dining & activity area, a day room therapy area, a private consultation room and an isolation/seclusion room. The applicant indicates safety features will be added to each patient room in accordance with the American Institute of Architects (AIA) guidelines. If approved, the applicant plans to hire Psychiatric Resource Partners, Inc. of Franklin Tennessee, to provide management services to the proposed geriatric psychiatric unit.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW:

Psychiatric Inpatient Services

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).

   *Using the population estimates prepared by the Department of Health, the Guidelines for Growth Bed Need Formula calculate the following total bed need for inpatient psychiatric services:*

   *2012 Population:*
   *Total 302,582 X 30 beds/100,000 = 91 Beds*

   *2016 Population:*
   *Total 309,029 X 30 beds/100,000 = 93 Beds*

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

   *2012 Population:*
   *Age 18+ 233,350 X 30 beds/100,000 = 70.0 Beds*
   *Age 65+ 48,290 X 30 beds/100,000 = 14.5 Beds*

   *2016 Population:*
   *Age 18+ 238,412 X 30 beds/100,000 = 71.5 Beds*
   *Age 65+ 52,462 X 30 beds/100,000 = 15.7 Beds*

3. For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.

*This criterion does not apply to this application.*

4. These estimates for total need should be adjusted by the existent staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

*There are 63 staffed beds and no Certificate of Need approved beds operating in the service area, leaving calculated Net Bed Needs (depending on the population groups) of:*

*2012 Population:*

| | *Gross Bed Need* | *minus* | *Existing and CON Approved Beds* | = | *Net Bed Need* |
|---|---|---|---|---|---|
| *Total* | *91 beds* | | *63 beds* | | *28 beds* |
| *Age 18+* | *70 beds* | | *63 beds* | | *7 beds* |
| *Age 65+* | *15 beds* | | *16 beds* | | *-1 beds* |

*2016 Population:*

| | | | |
|---|---|---|---|
| *Total* | *93 beds* | *63 beds* | *30 beds* |
| *Age 18+* | *72 beds* | *63 beds* | *9 beds* |
| *Age 65+* | *16 beds* | *16 beds* | *0 beds* |

*It would appear the application does not meet this criterion.*

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

*The applicant indicates it has chosen an 8 county service area from which the Baptist Memorial Hospital - Huntingdon (BMH-H) received 99.3% of its patients last year – 2011. BMH-H indicates 94% of its inpatients originated from Carroll and Benton Counties (its primary service area).*

*It would appear the application meets this criterion.*

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

   *The applicant intends to focus on the psychiatric and medical needs of patients age 65+ and will accept involuntary admissions of geriatric psychiatric patients when capacity is available and the patient needs for stabilization and treatment can be appropriately addressed by the cross trained hospital and psychiatric staff.*

   *It would appear the application meets this criterion.*

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

   *The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) supports the philosophy of providing care as close as possible to an individual's home community in order to increase the potential involvement of family, the individual's support system, and aftercare providers in the treatment process. In addition, the 2010 State Health Plan includes "Goal 2A: Ensure all Tennesseans have access to primary mental health and physical care, including preventive care and oral care." One of the strategies to meet that goal is "ensure that adequate inpatient mental health services exist." The applicant is proposing to open an adult inpatient psychiatric unit which will allow adult inpatient psychiatric services to be provided to patients age 65+ closer to home as evidenced by the driving distances (28 to 39 miles) and times (37 to 59 minutes) to the closest licensed adult psychiatric facilities.*

   *It would appear the application meets this criterion.*

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

*According to the Tennessee Department of Health, Division of Community Health Services, the eight counties designated as the applicant's service area are also designated by the Federal Health Services and Resources Administration (HSRA) as "Designated Federal Mental Health Professional Shortage Areas (HPSAs)" for mental health outpatient services. They are also designated as Medical Underserved Areas (MUAs) for primary medical care services.*

*It would appear the application meets this criterion.*

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

*The largest of the three private licensed adult psychiatric facilities/units in the service area, Pathways of Tennessee in Jackson, TN does not serve the same types of patients as the proposed facility (addiction vs. gero-psychiatric). The TDMHSAS does have a contract with Pathways of Tennessee for substance abuse and addiction treatment, but not gero-psychiatric services. According to the JAR for the past three years (2009-2011), the facility which specifically focuses the gero-psychiatric patients, Behavioral Health Care Center at Martin, receives 70% of its patients which account for 72% of its patient days from the applicant's declared 8 county service area. Its 2011 occupancy of its 16 bed unit was 77.7%. The third adult psychiatric facility, Henry County Medical Center, recently designated a portion of their dedicated inpatient adult psychiatric unit as gero-psychiatric beds. According to the 2011 JAR, 17% of HCMC's adult psychiatric patients and 20% of its patient days are patients age 65+. The 22 bed unit's 2011 occupancy was 40.5%. Based on the 2011, Joint Annual Report, the state owned Western Mental Health Institute (WMHI) served 579 patients from the applicant's service area, which accounted for 41.5% of its admissions. However, since 97.5 % of its admissions are Ages 18-64, it appears that the proposed project will not have a significant impact on WMHI.*

*It would appear the application will have an impact on two of the four licensed adult inpatient psychiatric units.*

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

*The applicant will accept involuntary admissions of geriatric psychiatric patients when capacity is available and the patient needs for stabilization and treatment can be appropriately addressed by the cross trained hospital and psychiatric staff.*

*It would appear the application meets this criterion.*

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

*The applicant participates in both the Medicare and TennCare programs and contracts with two of TennCare MCOs operating in the west Tennessee Region.*

*It would appear the application meets this criterion.*

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.

*There are 3 inpatient adult psychiatric units in hospitals with 63 (operating and CON approved) beds. The largest of the units (25 beds) primarily treats patients with addiction issues with associated psychiatric disorders and has an average of 33% occupancy over the past three years. It is a 51 minute drive from Huntingdon. The second facility is a freestanding geriatric psychiatric hospital which is almost a one hour's drive from Huntingdon and has experienced 77.7% average occupancy of its 16 beds over the past three years. A third 22 bed unit is experiencing occupancies over the past three years which average 35%. Like the applicant's proposed unit, it is located in an acute care medical surgical facility, which is approximately a 37 minute drive from Huntingdon. The applicant has provided the access information and utilization trends for the three closest licensed adult psychiatric units to the proposed project.*

*It appears that the criterion has been met.*

2. Accessibility to specific special need groups should be an important factor.

*The elderly population in the eight (8) county service areas constitutes 16% of the service area's population and is projected to grow 8.6% over the next four years. This compares to the 65+ cohort constituting 15% of the statewide population. 21.2% of the service area's population is enrolled in the TennCare program compared to the statewide average of 19.1%*

*It would appear the application meets this criterion.*

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

*This section of the criteria and standards refers to a facility meeting DMHSAS licensure standards. However, since this unit is part of a general hospital, it will be licensed by the Department of Health and will be required to meet Medicare conditions of participation related to inpatient psychiatric facilities. Agency staff reviewed state and federal requirements and found that both refer to "adequate numbers" of nurses and other personnel under a Nursing Director's supervision. Given the concern raised in DMHSAS memo, Agency staff advised the applicant to address staffing during its presentation.*

*It appears that the criterion has <u>not</u> been met.*

<u>SUMMARY:</u>

Baptist Memorial Hospital-Huntingdon is proposing to initiate geriatric psychiatric services by converting and renovating a 12 bed medical surgical unit to create a physical environment designed to minimize confusion for the elderly, while providing the safest environment possible. The Inpatient Geriatric Psychiatric Program will initially focus on treating individuals 65 years of age and older who are suffering from a primary psychiatric diagnosis and would benefit from acute care psychiatric hospitalization. The most prevalent diagnoses are expected to be major depression, psychotic disorder, bi-polar disorder and schizophrenia. The applicant states the hospital setting is important for the effectiveness of the program and the program will strengthen the productivity of the existing hospital resources. According to the applicant, the majority of

patients admitted to geriatric psychiatric programs often fall into exclusionary criteria of general adult psychiatric programs due to secondary medical conditions or physical limitations in areas of adaptive living, such as bathing, toileting or ambulation. BMH-H's medical staff members have recognized the needs among many of their patients (in particular area nursing home residents) that will be positively met by the addition of the gero-psychiatric service. Psychiatrists can work very closely with primary care physicians on the unit to ensure monitoring of medical conditions along with the psychiatric problem. The typical older psychiatric inpatient, due predominantly to their advanced age, is often prescribed medications from a variety of medical specialists. Management of potential drug interactions is a significant area of focus for physicians specializing in inpatient geriatric psychiatry. The applicant indicates published data also indicate that patients admitted to a geriatric inpatient unit have at least one or more serious secondary medical diagnoses such as diabetes, cardiac complications, and/or hypertension. The psychiatric unit will be staffed with a blend of medical/surgical nurses and psychiatric nurses. The staff will be cross-trained to better intervene on the psychiatric and medical complexities of the unit's elderly patients. The applicant indicates the geriatric-psychiatric services which are proposed to be added at BMH-Huntingdon will improve access to a unit and program designed to meet the unique and highly diverse needs of this specialized population, and their families. According to the applicant, involuntary admission of geriatric psychiatric patients will be accepted when capacity is available and the patient needs for stabilization and treatment can be appropriately addressed by the cross trained hospital and psychiatric unit staff.

Licensed by the Tennessee Department of Health and accredited by The Joint Commission, Baptist Memorial Hospital-Huntingdon is a nonprofit corporation wholly owned by Baptist Memorial Health Care Corporation (BMHCC), another Tennessee nonprofit corporation. Baptist Memorial Health Care Corporation operates 15 hospitals with 2,625 licensed beds in three (3) states: 9 in Tennessee, 5 in Mississippi and 1 in Arkansas. *The applicant has provided a BMHCC organization chart in Attachment A.4 of the original application.* Besides the hospitals, BMHCC affiliates include 5 licensed home care agencies and six licensed hospice providers.

According to 2011 Joint Annual Report (JAR), Baptist Memorial Hospital-Huntingdon staffed 33 of its 70 licensed acute care beds and recorded a licensed occupancy of 14.0% and a staffed occupancy of 29.7%. According to the Department of Health's Joint Annual Report the two bed categories are defined as follows:

*Licensed Beds- The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).*

*Staffed Beds-The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.*

Baptist Memorial Hospital-Huntingdon indicates its primary and secondary service areas for this project are determined by the origin of patients currently serviced at the BMH-Huntingdon. Carroll and Benton Counties, which serve 94% of the BMH-H's inpatient admissions, serve as the primary services area counties. The hospital's secondary area includes 6 additional west Tennessee counties: Decatur, Gibson, Henderson, Henry, Madison and Weakley Counties. *See map in Attachment C.3.*

The current aggregate population of the applicant's service area counties is 302,582. By 2016, the service area population is expected to grow by 2.1% to 309,029. The applicant's target population of adults ages 65+ will increase by 8.6% between 2012 and 2016. The percentage of the proposed service area population enrolled in TennCare is 21.2% as compared to the statewide enrollment of 19.1%.

**BMH-H Population Demographics with Projected Changes 2012-2016**

| 8 County West Tennessee Service Area | 8 County Service Area 2012 | 8 County Service Area 2016 | % Change | State of Tennessee Total 2012 | State of Tennessee Total 2016 | % Change |
|---|---|---|---|---|---|---|
| Total Population | 302,582 | 309,029 | 2.1% | 6,361,070 | 6,575,165 | 3.3% |
| Age 18+ Population | 233,350 | 238,412 | 2.2% | | | |
| Age 65+ Population | 48,290 | 52,462 | 8.6% | 878,496 | 987,074 | 11.0% |
| Age 65+ % of Total Pop. | 16.0% | 17.0% | - | 13.8% | 15.0% | - |
| Median Household Income | $35,596 | - | - | $43,413 | - | - |
| % Pop below Poverty Level | 18.78% | - | - | 16.50% | - | - |
| TennCare Enrollees | 64,059 | - | - | 1,211,113 | - | - |
| TennCare Enrollees as % of Total Pop. | 21.2% | - | - | 19.1% | - | - |

Using the formula for psychiatric beds contained in the *Guidelines for Growth (30 beds per 100,000 population)*, DoH estimates that there is currently a need for a total of 93 inpatient psychiatric beds for all ages in the service area by 2016. The

*Guidelines for Growth* states "for adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed." Thus, utilizing the projected 18 and over population for 2016 for the eight county service area (237,791) and multiplying it by 30 beds/100,000 population the formula computes to an adult psychiatric bed need of 72 beds. For the age cohort 65+, there is a calculated gero-psychiatric bed need of 16 beds for 2016.

The *Guidelines for Growth* states further that "these estimates for total bed need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report." The TDOH indicates there are currently 63 adult beds licensed and operating psych beds in the applicant's service area: 22 adult psychiatric beds at Henry County Medical Center in Paris (Henry County), TN; 25 adult psychiatric beds at Pathways of Tennessee in Jackson (Madison County), TN; and 16 beds at Behavioral Healthcare Center at Martin in Martin (Weakley County), TN.

Below is a chart outlining their locations, distance and driving times from Huntingdon, their capacity, and recent utilization.

| Facility | City | County | Distance | Drive Time | Beds | 2009 Occup. | 2010 Occup. | 2011 Occup. |
|---|---|---|---|---|---|---|---|---|
| Behavioral Healthcare Center at Martin | Martin | Weakley | 39 mi | 59 min | 16 | 78.5% | 76.0% | 77.7% |
| Henry County Medical Center | Paris | Henry | 28 mi | 37 min | 22 | 23.2% | 39.8% | 40.5% |
| Pathways of Tennessee | Jackson | Madison | 38 mi | 51 min | 25 | 26.8% | 37.5% | 33.8% |
| | | | | | | | | |
| Total | | | | | 63 | 38.9% | 48% | 47.3% |

Source: Tennessee Department of Health, Joint Annual Reports - 2009, 2010, 2011; 2010 Census Centers of Population by County

Of the 63 licensed adult psychiatric beds, DoH indicates there are 16 designated as gero-psychiatric beds at the freestanding Behavioral Healthcare Center at Martin. The 25 adult psychiatric beds at Pathways of Tennessee are primarily focused on treating addiction patients with associated psychiatric disorders. Henry County Medical Center primarily serves adult psychiatric patients ages 18-64 (83% of admissions, according to their 2011 JAR), but does treat some elderly patients with psychiatric diagnoses (17% of adult psychiatric admissions and 20% of patient days in 2011). Beginning with their 2011 Joint Annual Report, Henry County Medical Center reported that some of the beds in their dedicated 22 adult psychiatric bed unit are designated as gero-psychiatric beds.

Subtracting the existing operating and approved beds for the *Guidelines for Growth* Inpatient Psychiatric Bed Formula's need calculation, there is a NET 2016 PSYCHIATRIC BED NEED in the 8 county west Tennessee service area of 30 beds for all ages; 9 beds for the Age 18+ population group; and 0 beds for the Age 65+ age cohort.

The applicant indicates the need for 12 additional geriatric psychiatric beds can be demonstrated by employing two methodologies as outlined on pages 11-13 of the supplemental response:

1) Based on the Department of Health's population projections, the population of patients age 65+ will increase by 13.25% from 2012 to 2018. *Note to Agency members: This calculation projects two years beyond the Guidelines for Growth's 4 year projection period recommendation.* When the need for 9 beds is increased with allowance for population increase and occupancy, the need is rounded to 12 beds, according to the applicant.
2) The counties which the applicant designates as its primary service area (Carroll and Benton) constitute 94% of the hospital's admission and 94% of its outpatient registrations. The 2018 Department of Health's population projections for the 18+ population for these two counties constitutes 36,788 adults. *Note to Agency members: This calculation projects two years beyond the Guidelines for Growth's 4 year projection period recommendation.* Applying the Guideline's for Growth formula of 30 Beds per 100,000 population calculates a bed need of 11.26 or 12 beds. The remainder of the justification conveys the published data that an average of 83% of patients admitted to a geriatric inpatient unit have at least one or more serious secondary medical diagnoses. Thus, the proposed unit will in a medical-surgical facility will be able to take care of multiple health issues (psychiatric and medical) simultaneously upon the same admission. *See pages 11-13 of the supplemental response for a more detailed explanation.*

*Note to Agency members: The applicant indicates on page 12 of the supplemental response that 94% of its patients originate from Carroll and Benton Counties. Utilizing the Guidelines for Growth's adult inpatient psychiatric Bed Need Formula for adult inpatient psychiatric beds (30 beds/ 100,000 population), the bed need for gero-psychiatric beds for persons 65+ living in Carroll and Benton Counties calculates to 2.9 beds for 2016.*

The applicant projects 243 gero-psychiatric admissions and utilization of 2,920 patient days for an occupancy rate of 67% in the first year of the project increasing by 12.6% to 274 gero-psychiatric admissions and 3,285 patients days

and occupancy rate of 75% in the second year. The applicant supported their projections by stating they analyzed patient data from 3 fiscal years to identify patients with secondary diagnosis that would indicate potential need for admission to a gero-psychiatric unit, including Alzheimer's, anxiety, anxiety and depression, bipolar disorder, change in mental status, dementia, panic disorder, psychosis and suicidal ideation. According to the applicant, the numbers reflect a positive annual trend: FY 2009 - 163; FY 2010 - 186; FY 2011 - 154 and YTD 2012 - 199. In addition, several physicians, who were also medical directors at community nursing homes, expressed a need for a geriatric-psychiatric unit to meet community needs and supplied data about potential patients: Lee M Carter, MD - 5 patients/month, 60 patients /year; Thomas Paul Evans, MD – 20 patients/month, 240 patients/year; Scott Portis, MD - 12 patients/month, 144 patient/year; James S. Williamson, MD, an unspecified number of patients. *Copies of the physician support letters are included on pages 23-26 of the supplemental response.*

According to the applicant's Projected Data Chart, total gross operating revenue is $6,056,343.00 ($2,074 per patient per day) in year one of the project. Gross operating revenue increases to $6,813,386 in year two. The unit is projected to be profitable in year one, producing a Net Operating Income of $796,636 which will increase to $1,025,889 in year two. The unit will be professionally staffed by 12.3 FTE clinical workers (1 FTE Nurse Manager) 4.20 FTE RN's, 2.8 FTE Nursing Assistants, 1.0 FTE Social Worker, 1.2 FTE OT/AT/RT (Occupational Therapy/Activities Therapy/Recreational Therapy) and 2.1 FTE unit clerks).

The applicant indicates this unit will bill Medicare $5,511,272 (or 91% of Gross Operating Revenues) in the first year of the project. BMH-H has contracts with BlueCare and United Healthcare Community Plan. TennCare revenue has been projected at 0.25% of Gross Operating Revenues, or $15,000.

Per the Historical Data Chart, Baptist Memorial Hospital-Huntingdon has experienced Net Operating Losses, in each of the three previous years of operation: ($1,304,578) in 2009, ($2,134,138) in 2010, and ($2,919,214) in 2011.

A May 10, 2012 letter from Baptist Memorial Health Care Corporation's Chief Financial Officer attests to BMHCC's intent and ability to fund the project through cash reserve of BMHCC's affiliated entities. Review of the Baptist Memorial Hospital-Memphis' unaudited financial statements of September 30, 2011 in the supplemental response revealed BMH-M cash and cash equivalents balance of $186,084,744 and a current assets to current liabilities ratio (5.5 to 1).

The total estimated project cost is $727,000.00, of which 71% of the project's cost is attributable to construction costs plus contingency amounts to $514,495, or approximately $111.58/square foot. *This amount falls within the first (lowest) quartile of hospital renovation construction costs for facilities reviewed in 2009-2011 by the HSDA.* Equipment and furnishings are budgeted at $165,700. Architectural and Engineering fees amount to $43,805. CON fees are $3,000.00.

*The applicant has submitted the required information on corporate documentation and title and deeds. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency's office.*

Should the Agency vote to approve this project, the CON would expire in three years.

**CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:**

There are no other Letters of Intent, denied applications or outstanding Certificates of Need for this applicant.

*Baptist Memorial Hospital – Tipton is owned by Baptist Memorial Health Care Corporation of Memphis, Tennessee, which has financial interests in this project. Baptist Memorial Health Care Corporation has no other Letters of Intent, denied or pending applications.*

Pending Applications

**Baptist Memorial Hospital-Tipton, CN1205-026,** has a pending application which was scheduled to be heard at the August 22, 2012 Agency meeting, but has been deferred to a later meeting at the request of the applicant. The application is for modification to CN1105-028A by adding 52,688 square feet to the building, $29,117,691 to the project's cost, change the source of the PET/CT to be relocated to the Baptist Center for Cancer Care, and replace rather than relocate one of the linear accelerators being relocated from Baptist Memorial Hospital-Memphis. CN1105-028A was approved for the construction of a comprehensive cancer center; initiating linear accelerator and PET services; relocate 2 linear accelerators, PET, previously approved cyberknife (CN1010-050) from Baptist Memorial Hospital- Memphis to the proposed Baptist Center for Cancer Care. The estimated cost of the full project following modification is **$94,042,916.00.**

Outstanding Certificates of Need

**Baptist Memorial Hospital-Tipton, CN1105-018A,** has an outstanding Certificate of Need that will expire on October 1, 2014. The CON was approved at the August 24, 2011 Agency meeting for construction of a comprehensive cancer center; initiating linear accelerator and PET services; relocate 2 linear accelerators, PET, previously approved cyberknife (CN1010-050) from Baptist Memorial Hospital- Memphis to the proposed Baptist Center for Cancer Care. The estimated cost of the project is **$64,925,225.00.** *Project Status Update: During the planning phase of the project the applicant has received additional interest in the project requiring them to expand the project and file for an expanded Certificate of Need CN1205-026.*

**Baptist Memorial Hospital-Tipton, CN1111-050A,** has an outstanding Certificate of Need that will expire on March 1, 2015. The CON was approved at the January 25, 2012 Agency meeting to acquire a PET/CT unit and initiate PET services from a unit that was previously owned and operated at the same site (CN0511-105A - UT Cancer Institute, owned & managed by The Boston Baskin Cancer Group). The unit will continue in leased space at this site. The estimated project cost is**$1,359,221.00.** *Project Status Update: The project has been implemented and the Final Project Report is expected to be filed soon. This PET/CT unit is proposed to be moved to the BCCC site, if CN1205-026 is approved and implemented.*

**CERTIFICATE OF NEED INFORMATION FOR OTHER FACILITIES IN THE SERVICE AREA:**

There are no Letters of Intent, denied or pending applications, or outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF MENTAL HEALTH FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**

PMW
(8/7/12)

# LETTER OF INTENT

2012 MAY -9 AM 9: 49

# LETTER OF INTENT
# TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Carroll County News-Leader (Name of Newspaper) which is a newspaper of general circulation in Carroll (County), Tennessee, on or before May 9 (Month / day), 2012 (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:

Baptist Memorial Hospital-Huntingdon (Name of Applicant), a hospital (Facility Type-Existing)

owned by: Baptist Memorial Hospital-Huntingdon with an ownership type of non-profit corporation intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: the conversion of 12 currently licensed med-surg beds to 12 beds for initiation of geriatric psychiatric services located at Baptist Memorial Hospital-Huntingdon, 631 R. B. Wilson Drive, Huntingdon, Tennessee 38344. The geriatric psychiatric service will be managed by Psychiatric Resource Partners, Inc. The project involves renovation of approximately 4,600 sq ft. There are no additional services, major medical equipment, or additional beds involved. There will be no change in the hospital license total bed count of 70 beds. The estimated project cost is $727,000.

The anticipated date of filing the application is: May 14, 20 12

The contact person for this project is Arthur Maples (Contact Name) Dir. of Strategic Analysis (Title)

who may be reached at: Baptist Memorial Health Care Corporation (Company Name) 350 N. Humphreys Blvd (Address)

Memphis (City) TN (State) 38120 (Zip Code) 901 / 227-4137 (Area Code / Phone Number)

Arthur Maples (Signature) 5/8/2012 (Date) Arthur.Maples@bmhcc.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**
**500 Deaderick Street, Suite 850**
**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.

==========



HF0051 (Revised 05/03/04 – all forms prior to this date are obsolete)

# ORIGINAL APPLICATION

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

2012 MAY 14 PM 4:09

Baptist Memorial Hospital - Huntingdon
Name

631 R.B. Wilson Drive — Carroll
Street or Route — County

Huntingdon — TN — 38344
City — State — Zip Code

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

Arthur Maples — Dir. Strategic Analysis
Name — Title

Baptist Memorial Health Care Corporation — Arthur.Maples@bmhcc.org
Company Name — Email address

350 N. Humphreys Blvd. — Memphis — TN — 38120
Street or Route — City — State — Zip Code

Employee — 901-227-4137 — 901-227-5004
Association with Owner — Phone Number — Fax Number

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

Baptist Memorial Hospital - Huntingdon
Name

631 R.B. Wilson Drive — Carroll
Street or Route — County

Huntingdon — TN — 38344
City — State — Zip Code

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

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

**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)***

Psychiatric Resource Partners, Inc.
Name

2012 MAY 14 PM 4:09

830 Crescent Center Drive — Davidson
Street or Route — County

Franklin — TN — 37067
City — State — 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 | X | D. | Option to Lease | |
| B. | Option to Purchase | | E. | Other (Specify) _____ | |
| C. | Lease of _____ Years | | | | |

**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)_____ | 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*] | X |
| B. | Replacement/Existing Facility | | | | |
| C. | Modification/Existing Facility | | | | |
| D. | Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) Geriatric Psych | X | H. | Change of Location | |
| E. | Discontinuance of OB Services | | I. | Other (Specify)_____ | |
| F. | Acquisition of Equipment | | | _____ | |

9. **Bed Complement Data**

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

2012 MAY 14 PM 4:08

| | | Current Beds Licensed | *CON | Staffed Beds | Beds Proposed | TOTAL Beds at Completion |
|---|---|---|---|---|---|---|
| A. | Medical | 49 | | 49 | -12 | 37 |
| B. | Surgical | | | | | |
| C. | Long-Term Care Hospital | | | | | |
| D. | Obstetrical | | | | | |
| E. | ICU/CCU | 6 | | | | 6 |
| F. | Neonatal | | | | | |
| G. | Pediatric | | | | | |
| H. | Adult Psychiatric | | | | | |
| I. | Geriatric Psychiatric | | | | 12 | 12 |
| J. | Child/Adolescent Psychiatric | | | | | |
| K. | Rehabilitation | | | | | |
| 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 | 15 | | | | 15 |
| T. | Mental Health Residential Treatment | | | | | |
| U. | Residential Hospice | | | | | |
| | **TOTAL** | **70** | | | | **70** |

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** 44-0016 44-U016

**Certification Type** Acute Care Hospital Swing beds

11. **Medicaid Provider Number** 00440016

**Certification Type** Acute Care Hospital

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

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.***

Response

BMH-Huntingdon has a contract with BlueCare and UHC.

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

**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.

## Executive Summary

Baptist Memorial Hospital-Huntingdon (BMH-Huntingdon) is proposing to establish a geriatric psychiatric service by converting 12 Medical Surgical beds and renovating the surroundings to provide a physical environment designed to minimize confusion for the elderly while providing the safest environment possible. The Inpatient Geriatric Psychiatric Program will focus on treating individuals 65 years of age and older who are suffering from a primary psychiatric diagnosis and would benefit from acute care psychiatric hospitalization. The most prevalent diagnoses are expected to be major depression, psychotic disorder, bi-polar disorder and schizophrenia. The American Board of Psychiatry and Neurology has established Geriatric Psychiatry as a specialty area requiring psychiatrists to sit for a grouping of special exams if they desire to be Boarded in Geriatric Psychiatry. It is the very unique and highly diverse needs of this specialized population, and their families, that distinguish geriatric psychiatric programs from adult programs.

The service will be managed by Psychiatric Resource Partners (PRP) that is a subsidiary of Acadia Healthcare based in Nashville. The psychiatric unit will be staffed with a blend of medical/surgical nurses and psychiatric nurses. The staff will be cross-trained to better intervene on the psychiatric and medical complexities of the unit's elderly patients. PRP will be responsible for recruiting a qualified medical director, nursing director, social worker and other key personnel.

The hospital setting is important for the effectiveness of the program and the program will strengthen the productivity of the existing hospital resources. The majority of patients admitted to geriatric psychiatric programs often fall into exclusionary criteria of general adult psychiatric programs due to secondary medical conditions or physical limitations in areas of adaptive living, such as bathing, toileting or ambulation. Medical staff members have commented about the needs that will be positively met by the addition of the geropsychiatric service. Psychiatrists can work very closely with primary care physicians on the unit to ensure monitoring of medical conditions along with the psychiatric problem. The typical older psychiatric inpatient, due predominantly to their advanced age, is often prescribed medications from a variety of medical specialists. Management of potential drug interactions is a significant area of focus for physicians specializing in inpatient geriatric

psychiatry. Published data also indicate that patients admitted to a geriatric inpatient unit have at least one or more serious secondary medical diagnoses such as diabetes, cardiac complications, and/or hypertension.

The service area is the source of the current hospital inpatient population that includes Carroll, and the adjacent counties of Benton, Decatur, Gibson, Henderson, Henry, Madison and Weakley. Although there is an adult hospital based psychiatric program in Henry County, the closest dedicated hospital geropsychiatric unit is approximately 1.5 hours away from BMH-Huntingdon in Perry County.

The project renovation will be funded by Baptist Memorial Health Care Corporation that is the sole member of BMH-Huntingdon. The financial feasibility of the project is demonstrated by the positive financial contribution shown in the projected financial reports.

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

The proposed geriatric psychiatric unit will be located in approximately 4,611 square feet. The renovation is projected to cost approximately $95 per square foot (sq ft) for a total of $438,045. The cost is reasonable based on other projects within the BMHCC system and others in the state.

For example, CN1101-003 was for renovation of 2,146 sq ft for 9 geriatric-psychiatric beds and was projected at $163 per sq ft.

Medical-Surgical beds will be converted in their present location and reopened as geriatric psychiatric beds.

In accordance with American Institute of Architects guidelines, safety feature will be added to each patient room.

Since the cost is below $5 million, the square footage chart will not be completed.

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

The proposed project will convert 12 Medical-surgical beds to 12 geriatric-psychiatric beds. Other services will not be affected.

# SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

| A. Unit / Department | Existing Location | Existing SF | Temporary Location | Proposed Final Location | Proposed Final Square Footage | | | Proposed Final Cost/ SF | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Renovated | New | Total | Renovated | New | Total |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| B. Unit/Depart. GSF Sub-Total | | | | | | | | | | |
| | | | | | | | | | | |
| C. Mechanical/ Electrical GSF | | | | | | | | | | |
| D. Circulation /Structure GSF | | | | | | | | | | |
| E. Total GSF | | | | | | | | | | |

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
As previously described, geriatric-psychiatric services are proposed to be added at BMH-Huntingdon to improve access to a unit and program designed to meet the unique and highly diverse needs of this specialized population, and their families.

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

Response
NOT APPLICABLE

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:

Response
NOT APPLICABLE

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.

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.

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.

**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**:

Response
A plot plan for the BMH-Huntingdon 10 acre campus is provided.

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.***

(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
Access to the hospital is provided by individual vehicles although the hospital is located along a major thoroughfare. Ample and convenient parking is provided.

**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
A floor plan showing the 12 bed geriatric-psychiatric unit is provided as an attachment.

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

## 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
   Responses to criteria are provided on the following pages.

   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

# PSYCHIATRIC INPATIENT SERVICES
# GUIDELINES FOR GROWTH

2012 MAY 14 PM 4: 10

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports)

Response

As shown in the Tables below, population estimates from the Department of Health Statistics have been used to determine the number of adult psychiatric beds need in the service area.

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

Response

The tables below show the bed need for ages 18 and older and for ages 65 and older

## ADULT POPULATION 18 YRS AND ABOVE

| County | Age | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|---|
| Madison | 18 plus | 75,907 | 76,605 | 77,358 | 78,154 | 78,744 | 79,361 | 80,031 |
| Henderson | 18 plus | 21,489 | 21,674 | 21,871 | 22,081 | 22,222 | 22,367 | 22,527 |
| Gibson | 18 plus | 37,530 | 37,571 | 37,636 | 37,710 | 37,721 | 37,748 | 37,786 |
| Weakley | 18 plus | 26,074 | 26,095 | 26,123 | 26,180 | 26,201 | 26,230 | 26,276 |
| Henry | 18 plus | 25,812 | 25,954 | 26,106 | 26,269 | 26,350 | 26,432 | 26,538 |
| Carroll | 18 plus | 23,375 | 23,481 | 23,595 | 23,727 | 23,796 | 23,873 | 23,960 |
| Benton | 18 plus | 13,413 | 13,460 | 13,513 | 13,580 | 13,574 | 13,576 | 13,590 |
| Decatur | 18 plus | 9,150 | 9,168 | 9,180 | 9,207 | 9,183 | 9,184 | 9,183 |

| 18+ POPULATION | 232,750 | 234,009 | 235,382 | 236,909 | 237,792 | 238,771 | 239,889 |
|---|---|---|---|---|---|---|---|
| Bed Need Calculation 30 beds/100,000 | 69.82 | 70.20 | 70.61 | 71.07 | 71.34 | 71.63 | 71.97 |
| Adult Beds in Area | 63 | 63 | 63 | 63 | 63 | 63 | 63 |
| Need | 6.82 | 7.20 | 7.61 | 8.07 | 8.34 | 8.63 | 8.97 |

| ADULT POPULATION 65 YRS AND ABOVE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| County | Age | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| Madison | 65 plus | 12,914 | 13,277 | 13,670 | 14,075 | 14,539 | 15,013 | 15,522 |
| Henderson | 65 plus | 4,169 | 4,284 | 4,402 | 4,525 | 4,627 | 4,730 | 4,843 |
| Gibson | 65 plus | 8,523 | 8,634 | 8,750 | 8,870 | 8,973 | 9,081 | 9,194 |
| Weakley | 65 plus | 5,055 | 5,118 | 5,183 | 5,257 | 5,332 | 5,411 | 5,496 |
| Henry | 65 plus | 6,356 | 6,480 | 6,603 | 6,731 | 6,856 | 6,982 | 7,115 |
| Carroll | 65 plus | 5,495 | 5,597 | 5,698 | 5,810 | 5,897 | 5,982 | 6,075 |
| Benton | 65 plus | 3,457 | 3,539 | 3,616 | 3,702 | 3,758 | 3,820 | 3,877 |
| Decatur | 65 plus | 2,321 | 2,366 | 2,402 | 2,445 | 2,480 | 2,527 | 2,566 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **65+ POPULATION** | 48,290 | 49,295 | 50,324 | 51,415 | 52,462 | 53,546 | 54,688 |
| Bed Need Calculation 30 beds/100,000 | 14.49 | 14.79 | 15.10 | 15.42 | 15.74 | 16.06 | 16.41 |
| Geriatric Psychiatric Beds | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Beds in Area | | | | | | | |

Range of Needed Beds in 2016 = 8 (Adult) to 16 (Geriatric Psychiatric )
**Mid point of Range = 12 Beds**

3. For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.
Response
NOT APPLICABLE

4. These estimates for total need should be adjusted by the existent staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.
Response
Please refer to the Table below that is the source for the Need Shown in the Tables above.

2012 MAY 14 PM 4:10

## Counties in BMH-Huntingdon Service Area

| COUNTY | FACILITY NAME | Psych Beds | TYPE |
|---|---|---|---|
| Weakley | Behavioral Healthcare Center at Martin | 16 | ADULT |
| | HealthSouth Cane Creek Rehab Center | 0 | |
| | Volunteer Community Hospital | 0 | |
| Henry | Henry County Medical Center | 22 | ADULT |
| Benton | Camden General Hospital | 0 | |
| Henderson | Henderson County Community Hospital | 0 | |
| Madison | Pathways of Tennessee | 25 | ADULT |
| | Jackson-Madison County General Hospital | 0 | |
| | Regional Hospital of Jackson | 0 | |
| Gibson | Gibson General Hospital | 0 | |
| | Humboldt General Hospital | 0 | |
| | Milan General Hospital | 0 | |
| Decatur | Decatur County General Hospital | 0 | |
| Carroll | Baptist Memorial Hospital - Huntingdon | 0 | |
| | McKenzie Regional Hospital | 0 | |

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

Response

The service area was determined by the hospital inpatient origin as shown in Joint Annual Report. The counties are Carroll, Decatur, Gibson, Madison, Henderson, Benton, Henry, and Weakley.

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

Response

As discussed in other areas of the application, the geriatric focus is for patients 65 years of age or older. Infrequently, if an older adult patient requires geriatric psychiatric services, the patient would be considered for admission on a case by case basis.

Involuntary admission of geriatric psychiatric patients will be accepted when capacity is available and the patient needs for stabilization and treatment can be appropriately addressed by the cross trained hospital and psychiatric unit staff.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

Response

The following Five Principles for Achieving Better Health are from The Tennessee State Health Plan:

1. The purpose of the State Health Plan is to improve the health of Tennesseans;

   Response

   The proposed project will improve the health of Tennesseans. It will treat individuals 65 years of age and older who are suffering from a primary psychiatric diagnosis and would benefit from acute care psychiatric hospitalization.

2. Every citizen should have reasonable access to health care;

   Response

   The proposed project will improve access for geriatric psychiatric services for the patients in Carroll County and the counties served by BMH-Huntingdon.

3. The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system;

   Response

   The utilization of existing health care resources will be improved with the continued development of new services in the area.

4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers; and

   Response

   The proposed service will work to attain the quality standards being established by CMS. PRP will also work with BMH-Huntingdon to minimize falls, minimize readmissions, and increase patient satisfaction scores.

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

   Response

   PRP and the hospital will work to recruit highly qualified professionals and will work to assure the highest possible staff satisfaction with their job responsibilities.

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

Response
As presented in other parts of this application, this service is focused on the needs of the geriatric population. Baptist Memorial Hospital- Huntingdon participates in the TennCare program. Since most of these patients will have Medicare, very few will be Medicaid patients. However, if a patient is infrequently in need of geriatric psychiatric services before they are covered by Medicare, the situation will be considered on a case by case basis.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

Response
This proposal will have a positive impact on access to geriatric psychiatric services and will have very little impact on state appropriations.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

Response
As previously discussed, involuntary admissions will be accepted when capacity is available and the patient needs for stabilization and treatment can be appropriately addressed by the cross trained hospital and psychiatric unit staff.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

Response
BMH-Huntingdon participates with the TennCare carriers in the West Tennessee area. Since it focuses on 65+ year old patients, most will be covered by Medicare. However, an amount has been identified for patients who may not have reached full Medicare coverage because they are slightly younger that 65 and in need of geriatric psychiatric service. The projected net revenue from Medicare is $2,239,625 and TennCare is $7,495.

D. Relationship to Existing Similar Services in the Area
1. The area's trends in occupancy and utilization of similar services should be considered.

Response
As shown in the table below, the existing services in Henry and Weakley counties are considered.

## UTILIZATION OF EXISTING ADULT PSYCHIATRIC BEDS ACCORDING TO CURRENTLY AVAILABLE JOINT ANNUAL REPORT

| 25 beds | MADISON CO. -Pathways 2011 | | Annual | Annual |
|---|---|---|---|---|
| No Gero | Age | Pts Sep 30 | Disch | Pt Days |
| | 0-17 | 0 | | |
| | 18-64 | 7 | 681 | 3036 |
| | 65+ | 0 | 10 | 49 |
| | Total | 7 | 691 | 3085 |

| 22 beds | HENRY CO Hospital - 2011 | | Annual | Annual |
|---|---|---|---|---|
| No Gero | Age | Pts Sep 30 | Disch | Pt Days |
| | 0-17 | 0 | | |
| | 18-64 | 7 | 287 | 2610 |
| | 65+ | 2 | 59 | 639 |
| | Total | 9 | 346 | 3249 |

| 16 Beds | WEAKLEY CO. Behavioral Health Martin 2010 | | Annual | Annual |
|---|---|---|---|---|
| No Gero | Age | Pts Sep 30 | Disch | Pt Days |
| | 0-17 | 0 | | |
| | 18-64 | 3 | 25 | 376 |
| | 65+ | 10 | 281 | 4059 |
| | Total | 13 | 306 | 4435 |

2. Accessibility to specific special need groups should be an important factor.

Response

As described in other parts of the application, this proposal is for the special needs of the elderly population.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

Response

The unit will be licensed as a Service of BMH-Huntingdon through the Department of Health licensing process.

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

Response

The long-range plan includes the objective of providing the highest quality health care services with the most advanced technological capabilities that can be appropriately maintained within the operational parameters of the facility. The hospital has consistently adjusted the services according to need. The need for the proposed geriatric psychiatric service need has been discussed by medical staff in the community and the psychiatric unit will be staffed with a blend of medical/surgical nurses and

psychiatric nurses. These groups will be cross-trained to better intervene on the psychiatric and medical complexities of the elderly patients. The capabilities and the operational efficiencies of the hospital will be improved.

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
A map is provided.

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

Response
As previously discussed, this proposal is focused on the senior population that is increasing at a more rapid rate than other cohorts. Additional demographics are provided in an attachment.

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
As previously discussed in other parts of the application, the geriatric psychiatric service surroundings will provide a physical environment designed to minimize confusion for the elderly while providing the safest environment possible.

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
The applicant is unaware of any unimplemented CON's in the service area.

| 25 beds | MADISON CO. -Pathways 2011 | | | |
|---|---|---|---|---|
| No Gero | 2012 MAY 14 PM 4:10 | Pts Sep 30 | Annual Disch | Annual Pt Days |
| | 0-17 | 0 | | |
| | 18-64 | 7 | 681 | 3036 |
| | 65+ | 0 | 10 | 49 |
| | Total | 7 | 691 | 3085 |

| 25 beds | MADISON CO. -Pathways 2010 | | | |
|---|---|---|---|---|
| No Gero | Age | Pts Sep 30 | Annual Disch | Annual Pt Days |
| | 0-17 | 0 | | |
| | 18-64 | 7 | 870 | 3351 |
| | 65+ | 0 | 15 | 67 |
| | Total | 7 | 885 | 3418 |

| 25 beds | MADISON CO. -Pathways 2009 | | | |
|---|---|---|---|---|
| No Gero | Age | Pts Sep 30 | Annual Disch | Annual Pt Days |
| | 0-17 | 0 | | |
| | 18-64 | 8 | 792 | 2362 |
| | 65+ | 0 | 26 | 84 |
| | Total | 8 | 818 | 2446 |

| | HENRY CO Hospital - 2011 | | | |
|---|---|---|---|---|
| 22 beds | Age | Pts Sep 30 | Annual Disch | Annual Pt Days |
| No Gero | 0-17 | 0 | | |
| | 18-64 | 7 | 287 | 2610 |
| | 65+ | 2 | 59 | 639 |
| | Total | 9 | 346 | 3249 |

| | HENRY CO Hospital - 2010 | | | |
|---|---|---|---|---|
| 22 beds | Age | Pts Sep 30 | Annual Disch | Annual Pt Days |
| No Gero | 0-17 | 0 | | |
| | 18-64 | 7 | 284 | 2445 |
| | 65+ | 3 | 62 | 751 |
| | Total | 10 | 346 | 3196 |

| | HENRY CO Hospital - 2009 | | | |
|---|---|---|---|---|
| 22 beds | Age | Pts Sep 30 | Annual Disch | Annual Pt Days |
| No Gero | 0-17 | 0 | | |
| | 18-64 | 6 | 194 | 1337 |
| | 65+ | 0 | 56 | 528 |
| | Total | 6 | 250 | 1865 |

| | WEAKLEY CO. Behavioral Health Martin 2010 | | | |
|---|---|---|---|---|
| 16 Beds | Age | Pts Sep 30 | Annual Disch | Annual Pt Days |
| No Gero | 0-17 | 0 | | |
| | 18-64 | 3 | 25 | 376 |
| | 65+ | 10 | 281 | 4059 |
| | Total | 13 | 306 | 4435 |

| | WEAKLEY CO. Behavioral Health Martin 2009 | | | |
|---|---|---|---|---|
| 16 Beds | Age | Pts Sep 30 | Annual Disch | Annual Pt Days |
| No Gero | 0-17 | 0 | | |
| | 18-64 | 1 | 37 | 468 |
| | 65+ | 14 | 283 | 4118 |
| | Total | 15 | 320 | 4586 |

| | WEAKLEY CO. Behavioral Health Martin 2008 | | | |
|---|---|---|---|---|
| 16 Beds | Age | Pts Sep 30 | Annual Disch | Annual Pt Days |
| No Gero | 0-17 | 0 | | |
| | 18-64 | 1 | 23 | 318 |
| | 65+ | 12 | 295 | 4120 |
| | Total | 13 | 318 | 4438 |

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

Projections are based on assessment with physicians and the previous experiences of PRP in similar locations and service areas.

| | | | | | 2013 | 2014 |
|---|---|---|---|---|---|---|
| **INDICATOR** | **2009** | **2010** | **2011** | | **Year 1** | **Year 2** |
| Admissions | 975 | 951 | 845 | | 845 | 887 |
| Registrations | 22,487 | 21,576 | 20,393 | | 20,393 | 21,413 |
| Geropsychiatric Admissions | 0 | 0 | 0 | | 243 | 274 |

## 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)

Response
The Chart is provided.

- 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.

## PROJECT COSTS CHART

2012 MAY 14 PM 4: 10

| | | |
|---|---|---|
| A. | Construction and equipment acquired by purchase: | |
| | 1. Architectural and Engineering Fees | 43,805 |
| | 2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees | - |
| | 3. Acquisition of Site | - |
| | 4. Preparation of Site | - |
| | 5. Construction Costs | 438,045 |
| | 6. Contingency Fund | 76,450 |
| | 7. Fixed Equipment (not in included in Construction Contract) | - |
| | 8. Moveable Equipment (List all equipment over $50,000) | - |
| | 9. Other (Specify) I/S, Telemedicine, Furniture | 165,700 |
| B. | Acquisition by gift, donation, or lease: | |
| | 1. Facility (inclusive of building and land) | - |
| | 2. Building only | - |
| | 3. Land only | - |
| | 4. Equipment (Specify) _____ | - |
| | 5. Other (Specify) _____ | - |
| C. | Financing Costs and Fees: | |
| | 1. Interim Financing | - |
| | 2. Underwriting Costs | - |
| | 3. Reserve for One Year's Debt Service | - |
| | 4. Other (Specify) _____ | - |
| D. | Estimated Project Cost (A + B + C) | 724,000 |
| E. | CON Filing Fee | 3,000 |
| F. | Total Estimated Project Cost (D + E) | |
| | **TOTAL** | $ 727,000 |

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--Appropriate documentation from Chief Financial Officer.

__ 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

   The cost is reasonable based on other projects within the BMHCC system and others in the state.

   For example, CN1101-003 was for renovation of 2,146 sq ft for 9 geriatric-psychiatric beds and was projected at $163 per sq ft.

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).

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

   Response

| | |
|---|---|
| Average Gross Charge | $2,074 per diem |
| Average Deduction | $1,259 per diem |
| Average Net Charge | $ 815 per diem |

## HISTORICAL DATA CHART

SUPPLEMENTAL

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in OCT 2012 MAY 29 PM 3:21

| | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|
| Utilization Date (Specify unit of measure) Patient | | | |
| A. Discharges | 1018 | 1002 | 843 |
| B. Revenue from Services to Patients | | | |
| 1. Inpatient Services | $ 11,215,521 | $ 13,278,736 | $ 10,683,655 |
| 2. Outpatient Services | $ 23,337,925 | $ 24,370,884 | $ 27,562,737 |
| 3. Emergency Serivces | | | |
| 4. Other Operating Revenue (specify) cafeteria, gift shop | $ 551,567 | $ 585,570 | $ 431,510 |
| **Gross Operating Revenue** | $ 35,105,013 | $ 38,235,190 | $ 38,677,902 |
| C. Deductions from Gross Operating Revenue | | | |
| 1. Contractual Adjustments | $ 16,910,348 | $ 21,332,206 | $ 23,009,676 |
| 2. Provision for Charity Care | $ 905,435 | $ 1,418,020 | $ 1,366,655 |
| 3. Provision for Bad Debt | $ 2,098,213 | $ 2,750,635 | $ 2,152,648 |
| **Total Deductions** | $ 19,913,996 | $ 25,500,861 | $ 26,528,979 |
| **NET OPERATING REVENUE** | $ 15,191,017 | $ 12,734,329 | $ 12,148,923 |
| D. Operating Expenses | | | |
| 1. Salaries and Wages | $ 7,559,112 | $ 7,781,459 | $ 8,280,536 |
| 2. Physician's Salaries and Wages | $ 479,029 | $ 465,046 | $ 679,047 |
| 3. Supplies | $ 1,714,134 | $ 1,907,983 | $ 1,600,253 |
| 4. Taxes | $ 37,478 | $ 39,449 | $ 47,716 |
| 5. Depreciation | $ 1,086,644 | $ 1,114,843 | $ 1,039,915 |
| 6. Rent | | | |
| 7. Interest, other than Capital | $ 11,146 | $ 27,274 | $ 28,603 |
| 8. Management Fees: *** | | | |
| a. Fees to Affilitates | $ 1,668,204 | $ 1,689,360 | $ 1,620,456 |
| b. Fees to Non-Affilitates | | | |
| 9. Other Expenses (Specify on separate page) | $ 3,977,395 | $ 1,823,562 | $ 1,827,336 |
| **Total Operating Expenses** | $ 16,533,142 | $ 14,848,976 | $ 15,123,862 |
| E. Other Revenue (Expenses ) - Net (Specify) | $ 37,547 | $ (19,491) | $ 55,725 |
| **NET OPERATING INCOME (LOSS)** | $ (1,304,578) | $ (2,134,138) | $ (2,919,214) |
| F. Capital Expenditures | | | |
| 1. Retirement of Principal | | | |
| 2. Interest | | | |
| **Total Capital Expenditures** | 0 | 0 | 0 |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | $ (1,304,578) | $ (2,134,138) | $ (2,919,214) |

***These management fees are for allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company and are reimbursed on availability of funds. These funds were not collected for 2009 - 2011 and are shown for information only and not included in Total Operating Expenses.

SUPPLEMENTAL

## PROJECTED DATA CHART

Give information for the last two (2) years following the completion of this proposal. 2012 MAY 29 PM 3: 21
The fiscal year begins in OCT (Month)

| | Year 1 | Year 2 |
|---|---|---|
| A. Utilization Date (Specify unit of measure) | ADC = 8 | ADC = 9 |
| B. Revenue from Services to Patients | | |
| 1. Inpatient Services | $ 6,056,343 | $ 6,813,386 |
| 2. Outpatient Services | | |
| 3. Emergency Serivces | | |
| 4. Other Operating Revenue (specify) _____ | | |
| **Gross Operating Revenue** | $ 6,056,343 | $ 6,813,386 |
| C. Deductions from Gross Operating Revenue | | |
| 1. Contractual Adjustments | $ 3,584,154 | $ 4,032,111 |
| 2. Provision for Charity Care | $ 12,000 | $ 12,265 |
| 3. Provision for Bad Debt | $ 90,845 | $ 102,201 |
| **Total Deductions** | $ 3,686,999 | $ 4,146,577 |
| **NET OPERATING REVENUE** | $ 2,369,344 | $ 2,666,809 |
| D. Operating Expenses | | |
| 1. Salaries and Wages | $ 829,113 | $ 829,163 |
| 2. Physician's Salaries and Wages | $ 175,000 | $ 175,000 |
| 3. Supplies | $ 222,137 | $ 247,654 |
| 4. Taxes | | |
| 5. Depreciation | $ 40,250 | $ 40,250 |
| 6. Rent | | |
| 7. Interest, other than Capital | | |
| 8. Management Fees: | | |
| a. Fees to Affilitates | | |
| b. Fees to Non-Affilitates | $ 214,120 | $ 236,385 |
| 9. Other Expenses (Specify on separate page) | $ 92,088 | $ 112,468 |
| **Total Operating Expenses** | $ 1,572,708 | $ 1,640,920 |
| E. Other Revenue (Expenses ) - Net (Specify) | | |
| **NET OPERATING INCOME (LOSS)** | | |
| F. Capital Expenditures | | |
| 1. Retirement of Principal | | |
| 2. Interest | | |
| **Total Capital Expenditures** | $ - | $ - |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | $ 796,636 | $ 1,025,889 |

SUPPLEMENTAL

## HISTORICAL DATA CHART-OTHER EXPENSES

| OTHER EXPENSES CATEGORIES | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|
| 1. Purchased Services | $ 427,313 | $ 380,245 | $ 418,198 |
| 2. Insurance | $ 44,747 | $ 101,503 | $ 87,047 |
| 3. Utilities | $ 450,441 | $ 441,162 | $ 503,144 |
| 4. Other Expenses | $ 2,262,531 | $ 337,113 | $ 235,819 |
| 5. Professional Fees | $ 792,363 | $ 563,539 | $ 583,128 |
| 6 | | | |
| 7 | | | |
| **Total Other Expenses** | **$ 3,977,395** | **$ 1,823,562** | **$ 1,827,336** |

## PROJECTED DATA CHART-OTHER EXPENSES

| OTHER EXPENSES CATEGORIES | Year 1 | Year 2 |
|---|---|---|
| 1. Maintenance | $ 17,024.00 | $ 25,524.00 |
| 2. Dietary | $ 24,820.00 | $ 27,923.00 |
| 3. Housekeeping | $ 6,687.00 | $ 10,019.00 |
| 4. Pharmacy | $ 26,767.00 | $ 30,113.00 |
| 5. Laundry | $ 16,790.00 | $ 18,889.00 |
| 6 | | |
| 7 | | |
| **Total Other Expenses** | **$ 92,088.00** | **$ 112,468.00** |

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
This is a new service and there will be no impact on existing patient charges.

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
The Average gross charge per patient day is $2,074.

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

Response
The effectiveness is demonstrated by the financial projections provided in an enclosed chart. The service maintains a positive contribution in year 1 that increases in year 2.

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
The effectiveness is demonstrated by the financial projections provided in an enclosed Chart. The service maintains a positive contribution in year 1 that increases in year 2.

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
As previously presented, since the proposal focuses on geriatric psychiatry for patients 65 years or older, most will have Medicare as the primary coverage. TennCare and Medicaid will be included on occasion for co-pays or in occasional circumstances when a patient has not yet achieved full Medicare participation.

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

The balance sheet and income statement are provided.

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.

    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

    One alternative was to send an increasing number of patients in need of geriatric psychiatry to locations outside of the service area. However, on advice of Medical staff, this solution caused separation of caregivers and was not in the best interest of patients and their families. Concern was that the need would remain unmet. Clinical programming, group, and individual counseling are specifically geared toward the issues of the elderly and their families.

    Another alternative was to develop a service within the hospital rather than establish a distinct part unit. The benefit of a physical environment designed to minimize confusion for the elderly while providing the safest environment possible would not have been attained.

## 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

   Transfer arrangements will be available with other hospitals within the Baptist system.

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
This project will benefit the health care system by improving the effectiveness of existing resources. The new services will benefit patients, family members and will be a positive contribution to the hospital. No new major medical equipment that requires CON approval is involved and negative effects are not anticipated.

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

| Job Title | FTE | Hourly |
|---|---|---|
| Nurse Mgr | 1 | |
| Registered Nurse | 4.20 | 22.58 |
| Nursing Assistant | 2.80 | 9.58 |
| Social Worker | 1 | |
| OT/AT/RT | 1.2 | 23 |
| Unit Clerk | 2.1 | 9.58 |
| | | |
| Total | 12.3 | |

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
PRP will assist with recruitment and difficulties are not anticipated.

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
BMH-Huntingdon is an established Joint Commission accredited Hospital licensed by the Tennessee Department of Health. The facility understands requirements and regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping and staff education.

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
Baptist Memorial Health Care Corporation and BMH-Huntingdon are strong supporters of educational opportunities throughout the region. Baptist's Philosophy and Mission for the system states that, "… it seeks to ENCOURAGE, GUIDE, and INSTRUCT those individuals entering into professions related to the healing of the body, mind and spirit."

Baptist Memorial College of Health Sciences was chartered in 1994 as a specialized college offering baccalaureate degrees in nursing and in allied health sciences as well as continuing education opportunities for healthcare professionals.

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
BMH-Huntingdon has reviewed and understands the licensure requirements of the Department of Health and applicable Medicare requirements.

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

Licensure: Tennessee Depart of Health

Accreditation: Joint Commission

(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
The current license is provided as an attachment.

(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
The last completed licensure/certification survey with an approved plan of correction is included as an attachment.

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 are no final orders or judgments to report

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 are no final civil or criminal judgments to report.

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
BMH-Huntingdon 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.

ninutes
a new
t to the

3: 180
ingdon,

er was
ower(s)
Code
his sale
shown
ed plat;
strictive
setback
ole; any
mption
agency,
or liens
as any
fixture
that an
remises
on, the
aim an
erenced
Rich;
Bank
ang to,
sounded
rustee's
e right
he day
, time,
further
cement
he sale
A No.

ATES,
L.L.C.,
Trustee

illie

TION,
COM
RAC.

),16,23
ID
County
Group
Special

until 11 a.m., June 4, 2012. Bids for bread items will be accepted until 11:30 a.m., June 4, 2012. For complete specifications and a bid packet, contact Janet Winchester, Child Nutrition Supervisor, at WCSSD, 1415 Hwy. 77, Atwood, TN, or by telephone at 731-662-4200.

In accordance with Federal Law and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call 800-795-3272 or 202-720-6382 (TTY). USDA is an equal opportunity provider and employer.

5/9,16

**ADVERTISEMENT FOR BID**
**HUNTINGDON SPECIAL SCHOOL DISTRICT**

Sealed bids for construction of New Sports Field Lighting at Huntingdon High School and Huntingdon Middle School, TN 38344, at which time and place they will be publicly opened and read aloud.

Contract Documents may be examined of the office of the Kaatz, Binkley, Jones & Morris Architects, Inc., 1008 Charlie Daniels Parkway, Mt. Juliet, Tennessee. Plans Deposit: $500.00 per one set to Contractors. 5% Bidders Bond is required.

Performance Bond and Payment Bond in the full amount of the bid will be required. All bidders must be licensed Contractors as required by the Contractors' Licensing Act of 1976, as currently amended.

The Huntingdon Special School District Board of Education reserves the right to reject any or all bids, any or all portions of specific bids, and to select the best bid which may or

The Tennessee Department of Agriculture Forestry Division is offering for sale certain tracts of timber at Natchez Trace State Forest near Lexington, Tennessee. Sealed bids will be received in the West Tennessee District Office of the Forestry Division, P.O. Box 438, Lexington, TN 38351 until 10:30 am on the following dates. A-09-12-04 and A-09-12-05 will be sold to the highest bidder on June 7, 2012. A-09-13-01 will State Forest Headquarters on Natchez Trace State Forest at 9:30 A.M.

Interested bidders may obtain additional information by contacting District Forester Roy Ward, P.O. Box 438, Lexington TN 38351, (731) 968-6676, or State Forester, Richard Sanderson, 10150 Corinth Rd. Wildersville, TN 38388, (731) 394-5383.

5/9,16


**DEBT RELIEF-BANKRUPTCY**
**PROTECT YOUR HOME, CARS AND WAGES**
LEGAL FEES - $500.00
WITH NO DOWN PAYMENT AND MONTHLY INSTALLMENTS
**731-986-2418**
*FREE CONSULTATION*
**BENJAMIN S. DEMPSEY**
ATTORNEY AT 143 COURT SQUARE IN HUNTINGDON, TN.
WE ARE A DEBT RELIEF AGENCY. WE HELP PEOPLE FILE BANKRUPTCY RELIEF UNDER THE BANKRUPTCY CODE.
WE ALSO PROVIDE ALL TYPES OF CREDIT ADVICE-COUNSELING



Chapter 7 Chapter 13
**BANKRUPTCY?**
*Our office has helped thousands of people in financial hardship.*
Let us explain your bankruptcy rights and options.
Your first consultation is always free.
We Are A Debt Relief Agency
*We help people file for bankruptcy relief under the bankruptcy code.*
**1-800-748-9889**

**WALKER, WALKER & WALKER, PLC**
Ken Walker Richard Walker
2 Locations To Serve You: Jackson & Lexington


a citation in Gibson County on April 4, 2011.

...

**Driving Under the Influence**

A Lexington man was arrested for driving under the influence on May 3.

the process of manufacturing methamphetamine and after further investigation the white male who fled the scene was identified as Richard Stephenson, 40, of 161 Linda Vista, Jackson.

**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 Baptist Memorial Hospital-Huntingdon a hospital owned by itself with an ownership type of non-profit corporation intends to file an application for a Certificate of Need for the conversion of 12 currently licensed med-surg beds to 12 beds for initiation of geriatric psychiatric services located at Baptist Memorial Hospital-Huntingdon, 631 R. B. Wilson Drive, Huntingdon, Tennessee 38344. The geriatric psychiatric service will be managed by Psychiatric Resource Partners, Inc. The project involves renovation of approximately 4,600 sq ft. There are no additional services, major medical equipment, or additional beds involved. There will be no change in the hospital license total bed count of 70 beds. The estimated project cost is $727,000. The anticipated date of filing the application is May14, 2012. The contact person for this project is Arthur Maples, Dir. of Strategic Analysis, who may be reached at: Baptist Memorial Health Care Corporation 350 N. Humphreys Blvd, Memphis, TN 38120, (901) 227-4137.

**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**
**500 Deaderick Street, Suite 850**
**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.**

2012 MAY 14

## 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.**

## 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.**

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

SUPPLEMENTAL

# PROJECT COMPLETION FORECAST CHART

2012 MAY 29 PM 3: 21

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): August 22, 2012

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.

| Phase | DAYS REQUIRED | Anticipated Date (MONTH/YEAR) |
|---|---|---|
| 1. Architectural and engineering contract signed | 7 | 09/2012 |
| 2. Construction documents approved by the Tennessee Department of Health | 57 | 10/2012 |
| 3. Construction contract signed | 64 | 10/2012 |
| 4. Building permit secured | 71 | 11/2012 |
| 5. Site preparation completed | 78 | 11/2012 |
| 6. Building construction commenced | 86 | 11/2012 |
| 7. Construction 40% complete | 116 | 12/2012 |
| 8. Construction 80% complete | 147 | 01/2013 |
| 9. Construction 100% complete (approved for occupancy | 166 | 02/2013 |
| 10. *Issuance of license | 180 | 02/2013 |
| 11. *Initiation of service | 194 | 03/2013 |
| 12. Final Architectural Certification of Payment | 203 | 03/2013 |
| 13. Final Project Report Form (HF0055) | 250 | 05/2013 |

**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

CARROLL COUNTY

Copy of Advertisement

## 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 Baptist Memorial Hospital-Huntingdon a hospital owned by itself with an ownership type of non-profit corporation intends to file an application for a Certificate of Need for the conversion of 12 currently licensed med-surg beds to 12 beds for initiation of geriatric psychiatric services located at Baptist Memorial Hospital-Huntingdon, 631 R. B. Wilson Drive, Huntingdon, Tennessee 38344. The geriatric psychiatric service will be managed by Psychiatric Resource Partners, Inc. The project involves renovation of approximately 4,600 sq ft. There are no additional services, major medical equipment, or additional beds involved. There will be no change in the hospital license total bed count of 70 beds. The estimated project cost is $727,000. The anticipated date of filing the application is May14, 2012. The contact person for this project is Arthur Maples, Dir. of Strategic Analysis, who may be reached at: Baptist Memorial Health Care Corporation 350 N. Humphreys Blvd, Memphis, TN 38120, (901) 227-4137.

**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**
**500 Deaderick Street, Suite 850**
**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
Affadavit of Publication

Personally appeared before me, Dennis Richardson, Publisher of the Carroll County News-Leader, a weekly newspaper published at Huntingdon, Tennessee who certifies that the annexed advertisement has been published in said paper 1 consecutive weeks. The first insertion thereof being on the 9 of May, 2012; second on _____ of _____, 2012; third on ___ of _____, 2012; fourth on _____ of _____, 2012 and that the fees $ 116.00 are due and **have/have not** been paid.

The Carroll County News-Leader is published each Wednesday in Carroll County, Tennessee and has an audited circulation of 3,400.

Dennis Richardson, Publisher

Sworn to and subscribed before me, this 9 day of May, 2012

Cheryl Young,
State of Tennessee Notary

My commission expires on:
July 5, 2015

CHERYL YOUNG
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF BENTON

**AFFIDAVIT**

2012 MAY 14 PM 4: 11

STATE OF Tennessee

COUNTY OF Shelby

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

Arthur Maples / Dir. Strategic Analysis
SIGNATURE/TITLE

Sworn to and subscribed before me this 11th day of May (Month), 2012 (Year) a Notary Public in and for the County/State of Tennessee.

Paulette E. Kearney
NOTARY PUBLIC

My Comm. Exp. 9-26-2012

My commission expires _____ (Month/Day), _____ (Year).

PAULETTE E. KEARNEY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

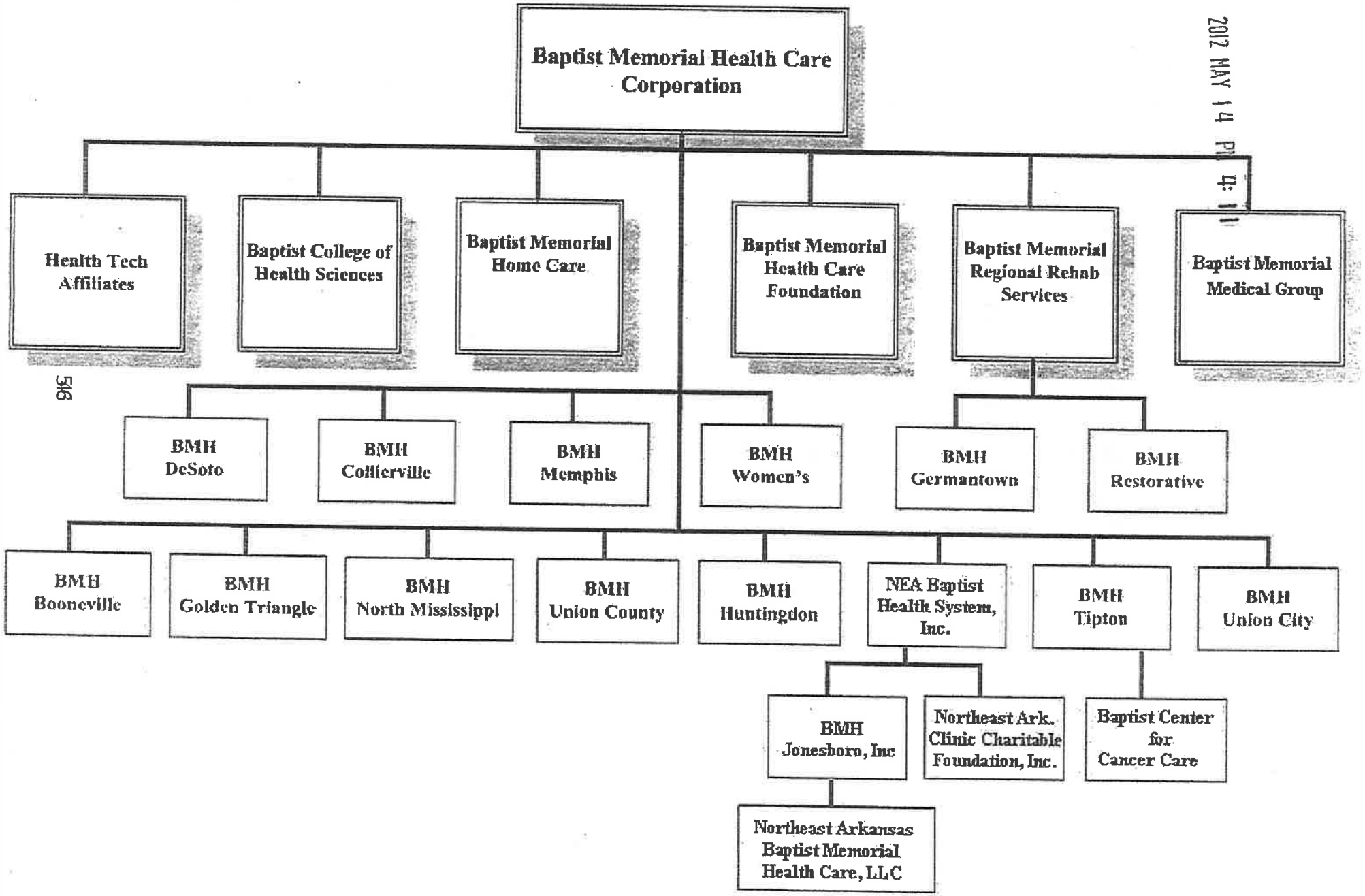
## INDEX OF ATTACHMENTS


| | |
|---|---|
| Organizational Documentation | Section A-3 |
| Organizational Chart | Section A-4 |
| Services Agreement | Section A-5 |
| Deed | Section A-6 |
| Plot Plan | Section B, III, A (1) |
| Floor Plan | Section B, IV |
| Service Area Map | Section C, 3 |
| Architect Letter | Economic Feasibility 1 |
| Chief Financial Officer Letter | Economic Feasibility 2(E) |
| Balance Sheet and Income Statements | Economic Feasibility, 10 |
| License | Orderly Development 7 (c) |
| State Survey/Inspection | Orderly Development 7 (d) |
| Letters of Support | |

# Organizational Chart

# Section A-4

# Baptist Memorial Health Care System
# Memphis, Tennessee

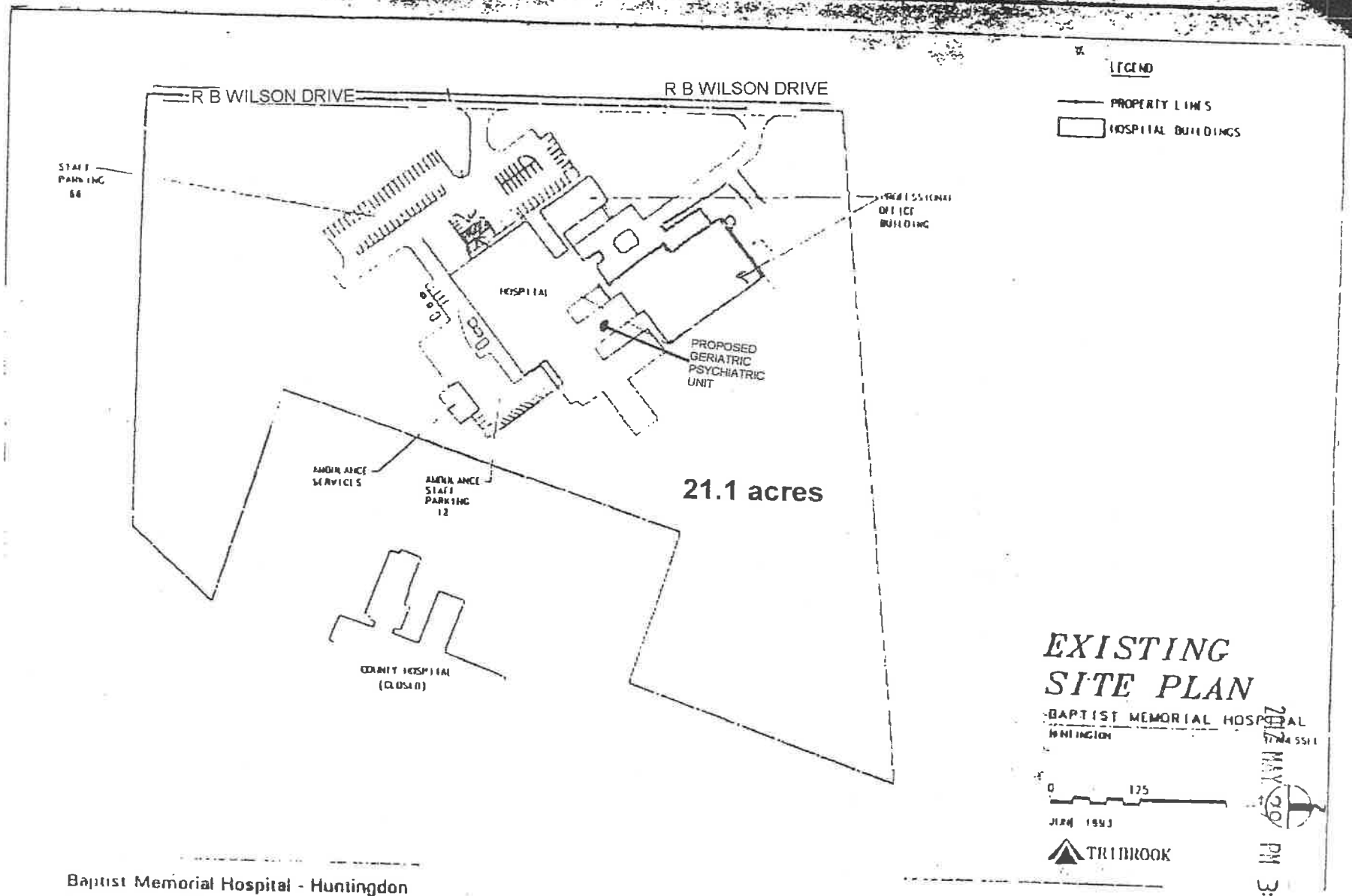



2012 MAY 14 PM 4: 11

# Plot Plan

# Section B, III, A (1)

# BAPTIST MEMORIAL HOSPITAL - HUNTINGDON



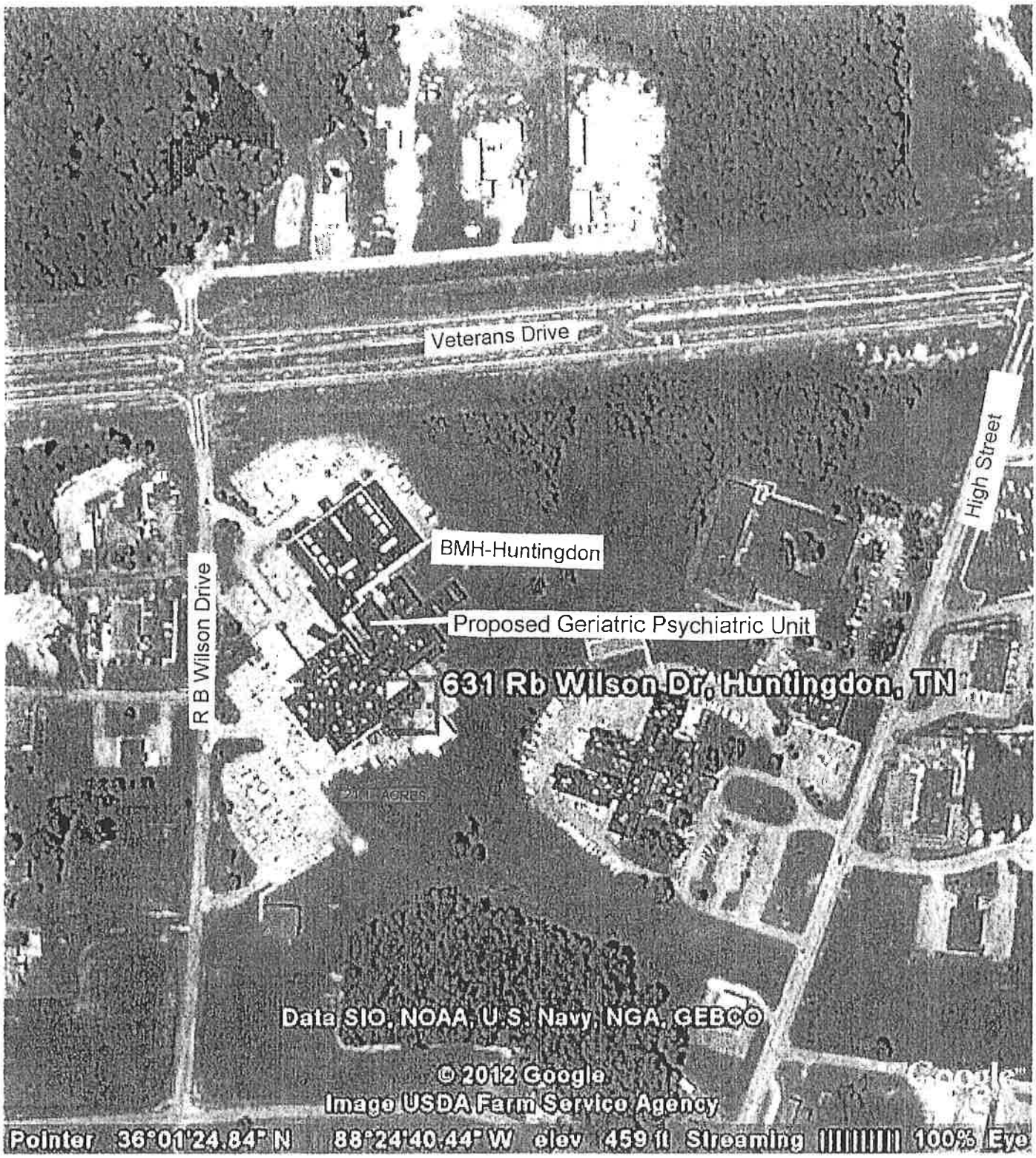

Baptist Memorial Hospital - Huntingdon
Huntingdon, TN
August 1993



TRIBROOK

2012 MAY 29 PM 3:21

SUPPLEMENTAL


Veterans Drive
High Street
BMH-Huntingdon
Proposed Geriatric Psychiatric Unit
R B Wilson Drive
631 Rb Wilson Dr, Huntingdon, TN
Data SIO, NOAA, U.S. Navy, NGA, GEBCO
© 2012 Google
Image USDA Farm Service Agency
Pointer 36°01'24.84" N 88°24'40.44" W elev 459 ft Streaming 100% Eye

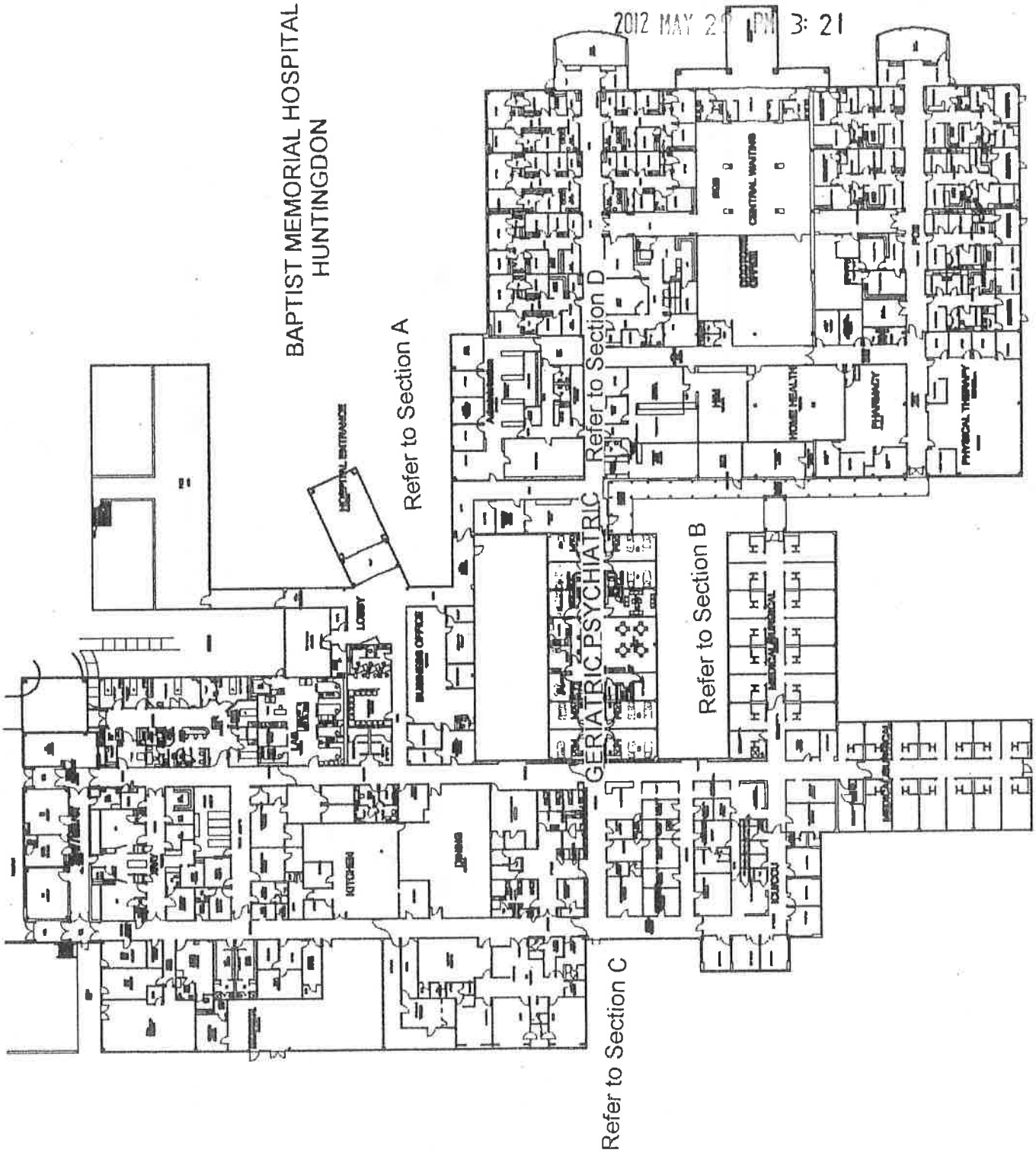
# Floor Plan

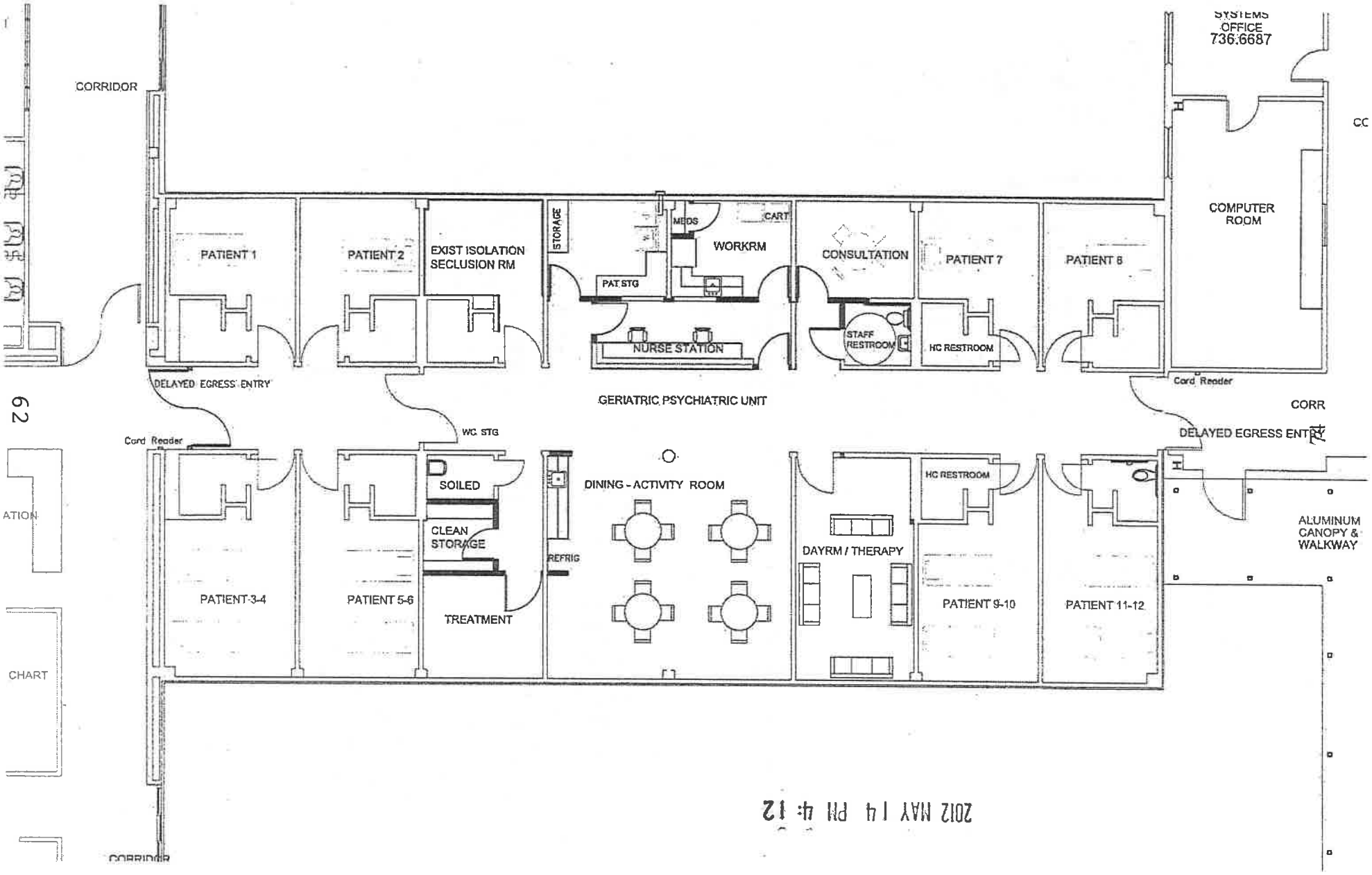
# Section B, IV

SUPPLEMENTAL

2012 MAY 2 PM 3: 21

BAPTIST MEMORIAL HOSPITAL
HUNTINGDON

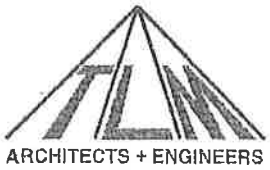





62

2012 MAY 14 PM 4:12

SUPPLEMENTAL




May 11, 2012

Ms. Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
8th Floor – Andrew Jackson Building, Suite 850
Nashville, TN 37242

RE: Geriatric Psychiatric Unit
Baptist Memorial Hospital - Huntingdon

Dear Ms. Hill:

TLM Associates, Inc. is a full-service architectural and engineering firm offering professionals in the fields of architecture, civil engineering, structural/industrial engineering, mechanical engineering, and interior design. Please be assured our renovation design for the Geriatric Psychiatric Unit at Huntingdon will be in accordance with each of the following building codes and standards:

- AIA Guidelines for the Design and Construction of Healthcare Facilities
- International Building Code
- Standard Mechanical Code
- Standard Plumbing Code
- Standard Gas Code
- NFPA Life Safety Code
- Rules of Tennessee Department of Health and Environment Board for Licensing Healthcare Facilities
- Americans with Disabilities Act

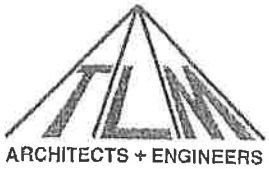
I would be delighted to speak with you concerning any questions regarding this or any other part of the design. Please contact my office at (731) 988-9840 or email me directly at j.hartsfield@tlmassociates.com.

Respectfully,

Jerry L. Hartsfield, AIA

TLM ASSOCIATES, INC. • 117 E. LAFAYETTE STREET • JACKSON, TENNESSEE 38301
PHONE: 731-988-9840 • www.tlmassociates.com • FAX: 731-988-9959

SUPPLEMENTAL




May 14, 2012

Ms Melanie Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

RE: Geriatric Psychiatric Unit
Baptist Memorial Hospital-Huntingdon
Carroll County

Dear Ms Hill:

TLM Associates, Inc. has reviewed the costs indicated as $438,045 for the referenced project and find the costs to be reasonable for the described renovation. The costs have considered recent market conditions and inflation projections. Architectural and Engineering fees of $43,800 have also been estimated for the project.

Sincerely,

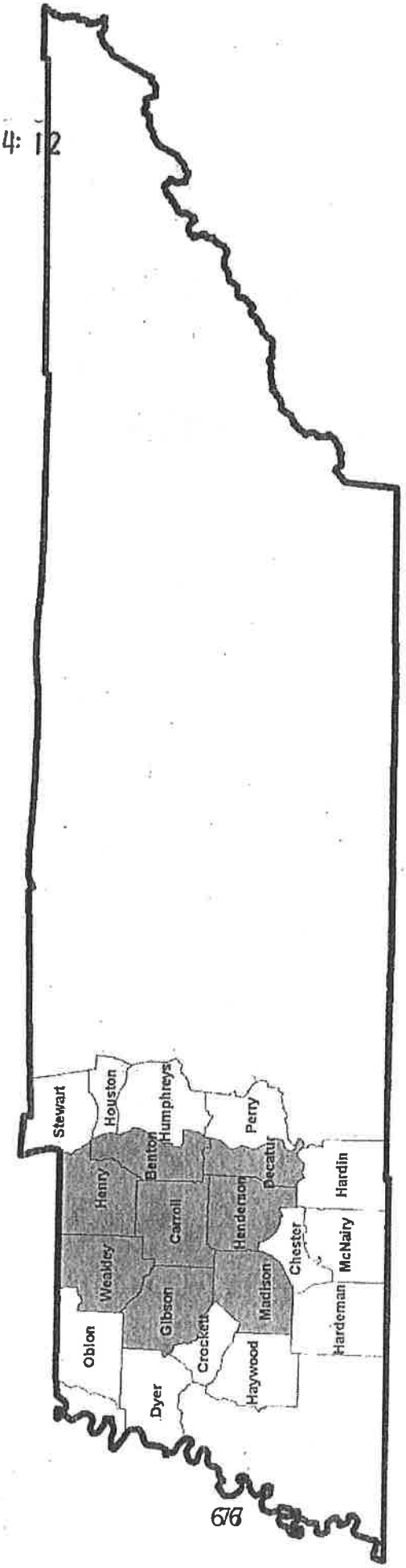
Jerry L. Hartsfield, AIA
Principal

TLM ASSOCIATES, INC. • 117 E. LAFAYETTE STREET • JACKSON, TENNESSEE 38301
PHONE: 731-988-9840 • www.tlmassociates.com • FAX: 731-988-9959

# Service Area Map

# Section C, 3

2012 MAY 14 PM 4: 12




676

# Architect Letter

# Economic Feasibility 1

# Chief Financial Officer Letter

# Economic Feasibility 2(E)

SUPPLEMENTAL

BAPTIST MEMORIAL HEALTH CARE CORPORATION

May 10, 2012

Ms. Melanie Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building
500 Deadrick Street, Suite 850
Nashville, Tennessee 37243

RE: Geriatric Psychiatric Unit
Baptist Memorial Hospital-Huntingdon
Carroll County

Dear Ms. Hill:

As the Chief Financial Officer of Baptist Memorial Health Care Corporation (BMHCC), I have reviewed the financial statements and requirements in the certificate of need application for the proposed geriatric psychiatric unit for Baptist Memorial Hospital-Huntingdon. The project has an anticipated cost, for CON purposes, of approximately $727,000.

The proposed unit will be a service of Baptist Memorial Hospital – Huntingdon. Financial statements have been provided for Baptist Memorial Hospital –Huntingdon that accurately reflect the operations as audited by Deloitte & Touche as part of the combined financial statements of Baptist Memorial Health Care Corporation.

In my opinion, funds to complete the project are available through BMHCC affiliated entities such as Baptist Memorial Hospital – Memphis (BMH – Memphis). To demonstrate that funds are available, the financial statements for BMH – Memphis are provided. As the sole member of Baptist Memorial Hospital – Huntingdon, BMHCC will fund the project as described.

We are available to provide additional necessary information.

Sincerely,

Donald R. Pounds
Chief Financial Officer



350 NORTH HUMPHREYS BOULEVARD MEMPHIS, TENNESSEE 38120-2177

# Balance Sheet and Income Statements

# Economic Feasibility, 10

BMH-HUNTINGDON
BALANCE SHEET
12 MONTHS ENDED SEPTEMBER 30
Unaudited

| | 2011 | 2010 | 2009 | 2008 |
|---|---|---|---|---|
| CURRENT ASSETS: | | | | |
| Cash and cash equivalents | 771,499 | 628,622 | 1,083,475 | 1,760,053 |
| Patient accounts receivable, net | 1,127,174 | 1,042,642 | 1,031,685 | 1,059,124 |
| Other Receivables | 4,967 | 80,236 | 195,523 | 362,871 |
| Third party settlements | 16,509 | 15,299 | 20,326 | 64,531 |
| Supplies, Inventory and Prepaid | 614,028 | 604,315 | 622,721 | 589,772 |
| Total current assets | 2,534,178 | 2,371,114 | 2,953,730 | 3,836,351 |
| INVESTMENTS | 36,347 | (22,068) | 218,400 | 214,845 |
| PROPERTY AND EQUIPMENT, net | 8,582,468 | 9,029,980 | 9,988,975 | 9,595,506 |
| OTHER ASSETS | 0 | 0 | 0 | 0 |
| TOTAL ASSETS | 11,152,993 | 11,379,027 | 13,161,105 | 13,646,702 |
| CURRENT LIABILITIES: | | | | |
| Current portion-long-term debt & CLO | 0 | 0 | 0 | 0 |
| Accounts payable | 309,708 | 172,287 | 207,989 | 215,965 |
| Due to affiliates | 8,192,463 | 5,152,395 | 4,512,587 | 355,612 |
| Third party settlements | 113,361 | 160,417 | 17,685 | 54,195 |
| Accrued expenses and other current | 608,843 | 678,864 | 577,543 | 527,141 |
| Total current liabilities | 9,224,375 | 6,163,963 | 5,315,804 | 1,152,912 |
| LONG-TERM DEBT and CLO to AFFILIATES | 553,866 | 618,756 | 662,179 | 719,467 |
| OTHER LONG-TERM LIABILITIES | 0 | 0 | (480) | 0 |
| FUND BALANCE (DEFICIT) | 1,374,753 | 4,596,308 | 7,183,602 | 11,774,323 |
| TOTAL LIABILITIES & FUND BALANCE | 11,152,993 | 11,379,027 | 13,161,105 | 13,646,702 |

2012 MAY 14 PM 4:13

BMH-HUNTINGDON
STATEMENT OF REVENUES AND EXPENSES
12 MONTHS ENDED SEPTEMBER 30
Unaudited

| | 2011 | 2010 | 2009 | 2008 |
|---|---|---|---|---|
| UNRESTRICTED REVENUES AND OTHER SUPPORT: | | | | |
| Net patient service revenue | 14,073,824 | 15,255,159 | 14,946,961 | 15,130,399 |
| Other revenue | 227,732 | 229,790 | 244,020 | 200,549 |
| Total unrestricted revenues and other support | 14,301,556 | 15,484,948 | 15,190,982 | 15,330,948 |
| EXPENSES: | | | | |
| Salaries and benefits | 8,280,505 | 7,781,459 | 7,559,090 | 7,771,212 |
| Supplies | 1,600,253 | 1,907,984 | 1,714,135 | 1,710,892 |
| Purchased Services and other | 1,742,682 | 1,715,526 | 1,812,312 | 1,766,060 |
| Management fees | 1,620,456 | 1,689,360 | 1,668,204 | 1,114,704 |
| Professional fees | 792,363 | 563,539 | 583,346 | 560,330 |
| Depreciation and amortization | 1,039,917 | 1,080,020 | 1,086,646 | 1,086,978 |
| Interest | 28,602 | 27,274 | 11,144 | 26,334 |
| Provision for bad debts | 2,152,643 | 2,750,635 | 2,098,214 | 2,439,805 |
| Total Expenses | 17,257,421 | 17,515,797 | 16,533,091 | 16,476,315 |
| NONOPERATING INCOME(EXPENSE): | 36,718 | (19,475) | 37,547 | 51,456 |
| REVENUES IN EXCESS OF EXPENSES | (2,919,147) | (2,050,323) | (1,304,563) | (1,093,912) |

2012 MAY 14 PM 4:13

BMH-MEMPHIS
BALANCE SHEET
12 MONTHS ENDED SEPTEMBER 30
Unaudited

| | 2011 | 2010 | 2009 | 2008 |
|---|---|---|---|---|
| CURRENT ASSETS: | | | | |
| Cash and cash equivalents | 186,084,744 | 217,083,811 | 171,275,016 | 112,905,507 |
| Patient accounts receivable, net | 66,983,817 | 64,083,110 | 58,279,655 | 61,611,658 |
| Other Receivables | 15,210,227 | 15,191,387 | 14,305,077 | 12,664,414 |
| Third party settlements | 3,970,657 | 5,591,661 | 9,821,014 | 2,609,069 |
| Supplies, Inventory and Prepaid | 16,342,975 | 15,702,762 | 16,559,835 | 14,850,885 |
| Total current assets | 288,592,420 | 317,652,731 | 270,240,596 | 204,641,533 |
| INVESTMENTS | 732,471 | 597,424 | 3,421,677 | 2,316,915 |
| PROPERTY AND EQUIPMENT, net | 197,690,647 | 199,796,666 | 209,555,994 | 211,242,758 |
| OTHER ASSETS | 115,813,276 | 129,261,495 | 138,340,478 | 150,128,204 |
| TOTAL ASSETS | 602,828,814 | 647,308,316 | 621,558,745 | 568,329,410 |
| CURRENT LIABILITIES: | | | | |
| Current portion-long-term debt & CLO | 15,235,000 | 14,630,000 | 13,640,000 | 12,775,000 |
| Accounts payable | 7,614,319 | 18,973,275 | 7,252,048 | 8,822,098 |
| Due to affiliates | (1,713,670) | 1,987,007 | 8,180,134 | (9,835,959) |
| Third party settlements | 4,591,585 | 2,391,096 | 2,391,096 | 6,002,218 |
| Accrued expenses and other current | 26,595,006 | 22,006,973 | 21,139,175 | 21,399,262 |
| Total current liabilities | 52,322,240 | 59,988,351 | 52,602,453 | 39,162,618 |
| LONG-TERM DEBT and CLO | 131,872,732 | 147,322,892 | 159,780,000 | 173,420,000 |
| POST RETIREMENT BENEFIT OBLIGATION | 30,324,823 | 29,918,325 | 31,959,438 | 27,630,967 |
| OTHER LONG-TERM LIABILITIES | 2,138,048 | 2,170,941 | 2,203,834 | 2,236,727 |
| FUND BALANCE (DEFICIT) | 386,170,972 | 407,907,808 | 375,013,020 | 325,879,098 |
| TOTAL LIABILITIES & FUND BALANCE | 602,828,814 | 647,308,316 | 621,558,745 | 568,329,410 |



SUPPLEMENTAL

BMH-MEMPHIS
STATEMENT OF REVENUES AND EXPENSES
12 MONTHS ENDED SEPTEMBER 30
Unaudited

| | 2011 | 2010 | 2009 | 2008 |
|---|---|---|---|---|
| UNRESTRICTED REVENUES AND OTHER SUPPORT: | | | | |
| Net patient service revenue | 498,881,984 | 497,462,698 | 504,893,566 | 478,580,293 |
| Other revenue | 15,453,287 | 16,137,294 | 14,045,914 | 14,462,669 |
| Total unrestricted revenues and other support | 514,335,271 | 513,599,992 | 518,939,481 | 493,042,962 |
| EXPENSES: | | | | |
| Salaries and benefits | 196,939,281 | 188,488,524 | 188,995,399 | 189,740,832 |
| Supplies | 130,154,044 | 127,655,043 | 130,515,438 | 124,247,206 |
| Purchased Services and other | 28,290,078 | 28,294,088 | 29,807,439 | 34,194,663 |
| Management fees | 48,849,348 | 44,558,976 | 42,187,353 | 43,849,019 |
| Professional fees | 22,407,905 | 20,595,504 | 19,217,441 | 18,813,225 |
| Depreciation and amortization | 23,906,837 | 22,969,303 | 23,103,058 | 23,471,138 |
| Interest | 952,715 | 908,476 | 128,800 | 1,119,466 |
| Provision for bad debts | 48,833,577 | 41,616,620 | 40,386,119 | 36,760,672 |
| Total Expenses | 500,333,785 | 475,086,533 | 474,341,046 | 472,196,221 |
| NONOPERATING INCOME(EXPENSE): | 9,785,270 | 4,770,296 | (186,094) | (233,444) |
| REVENUES IN EXCESS OF EXPENSES | 23,786,756 | 43,283,754 | 44,412,340 | 20,613,297 |



SUPPLEMENTAL

# License

# Orderly Development 7 (c)

# Board for Licensing Health Care Facilities

State of Tennessee

0000000010

No. of Beds 0070

## DEPARTMENT OF HEALTH

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

BAPTIST MEMORIAL HOSPITAL-HUNTINGDON *to conduct and maintain a*

*Hospital* BAPTIST MEMORIAL HOSPITAL - HUNTINGTON

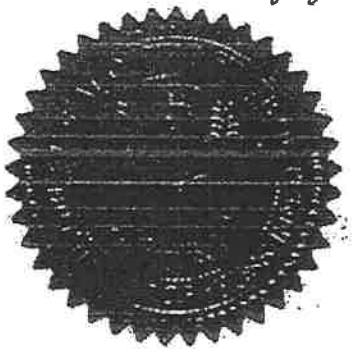
*Located at* 631 R.B. WILSON DRIVE, HUNTINGDON

*County of* CARROLL *, Tennessee.*

*This license shall expire* JUNE 30 *,* 2012 *, 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* 1ST *day of* JULY *,* 2011 *.*

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



*By* _____, NPM
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

*By* Susan R Cooper MSN, RN
COMMISSIONER

786

# State Survey/Inspection

# Orderly Development 7 (d)

SUPPLEMENTAL

file

STATE OF TENNESSEE
**DEPARTMENT OF HEALTH**
WEST TENNESSEE HEALTH CARE FACILITIES
781-B AIRWAYS BOULDEVARD
JACKSON, TENNESSEE 38301-3203

August 30, 2004

Ms. Susan Breeden, Administrator
BMH – Huntingdon
631 RB Wilson Drive
Huntingdon, TN 38344

**RE: Licensure Survey**

Dear Ms. Breeden:

We are pleased to advise you that no deficiencies were cited as a result of the licensure survey conducted at your facility on August 24, 2004. The attached form is for your files.

If this office may be of any assistance to you, please do not hesitate to call (731) 421-5113.

Sincerely,

Celia Skelley

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CES/TJW

Enclosure

SUPPLEMENTAL
PRINTED: 8/25/2004
FORM APPROVED

State of Tennessee, Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10 | A. BUILDING 2012 MAY 29 PM 3:21<br>B. WING | 8/24/2004 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BMH-HUNTINGDON | 531 R. B. WILSON DRIVE<br>HUNTINGDON, TN 38344 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 002 | 1200-8-1 No Deficiencies<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, it was determined the facility was in compliance with state licensure requirements for a hospital. No deficiencies were cited during this annual survey. | H 002 | | |

BHLR Licensure Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

SUPPLEMENTAL

STATE OF TENNESSEE
**DEPARTMENT OF HEALTH**
WEST TENNESSEE HEALTH CARE FACILITIES
781-B AIRWAYS BOULDEVARD
JACKSON, TENNESSEE 38301-3203

August 30, 2004

Ms. Susan Breeden, Administrator
BMH – Huntingdon
631 RB Wilson Drive
Huntingdon, TN 38344

**RE: Licensure Survey – Pediatric Emergency Care Unit**

Dear Ms. Breeden:

We are pleased to advise you that no deficiencies were cited as a result of the licensure survey conducted at your facility on August 24, 2004. The attached form is for your files.

If this office may be of any assistance to you, please do not hesitate to call (731) 421-5113.

Sincerely,

Celia Skelley, MSN

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CES/TJW

Enclosure

SUPPLEMENTAL
PRINTED: 8/25/2004
FORM APPROVED

State of Tennessee, Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10 | | 8/24/2004 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BMH-HUNTINGDON | 531 R. B. WILSON DRIVE<br>HUNTINGDON, TN 38344 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 |
|---|---|---|---|---|
| P 002 | 1200-8-30 No Deficiencies<br><br>This Rule is not met as evidenced by:<br>Based on observations, review of the pediatric facility notebook and interview, it was determined the facility was in compliance with state requirements for a basic pediatric emergency care unit (PECU). No deficiencies were cited during this annual licensure survey. | P 002 | | |

BHLR Licensure Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

SUPPLEMENTAL

STATE OF TENNESSEE
**DEPARTMENT OF HEALTH**
WEST TENNESSEE HEALTH CARE FACILITIES
781-B AIRWAYS BOULEVARD
JACKSON, TENNESSEE 38301-3203

April 3, 2006

Administrator
Baptist Memorial Hospital - Huntingdon
631 RB Wilson Drive
Huntingdon, TN 38344

Dear Administrator:

We are pleased to advise you that no deficiencies were cited as a result of the fire safety occupancy approval survey(s) conducted by our professional staff of this office on March 31, 2006 at your facility.

If this office may ever be of assistance to you, please feel free to call.

Sincerely,

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CES/TJW

The Joint Commission

March 16, 2012

2012 MAY 14 PM 4: 13

Susan Breeden
Chief Executive Officer
Baptist Memorial Hospital Huntingdon
631 R. B. Wilson Drive
Huntingdon, TN 38344

Joint Commission ID #: 7920
Program: Hospital Accreditation
Accreditation Activity: Unannounced Full Event
Accreditation Activity Completed: 03/15/2012

Dear Ms. Breeden:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

Baptist Memorial Hospital Huntingdon
631 R. B. Wilson Drive
Huntingdon, TN 38344

**Organization Identification Number: 7920**

| **Program(s)** | **Survey Date(s)** |
| --- | --- |
| Hospital Accreditation | 03/13/2012-03/15/2012 |
| Home Care Accreditation | |

**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)

**Home Care 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.

## The Joint Commission
## Summary of Findings

**Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day this report is posted to your organization's extranet site:**

| | | |
|---|---|---|
| **Program:** | Hospital Accreditation Program | |
| **Standards:** | EC.02.02.01 | EP6,EP12 |
| | EC.02.05.01 | EP6 |
| | MM.03.01.01 | EP7 |
| | PC.01.02.07 | EP3 |
| **Program:** | Home Care Accreditation Program | |
| **Standards:** | RC.02.01.01 | EP2 |

**Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day this report is posted to your organization's extranet site:**

| | | |
|---|---|---|
| **Program:** | Hospital Accreditation Program | |
| **Standards:** | EC.02.01.01 | EP1 |
| | EC.02.03.05 | EP5 |
| | EM.03.01.01 | EP3 |
| | EM.03.01.03 | EP3 |
| | LS.02.01.10 | EP9 |
| | RC.01.01.01 | EP19 |

**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 |
| §482.24(c)(1)(i) | A-0454 | HAP - RC.01.01.01/EP19 | Standard |

---

**CoP:** §482.26 **Tag:** A-0528 **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.26 Condition of Participation: Radiologic Services

The hospital must maintain, or have available, diagnostic radiologic services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

| CoP Standard | Tag | Corresponds to | Deficiency |
|---|---|---|---|
| §482.26(b)(1) | A-0536 | HAP - EC.02.02.01/EP6 | Standard |

---

**CoP:** §482.41 **Tag:** A-0700 **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

| CoP Standard | Tag | Corresponds to | Deficiency |
|---|---|---|---|
| §482.41(a) | A-0701 | HAP - EC.02.01.01/EP1, EM.03.01.03/EP3 | Standard |
| §482.41(c)(4) | A-0726 | HAP - EC.02.05.01/EP6 | Standard |
| §482.41(b)(1)(i) | A-0710 | HAP - EC.02.03.05/EP5, LS.02.01.10/EP9 | Standard |

---

**CoP:** §482.53 **Tag:** A-1026 **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.53 Condition of Participation: Nuclear Medicine Services

If the hospital provides nuclear medicine services, those services must meet the needs of the patients in accordance with acceptable standards of practice.

| CoP Standard | Tag | Corresponds to | Deficiency |
|---|---|---|---|
| §482.53(b) | A-1035 | HAP - EC.02.02.01/EP12 | Standard |

---

## The Joint Commission
## Findings

**Chapter:** Emergency Management

**Program:** Hospital Accreditation

**Standard:** EM.03.01.01 ESC 60 days

**Standard Text:** The hospital evaluates the effectiveness of its emergency management planning activities.

**Primary Priority Focus Area:** Communication

**Element(s) of Performance:**

3. The hospital conducts an annual review of its inventory. The findings of this review are documented.

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s):**

EP 3
Observed in Emergency Management Session at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site.
There was no evidence that an inventory of the hospital's 96 hour supply had been conducted since 2008.

---

**Chapter:** Emergency Management

**Program:** Hospital Accreditation

**Standard:** EM.03.01.03 ESC 60 days

**Standard Text:** The hospital evaluates the effectiveness of its Emergency Operations Plan.

**Primary Priority Focus Area:** Communication

**Element(s) of Performance:**

3. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an escalating event in which the local community is unable to support the hospital.
Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 4.
Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s):**

EP 3
§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 Emergency Management Session at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
The hospital's critique of the community November 2011 drill did not reflect the inability of the community to support the hospital. There was no evidence of a hospital specific critique from the hospital's participation in the February 2011 regional earthquake drill.

---

**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.01.01 ESC 60 days

**Standard Text:** The hospital manages safety and security risks.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

1. The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. 4
Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. (See also EC.04.01.01, EP 14)

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s):**

EP 1
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
Electrical panel EQL on the Siegal wing was not labeled with areas served for switch #'s 11,12,13,16

---

**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.02.01 ESC 45 days

**Standard Text:** The hospital manages risks related to hazardous materials and waste.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

6. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials.

**Scoring Category :** A
**Score :** Insufficient Compliance

12. The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. *
Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s):**

EP 6
§482.26(b)(1) - (A-0536) - (1) Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
Doors to the hot lab were unsecured. I was able to enter the hot lab, with no staff present in the hot lab.

EP 12
§482.53(b) - (A-1035) - §482.53(b) Standard: Delivery of Service

Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
Ventilation of the lab hood on the roof is not identified as biohazardous exhaust.

---

**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.03.05 ESC 60 days

**Standard Text:** The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

5. Every quarter, the hospital tests fire alarm equipment for notifying off-site fire responders. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7 -3.2).

**Scoring Category :** A
**Score :** Insufficient 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 Document Review at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
Off premises fire alarm equipment notification was not timed to show that notification was received within 90 seconds.

---

**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.05.01 ESC 45 days

**Standard Text:** The hospital manages risks associated with its utility systems.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

6. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies.
Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in 'protective environment' rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s):**

## The Joint Commission
## Findings

EP 6 .
§482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
The Biohazard (soiled) room off the dock was under positive pressure.

Observed in Building Tour at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
The Biohazard (soiled) room in the Emergency Department was under positive pressure

Observed in Building Tour at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
The Biohazard (soiled) room in the hallway between the Siegal and main nursing stations was under positive pressure

---

**Chapter:** Life Safety

**Program:** Hospital Accreditation

**Standard:** LS.02.01.10

ESC 60 days

**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material. 4
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

**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 Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
There was one penetration around a domestic water line in the fire wall, hallway side, outside of nuclear medicine.

Observed in Building Tour at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
There was one large gap above ceiling around a ceiling support in the fire wall, hallway side, outside of nuclear medicine.

---

**Chapter:** Medication Management

**Program:** Hospital Accreditation

**Standard:** MM.03.01.01 ESC 45 days

**Standard Text:** The hospital safely stores medications.

**Primary Priority Focus Area:** Medication Management

**Element(s) of Performance:**

7. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings. 3

**Scoring Category :** C
**Score :** Partial Compliance

**Observation(s):**

EP 7
Observed in Individual Tracer at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site. An opened multidose vial of insulin was found in a medication cart. The vial had not been labeled with a new expiration date after it was opened.

Observed in Individual Tracer at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site. A second opened multidose vial of insulin was found in a medication cart. This vial also had not been labeled with a new expiration date after it was opened.

---

**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.

## The Joint Commission
## Findings

**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 Individual Tracer at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site. A patient was given an oral prn pain medication. There was no documentation of a reassessment of the patient's pain following this intervention. Hospital policy requires that a pain reassessment be completed within two hours after pain medication is given.

Observed in Individual Tracer at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site. A patient received a prn medication for pain but there was no documented pain reassessment within two hours as is required by hospital policy.

---

**Chapter:** Record of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** RC.01.01.01 ESC 60 days

**Standard Text:** The hospital maintains complete and accurate medical records for each individual patient.

**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 :** Partial Compliance

**Observation(s):**

EP 19
§482.24(c)(1)(i) - (A-0454) - (i) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
Medication orders found in a patient's medical record were dated but were not timed.

§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site for the Hospital deemed service.
The handwritten Emergency Department history and physical examination found in an inpatient's medical record was dated but was not timed.

---

# The Joint Commission
## Findings

**Chapter:** Record of Care, Treatment, and Services

**Program:** Home Care Accreditation

**Standard:** RC.02.01.01 ESC 45 days

**Standard Text:** The patient record contains information that reflects the patient's care, treatment, or services.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

2. The patient record contains the following clinical information:
- Any medications administered, including dose
- Any activity restrictions
- Any changes in the patient's condition
- Any summaries of the patient's care, treatment, or services furnished to the patient's physician or licensed independent practitioner(s)
- The patient's medical history
- Any allergies or sensitivities
- Any adverse drug reactions
- The patient's functional status
- Any diet information or any dietary restrictions
- Diagnostic and therapeutic tests, procedures, and treatments, and their results
- Any specific notes on care, treatment, or services
- The patient's response to care, treatment, or services
- Any assessments relevant to care, treatment, or services
- Physician orders
- Any information required by organization policy, in accordance with law and regulation
- A list of medications, including dose, frequency, and route of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services
- The plan of care
- For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician. (See also PC.01.02.01, EP 1; PC.01.03.01, EPs 1 and 23)

Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.

Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff.

**Scoring Category :** C

**Score :** Insufficient Compliance

**Observation(s):**

## The Joint Commission
## Findings

EP 2
Observed in Individual Tracer at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site. Three of six records reviewed did not contain all information that reflected the patients' care and services. The record of hospice patient #2 did not include documentation of a telephone order received for a medication. In interview the nurse stated that she had received the order, written it down and read it back for verification but the order was not entered into the computer record. There was also no signed order for the medication. This was reviewed and validated with the clinical coordinator for the hospice program.

Observed in Individual Tracer at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site. For home care patient #1 there was no documentation of communication between the physical therapist (PT) and the physical therapist assistant (PTA). The PTA stated that the PT performed the initial assessment and established the plan of care. Before the PTA made his first visit he had a discussion with the PT about the assessment findings and the plan of care. However, there was no documentation of this delegation of care. This was validated with the Home Care director.

Observed in Record Review at Baptist Memorial Hospital Huntingdon (631 R.B. Wilson Drive, Huntingdon, TN) site. In the record of hospice patient #3, the documented interdisciplinary plan of care did not address the care of the volunteer chaplain. In discussion with the volunteer coordinator, it was stated that the services were discussed at the IDG meeting but the goals were not added to the documented plan of care. There was an issue with the computer program that did not allow volunteers to document electronically and the other disciplines did not have the access to add these goals to the record.

---

# Letters of Support

BAPTIST | MEMORIAL MEDICAL GROUP
HUNTINGDON PRIMARY CARE

2012 MAY 14 PM 4: 13

May 11, 2012

State of Tennessee

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I have practiced medicine in Huntingdon for 34 years. In addition, I was raised in this community and am aware of the needs of the population. Currently serving as a Family Practice Physician has provided a perspective of the need and potential benefit that a geriatric behavior unit close to the homes of the residents' families can provide. Due to travel and distance some patients are hampered from receiving mental health care which can result in earlier admission to a nursing home. The needs of many of the elderly patients that I see can be served in a specialized geriatric behavior health program if it was available closer to their home and family members. In my practice many of my patients would meet the criteria for admission to a geriatric behavior health unit.

As a member of the medical staff of Baptist Memorial Hospital-Huntingdon and a citizen in the community, I believe that a geriatric service at the hospital is needed and will benefit as they seek approval to implement a Geriatric Behavior Health Program. Baptist Memorial Hospital-Huntingdon has consistently provided excellent care for the acute needs patients of the community and I believe that the hospital will also provide excellent service to the patients of this unit as they struggle with behavior issues in their senior years.

Sincerely,

James S. Williamson MD

James S. Williamson, MD

JSW/amc

641 R.B. Wilson Drive, Suite G, Huntingdon, Tennessee 38344

2012 MAY 14 PM 4:13

LEE M. CARTER, M.D.

641 R. B. Wilson Drive
Huntingdon, TN 38344

Phone: 731-986-7305

May 11, 2012

State of Tennessee

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I have practiced medicine in Huntingdon for 20 years. In addition, I was raised in this community and am aware of the needs of the population. Currently serving as the Medical Director for Huntingdon Health and Rehab has provided a perspective of the need and potential benefit that a geriatric behavior unit close to the homes of the residents' families can provide. Due to travel and distance some patients are hampered from receiving mental health care which can result in earlier admission to a nursing home. The needs of many of the elderly patients that I see can be served in a specialized geriatric behavior health program if it was available closer to their home and family members. Approximately 5 of my patients each month would meet the criteria for admission to a geriatric behavior health unit.

As a member of the medical staff of Baptist Memorial Hospital-Huntingdon and a citizen in the community, I believe that a geriatric service at the hospital is needed and will benefit as they seek approval to implement a Geriatric Behavior Health Program. Baptist Memorial Hospital-Huntingdon has consistently provided excellent care for the acute needs patients of the community and I believe that the hospital will also provide excellent service to the patients of this unit as they struggle with behavior issues in their senior years.

Sincerely,

Lee M. Carter, M.D.

# SUPPLEMENTAL

1. **Section B, Project Description, Item B. III**

Your response is noted. However, there are several required information items which are missing or in conflict.

A) Please clearly identify the location of the proposed project within the building.
Response:
An aerial view is provided indicating the location of the proposed geriatric psychiatric unit in the hospital building.

B) Please identify all street, roads, or highways that cross or border the site.
Response:
The aerial view also indicates the highways and roads that border the site.

C) The text in the application says Baptist Memorial Hospital – Huntingdon is on a 10 acre campus, while the plot plan states 21.1 acres. Please provide the correct acreage on the Plot plan and in the text.
Response:
The site is 21.1 acres as indicated on the aerial view. A replacement page correcting the text is also provided.

4. Documentation of FDA approval.

b. Provide current and proposed schedules of operations.

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.

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.

**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:**

Response
A plot plan and aerial view of the BMH-Huntingdon 21.1 acre campus is provided.

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.***

**(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
Access to the hospital is provided by individual vehicles although the hospital is located close to a major thoroughfare. Ample and convenient parking is provided.

**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
A floor plan showing the 12 bed geriatric-psychiatric unit is provided as an attachment.

**2. Section B, Project Description, Item B.IV**

The floor plans submitted are noted. Please provide a floor plan of the hospital areas around the proposed geriatric-psychiatric unit.

Response:
A floor plan of the hospital showing the proposed geriatric psychiatric unit is provided in the following 3 pages.

1) The first shows the location in relation to the main hospital entrance and other hospital departments.
2) The second is enlarged to more clearly indicate the main departments.
3) The third is redrawn to indicate the areas adjacent to the Geriatric Psychiatric Unit entrance.

3. **Section C, Need,** Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 1-4))

A) The tables on page 12 presenting population based Age 18+ psychiatric bed need based on 30 beds/100,000 population. Based on the formula, the tables display a service area need for 72 beds in 2016 for adult psychiatric patients. Currently there are 63 operational adult psychiatric beds in the service area, (22 beds at Henry County Medical Center, 16 beds at Behavioral Healthcare Center at Martin in Weakley County and 25 beds at Pathways of Tennessee in Jackson in Madison County). According to the Joint Annual Report (JAR), all 16 beds at the Behavioral Healthcare Center at Martin are designated as a gero-psychiatric unit. In its 2011 JAR, Henry County has designated some of its 22 beds as gero-psychiatric. With only a Net Adult Psychiatric Bed Need for 9 beds, please discuss why the applicant feels there is a need for 12 more adult psychiatric beds as proposed.

Response:
The need for 12 beds can be determined by 2 methods.

Method 1
Based on population projections provided by the Tennessee Department of Health, the population of patients 65+ will increase by 13.25% from 2012 to 2018 as shown in the following table:

| County | Age | 2012 | 2018 | % Change |
|---|---|---|---|---|
| Madison | 65 plus | 12,914 | 15,522 | 20.20% |
| Henderson | 65 plus | 4,169 | 4,843 | 16.17% |
| Gibson | 65 plus | 8,523 | 9,194 | 7.87% |
| Weakley | 65 plus | 5,055 | 5,496 | 8.72% |
| Henry | 65 plus | 6,356 | 7,115 | 11.94% |
| Carroll | 65 plus | 5,495 | 6,075 | 10.56% |
| Benton | 65 plus | 3,457 | 3,877 | 12.15% |
| Decatur | 65 plus | 2,321 | 2,566 | 10.56% |
| **POPULATION** | | 48,290 | 54,688 | 13.25% |

When the need for 9 beds is increased with allowance for population increase and occupancy, the need is rounded to 12 beds.

The applicant referred to the available 2009, 2010 and 2011 Joint Annual Reports. For the first time in the 2011 report, Henry County Medical Center indicated that it had a designated Gero-Psychiatric unit. However, the percent of geriatric admissions was approx 17% of the total psychiatric admissions

and the days approx 20% of the total psychiatric days of service provided for the entire year.

Method 2:
As discussed in response to the following question regarding determination of the service area, the primary area of patient origin for BMH-Huntingdon is Carroll and Benton Counties. Together, the counties account for more than 94% of inpatient admissions and approximately 94% of outpatient registrations and inpatient admissions.

The following chart indicates that in 2012 Carroll and Benton have a population of 36,788 adults (23,375 +13,413). Applying the state's criteria of 30 beds per 100,000 population, a need for 11.03 beds is indicated. In 2018 the need changes to 11.26 beds or 12 beds.

| County | Age | 2012 | 2018 |
|---|---|---|---|
| Carroll | 18 plus | 23,375 | 23,960 |
| Benton | 18 plus | 13,413 | 13,590 |

B) The tables on page 13 presenting population based Age 65+ psychiatric bed need based on 30 beds/100,000 population. Based on the formula, the tables display a service area need for 16 beds in 2016 for geriatric-psychiatric patients. There are presently 16 beds at the Behavioral Healthcare Center at Martin, with only a Net Geriatric Psychiatric Bed Need for 0 Geriatric Psychiatric beds, please discuss why the applicant feels there is a need for 12 more geriatric psychiatric beds as proposed.

Response:
A dedicated, medical surgical hospital based geriatric psychiatric inpatient program provides an admission policy that allows for much more medically compromised patients than are admitted to traditional adult psychiatric programs. The majority of patients admitted to geriatric psychiatric programs typically fall into exclusionary criteria of general adult psychiatric programs due to secondary medical conditions or physical limitations in areas of adaptive living, such as bathing, toileting or ambulation. Facilitating admission from the medically acute facility to the geriatric psychiatric unit, psychiatrists work very closely

with primary care physicians on the unit to ensure monitoring of medical conditions along with the psychiatric problem. The typical older psychiatric inpatient, due predominantly to their advanced age, is prescribed an average of five (5) medications, often from a variety of medical specialists. Management of potential drug interactions is a significant area of focus for physicians specializing in inpatient geriatric psychiatry. Published data indicate an average of eighty-three percent (83%) of patients admitted to a geriatric inpatient unit have at least one or more serious secondary medical diagnoses. Examples of these diagnoses are: diabetes, cardiac complications, hypertension, COPD, status post CVA, etc.

Also significant is that in the proposed service area there many nursing homes and letters of support have been provided from physicians who serve as medical directors for nursing homes. Nursing homes typically account for approximately one third of admissions to geriatric psychiatric programs across the United States. The estimated prevalence of psychiatric disorders in nursing home residents ranges from 68 percent to 94 percent according to published documents in Psychiatric Services, a Journal of the American Psychiatric Association. Also well documented in professional literature is the prevalence of undiagnosed psychiatric illness amongst nursing home residents as major depression can be masked as compliance and other behaviors are simply attributed to 'symptoms of old age.'

A 2002 study in Psychiatric Services cited untreated psychiatric symptoms in nursing home residents as contributing to "complicate the course of medical illness, interfere and confound nursing and medical care, increase residents' disability, raise health care costs and diminish residents' quality of life." It has been well documented that medical surgical hospitals offer a highly important distinction from non-medical hospital programs in that the frail elderly most often have high levels of co-morbidity which may only be, or more adequately be, addressed in a medical surgical environment.

4. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services B. 1. Service Area and Section C. Need. Item 3 Service Area**

Your response is noted. The application question asked the applicant to identify and justify the reasonableness of the proposed service area. Please provide the number of patients by county of residence for the most recent year available at BMH-H.

Response:

The charts are completed for inpatient origin and for both inpatient admission and outpatient registrations. The proposed geriatric-psychiatric unit is anticipated to be utilized more by patients and families who reside closer to BMH-Huntingdon.

As discussed in response to the previous item, the primary area served by BMH-Huntingdon is Carroll and Benton Counties. Together, they account for more than 94% of in patient admissions and approximately 94% of outpatient registrations and inpatient admissions as shown in the charts.

Inpatient (IP) Admissions

| County | No. of BMH-H Patients | % of total patients |
|---|---|---|
| Carroll | 736 | 87.3% |
| Benton | 61 | 7.2% |
| Decatur | 0 | 0.0% |
| Gibson | 2 | 0.2% |
| Henderson | 9 | 1.1% |
| Henry | 13 | 1.5% |
| Madison | 2 | 0.2% |
| Weakley | 14 | 1.7% |
| Other | 6 | 0.7% |
| Total | 843 | 100% |

OP Registrations and IP Admits

| County | No. of BMH-H Patients | % of total patients |
|---|---|---|
| Carroll | 15,684 | 86.0% |
| Benton | 1,034 | 5.7% |
| Decatur | 42 | 0.2% |
| Gibson | 198 | 1.1% |
| Henderson | 362 | 2.0% |
| Henry | 278 | 1.5% |
| Madison | 118 | 0.6% |
| Weakley | 212 | 1.2% |
| Other | 312 | 1.7% |
| Total | 18,240 | 100.0% |

SUPPLEMENTAL

5. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services B. 2. Service Area Demographics and Section C. Need. Item 4 Service Area Demographics**

2012 MAY 22 PM 3: 21

Please complete the following chart.
Response:
The chart is completed below.

| Demographic Data | Carroll County | Benton County | Decatur County | Gibson County | Henderson County | Henry County | Madison County | Weakley County | Service Area Total | State of TN Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Total 2012 Population | 29,843 | 16,726 | 11,495 | 49,169 | 27,955 | 32,672 | 100,816 | 33,906 | 302,582 | 6,361,070 |
| Total 2016 Population | 30,345 | 16,922 | 11,526 | 49,750 | 28,795 | 33,284 | 104,160 | 34,247 | 309,029 | 6,575,165 |
| Total 2016 Population % Change | 1.65% | 1.16% | 0.27% | 1.17% | 2.92% | 1.84% | 3.21% | 1.00% | 2.09% | 3.26% |
| 65+ Pop. - 2012 | 5,495 | 3,457 | 2,321 | 8,523 | 4,169 | 6,356 | 12,914 | 5,055 | 48,290 | 878,496 |
| 65+ Pop. - 2016 | 5,897 | 3,758 | 2,480 | 8,973 | 4,627 | 6,856 | 14,539 | 5,332 | 52,462 | 987,074 |
| 65+ Population % Change | 6.82% | 8.01% | 6.41% | 5.02% | 9.90% | 7.29% | 11.18% | 5.20% | 7.95% | 11.00% |
| 65+ Population % of Total Population | 19.43% | 22.21% | 21.52% | 18.04% | 16.07% | 20.60% | 13.96% | 15.57% | 16.98% | 15.01% |
| Median Household Income | $ 36,160 | $ 33,953 | $ 30,445 | $ 35,947 | $ 38,887 | $ 36,836 | $ 40,178 | $ 32,358 | $ 35,596 | $ 43,413 |
| TennCare Enrollees | 6,632 | 3,483 | 2,551 | 11,030 | 6,090 | 6,937 | 20,950 | 6,386 | 64,059 | 1,211,113 |
| TennCare Enrollees as % of Total Population | 22.22% | 20.82% | 22.19% | 22.43% | 21.79% | 21.23% | 20.78% | 18.83% | 21.17% | 19.04% |
| Persons Below Poverty Level | 5,849 | 2,944 | 2,333 | 9,391 | 4,585 | 5,620 | 18,752 | 7,358 | 56,831 | 1,049,577 |
| % of Total Population below Poverty Level | 19.60% | 17.60% | 20.30% | 19.10% | 16.40% | 17.20% | 18.60% | 21.70% | 18.78% | 16.50% |

6. **Section C, Need, Item 1.a., Service-Specific Criteria (Psychiatric Inpatient Services (C.1.))**

Please complete the following chart:
Response:
The Chart is completed below. Source of the center of county population is the 2010 Census Centers of Population by County.

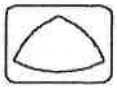
| County (Epicenter) | Distance to BMH-Huntingdon | Distance to Henry County Medical Center | Distance to Behavioral Healthcare Center at Martin | Distance to Pathways of Tennessee |
|---|---|---|---|---|
| Carroll | 4.6 mi<br>9 min | 27.9 mi<br>37 min | 38.8 mi<br>59 min | 38.4 mi<br>51 min |
| Benton | 21.3 mi<br>31 min | 21.3 mi<br>31 min | 54.2 mi<br>1 hr 19 min | 64.2 mi<br>1 hr 16 min |
| Decatur | 49.6 mi<br>1 hour 3 min | 53.7 mi<br>1 hr 10 min | 85.6 mi<br>1 hr 53 min | 47.8 mi<br>1 hr 1 min |
| Gibson | 33.9 mi<br>51 min | 47.2 mi<br>1 hr min | 36 mi<br>50 min | 24.8 mi<br>38 min |
| Henderson | 28.5 mi<br>47 min | 50.6 mi<br>1 hr 17 min | 66.6 mi<br>1 hr 31 min | 29 mi<br>39 min |
| Henry | 25.7 mi<br>40 min | 2.4 mi<br>6 min | 35.3 mi<br>56 min | 62 mi<br>1 hr 22 min |
| Madison | 37.2 mi<br>48 min | 60 mi<br>1hr 19 min | 52.3 mi<br>1 hr 15 min | 1.7 mi<br>6 min |
| Weakley | 31 min<br>51 min | 27.2 mi<br>41 min | 8.1 mi<br>16 min | 54.4 mi<br>1 hr 17 min |

7. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services B. 2. Service Area Demographics ( Involuntary Admissions)**

Your discussion of accepting "Involuntary Admissions" has conditions connected with accepting involuntary admissions. Please discuss these conditions in further detail with examples of when the applicant could not accept an "Involuntary Admission." In a situation where the applicant could not take an "Involuntary Admission", what protocols would the applicant enact to assure the patient could receive proper treatment?

Response:
The Admission Policy for the proposed Geriatric Psychiatric unit follows this page.

SUPPLEMENTAL



BAPTIST MEMORIAL HOSPITAL –HUNTINGDON

| Effective Date: Draft<br>Last Review / Revision:<br><br>Ref: | **Admission/Exclusionary/Continued Stay/Discharge Criteria** |
|---|---|

***POLICY/PROCEDURE***

It is the policy of the Behavioral Health Service to provide the most appropriate level of psychiatric care in the least restrictive and age appropriate environment utilizing the following criteria. Treatment is offered without regard to race, color, religion, sex, national origin, sexual orientation, age, physical disability, payer source or socioeconomic status. Patients are admitted by voluntary consent or involuntary in accordance with state regulations. The physician has the responsibility to admit or discharge a patient based on medical necessity and achievement of treatment goals.

The Geropsychiatric service is a hospital based subspecialty medically managed program. The program structure is designed to meet the individual developmental needs, cognitive and physical limitations of the geriatric adult. There is a complex interplay between the presenting acute psychiatric symptoms, multiple medical co-morbidities and neurological deficits that are assessed by the physicians and clinical staff to develop a plan of care that meets the patient's individual needs.

**A. Admission Criteria: (Intensity of Service):**

1. The patient must require intensive, comprehensive, multimodal treatment with medical supervision and coordination 24 hours a day

2. The patient needs 24 hour nursing or medical supervision for safety to protect self or others, psychiatric diagnostic evaluation, exacerbation of acute psychiatric symptoms or behaviors impacting medical co-morbidity management, potential severe side effects of psychotropic medications associated with medical or psychiatric comorbidities and/or changes in psychotropic medications.

3. The acute psychiatric symptoms and behaviors being evaluated and treated must require active treatment, including a combination of services such as intensive nursing and medical intervention/management, psychotherapy, occupational, recreational and activity therapy. The intensity and frequency of these therapies and interventions exceed those services available in an outpatient setting.

**Admission Criteria: (Severity of Illness):**

1. The patient poses a threat to self-requiring 24 hour professional observation:

    1.1. Suicidal ideation or gesture within 72 hours prior to admission
    1.2. Actual or threatened self-injury/mutilation within 72 hours prior to admission
    1.3. Chronic and continuing self-destructive behavior that poses a significant and/or immediate threat to life, limb or bodily function.

2. The patient poses a threat to others requiring 24 hour professional observation:

    2.1. Assaultive behavior threatening other within 72 hours of admission
    2.2. Significant verbal threat to the safety of others within 72 hours of admission

3. Command hallucinations directing harm to self or others where there is the risk of the patient taking action.

4. Acute disordered/bizarre behavior or psychomotor agitation or retardation that interferes with individual's ability to function with activities of daily living at a less intensive level of care during evaluation and treatment.

5. Cognitive impairment (disorientation or memory loss) due to an acute Axis I disorder that endangers the welfare of the patient of others

6. Patients with a dementing disorder for evaluation or treatment of a psychiatric comorbidity (e.g. risk of suicide, violence, severe depression) that warrants an inpatient admission.

7. A mental disorder that causes an inability to maintain adequate nutrition or self-care, lack of reliable family/community support or essential care so that the patients cannot function in a less intensive level of care during evaluation and treatment.

8. A mental disorder causing major disability in medical co-morbidity management, social, occupational, educational and/or interpersonal functioning that is leading to life-threatening or dangerous functioning and can only be addressed in an acute inpatient setting.

9. Failure of outpatient psychiatric treatment so that the patient requires 24 hour professional observation and care. Reasons for failure of outpatient treatment may include: increase severity of symptoms, noncompliance with medication due to severity of symptoms, inadequate clinical response to psychoactive medications.

B. Adults 65 years of age or older who meet the admission criteria and who have a DSM IV Axis I diagnosis may be admitted to the Behavioral Health Service with a physician order.

C. The admission criteria are applied consistently to all patients regardless of payor sources or reimbursement.

D. The severity and acuity of symptoms along with the likelihood of patients' response to treatment combined with the requirement for an intensive, 24 hour level of care are the significant factors in determining the medical necessity of admission for inpatient psychiatric treatment.

E. **Exclusionary Criteria:**

1. Patients who require primarily social, custodial, recreational or respite care

2. Patients whose clinical acuity requires less than 24 hour of supervised care a day.

3. Patients whose primary problem is a physical health problem without a concurrent psychiatric episode or diagnosis.

4. Patients who cannot participate on active treatment due to significant physical limitations and are bedfast.

5. Patients with alcohol or substance abuse problems that do not have a combined need for active treatment and psychiatric care.

6. Patients with a known dementia diagnosis with no acute behavior change or psychiatric disorder.

7. Patients for whom inpatient psychiatric admission is being used as an alternative to incarceration.

F. **Continued Stay Criteria:**

1. The patient continues to pose actual or imminent danger to self, others, or property.

2. The patient continues to have the acute disturbance of mood, behavior, or thinking that required the initial admission.

3. The patient's level of functioning has regressed since the last review.

4. The patient continues to need re-stabilization to reach baseline functioning with further improvement in his or her condition is expected.

5. The patient demonstrates an inability to function at a lesser level of care.

6. The patient has developed psychotic symptomology not present at last review.

**G. Discharge Criteria**

1. The goals of the treatment have been substantially met at this level of care (unless transfer to another hospital setting is indicated).

2. Follow-up goals, treatment plans and safety plans have been established for a lesser level of care.

3. Releasing or transferring the patient to a less intensive level of care does not pose a threat to him/her, others, or property.

**REFERENCES**

Wisconsin Physician Services Local Coverage Determination for Psychiatric Inpatient Hospitalization

CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2 Section 30.3

CMS PPS Excluded Unit Common Requirements: 42 CFR 412.25 (2)

CMS PPS Excluded Units: Additional Requirements: 42 CFR 412.27 (a), 412.27 (c)(1)(ii)

CMS Condition of Participation for Psychiatric Hospitals 42 CFR 482.61 (a)(3)

Title XVIII of the Social Security Act, Section 1862(a) (1) (A)

CMS Publication 100-03, Chapter 1, Section 130.1 and 130.6

Joint Commission Hospital Accreditation Standards:
PC.01.01.01

**8. Section C, Need, Item 6**

Your response to this item is noted.

A) What have been the annual number of patients who the local physicians have referred to other facilities for geriatric psychiatric services in the past three years

Response:
Data from independent physician practices is not available. However, 3 physicians have provided estimates of patients as indicated below and on the letters following this page.

| Doctor Name | Potential Patients | |
|---|---|---|
| Lee M. Carter, MD | 5 per month | 60 per year |
| Thomas Paul Evans, MD | 20 per month | 240 per year |
| Scott Portis, MD | 12 per month | 144 per year |
| James S. Williamson, MD | Unspecified | |

SUPPLEMENTAL

LEE M. CARTER, M.D.

641 R. B. Wilson Drive
Huntingdon, TN 38344

Phone: 731-986-7305

May 11, 2012

State of Tennessee

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I have practiced medicine in Huntingdon for 20 years. In addition, I was raised in this community and am aware of the needs of the population. Currently serving as the Medical Director for Huntingdon Health and Rehab has provided a perspective of the need and potential benefit that a geriatric behavior unit close to the homes of the residents' families can provide. Due to travel and distance some patients are hampered from receiving mental health care which can result in earlier admission to a nursing home. The needs of many of the elderly patients that I see can be served in a specialized geriatric behavior health program if it was available closer to their home and family members. Approximately 5 of my patients each month would meet the criteria for admission to a geriatric behavior health unit.

As a member of the medical staff of Baptist Memorial Hospital-Huntingdon and a citizen in the community, I believe that a geriatric service at the hospital is needed and will benefit as they seek approval to implement a Geriatric Behavior Health Program. Baptist Memorial Hospital-Huntingdon has consistently provided excellent care for the acute needs patients of the community and I believe that the hospital will also provide excellent service to the patients of this unit as they struggle with behavior issues in their senior years.

Sincerely,

Lee M. Carter, M.D.

SUPPLEMENTAL

# EVANS MEDICAL CLINIC, PLLC

*Internal Medicine / Pediatrics / Family Practice / Obstetrics / Gynecology*

Thomas Paul Evans, M.D.
Jerry F. Atkins, M.D.
Pamela R. M. Evans, M.D.
Paul Brinkman, PA-C
Nancy Caterina, PA-C
Kathy Kee, RN, MSN, FNP
Tonya Nash, PA-C

3493 Veterans Drive North
Suite C
P O Box 465
Huntingdon, TN 38344
Phone: (731)986-2933
Fax: (731)986-2938

May 11, 2012

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I have practiced medicine in Huntingdon for 15 years. In addition, my clinic consists of four nurse practitioners and physician assistants, one OB/GYN physician, two part time family medicine physicians, and myself. These providers are well aware of the needs of the populations as they not only provide care, but are residents of the community. Additionally, I serve as the Director of Hospitalist Services at BMH-Huntingdon. My roles have provided a perspective of the need and potential benefit that a geriatric behavior unit close to the homes of the residents' families can provide. Due to financial restraints, travel, and distance, some patients are prevented from receiving mental health care which could possibly result in an earlier admission to a nursing home. The needs of many of the elderly patients that I see can be served in a specialized geriatric behavior health program, if it was available closer to their home and family members. Approximately twenty of my patients each month would meet criteria for admission to a geriatric behavior health unit.

As a member of the medical staff of Baptist Memorial Hospital-Huntingdon and a member of our community, I believe that your approval of a Geriatric Behavior Health Program would tremendously benefit the population of our service area. Baptist Memorial Hospital-Huntingdon has consistently provided excellent care to our community and I believe that the hospital will continue to provide the same care to the patients of this unit as they struggle with behavior issues in their senior years.

Sincerely,

Thomas Paul Evans, M.D

SUPPLEMENTAL

May 14, 2012

State of Tennessee

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I am a lifelong resident of Carroll County and have been privileged to serve the residents of Carroll County as an Emergency Department Physician, as well as in private practice. I have been a member of the medical staff at BMH-Huntingdon for 38 years. I have served as the Director of Emergency Services at BMH-Huntingdon for the past 28 years. I have encountered numerous issues in the emergency department with behavior health transfers due to many underlying social issues of the patients. Financial and travel concerns for the caregiver, as well as difficulty with transfers to other facilities continue to hamper the mental healthcare given to our geriatric population. The needs of many of the elderly patients that I see in the emergency department can be served in a geriatric behavior health program if it was available closer to their home and family members. Our emergency room sees approximately 12 patients a month that could benefit from the proposed unit.

As a longstanding member of our community and healthcare provider, I strongly support your approval of a Geriatric Behavior Health Program at BMH-Huntingdon. Throughout my career, Baptist Memorial Hospital-Huntingdon has provided superior care to our community. I am certain the same care will be afforded to the patients of this unit.

Sincerely,

Scott Portis, M.D.
Emergency Medical Director
Emergency Coverage Corp.

**DR. B. SCOTT PORTIS**
EMERGENCY MEDICAL DIRECTOR
632 R. B. Wilson Drive
Huntingdon, TN 38344
(731) 986-4461

SUPPLEMENTAL

May 11, 2012

State of Tennessee

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I have practiced medicine in Huntingdon for 34 years. In addition, I was raised in this community and am aware of the needs of the population. Currently serving as a Family Practice Physician has provided a perspective of the need and potential benefit that a geriatric behavior unit close to the homes of the residents' families can provide. Due to travel and distance some patients are hampered from receiving mental health care which can result in earlier admission to a nursing home. The needs of many of the elderly patients that I see can be served in a specialized geriatric behavior health program if it was available closer to their home and family members. In my practice many of my patients would meet the criteria for admission to a geriatric behavior health unit.

As a member of the medical staff of Baptist Memorial Hospital-Huntingdon and a citizen in the community, I believe that a geriatric service at the hospital is needed and will benefit as they seek approval to implement a Geriatric Behavior Health Program. Baptist Memorial Hospital-Huntingdon has consistently provided excellent care for the acute needs patients of the community and I believe that the hospital will also provide excellent service to the patients of this unit as they struggle with behavior issues in their senior years.

Sincerely,

James S. Williamson MD

James S. Williamson, MD

JSW/amc

641 R.B. Wilson Drive, Suite G, Huntingdon, Tennessee 38344

B) Please provide the details regarding the methodology used to project 243 gero psych admissions and 2,920 patient days during the first year of operation (2013) and 274 gero psych admissions and 3,285 patient days during the second year of operation. What is the applicant's basis for project 12 day ALOS? The methodology must include detailed calculations or documentation from referral sources. Providing only statements such as "based on the applicant's or service manager's experience" will not be considered an adequate response.

Response:
The methodology involved assessments from 4 sources:

1) Secondary diagnosis of hospital patients
BMH-Huntingdon analyzed patient data from the previous 3 fiscal years (Oct 1st - Sept 30th) and FY 2012 YTD to identify patients with a secondary diagnosis that would indicate a potential need for admission to a geriatric psychiatric unit. The conditions include alzheimers, anxiety, anxiety and depression, bipolar, change in mental status, dementia, depression, panic, psychosis, and suicidal ideation. The numbers reflect a positive annual trend. The results are shown in the following table.

| BMH-Huntingdon Patients<br>Secondary Diagnosis as Indicator | | |
|---|---|---|
| Period | Patients | |
| FY 2009 | 163 | |
| FY 2010 | 186 | |
| FY 2011 | 154 | |
| YTD 2012 | 199 | (Annualized) |

2) As previously referenced in Part A above, physicians who had expressed concern for a geriatric psychiatric unit to meet community need provided data about potential patients.

| Doctor Name | Potential Patients | |
|---|---|---|
| Lee M. Carter, MD | 5 per month | 60 per year |
| Thomas Paul Evans, MD | 20 per month | 240 per year |
| Scott Portis, MD | 12 per month | 144 per year |
| James S. Williamson, MD | Unspecified | |

Both of the previous steps indicate a need for the service. The need is present and growing. If the number of patients reflects the same number from 2012 to 2013 as it did from 2011 to 2012 in the hospital counts, based on the indication from the hospital analysis, an expected number of admissions would be 199 + 45 or approximately 244 patients. The projected increase in year 2 to 275 patients assumes an increase of approx. 13%.

3) PRP provided data based on experience in similar communities, and references to published studies regarding Length of Stay. The table below is from National Association of Psychiatric Health Systems Annual 2010 Survey that was published in 2011. The ALOS for an older adult program is 12.5 days. The following page that was updated April 28, 2011 indicates a fluctuation in days ending with an average LOS of 12.5 days.

Table 16. Average Inpatient Hospital Length of Stay by Program (trimmed at 30 days) (in psychiatric hospitals and general hospital behavioral health units)

| Program | 2009 (Days) |
|---|---|
| Total inpatient hospital (all programs combined–trimmed at 30 days) | 9.0 |
| Child program | 10.8 |
| Adolescent program | 9.4 |
| Adult program | 8.3 |
| Older adult program | 12.5 |
| Alcohol and drug use program for adults | 7.6 |
| Alcohol and drug use program for youth | 9.1 |

4) Finally a review of Hospital Joint Annual Report data from the 2010 hospitals indicates an average LOS of 13.7 days for this population.

| Hospital Name | County Name | Dedicated Geriatric | 65+ Admits | 65+ Days | 65+ ALOS | |
|---|---|---|---|---|---|---|
| Saint Thomas Hospital | Davidson | Yes | 213 | 4,299 | 20.18 | |
| Vanderbilt Univeristy Hospitals | Davidson | No | 75 | 721 | 9.61 | |
| Centennial Medical Center | Davidson | Yes | 1,124 | 19,589 | 17.43 | |
| Skyline Medical Center Campus | Davidson | Yes | 382 | 3,857 | 10.10 | |
| Horizon Medical Center | Dickson | Yes | 130 | 1,589 | 12.22 | |
| Parkwest Medical Center | Knox | Yes | 472 | 3,854 | 8.17 | |
| Wellmont Bristol Regional Medical Center | Sullivan | No | 111 | 950 | 8.56 | |
| Perry Community Hospital | Perry | Yes | 201 | 2,198 | 10.94 | |
| | | | 2,708 | 37,057 | 13.68 | Average |

National Association of Psychiatric Health Systems

900 17th Street, NW, Suite 420
Washington, DC 20006-2507
Phone: 202/393-6700
Fax: 202/783-6041
Web: www.naphs.org

# LENGTH OF STAY DATA

Total average length of stay (which looks at all hospital-based programs combined -- including adult/geriatric, child/ adolescent, and substance abuse programs) is provided below, as well as specific length of stay data for child and adolescent programs where available.

When this data is used, credit must be given to:

© National Association of Psychiatric Health Systems
From NAPHS *Annual Survey Reports* from selected years.

NOTE: *Data was not collected—and is not reported below—for 1998.*

## Average Length of Stay (in days)

| Program | 1987 * | 1988 * | 1989 * | 1990 ** | 1991 ** | 1992 ** | 1993 *** | 1994 *** | 1995 *** | 1996 *** | 1997 ** | 1999 *** | 2000 *** | 2001 *** | 2002 *** | 2003 *** | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Inpatient | 30.5 | 29.1 | 27.0 | 25.6 | 23.1 | 19.8 | 16.2 | 10.4 | 11.7 | 11.5 | 10.2 | 10.2 | 10.0 | 9.3 | 10.3 | 9.8 | 9.4 | 9.5 | 9.9 | 9.3 | 9.4 | 9.0 |
| Adult | | – | – | – | – | 14.6 | 13.7 | 9.3 | 9.9 | 9.7 | 8.8 | – | 8.6 | 7.9 | 8.5 | 8.6 | 7.9 | 8.5 | 8.9 | 8.4 | 8.3 | 8.3 |
| Child | 48.1 | 46.7 | 41.7 | 36.4 | 33.4 | 27.6 | 21.0 | 12.7 | 14.6 | 14.1 | 12.8 | – | 11.1 | 11.7 | 11.1 | 11.8 | 12.0 | 11.4 | 12.4 | 12.2 | 12.6 | 10.8 |
| Adolescent | 43.8 | 40.0 | 35.0 | 33.0 | 23.6 | 21.4 | 19.2 | 10.6 | 12.2 | 11.4 | 10.9 | – | 10.2 | 9.8 | 10.2 | 10.2 | 9.9 | 9.7 | 10.1 | 10.2 | 10.0 | 9.4 |
| Alcohol & drug / adults | | | | | | | | | | | | | | | | | | 6.7 | 8.0 | 7.1 | 7.8 | 7.6 |
| Alcohol & drug /youth | | | | | | | | | | | | | | | | | | 12.7 | 13.8 | 12.7 | 12.6 | 9.1 |
| Older adult | | | | | | | | | | | | | 15.6 | 13.7 | 14.3 | 13.7 | 13.2 | 14.3 | 14.8 | 14.5 | 13.5 | 12.5 |

* trimmed at 90 days **trimmed at 60 days ***trimmed at 30 days

NOTE: The years 1990, 1991, and 1992 provide trended data. Trended data were included only for those organizations that supplied specific information for the years 1990, 1991, and 1992.

**SOURCE:** *Annual Survey Reports*, National Association of Psychiatric Health Systems (From reports from 1988 through 2010--published 2011). Washington, DC.

**UPDATED April 28, 2011**

***If you're looking for additional historical information***, you may be able to get assistance from the Survey and Analysis Branch of the Center for Mental Health Services, phone: 240-276-1780. They publish *Mental Health, United States*, which provides an overview of mental health data trends over the past 20 years. The most recent edition is *Mental Health, United States, 2008* (available as a pdf at http://store.samhsa.gov/shin/content//SMA10-4590/SMA10-4590.pdf or under "publications" at www.samhsa.gov). Historic data is also available in earlier editions, such as *Mental Health, United States, 2004* at http://store.samhsa.gov/shin/content//SMA06-4195/SMA06-4195.pdf.



SUPPLEMENTAL

**9. Section C. Economic Feasibility Item 1 (Project Cost Chart)**

Please provide documentation from a licensed architect or construction professional:

1) a general description of the project,
2) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and
3) attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the new 2006 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities

Response:
Please refer to both letters from the architect provided in the Attachments for

- Plot Plan Section B,III, A(1)
- Floor Plan Section B, IV

B) The latest HSDA Hospital Construction Cost per Square Foot analysis for projects approved by the HSDA 2009-2011 is provided

**10. Section C. Economic Feasibility Item 3 (Reasonableness of Project Cost)**
The latest HSDA Hospital Construction Cost per Square Foot analysis for projects approved by the HSDA 2009-2011 is provided below The applicant may wish to addend its answer to this question as well as the Project Description response.

**Hospital Construction Cost Per Square Foot**
**Years: 2009 – 2011**

| | Renovated Construction | New Construction | Total Construction |
|---|---|---|---|
| **1st Quartile** | $125.84/sq ft | $235.86/sq ft | $167.99/sq ft |
| **Median** | $177.60/sq ft | $274.63/sq ft | $249.32/sq ft |
| **3rd Quartile** | $273.69/sq ft | $324.00/sq ft | $301.74/sq ft |

*Source: CON approved applications for years 2009 through 2011*

Response:
As previously explained, the renovation is projected to cost approximately $95 per square foot (sq ft) for a total of $438,045. The renovation expense is in the 1st quartile which demonstrates the reasonableness of the cost. The cost is also reasonable based on other projects within the BMHCC system.

SUPPLEMENTAL

**11. Section C. Economic Feasibility Item2.**

Since the Baptist Memorial Health Care Corporation is the funding source for this proposed project, please provide a copy of the latest available Financial Statements for Baptist Memorial Health Care Corporation.

Response:

The financial statements from Baptist Memorial Hospital-Memphis are provided to demonstrate that funds are available to fund the project. An additional letter is provided from Donald R. Pounds to clarify the funding source.

**12. Section C. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)**

Response:
The charts are completed in the new format.

SUPPLEMENTAL

**14. Section C, Economic Feasibility, Item 6.B.**

Please provide comparative charges to similar gero-psychiatric facilities in the west Tennessee area or recently approved CON projects by the HSDA

| | | | | |
|---|---|---|---|---|
| CN1205-021 | BMH-Huntingdon | Proposed Gross<br>Proposed Net | Gross<br>Net | $2,074<br>$815 |
| CN1101-003 | Saint Thomas Hospital | Approved April 27, 2011 | Gross<br>Net | $1,628<br>$842 |
| 2010 Joint Annual Report | Behavioral Healthcare Center at Martin | CY 2010 | Gross<br>Net | $987<br>$899 |
| CN1202-007 | Parkridge Valley Adult Services | Approved May 23, 2012 (incl. 18+) | Gross<br>Net | $3,074<br>$762 |

**15. Section C, Economic Feasibility, Item 9.**

Please provide estimated Gross Medicare and TennCare along with their percentage of the Total estimated Gross Revenues for the first year of operation.

Response:
BMH-Huntingdon participates with the TennCare carriers in the West Tennessee area. Since this service focuses on 65+ year old patients, most will be covered by Medicare. However, an amount has been identified for patients who may not have reached full Medicare coverage because they are slightly younger than 65 and in need of geriatric psychiatric service. The projected gross revenue from Medicare is $5,511,272 and Medicare net is $2,239,625. Estimated TennCare gross is approx. $15,000 and net is $7,495.

**16. Section C, Contribution to Orderly Development, Item 3**

The FTEs mentioned in the discussion of Exhibit 12 don't appear to match the FTE number in Exhibit 12. Please explain.

Response:
The FTE's and wage comparisons are provided in the following chart:

| Job Title | FTE | Hourly | Median Wage |
|---|---|---|---|
| Nurse Mgr | 1 | | $ 26.92 |
| Registered Nurse | 4.2 | 22.58 | $ 26.92 |
| Nursing Assistant | 2.8 | 9.58 | $ 10.52 |
| Social Worker | 1 | | $ 20.67 |
| OT/AT/RT | 1.2 | 23 | $ 26.92 |
| Unit Clerk | 2.1 | 9.58 | $ 11.19 |
| | | | |
| Total | 12.3 | | |

Source: Bureau of Labor Statistics – May 2011 State Occupational Employment and Wage Estimates Tennessee. http://www.bls.gov/oes/current/oes_tn.htm

SUPPLEMENTAL

**17. Section C, Contribution to Orderly Development, Item 7**

Please provide the latest results of the state licensure survey along with the applicant's responses. Please discuss what measures the applicant has taken to prevent these citations, if any, from occurring again.

Response:
The latest state survey results are provided. No deficiencies were cited.

**20. Annual Progress Report**

According to HSDA records an affiliated facility has an outstanding CON:

1. CN0709-069A – Baptist Memorial Home Care dba Baptist Trinity Hospice House – licensed on 1/25/11

2. CN1001-004A - Baptist Rehabilitation Germantown

3. CN1010-050A – Baptist Memorial Hospital – Memphis

Please submit a 2-3 sentence update on the progress regarding each of these Outstanding CONs.

Response:
Completion reports have been filed for the projects listed above.

SUPPLEMENTAL

**AFFIDAVIT**

2012 MAY 29 PM 3:20

STATE OF TENNESSEE

COUNTY OF Shelby

NAME OF FACILITY: Baptist Memorial Hospital-Huntingdon

I, Gregory Duckett, 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.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 24th day of May, 2012, witness my hand at office in the County of Shelby, State of Tennessee.

NOTARY PUBLIC

PAULETTE E. KEARNEY STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

My commission expires My Comm. Exp. 9-26-2012.

HF-0043

Revised 7/02

301 TYSON AVENUE
P.O. BOX 1030
PARIS, TENNESSEE 38242
(731) 642-1220

2012 AUG 3 AM 9 42

HENRY COUNTY MEDICAL CENTER

August 2, 2012

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
500 Deaderick St. Suite 850
Nashville, TN. 37243

RE: Certificate of Need #CN1205-021

Dear Ms. Hill,

This letter is to notify the Health Services and Development Agency of the intent of Henry County Medical Center to oppose the certificate of need application filed by the Baptist Memorial Health Care Corporation to establish geriatric psychiatric services at its hospital in Huntingdon, Tennessee. We oppose this application on the grounds that it will not contribute to the orderly development of health services in Northwest Tennessee. At the present time there are three established psychiatric units within the limited service area of Huntingdon with an average occupancy of 47%. We respectfully request that the HSDA deny the issuance of a certificate of need for this service.

We will plan to appear before the Agency at its meeting on August 22, 2012 to oppose this application. If you need additional information from our organization please contact me at the above address or by phone at 731-644-8537 or e-mail at tgee@hcmc-tn.org.

Sincerely yours,

Thomas H. Gee, FACHE
Chief Executive Officer

Cc: Arthur Maples, Baptist Memorial Health Care Corporation

FARRIS MATHEWS BOBANGO PLC

ATTORNEYS AT LAW

Nashville · Memphis

HISTORIC CASTNER-KNOTT BUILDING
618 CHURCH STREET, SUITE 300
NASHVILLE, TENNESSEE 37219

(615) 726-1200 telephone · (615) 726-1776 facsimile

Jerry W. Taylor
jtaylor@farrismathews.com

Direct Dial:
(615) 687-4228

2012 AUG 7 PM 2 14

August 7, 2012

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Baptist Memorial Hospital Huntingdon
CN1205-021

Dear Ms. Hill:

This letter is on behalf of Behavioral Healthcare Center at Martin ("BHC-Martin") to express its opposition to the certificate of need application by Baptist Memorial Hospital–Huntingdon ("BMH-H") to initiate geriatric psychiatric services and establish a 12 bed geriatric psychiatric unit at that facility.

BHC-Martin is a 16 bed mental health hospital located in Weakley County, licensed by the Department of Mental Health. All 16 of its beds are dedicated to providing inpatient mental health services to the elderly population (generally those 65 years of age and older). The statements in the application that there are no dedicated geriatric psychiatric beds in the service area are erroneous.

BMH-H proposes to provide the same services provided by BHC-Martin, and serve the same service area and population as are served by BHC-Martin. The approval of this duplicative service would adversely impact BHC-Martin and make it more difficult to continue to provide its services in an efficient manner.

The BMH-H proposal is not needed, is not economically feasible and will not contribute to the orderly development of health care services and facilities. Accordingly, BHC-Martin respectfully urges the Agency to deny this application.

Sincerely yours,

**FARRIS MATHEWS BOBANGO PLC**

By: Jerry W. Taylor

cc: Arthur Maples

# EVANS MEDICAL CLINIC, PLLC

*Internal Medicine / Pediatrics / Family Practice / Obstetrics / Gynecology*

Thomas Paul Evans, M.D.
Jerry F. Atkins, M.D.
Pamela R. M. Evans, M.D.
Paul Brinkman, PA-C
Nancy Caterina, PA-C
Kathy Kee, RN, MSN, FNP
Tonya Nash, PA-C

3493 Veterans Drive North
Suite C
P O Box 465
Huntingdon, TN 38344
Phone: (731)986-2933
Fax: (731)986-2938

May 11, 2012

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I have practiced medicine in Huntingdon for 15 years. In addition, my clinic consists of four nurse practitioners and physician assistants, one OB/GYN physician, two part time family medicine physicians, and myself. These providers are well aware of the needs of the populations as they not only provide care, but are residents of the community. Additionally, I serve as the Director of Hospitalist Services at BMH-Huntingdon. My roles have provided a perspective of the need and potential benefit that a geriatric behavior unit close to the homes of the residents' families can provide. Due to financial restraints, travel, and distance, some patients are prevented from receiving mental health care which could possibly result in an earlier admission to a nursing home. The needs of many of the elderly patients that I see can be served in a specialized geriatric behavior health program, if it was available closer to their home and family members. Approximately twenty of my patients each month would meet criteria for admission to a geriatric behavior health unit.

As a member of the medical staff of Baptist Memorial Hospital-Huntingdon and a member of our community, I believe that your approval of a Geriatric Behavior Health Program would tremendously benefit the population of our service area. Baptist Memorial Hospital-Huntingdon has consistently provided excellent care to our community and I believe that the hospital will continue to provide the same care to the patients of this unit as they struggle with behavior issues in their senior years.

Sincerely,

Thomas Paul Evans, M.D

BAPTIST | MEMORIAL MEDICAL GROUP
HUNTINGDON PRIMARY CARE

May 11, 2012

State of Tennessee

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I have practiced medicine in Huntingdon for 34 years. In addition, I was raised in this community and am aware of the needs of the population. Currently serving as a Family Practice Physician has provided a perspective of the need and potential benefit that a geriatric behavior unit close to the homes of the residents' families can provide. Due to travel and distance some patients are hampered from receiving mental health care which can result in earlier admission to a nursing home. The needs of many of the elderly patients that I see can be served in a specialized geriatric behavior health program if it was available closer to their home and family members. In my practice many of my patients would meet the criteria for admission to a geriatric behavior health unit.

As a member of the medical staff of Baptist Memorial Hospital-Huntingdon and a citizen in the community, I believe that a geriatric service at the hospital is needed and will benefit as they seek approval to implement a Geriatric Behavior Health Program. Baptist Memorial Hospital-Huntingdon has consistently provided excellent care for the acute needs patients of the community and I believe that the hospital will also provide excellent service to the patients of this unit as they struggle with behavior issues in their senior years.

Sincerely,

James S. Williamson MD

James S. Williamson, MD

JSW/amc

641 R.B. Wilson Drive, Suite G, Huntingdon, Tennessee 38344

5/22/12

To Whom It May Concern:

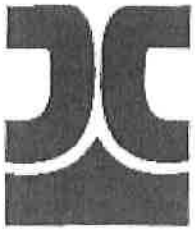
This letter is to voice my support for a proposed unit at Baptist Memorial Hospital, Huntingdon, TN to care for Geriatric patients with behaviorial needs. My mother recently encountered this need which required her to be transferred to a facility over one hour away. This is inconvenient and difficult for family members and caregivers, especially those adult children still trying to work. There is a significant need in our area for with the elderly population we have and this type of care nearer to us would be valuable.

I would be happy to talk with anyone about this issue.

Sincerely,

Mark Crocker

Mark Crocker
160 Cockrill Lane
McLemoresville, TN



# The Jackson Clinic
*Professional Association*

616 West Forest Avenue
Jackson, TN 38301
731-422-0330
WATS 1-800-372-8225

1568 Chere Carol
Humboldt, TN 38343
731-784-7602

20719 E. Main Street
Huntingdon, TN 38344
731-986-2056

2849 & 2863 Hwy. 45 Bypass
Jackson, TN 38305
731-664-1375

87-B Murray Guard Drive
Jackson, TN 38305
731-664-8140

132 Hospital Drive
McKenzie, TN 38201
731-352-7435

4037 S. Highland, Suite 4
Milan, TN 38358
731-686-8095

Amanda Reiter, M.D.
Jackson Clinic - Huntingdon
20719 E. Main Street
Huntingdon, TN 38344

June 27, 2012

To whom it may concern:

I am writing to you regarding the certificate of need for Baptist Memorial Hospital, in Huntingdon, Tennessee. They are seeking approval for a Geriatric Behavioral Health Program. I would strongly urge you to consider granting approval for this request. I am medical director for local nursing home and rehab Center, Lifecare, in Bruceton, Tennessee. We often have patients who need inpatient psychiatric evaluation and medication adjustment. Currently, we do not have a facility in our county that can mee the needs of these patients. Our patients are not even able to travel to a contiguous county since there is not a facility dedicated to the geriatri population nearby. This places a burden on the patients. It also places a burden on the family and caregivers of my patient's who have to travel to be near their loved ones.

I think that the patients in Carroll County would benefit from having a dedicated geriatric behavioral health Center here in Huntingdon.

Sincerely,

Amanda Reiter, M.D

May 14, 2012

State of Tennessee

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I am a lifelong resident of Carroll County and have been privileged to serve the residents of Carroll County as an Emergency Department Physician, as well as in private practice. I have been a member of the medical staff at BMH-Huntingdon for 38 years. I have served as the Director of Emergency Services at BMH-Huntingdon for the past 28 years. I have encountered numerous issues in the emergency department with behavior health transfers due to many underlying social issues of the patients. Financial and travel concerns for the caregiver, as well as difficulty with transfers to other facilities continue to hamper the mental healthcare given to our geriatric population. The needs of many of the elderly patients that I see in the emergency department can be served in a geriatric behavior health program if it was available closer to their home and family members. Our emergency room sees approximately 12 patients a month that could benefit from the proposed unit.

As a longstanding member of our community and healthcare provider, I strongly support your approval of a Geriatric Behavior Health Program at BMH-Huntingdon. Throughout my career, Baptist Memorial Hospital-Huntingdon has provided superior care to our community. I am certain the same care will be afforded to the patients of this unit.

Sincerely,

Scott Portis MD

Scott Portis, M.D.
Emergency Medical Director
Emergency Coverage Corp.

DR. B. SCOTT PORTIS
EMERGENCY MEDICAL DIRECTOR
631 R. B. Wilson Drive
Huntingdon, TN 38344
(731) 986-4461

**Andy Holt**
State Representative
76th District
rep.andy.holt@capitol.tn.gov

**HOUSE OF REPRESENTATIVES**
**STATE OF TENNESSEE**

**District Office:**
461 Jewell Store Road
Dresden, TN 38225
(731) 364-6029

**Committees:**
- Agriculture
- Environment & Conservation

**Legislative Office:**
205 War Memorial Building
301 6th Ave. North
Nashville, TN 37243
(615) 741-7847

August 6, 2012

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

It is my privilege to serve the people of Weakley County and part of Carroll County as the District 76 State Representative. As the representative of this population, I hear about the healthcare needs and the services necessary for our area. Alzheimer's disease and senile dementia is on the rise in our communities, and I feel the geriatric need for care and medication adjustment is greatly needed in our area and would be very well served by a geropsych unit at BMH-Huntingdon. Due to travel and distance, some patients are hampered from receiving mental health stabilization which can improve the quality of life for these citizens.

Baptist Memorial Hospital-Huntingdon has consistently provided excellent care for the acute needs patients of the community, and I am confident the hospital will work to provide quality, efficient, therapeutic care to the senior patients dealing with confusion and coping issues in their aging years.

I encourage the State of Tennessee to support BMH-Huntingdon as they seek to meet the mental health needs of our geriatric patients. We are all working for the better good of our citizens. Please offer BMH-Huntingdon the opportunity to better encompass the needs of their patient population.

Sincerely,

Andy Holt

**Representing Weakley & Northern Carroll Counties**

LEE M. CARTER, M.D.

641 R. B. Wilson Drive
Huntingdon, TN 38344

Phone- 731-986-7305

May 11, 2012

State of Tennessee

To Whom It May Concern:

It is my pleasure to write a letter in support of the project proposal presented by Baptist Memorial Hospital-Huntingdon for a Geriatric Behavior Health Program.

I have practiced medicine in Huntingdon for 20 years. In addition, I was raised in this community and am aware of the needs of the population. Currently serving as the Medical Director for Huntingdon Health and Rehab has provided a perspective of the need and potential benefit that a geriatric behavior unit close to the homes of the residents' families can provide. Due to travel and distance some patients are hampered from receiving mental health care which can result in earlier admission to a nursing home. The needs of many of the elderly patients that I see can be served in a specialized geriatric behavior health program if it was available closer to their home and family members. Approximately 5 of my patients each month would meet the criteria for admission to a geriatric behavior health unit.

As a member of the medical staff of Baptist Memorial Hospital-Huntingdon and a citizen in the community, I believe that a geriatric service at the hospital is needed and will benefit as they seek approval to implement a Geriatric Behavior Health Program. Baptist Memorial Hospital-Huntingdon has consistently provided excellent care for the acute needs patients of the community and I believe that the hospital will also provide excellent service to the patients of this unit as they struggle with behavior issues in their senior years.

Sincerely,

Lee M. Carter, M.D.

**STATE OF TENNESSEE**
**DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**
ANDREW JOHNSON TOWER, 11th FLOOR
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-0675

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

MEMORANDUM

TO: Melanie Hill, Executive Director
Health Services and Development Agency

CC: Department of Health
E. Douglas Varney, Commissioner, TDMHSAS
Marie Williams, Deputy Commissioner, TDMHSAS
John Arredondo, Assistant Commissioner, Hospital Services, TDMHSAS

FROM: Sandra Braber-Grove, Assistant General Counsel
TDMHSAS Division of General Counsel, Office of Legal Counsel

DATE: August 6, 2012

RE: Certificate of Need Application
Baptist Memorial Hospital - Huntingdon
CN1205-021

---

The Tennessee Department of Health is the licensing agency for the Baptist Memorial Hospital-Huntingdon facility and would also be the licensing agency for the proposed inpatient geriatric psychiatric (gero-psych) unit if the subject Certificate of Need (CON) application is approved.

The subject CON application (CN1205-021) is for the establishment of an inpatient geriatric psychiatric program at Baptist Memorial Hospital-Huntingdon by converting twelve (12) existing medical-surgical beds into gero-psych beds. The Applicant reports that the conversion results in no change to the total number of existing beds at the facility.

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), formerly the Tennessee Department of Mental Health (TDMH), has been asked to review the application to address the need for additional gero-psych beds in the Applicant's proposed service area comprised of the following Tennessee counties: Carroll, Benton, Decatur, Gibson, Henderson, Henry, Madison, and Weakley.

Several staff members of the TDMHSAS have been consulted, including the Assistant Commissioner of Hospital Services, the Medical Director/Assistant Commissioner of Clinical Leadership, the Director of Hospital Services, and the Director of Licensure and Review.

There are specific criteria for psychiatric inpatient services set forth in the publication Tennessee's Health: Guidelines for Growth, 2000 Edition. The TDMHSAS understands

that the Tennessee Department of Health, as the licensing agency, has analyzed these criteria and issued a full report.

This memorandum, as mentioned, will address the need for additional gero-psych beds in the Applicant's proposed service area comprised of the following Tennessee counties: Carroll, Benton, Decatur, Gibson, Henderson, Henry, Madison, and Weakley. Staff of the TDMHSAS have reviewed and analyzed the application and offer the following in general support of approval of the application, but we are including some discussion on staffing since we are concerned that the reported staffing pattern is insufficient for the proposed unit.

Need

A note about inpatient psychiatric beds. As mentioned in a report for an earlier CON application, the Guidelines for Growth publication specifies a formula of thirty (30) beds per a population of one hundred thousand (100,000) to determine the need for inpatient psychiatric beds. As also mentioned in that earlier report, in practice, application of the formula has often resulted in an underestimation of the number of inpatient psychiatric beds needed due to the impact of other factors on bed utilization, including: the willingness of the provider to accept emergency involuntary admissions; the extent to which the provider serves the TennCare population and/or the indigent population; and the number of beds designated as "specialty" beds (gero-psych units or units established to treat patients with specific diagnoses). These factors limit the availability of beds for the general population, as well as for specialty populations, depending on how the beds are distributed.

There may be a need. While the numbers do not show a need, it does not necessarily mean that there isn't a need. The Applicant reports that the focus of the proposed new service will be on treating individuals sixty-five years of age and older (65+) who are suffering from a primary psychiatric diagnosis and would benefit from acute care psychiatric hospitalization [gero-psych]. Since the adult population, those 18-64 years of age, are not the focus, those population figures are not addressed in this memorandum. As reported in the application [Application, Page 13] and taken from the "Population Projections, Tennessee Counties and the State, 2010-2020" [Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics], total population numbers for the age group (65+ years) in the proposed service area show that current (2012) population is 48,290. Applying the formula [48,290/100,000x30] appears to result in an unmet need of 14.49 inpatient psychiatric beds for this population (gero-psych). However, one must factor in the number of existing beds in the proposed service area to determine actual need. The Applicant reports that there are zero (0) gero-psych beds in the proposed service area, when in fact there are sixteen (16) existing gero-psych beds at the Behavioral Healthcare Center at Martin (Weakley County, Tennessee) [reported as "adult" by the Applicant on Page 14 of the application]. When these existing gero-psych beds are factored into the calculation, there are actually 1.5 more beds in existence than the population numbers show are needed. When reviewing the population figures presented in the application for years 2013 through 2018 [Application, Page 13], there appears to be an unmet need of 14.79 (2013) to 16.41 (2018) beds for the intended population (those 65+ years of age); however, again taking into consideration the sixteen (16) existing gero-psych beds in the proposed service area, there will continue to be more beds in existence than the population numbers show are needed.

As previously noted, however, there are other factors to consider in addition to applying the formula to population numbers. The TDMHSAS believes in serving people, if and when possible, in the community in which they live, thereby increasing the potential involvement of family, the individual's support system, and access to other needed

services. The Applicant reports that the most prevalent diagnoses for the proposed population (those 65+ years of age) are expected to be major depression, psychotic disorder, bi-polar disorder, and schizophrenia. The Applicant also reports that published data indicates that patients admitted to a geriatric inpatient psychiatric unit have at least one or more serious secondary medical diagnoses such as diabetes, cardiac complications, and/or hypertension, so would benefit from the medical care available at this facility. The Applicant further reports that the majority of patients admitted to geriatric psychiatric programs often fall into exclusionary criteria of general adult psychiatric programs due to secondary medical conditions or physical limitations; therefore, the hospital setting is important for the effectiveness of the program and the program will strengthen the productivity of the existing hospital resources. The Applicant reports that they did consider an alternative plan of sending an increasing number of patients in need of geriatric psychiatric (gero-psych) care to locations outside of the proposed service area; this plan was not implemented on advice of medical staff who indicated that this solution would cause separation between caregivers and patients and would not be in the best interest of patients and their families.

Other factors to consider when assessing need are the utilization of existing beds and the county of residence of those admitted for those existing beds as well as the willingness of the provider to accept emergency involuntary admissions and the extent to which the provider serves the TennCare population and/or the indigent population. To review the utilization of existing beds in the proposed service area, a review of the 2010 Joint Annual Report-Individual Facility Report for the Behavioral Healthcare Center at Martin, Weakly County, Tennessee was conducted. This report shows that almost 90% of admissions (281) for the reported year (2010) are in the age group of 65+ years. This report also shows that the counties of residence for the highest number of admissions at this facility are Weakley and Gibson (58 admissions from each; roughly 21%); followed by Obion and Madison (37 admissions from each; roughly 13%); Dyer (27 admissions; roughly 10%); and Henry (19 admissions; roughly 7%). Further, there were 16 admissions (roughly 6%) from Carroll County and 2 admissions (roughly less than 1%) from Benton County. While not included in the proposed service area, Western Mental Health Institute, the State's psychiatric facility in Hardeman County, Tennessee, had thirty-five (35) admissions from this age group (65+ years) during state fiscal year 2012, with nine (9) of those from the proposed service area: 2 each from Carroll, Gibson, and Henderson Counties; and 1 each from Madison and Weakley Counties.

In Supplemental information provided by the Applicant, it is noted that 94% of inpatient admissions to the Huntingdon facility come from Carroll and Benton Counties. Further, the Applicant reports that there are many nursing homes in the proposed service area and some of the submitted letters of support are from physicians who serve as medical directors for nursing homes who typically account for approximately one-third of admissions to geriatric psychiatric (gero-psych) programs across the United States. The Applicant cited a 2002 study in *Psychiatric Services* in which it is reported that untreated psychiatric symptoms in nursing home residents contribute to complicating the course of medical illness and other matters. A medical-surgical hospital with a geriatric psychiatric (gero-psych) program can meet the needs of these individuals. As noted, the Applicant states that the need for the proposed geriatric psychiatric service (gero-psych) has been discussed by medical staff in the community and the cross-training of staff will permit better intervention on the psychiatric and medical complexities of those in the proposed population (those 65+ years of age). The Applicant submitted several letters of support and other comments from medical staff members about the needs that will be positively met by the addition of the gero-psych services at this facility. Also included (Supplemental, Page 22), in response to the request for the annual number of patients who the local physicians have referred to other facilities for geriatric psychiatric (gero-psych) services in the past three (3) years,

were the number of potential patients as estimated by at least three (3) physicians. This number totals 444 per year. The Applicant also reports that projected gero-psych admissions were calculated based on patient data from the previous three (3) fiscal years that show patients with a secondary diagnosis that indicates a potential need for admission to a gero-psych unit (anxiety, anxiety and depression, bi-polar disorder, dementia, depression, among others) range from 154 to 199 (annualized) in addition to those potential patients previously discussed. The Applicant reports that the need for these services is "present and growing". Elsewhere in the application, the Applicant reported that the facility does participate with the TennCare carriers in the West Tennessee area and will on a case-by-case basis provide care for someone younger than sixty-five (65) who may not have reached full Medicare coverage and is in need of gero-psych services, and will accept involuntary admissions when capacity is available and the patient needs for stabilization and treatment can be appropriately addressed by the cross-trained hospital and psychiatric unit staff.

Staffing. As previously noted, we are concerned that the reported staffing pattern is insufficient for the proposed unit. In response to a statement related to the development, recruitment, and retention of a sufficient and quality health care workforce, the Applicant reports that the hospital and Psychiatric Resource Partners, Inc. (the Management/Operating entity identified on Page 2 of the application) will work to recruit highly qualified professionals and work to assure the highest possible staff satisfaction with job responsibilities. The Services Agreement submitted with the application (Application, Pages 45-67) and a review of the staffing pattern chart (Application, Page 28) shows only 2.80 FTEs for Nursing Assistants. In consultation with the TDMHSAS Director of Hospital Services, a safe staffing pattern at any psychiatric facility would have at least two (2) persons on duty each shift, on each unit, with the responsibility of caring for patients. The number of Registered Nurses in the proposed staffing pattern appears to allow for at least one (1) per shift, per unit; however, the 2.80 FTEs of Nursing Assistants would leave several shifts per week without a Nursing Assistant. This situation raises the questions whether the proposed staffing pattern provides adequate staffing and whether it provides a safe environment for both staff and patients.

Please feel free to contact us if you have any questions or want any additional information.

:sbg

**CERTIFICATE OF NEED**
**REVIEWED BY THE DEPARTMENT OF HEALTH**
**DIVISION OF HEALTH STATISTICS**
615-741-1954

**DATE:** July 31, 2012

**APPLICATION #:** CN1205-021

**APPLICANT:** Baptist Memorial Hospital-Huntington
631 R. B. Wilson Drive
Huntington, Tennessee 38344

**CONTACT PERSON:** Arthur Maples, Director of Strategic Analysis
Baptist Memorial Health Care Corporation
350 North Humphreys Boulevard
Memphis, Tennessee 38120

**COST:** $727,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

**SUMMARY:**
The applicant, Baptist Memorial Hospital-Huntingdon (BMHH), located in Huntingdon (Carroll County), Tennessee, seeks Certificate of Need (CON) approval for the conversion of 12 currently licensed med-surg beds to 12 beds for initiation of geriatric services located at 631 R. B. Wilson Drive. The geriatric psychiatric service will be managed by Psychiatric Resource Partners, Inc (PRP). The project involves renovation of approximately 4,611 square feet. There are no additional services, major medical equipment, or additional beds involved. There will be no change in the hospital licensed total bed count of 70 beds.

The renovation is projected to cost approximately $438,045 or $95 per square foot. The applicant cites CN1101-003, the renovation of 2,146 square feet for 9 geriatric psychiatric beds at a projected cost of $163 per square foot, as an example of the reasonable cost of the proposed project.

Medical/surgical beds will be converted in their present location and reopened as geriatric psychiatric beds in accordance with American Institute of Architects guidelines.

Baptist Memorial Healthcare Corporation is the sole member of BMHH. The geriatric psychiatric services will be managed by Psychiatric Resource Partners, Inc. (PRP), a subsidiary of Acadia Healthcare based in Nashville.

The total estimated project cost is $727,000 and will be funded through cash reserves as document in a letter from the Chief Financial Officer locate in Attachment Economic Feasibility – 2(E).

**GENERAL CRITERIA FOR CERTIFICATE OF NEED**

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

**NEED:**
The applicant's service area consists of Benton, Carroll, Decatur, Gibson, Henderson, Henry,

Madison, and Weakley counties.

The following charts illustrate the total population, age 65 and older population, and 18 and older population projections for 2012 and 2016.

**Service Area Total Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Benton | 16,726 | 16,922 | 1.2% |
| Carroll | 29,843 | 30,345 | 1.7% |
| Decatur | 11,495 | 11,526 | 0.3% |
| Gibson | 49,169 | 49,750 | 1.2% |
| Henderson | 27,955 | 28,795 | 3.0% |
| Henry | 32,672 | 33,284 | 1.9% |
| Madison | 100,816 | 104,160 | 3.3% |
| Weakley | 33,906 | 34,247 | 1.0% |
| **Total** | **302,582** | **309,029** | **2.1%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

**Service Area Age 65 and Older Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Benton | 3,457 | 3,758 | 8.7% |
| Carroll | 5,495 | 5,897 | 7.3% |
| Decatur | 2,321 | 2,480 | 6.9% |
| Gibson | 8,523 | 8,973 | 5.3% |
| Henderson | 4,169 | 4,627 | 11.0% |
| Henry | 6,356 | 6,856 | 7.9% |
| Madison | 12,914 | 14,539 | 12.6% |
| Weakley | 5,055 | 5,332 | 5.5% |
| **Total** | **48,290** | **52,462** | **8.6%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

**Service Area Age 18 and Older Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Benton | 13,366 | 13,533 | 1.2% |
| Carroll | 23,361 | 23,783 | 1.8% |
| Decatur | 9,115 | 9,152 | 0.4% |
| Gibson | 37,423 | 37,611 | 0.5% |
| Henderson | 21,465 | 22,197 | 3.4% |
| Henry | 25,733 | 26,270 | 2.1% |
| Madison | 76,269 | 79,113 | 3.7% |
| Weakley | 26,618 | 26,753 | 0.5% |
| **Total** | **233,350** | **238,412** | **2.2%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

The service area psychiatric bed total is illustrated in the following table.

**Service Area Psychiatric Beds**

| County | Hospital | Psychiatric Bed Types |
|---|---|---|
| Henry | Henry County Medical Center | 22 Adult Psychiatric |
| Madison | Pathways of Tennessee | 25 Addiction Treatment/Psychiatric |
| Weakley | Behavioral Healthcare Center at Martin | 16 Geriatric Psychiatric |

Source: *Joint Annual Reports of Hospitals, 2010, Tennessee Department of Health, Division of Health Statistics*

According to the applicant, the Inpatient Geriatric Psychiatric Program will focus on treating individuals 65 years of age and older who are suffering from a primary psychiatric diagnosis and

would benefit from acute care psychiatric hospitalization. The most prevalent diagnoses are expected to be major depression, psychotic disorder, bi-polar disorder, and schizophrenia. The American Board of Psychiatry and Neurology has established Geriatric Psychiatry as a specialty area requiring psychiatrists to sit for a grouping of special exams if they desire to be Board Certified in Geriatric Psychiatry. It is the very unique and highly diverse needs of this specialized population and their families that distinguish geriatric psychiatric programs from adult programs.

The psychiatric unit will be staffed with a blend of medical/surgical nurses and psychiatric nurses. The staff will be cross-trained to better intervene on the psychiatric and medical complexities of the unit's elderly patients. Psychiatric Resource Partners will be responsible for recruiting a qualified medical director, nursing director, social worker, and other key personnel.

The applicant states the hospital setting is important for the effectiveness of the program and the program will strengthen the productivity of the existing hospital resources. The applicant reports the majority of patients admitted to geriatric psychiatric programs often fall into exclusionary criteria of general adult psychiatric programs due to secondary medical conditions or physical limitations in areas of adaptive living such as bathing, toileting or ambulation. Medical staff members have commented about the needs that will be positively met by the addition of the geropsychiatric service.

Psychiatrists can work closely with primary care physicians on the unit to ensure monitoring of medical conditions along with psychiatric problems. The typical older psychiatric inpatient, due predominantly to their advanced age, are often prescribed medications from a variety of medical specialists. Management of potential drug interaction is a significant area of focus for physicians specializing in inpatient geriatric psychiatry. The applicant states published data also indicates that patients admitted to a geriatric inpatient unit have at least one or more serious secondary medical diagnoses such as diabetes, cardiac complications, and/or hypertension.

The applicant calculated a service area bed need of 12 beds based on two methodologies. Method One is based on population projections for the 65+ population from 2012 to 2018 as shown in a table on page 11 of Supplemental 1. The applicant projects a 13.25% age 65+ population increase for the service area in 2018. The net 18 plus adult population as projected by the Division of Health Statistics is 238,412 in 2016, which indicates a need for 8.5 beds. The applicant states there is a need for 9 beds and believes that with allowance for population and occupancy, the need is rounded to 12 beds.

The applicant also referred to the 2009, 2010, and 2011 Joint Annual Report of Hospitals. According to the applicant, Henry Count Medical Center reported in 2011 for the first time they had a designated Geropsychiatric unit. However, the applicant reports the percent of geriatric admissions was approximately 17% of the total psychiatric admissions and the days approximately 20% of the total psychiatric days of service provided for the entire year.

In Method Two, the applicant states the primary area of patient origin for BMHH is Carroll and Benton counties. Together the counties account for more than 94% of inpatient admissions and approximately 94% of outpatient registrations and inpatient admissions.

The applicant provides a chart on page 12 of Supplemental 1 indicating that in 2012 Carroll and Benton counties have a combined population of 36,788 adults. The applicant reports that applying the State's criteria of 30 beds per 100,000 population, there is a need for 11.03 beds. On 2018, the applicant states the need changes to 11.26 beds or 12 beds. The Division of Health Statistics calculated the 2016 bed need to be 11.19.

HSDA staff noted that the applicant's age 65+ population on page 13 of the application indicated a need for 16 beds for 2016 and that there are presently 16 geriatric psychiatric beds at Behavioral Healthcare Center at Martin. HSDA staff stated there appeared to be a total bed need for 0 beds and asked the applicant to discuss why the applicant felt there is a need for 12 more geriatric beds in the service area. The applicant responded to HSDA staff's question regarding the applicant's

projected bed need of 12 beds by stating that a dedicated medical surgical hospital based geriatric inpatient program provides an admission policy that allows for much more medically compromised patients than are admitted to traditional adult psychiatric programs. The majority of patients admitted to geriatric psychiatric programs typically fall into exclusionary criteria of general adult psychiatric programs due to secondary medical conditions or physical limitations in areas of adaptive living such as bathing, toileting, or ambulation. Facilitating admission from the medically acute facility to the geriatric psychiatric unit, psychiatrists work very closely with primary care physicians on the unit to ensure monitoring of medical conditions along with the psychiatric disorder. The typical older psychiatric inpatient is prescribed an average of five medications from a variety of medical specialists. Management of potential drug interactions is a significant area of focus for physicians specializing in inpatient geriatric psychiatry. According to the applicant, published data indicates an average of 83% of patients admitted to geriatric inpatient units have at least one or more serious secondary medical diagnoses.

The applicant also states it is significant that in the proposed service area there are many nursing homes and letters of support have been provided from physicians who serve as medical directors for nursing homes. Nursing homes typically account for approximately one third of admissions to geriatric psychiatric programs across the United States. The applicant reports the estimated prevalence of psychiatric disorders in nursing home residents ranges from 68% to 94% according to published documents in Psychiatric Services, a Journal of the American Psychiatric Association. Also, the applicant states well documented in professional literature is the prevalence of undiagnosed psychiatric illness amongst nursing home residents as major depression can be masked as compliance and other behaviors are simply attributed to "symptoms of old age".

Additionally, the applicant reports a 2002 study in Psychiatric Services cited untreated psychiatric symptoms in nursing home residents as contributing to "complicate the course of medical illness, interfere and confound nursing and medical care, increase residents' disability, raise health care costs, and diminish residents' quality of life". The applicant states it has been well documented that medical surgical hospitals offer a highly important distinction from non-medical hospital programs in that the frail elderly most often have high levels of co-morbidity which may only be, or more adequately be, addressed in a medical surgical environment.

The applicant projected 243 geropsychiatric admissions and 2,920 patient days in year one and 274 geriatric psychiatric admissions and 3,285 patient days in year two of operation, with an average length of stay of 12 days. In Supplemental 1, HSDA staff requested the applicant's methodology for these projections. The applicant responded their methodology involved assessments from 4 sources:

<u>Secondary diagnosis of hospital patients</u>

1. BMHH analyzed patient data from the previous 3 physical years (Oct. 1st – Sept. 30th) and FY 2012 YTD to identify patients with a secondary diagnosis that would indicate a potential need for admission to a geriatric psychiatric unit. The conditions include Alzheimer's, anxiety, anxiety and depression, bipolar, change in mental status, dementia, depression, panic, psychosis, and suicidal ideation. The numbers reflect a positive annual trend; FY 2009 – 163; FY 2010 – 186; FY 2011 – 154; and YTD 2012 – 199.

2. Also included were physicians who had expressed concern for a geriatric unit to meet community need provided data about potential patients. Lee M. Carter, MD – 5 patients per month, 50 patients per year; Thomas Paul Evans, MD 20 patients per month, 240 patients per year; Scott Portis, MD 12 patient per month, 144 patients per year, and James S. Williamson, MD an unspecified number of patients.

The applicant believes both of the previous steps indicate a need for the service. The applicant states the need is present and growing. According to the applicant, if the number of patients reflects the same number from 2012 to 2013 as it did from 2011 to 2012 in the hospital counts based on the indication from hospital analysis, an expected number of admissions would be 199 +

45 or approximately 244 patients. The projected increase in year 2 to 275 patients assumes an increase of 13%.

3. PRP provided data based on experience in similar communities, and references to published studies regarding Length of Stay (LOS). The applicant provides a table in Supplemental 1, page 28, from the National Association of Psychiatric Health Systems Annual 2010 Survey that was published in 2011. The average length of stay (ALOS) for an older adult program is 12.5 days.

4. The applicant reviewed the Joint Annual Report of Hospitals, 2010 data which they state indicates an ALOS of 13.7 days for this population.

The applicant projects an average daily census in year one of 8 patients and an average daily census of 9 in year two of the proposed project. The applicant provides letters in Supplemental 1 from three physicians who provided estimates of the number of potential patients they might refer totaling 448 potential patients per year.

**TENNCARE/MEDICARE ACCESS:**
The following chart illustrates the TennCare enrollees in the applicant's projected service area.

**TennCare Enrollees in the Proposed Service Area**

| County | 2012 Population | TennCare Enrollees | % of Total Population |
|---|---|---|---|
| Benton | 16,726 | 3,483 | 20.8% |
| Carroll | 29,843 | 6,632 | 22.2% |
| Decatur | 11,495 | 2,551 | 22.2% |
| Gibson | 49,169 | 11,030 | 22.4% |
| Henderson | 27,955 | 6,090 | 21.8% |
| Henry | 32,672 | 6,937 | 21.2% |
| Madison | 100,816 | 20,950 | 20.8% |
| Weakley | 33,906 | 6,386 | 18.8% |
| **Total** | **302,582** | **64,059** | **21.2%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics and *Tennessee TennCare Management Information System, Recipient Enrollment,* Bureau of TennCare

BMHH participates with the TennCare carriers in the West Tennessee area. Since this service focuses on 65+ patients, most will be covered by Medicare. However, an amount has been identified for patients who may not have reached full Medicare coverage because they are slightly younger than 65 and in need of geriatric psychiatric services. The projected gross revenue from Medicare is estimated to be $5,511,272 and Medicare net revenues is $2,239,625. Estimated TennCare gross revenue is approximately $15,000 and net is $7,495.

**ECONOMIC FACTORS/FINANCIAL FEASIBILITY:**
In the Project Costs Chart, the applicant's estimated total project cost is $727,000, which includes $43,805 for architectural and engineering fees; $438,045 for construction costs; $76,450 for contingency fund; $165,700 I/S, Telemedicine, and furniture; and $3,000 of CON filing fees.

In the Historical Data Chart located in Supplemental 1, the applicant reported 1,018, 1,002, and 843 patient discharges in 2009, 2010, and 2011 with gross operating revenues of $35,105,013, $38,235,190, and $38,677,902 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $15,191,017, $12,734,329, and $12,148,923 each year. The applicant's management fees to affiliates were $1,668,204, $1,689,360, and $1,620,456 each year, respectively. The applicant reported a net operating (loss) of ($1,304,578, ($2,134,138), and ($2,919,214) each year, respectively.

In the Projected Data Chart located in Supplemental 1, the applicant projects an average year one daily census of 8 and a year two average daily census of 9, with gross operating revenues of

$6,056,343 and $6,813,386 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $2,369,344 and $2,666,809 each year. The applicant's management fees to affiliates are $214,120 and $236,385 each year. The applicant project a net operating income of $796,636 in year one and $1,025,889 in year two of the project.

The applicant proposes an average gross charge per Diem of $2,074, with an average deduction of $1,259, resulting in an average net charge per Diem of $815. The applicant provides comparative charges to similar geriatric psychiatric facilities in West Tennessee or recently approved CON projects on page 43 of Supplemental 1.

The applicant states one alternative was to send an increasing number of patients in need of geriatric psychiatry to locations outside of the service area. However, on the advice of medical staff, this solution caused separation of caregivers and was not in the best interest of patients and their families. Clinical programming, group, and individual counseling are specifically geared toward the issues of the elderly and their families.

Another alternative was to develop a service within the hospital rather than establish a distinct unit. The benefit of the physical environment designed to minimize confusion for the elderly while providing the safest environment possible would not have been attained.

**CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:**
The applicant states transfer agreements will be available with other hospitals within the Baptist system.

According to the applicant, this project will benefit the health care system by improving the effectiveness of existing resources. The new services will benefit patients, family members, and will be a positive contribution to the hospital. No new major medical equipment that requires CON approval is involved and negative effects are not anticipated.

The applicant anticipated staff includes 1.0 FTE nurse manager, 4.2 FTE registered nurses, 2.8 FTE nursing assistants, 1.0 FTE social worker, 1.2 FTE OT/AT/RT, and 2.1 FTE unit clerks.

Baptist Memorial Health Care Corporation and BMHH are strong supporters of education opportunities throughout the region. Baptist Memorial College of Health Sciences was chartered in 1994 as a specialized college offering baccalaureate degrees in nursing and allied health sciences as well as continuing education opportunities for healthcare professionals.

BMHH is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited by Joint Commission. The most recent licensure survey occurred On 8/24/04 and no deficiencies were noted.

## SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

## PSYCHIATRIC INPATIENT SERVICES

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).

   *The Division of Policy, Planning, and Assessment used the above formula to calculate the 2016 bed need to be 9 using the required 18 and older population. The total*

*calculated bed need was 72 beds. Currently, there are 63 psychiatric beds in the service area.*

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

   *The Division of Policy, Planning, and Assessment used the above formula to calculate the 2016 bed need to be 9 using the required 18 and older population. The total calculated bed need was 72 beds. Currently, there are 63 psychiatric beds in the service area.*

3. For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.

   *This criterion is not applicable. This application is for an adult geropsychiatric unit.*

4. These estimates for total need should be adjusted by the existent staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

   *The Division of Policy, Planning, and Assessment used the above formula to calculate the 2016 bed need to be 9 using the required 18 and older population. The total calculated bed need was 72 beds. Currently, there are 63 psychiatric beds in the service area.*

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

   *The applicant's service area consists of Benton, Carroll, Decatur, Gibson, Henderson, Henry, Madison, and Weakley counties, as determined by hospital inpatient origin.*

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

   *As discussed in other areas of the application, the geriatric focus is for patients 65 year of age or older. Infrequently, if an older adult patient requires geriatric psychiatric services, the patient would be considered for admission on a case by case basis.*

   *The applicant states involuntary admission of geriatric psychiatric patients will be accepted when capacity is available and the patient needs for stabilization and treatment can be appropriately addressed by the cross trained hospital and psychiatric staff.*

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

*The applicant answered the Five Principles for achieving Better Health from the Tennessee State Health Plan under this criterion. The applicant's responses to these principles are provided on page 15 of the application.*

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

   *The applicant, BMHH participates in the TennCare program. Since most of these patients will have Medicare, very few will be Medicaid patients. However, the applicant states if a patient is infrequently in need of geriatric psychiatric services before they are covered by Medicare, the situation will be considered on a case by case basis.*

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

   *The applicant believes this proposal will have a positive impact on access to geriatric psychiatric services and will have very little impact on State appropriations.*

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

   *As previously mentioned, involuntary admission of geriatric psychiatric patients will be accepted when capacity is available and the patient needs for stabilization and treatment cam be appropriately addressed by the cross trained hospital and psychiatric staff.*

   *At the request of HSDA staff, the applicant provided their admission policy for the proposed geriatric psychiatric unit on page 17 of Supplemental 1.*

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

   *BMHH participates with the TennCare carriers in the West Tennessee area. Since this service focuses on 65+ patients, most will be covered by Medicare. However, an amount has been identified for patients who may not have reached full Medicare coverage because they are slightly younger than 65 and in need of geriatric psychiatric services. The projected gross revenue from Medicare is estimated to be $5,511,272 and Medicare net revenues is $2,239,625. Estimated TennCare gross revenue is approximately $15,000 and net is $7,495.*

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.

   *The applicant provides utilization for three facilities located in Madison, Henry, and Weakley counties on page 17 of the application.*

***Service Area Psychiatric Beds***

| County | Hospital | Psychiatric Bed Types |
|---|---|---|
| Henry | Henry County Medical Center | 22 Adult Psychiatric |
| Madison | Pathways of Tennessee | 25 Addiction Treatment/Psychiatric |
| Weakley | Behavioral Healthcare Center at Martin | 16 Geriatric Psychiatric |

*Source: Joint Annual Reports of Hospitals, 2010, Tennessee Department of Health, Division of Health Statistics*

2. Accessibility to specific special need groups should be an important factor.

*The applicant states this proposal is for the special needs of the elderly population.*

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

*The applicant reports this unit will be licensed as a service of BMHH through the Department of Health licensing process.*

**HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING**
**SEPTEMBER 26, 2012**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | The Pavilion - THS |
| PROJECT NUMBER: | CN1204-016 |
| ADDRESS: | 1406 Medical Center Drive<br>Lebanon (Wilson County), Tennessee 37087 |
| LEGAL OWNER: | Total Care Systems, LLC<br>680 Tennessee Boulevard<br>Lebanon (Wilson County), Tennessee 37087 |
| OPERATING ENTITY: | Stein and Associates, LLC<br>8520 South 36th Terrace<br>Fort Smith (Sebastian County), Arkansas 72908 |
| CONTACT PERSON: | G. Frank Lannom<br>(615) 444-3995 |
| DATE FILED: | April 10, 2012 |
| PROJECT COST: | $1,823,093 |
| FINANCING: | Commercial Loan |
| REASON FOR FILING: | The addition of 24 dually certified Medicare/ Medicaid skilled nursing beds to an existing 60 bed dually certified skilled nursing facility. ***The 24 nursing home beds are subject to the 125 bed Nursing Home Bed Pool for the July 2011 to June 2012 state fiscal year period.*** |

DESCRIPTION:

The Pavilion - THS is seeking approval for the addition of 24 Medicare/Medicaid skilled beds to its sixty (60) bed nursing home, resulting in an eighty-four (84) bed nursing home in which all beds will be dually certified for Medicare and Medicaid. Twenty-two of the twenty-four nursing home beds will be located in 8,341 square feet addition to the three year old facility. All the

rooms in the new addition will be semi private rooms. The remaining two beds will be created by converting two single occupancy rooms into semi-private rooms within the existing facility. The facility as a whole will retain six (6) private rooms.

**Proposed Changes to The Pavilion THS's Patient Accommodation Mix**

| | Current Rooms | Current Beds | | Proposed Rooms | Proposed Beds |
|---|---|---|---|---|---|
| Semi-private Rooms | 26 | 52 | | 39 | 78 |
| Private Rooms | 8 | 8 | | 6 | 6 |
| Total | 34 | 60 | | 45 | 84 |

According to the applicant, the new addition to the Pavilion will be a single story, wood framed building with systems and finishes to match the existing phase one facility, including a full sprinkler system. It will essentially be a copy of one of the wings of the existing facility containing resident rooms, nursing areas, assisted bathing area and resident common living spaces. The facility as a whole is designed to provide a residential home-like environment for its residents, while at the same time maximizing resident safety and independence. Each semi-private room will have a shared bath. The semi-private rooms feature half-wall separation of sleeping areas instead of the traditional curtain separation. This will create a more residential dormitory room setting, rather than a clinical or institutional environment. There will be common dining and living areas within the addition which will contribute to the level of privacy for the residents who may seek a less institutionalized experience. *See Attachment B.IV. for a floor plan of the nursing home and its proposed addition.*

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW:

**NURSING HOME SERVICES**

**A. Need**

1. **According to TCA 68-11-108, the need for nursing home beds shall be determined by applying the following population-based statistical methodology:**

**County bed need = .0005 x pop. 65 and under, plus**
**.0120 x pop. 65-74, plus**
**.0600 x pop. 75-84, plus**
**.1500 x pop. 85, plus**

*See second criterion below.*

2. **The need for nursing home beds shall be projected two years into the future from the current year, as calculated by the Department of Health.**

   *Based on the projected population for Wilson County in 2014, the Tennessee Department of Health's Division of Health Statistics used the above formula to calculate a need of 639 nursing home beds for the applicant's declared service area, Wilson County.*

3. **The source of the current supply and utilization of licensed and CON approved nursing home beds shall be the inventory of nursing home beds maintained by the Department of Health.**

   *According to the Tennessee Department of Health's Division of Health Statistics, there currently are 516 licensed beds in the Wilson County service area, resulting in a Net Nursing Home Bed Need of 123 beds.*

   *It appears the application meets this criterion.*

4. **"Service Area" shall mean the county or counties represented on an application as the reasonable area to which a health care institution intends to provide services and/or in which the majority of its service recipients reside. A majority of the population of a service area for any nursing home should reside within 30 minutes travel time from that facility.**

   *The patient origin summary from the applicant's 2010 Joint Annual report shows that 78% of its patients were Wilson County residents. The facility is within a 30 minutes travel time for the majority of Wilson County residents.*

   *It appears the application meets this criterion.*

5. **The HSDA may consider approving new nursing home beds in excess of the need standard for a service area, but the following criteria must be considered:**

a. **All outstanding CON projects in the proposed service area resulting in a net increase in beds are licensed and in operation, and**

*Since the Net Nursing Home Bed Need for Wilson County is 639, the applicant's request for twenty-four beds is not in excess of the nursing home bed need standard for the service area.*

*It appears this criterion does not apply to the proposed project.*

b. **All nursing homes that serve the same service area population as the applicant have an annualized occupancy in excess of 90%.**

*As in 3.a., this criterion does not apply to the proposed project.*

B. **Occupancy and Size Standards:**

1. **A nursing home should maintain an average annual occupancy rate for all licensed beds of at least 90 percent after two years of operation.**

*The applicant states the current occupancy is 97% for 60 beds (58.6 average daily census) and projects occupancy rates of 92%for all 84 licensed beds (77 average daily census) after the first year and 96% occupancy for 84 beds (81 average daily census) after the second year of operation.*

*It appears the application meets this criterion in the second year of operation.*

2. **There shall be no additional nursing home beds approved for a service area unless each existing facility with 50 beds or more has achieved an average annual occupancy rate of 95 percent. The circumstances of any nursing home, which has been identified by the Regional Administrator, as consistently noncomplying with quality assurance regulations shall be considered in determining the service areas, average occupancy rate.**

*In 2010, Wilson County had 4 licensed nursing homes which had a licensed capacity of 50 beds or more. The occupancy rate for the whole group was 93%. One nursing home experienced 96% occupancy, two of the other nursing homes had occupancies of 91%*

*or greater, while the remaining nursing home, had an 86% occupancy.*

*It appears the application does not meet this criterion.*

3. **A nursing home seeking approval to expand its bed capacity must have maintained an occupancy rate of 95 percent for the previous year.**

*The Pavilion-THS experienced an occupancy rate of 97.7% in 2011.*

*It appears the application does meet this criterion.*

4. **A free-standing nursing home shall have a capacity of at least 30 beds in order to be approved. The HSDA may make an exception to this standard. A facility of less than 30 beds may be located in a sparsely populated rural area where the population is not sufficient to justify a larger facility. Also, a project may be developed in conjunction with a retirement center where only a limited number of beds are needed for the residents of that retirement center.**

*The Pavilion-THS has a current bed licensed capacity of 60 beds and proposes to add 24 beds.*

*It appears the application does meet this criterion.*

SUMMARY:

The Pavilion – THS is a 60 bed nursing home facility which is located at 1406 Medical Center Drive, Lebanon (Wilson County), TN. *See the Plot plan in Attachment B.III.A.* The facility currently provides care for private-pay, Medicare Skilled patients, and Medicaid patients. The applicant indicates there will be no change to the services currently provided. All 24 proposed new beds will be dually certified for Medicaid and Medicare.

The applicant indicates prior to The Pavilion opening in 2009, the operation was located in a fifty year old former private home that was in steep decline when it was bought by Community Progress Committee, Inc., which constructed the current facility and moved the residents there in late 2009. Community Progress Committee contracted with the management company Stein and Associates to rehabilitate the former facility and then manage the new

facility once it opened. Community Progress Committee, Inc. subsequently sold the facility to the current owner, Total Healthcare Systems, LLC, who continues to contract with Stein and Associates, LLC to provide the high level of care the facilities residents have come to expect. Total Healthcare Systems **LLC,** is a Tennessee limited liability company, owned by Gordon Bone (52% ownership interest), Hal Bone (24%) and Sue Ann Bone (24%). Neither the applicant nor the applicant's owner has a financial interest in any other healthcare institution in Tennessee. *See the organization chart located in Attachment A.4.* According to the applicant, Total Healthcare Systems LLC's management agreement with Stein and Associates, LLC is expected to continue following approval of the CON and completion of the facility expansion. *See Attachment A.5 for further information regarding the management company.*

The applicant notes the request for 24 beds should be granted for the following reasons:

- The applicant states the current building is quite new, and the only significant flaw is that it is now too small to meet the current and projected demand for nursing home beds in Wilson County, as the most desirable facility.

- Based on the formula from the 2000 Edition of the *Guidelines for Growth,* Wilson County has a need of 123 additional nursing home beds.

- An aging and rapidly growing population combined with the fact that the facility is fully occupied and has a wait list of 56 people presents a clear and present need for additional beds.

Wilson County will be the service area of the proposed additional nursing home beds. According to the Division of Health Statistics, Tennessee Department of Health (TDOH), the population of Wilson County is expected to increase by 5.9% from 114,437 residents in 2012 to 117,941 residents in 2014. The Wilson County population cohort of age 65 and older presently accounts for approximately 11.9% of the total population compared to a state-wide average of 13.8% in CY 2012. The age 65 and older cohort of Wilson County is expected to grow 8.8% by 2014, as compared to the statewide 6.1% growth rate over the two year period, 2012-1014. The percentage of the Wilson County populations who are enrolled in TennCare is 12%, compared to the statewide proportion of 19%.

Wilson County currently has four (4) existing nursing homes containing a total of 516 licensed beds. As reported by the Department of Health in the 2010 Joint Annual Reports, the combined occupancy rate of the 4 Wilson County providers reporting patient utilization averaged 93% occupancy of 516 licensed nursing home beds. Among the Wilson County nursing homes in 2010, there were 60 Medicare certified beds and 456 dually certified beds for a total of 516 beds available to receive skilled nursing patients. The Wilson County average daily census (ADC) for SNF Medicare patients was 81 patients, ADC for Skilled-Medicaid's patients was 70, the ADC for Skilled Care patients being paid for by all other payors was 3. The total ADC for skilled nursing patients was 479. The ADC for NF (non-skilled which includes Medicaid and non-certified) is 325 patients. Thus, the total ADC for the county's 516 nursing home beds was 479 patients.

The applicant expects the ADC of the proposed eighty-four (84) beds to increase from approximately 77 patients per day in the first year of operation (2014) to 81 patients per day by the second year of operation (2015). The corresponding facility occupancy for 84 beds is 92% in Year One and 96% in Year Two. The payor distribution of these patients is shown in the chart submitted by the applicant in the supplemental response and shown below:

| Year | Licensed Beds | *Medicare certified Beds | SNF Medicare ADC | SNF Medicaid ADC | SNF All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|
| 2014 | 84 | 84 | 13 | 46 | | 18 | 77 | 92% |
| 2015 | 84 | 84 | 13 | 49 | | 19 | 81 | 96% |

*Includes dually-certified beds

Per the Projected Data Chart for the eighty-four (84) beds, gross operating revenue on an occupancy rate of 92% is $6,713,463 ($211.95 per patient day) in Year One of the project, increasing by approximately 8.9% to $7,315,707 on an occupancy rate of 96% in Year Two. The applicant projects a net operating income $1,061,629 in project Year One, increasing to $1,275,004 in Year Two. The applicant indicates it is both Medicare and TennCare/Medicaid certified. Participation in the Medicare program during the first year of operation is anticipated to be 1,728,480 (26% of total gross operating revenues), while participation in Medicaid is estimated to be $2,817,651 (42% of total gross operating revenues).

Direct care nursing staff for the additional 24 bed nursing unit in the first year of the project's opening will consist of a total of 17 full-time equivalent (FTE) employees, including 1.0 FTE nursing managers, 5.0 FTE registered nurses/

licensed practical nurses, 9 FTE certified nursing assistants, and 1 FTE licensed therapist. During the second year the staff will be increased by two more FTEs to a total of 19 full-time equivalent (FTE) employees, including 1.0 FTE nursing managers, 7.0 FTE registered nurses/licensed practical nurses, 9.0 FTE certified nursing assistants, 2.0 FTE licensed therapists.

Per the Historical Data Chart, The Pavilion-THS reported Net Operating Losses Less Capital Expenditures of ($449,816) in 2009 and ($1,096,717) in 2010, while showing a Net Operating Gain Less Capital Expenditures of $164,904 in 2011.

The total estimated project cost is $1,823,093. This sum is composed of $1,543,992 in construction costs with contingency, $100,000 for moveable equipment, $40,000 in architectural and engineering fees, $10,000 for legal administrative and consultant fees; $62,508 in interim financing, $62,500 Reserve for first year's Debt Service and $4,093 for the CON filing fee. The $169.64/square foot projected construction cost falls in the 3rd quartile of the HSDA Construction Cost Data Base for nursing home projects approved within 2009-2011.

The applicant intends to finance the project through a bank loan. A copy of a Term Sheet prepared by Pinnacle Financial Partners indicating Pinnacle's interest in provide a $1,500,000 construction line of credit converting to a permanent term loan to Pavilion-THS, LLC and Total Healthcare Systems, LLC is provided in Attachment C. Economic Feasibility 2. The applicant remainder of the funding is identified to come from the applicant's cash accounts at Pinnacle National Bank. *See response and attachments to question 4 of the second supplemental response.*

*The applicant has submitted the required corporate and property documentation. Staff will have a copy of these documents available for member reference at the Agency meeting. Copies are also available for review at the Health Services and Development Agency office.*

*In light of July 1, 2012 changes in TennCare which were implemented following the application being declared complete, the Executive Director requested additional supplemental information from this applicant, a copy of which is attached following this Summary.*

Should the Agency vote to approve this project, the CON would expire in two years.

**CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT**

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for this applicant.

**CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:**

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**

PMW / 8/1/2012

NURSING HOME BED POOL STATS

# July 1, 2011 – June 30, 2012

## *125 BED POOL*

| | |
|---|---|
| NH BEDS APPROVED | **68 NURSING HOME BEDS** |
| NH BEDS PENDING | **54 NURSING HOME BEDS** |
| SWING BEDS APPROVED | **0 SWING BEDS** |
| SWING BEDS PENDING | **0 SWING BEDS** |
| TOTAL BEDS DENIED | **0 BEDS** |
| SUBTOTAL-- BEDS REQUESTED | **122 BEDS** |
| TOTAL BEDS AVAILABLE FROM POOL | **57 BEDS** |
| (TOTAL PENDING BEDS) | **(54 BEDS)** |

| COUNTY | PROJECT NUMBER | FACILITY | PROJECT DISPOSITION | MEETING DATE | *DESCRIPTION* |
|---|---|---|---|---|---|
| Knox | CN1111-049 | NHC HealthCare, Farragut | APPROVED | 2/22/2012 | The addition of ten (10) Medicare SNF nursing home beds to the currently operating ninety (90) bed nursing home for a total of 100 nursing home beds. |
| Davidson | CN1202-010 | McKendree Village | APPROVED | 5/23/2012 | The addition of thirty (30) Medicare skilled nursing home beds to the 150 nursing home beds it currently operates. If approved McKendree Village will operate a 180 bed nursing home that will be dually certified for Medicare and Medicaid partcipation. |
| Shelby | CN1202-011 | Collins Chapel Health & Rehabiltation | APPROVED | 6/27/2012 | The establishment of a nursing home with twenty-eight (28) Medicare skilled nursing home beds. Collins Chapel Connectional Hospital is a non-profit religious corporation affiliated with and a ministry of the Christian Methodist Episcopal Church. It proposes to establish this nursing home to provide skilled nursing facility services. |

| | | | | | |
|---|---|---|---|---|---|
| Wilson | CN1204-016 | The Pavilion-THS | PENDING | 9/26/2012 | To build an addition to the existing sixty (60) licensed bed nursing home; and add twenty-four (24) skilled nursing beds dually certified for Medicare and Medicaid. The expanded facility will have a total of eighty-four (84) licensed beds. The facility currently provides care for private-pay, Medicare Level II, and Medicaid Level I and II residents. There will be no change to the services currently provided. |
| Hamilton | CN1206-028 | Shallowford Healthcare, LLC | PENDING | 11/14/2012 | The establishment of a thirty (30)* skilled bed nursing home (subject to the 2011-2012 Nursing Home Bed Pool). This is the first of two (2) applications, both for thirty (30)* skilled nursing home beds--the second application, CN1207-032 (subject to the 2012-2013 Nursing Home Bed Pool). The applicant plans to eventually operate a sixty (60) bed facility. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. |

# RE: The Pavilion-THS-CON application for 24 additional Medicare skilled beds-CN1204-016

Melanie Hill

**Sent:** Monday, September 10, 2012 3:13 PM
**To:** franklannom@lannomwilliams.com; alex.bird@lannomwilliams.com
**Cc:** Phil Wells

Mr. Bird,

The referenced CON application is currently scheduled to be heard at the September 26, 2012 HSDA meeting. The application requests 24 additional Medicare skilled beds to the currently licensed 60 bed dually certified for Medicare and Medicaid facility for a total of 84 dually certified beds.

Please address the following concerns. If you would like to prepare a written response and submit if by September 19, I will e-mail it to Agency members. Otherwise, please be prepared to address these issues at the Agency meeting.

The application contains little documentation of the need for additional skilled beds other than the fact that the Wilson County shows a numeric bed need based on the formula from the Criteria and Standards for CON for Nursing Homes from the Guidelines for Growth developed in the year 2000.

On page 39 of the original application the applicant indicates that due to the wait list and bed unavailability it does not currently have the flexibility to "accommodate the needs of physicians." Staff notes that it is not uncommon for names to be added to a Wait List well before nursing home care is actually needed. Can you determine how many of the 56 people on the Wait List actually need nursing home care in the very immediate future? How many of those would qualify as skilled care? Typically, a patient being transferred from a hospital with a requirement for skilled nursing home care will move to the top of the Wait List and be eligible for the first available bed.

Has the applicant been able to obtain support letters from physicians or discharge planners? These letters might help document a perceived need or difficulty placing skilled patients in a local nursing home.

Medicaid reimbursement for nursing home care is based on two components-Level of Care & Financial Eligibility. Effective July 1, 2012 TennCare implemented changes to its Level of Care requirements. Previously, only one significant deficiency in a specified Activities of Daily Living was required to be met in order to qualify for Level 1 admission to a nursing home. Eligibility is now determined based upon a need for higher acuity care which is determined based upon a weighted scale. TennCare has already noted a decline in nursing home services as well as authorization for Level 2 reimbursement since the Long-Term Care Community Choices Act (CHOICES) was passed in 2008. Please be prepared to address the need for the additional beds in light of these changes. Here are some links to the TennCare

website that address these changes:

*TennCare Level of Care changes which have increased the required level of care to be admitted to a Medicaid facility. These were effective July 1.*

http://www.tn.gov/tenncare/forms/nflocguidetrackedchanges.pdf

*TennCare draft rules:*

http://www.tn.gov/tenncare/forms/locruledraft.pdf

*TennCare Q & A regarding changes*

http://www.tn.gov/tenncare/forms/locqa

The application references the outmigration of Wilson County residents but provides no explanation or even a theory as to why the residents are going out of Wilson County for nursing home care. There are many reasons people leave their home community for medical care including but not limited to location of the physician, familial relationships, facility environment, or access to a higher level of care. Does the applicant now or in the future intend to offer a higher level of care than is currently available Wilson County? If so, please describe.

Finally, the Agency has seen a trend in new nursing home construction, modification and renovation projects towards a more homelike environment including private bedrooms and baths. This application for new construction is for shared bedrooms and baths and actually decreases by one the number of private rooms in the facility. The applicant describes resident rooms as a "more residential dormitory setting." The Agency has recently approved a CON application for a facility in a county that had a significant outmigration to nursing homes in other counties which that applicant attributed to the condition of the facility. The addition proposed by that applicant was for private rooms and baths which that applicant believed would help stem the outmigration to other nursing homes. Can you provide more justification as to why the applicant did not propose private beds and baths in this new construction?

Please feel free to contact me if you have questions.

Melanie

# LETTER OF INTENT

2012 APR 10 PM 3:54

# PUBLICATION OF INTENT
# TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

**The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than two (2) columns by two (2) inches.**

==========

## 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:

The Pavilion-THS (Name of Applicant) Nursing Home (Facility Type-Existing)

owned by: Total Healthcare Systems, LLC with an ownership type of LLC

and to be managed by: Stein & Associates, LLC intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]:

The applicant, The Pavilion–THS, is a licensed 60 bed nursing home located at 1406 Medical Center Drive, Lebanon, Wilson County, Tennessee, 37087. The applicant proposes to build an addition to the currently existing facility. The applicant also seeks approval for the addition of 24 skilled nursing beds from the nursing home bed pool. All 24 beds will be dually certified for Medicaid and Medicare. The expanded facility will have a total of 84 licensed beds. The facility currently provides care for private-pay, Medicare Level II, and Medicaid Level I and II residents. There would be no change to the services currently provided. The estimated project cost is $1,823,092.75.

The anticipated date of filing the application is: April 13, 20 12

The contact person for this project is G. Frank Lannom (Contact Name) Attorney (Title)

who may be reached at: Lannom & Williams, PLLC (Company Name) 137 Public Square (Address)

Lebanon (City) TN (State) 37087 (Zip Code) (615) 444-3995 (Area Code / Phone Number)

**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**
**500 Deaderick Street, Suite 850**
**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.**

==========

HF0050 (Revised 05/03/04 – all forms prior to this date are obsolete)

# ORIGINAL APPLICATION

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

The Pavilion
**Name**

1406 Medical Center Drive
**Street or Route**

Wilson
**County**

Lebanon
**City**

Tennessee
**State**

37087
**Zip Code**

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

G. Frank Lannom
**Name**

Attorney
**Title**

Lannom & Williams, PLLC
**Company Name**

franklannom@lannomwilliams.com
**Email address**

137 Public Square
**Street or Route**

Lebanon
**City**

Tennessee
**State**

37087
**Zip Code**

Attorney
**Association with Owner**

(615) 444-3995
**Phone Number**

(615) 444-6516
**Fax Number**

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

Total Healthcare Systems, LLC
**Name**

(615) 444-4343
**Phone Number**

680 Tennessee Boulevard
**Street or Route**

Wilson
**County**

Lebanon
**City**

Tennessee
**State**

37087
**Zip Code**

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

**A. Sole Proprietorship** ____

**B. Partnership** ____

**C. Limited Partnership** ____

**D. Corporation (For Profit)** ____

**E. Corporation (Not-for-Profit)** ____

**F. Government (State of TN or Political Subdivision)** ____

**G. Joint Venture** ____

**H. Limited Liability Company** x

**I. Other (Specify)**_____ ____

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

A copy of the corporate articles of organization and certificate of corporate existence, from the Tennessee Secretary of State is attached as Attachment A, 3.

Ownership and organizational information is attached as Attachment A, 4.

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

Stein and Associates, LLC
**Name**
8520 South 36th Terrace
**Street or Route**
Fort Smith — **City**
Arkansas — **State**
Sebastian — **County**
72908 — **Zip Code**

**PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.**
A copy of the fully executed final contract and the management entity's experience is attached as Attachment A,5.

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

| | | | |
|---|---|---|---|
| **A. Ownership** | x | **D. Option to Lease** | |
| **B. Option to Purchase** | | **E. Other (Specify)** | |
| **C. Lease of Years** | | | |

**PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.**
A copy of the title/deed is attached as Attachment A,6.

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

| | | | |
|---|---|---|---|
| **A. Hospital (Specify)** _____ | | **I. Nursing Home** | x |
| **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]* | x |
| **B. Replacement/Existing Facility** | | | |
| **C. Modification/Existing Facility** | x | | |
| **D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)**_____ | | | |
| **E. Discontinuance of OB Services** | | **H. Change of Location** | |
| **F. Acquisition of Equipment** | | **I. Other (Specify)** _____ | |

**9. Bed Complement Data**

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

| | *Current Beds Licensed* | **CON* | *Staffed Beds* | *Beds Proposed* | *TOTAL at Licensed Completion* |
|---|---|---|---|---|---|
| **A. Medical** | | | | | |
| **B. Surgical** | | | | | |
| **C. Long-Term Care Hospital** | | | | | |
| **D. Obstetrical** | | | | | |
| **E. ICU/CCU** | | | | | |
| **F. Neonatal** | | | | | |
| **G. Pediatric** | | | | | |
| **H. Adult Psychiatric** | | | | | |
| **I. Geriatric Psychiatric** | | | | | |
| **J. Child/Adolescent Psychiatric** | | | | | |
| **K. Rehabilitation** | | | | | |
| **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)** | 60 | | 60 | 24 | 84 |
| **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** | 60 | | 60 | 24 | 84 |

***CON-Beds approved but not yet in service**

**10. Medicare Provider Number** 44-5500
**Certification Type** Skilled Nursing

**11. Medicaid Provider Number** Level I 7440606 Level II 44-5500
**Certification Type** Skilled Nursing

**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.***

United Healthcare Community Plan and AMERIGROUP

***Discuss any out-of-network relationships in place with MCOs/BHOs in the area.***
None at this time.

**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.**

**A Brief Description Of Proposed Services And Equipment:** The applicant, The Pavilion–THS, is a licensed 60 bed nursing home located at 1406 Medical Center Drive, Lebanon, Wilson County, Tennessee. The applicant proposes to build an addition to the currently existing facility. This application also seeks approval for the addition of 24 skilled nursing beds from the nursing home bed pool. All 24 beds will be dually certified for Medicaid and Medicare. The expanded facility will have a total of 84 licensed beds. The facility currently provides care for private-pay, Medicare Level II, and Medicaid Level I and II residents. There would be no change to the services currently provided. The estimated project cost is $1,823,092.75.

Please note that the facility was built in 2009, prior to that the operation was located in a fifty year old former private home that was in steep decline when it was bought by Community Progress Committee, Inc. who constructed the current facility and moved the residents there in late 2009. Community Progress Committee contracted with the management company Stein and Associates to rehabilitate the former facility and then manage the new facility once it opened. Community Progress Committee, Inc. subsequently sold the facility to the current owner Total Healthcare Systems, LLC who continue to contract with Stein and Associates, LLC to provide the high level of care the facilities residents have come to expect. As such, some of the attachments may reference Community Progress Committee, Inc.

**Ownership Structure:** The facility owner and operator, Total Healthcare Systems LLC, is a Tennessee limited liability company. Total Healthcare Systems LLC has an ongoing

management agreement with Stein and Associates, LLC. Stein and Associates currently manage the facility and will continue the same following approval of the CON and completion of the facility expansion.

**Service Area:** The service area will continue to be Wilson County.

**Need:** The current building is quite new, opening in late 2009 and the only significant flaw is that it is now too small to meet the current and projected demand for nursing home beds in Wilson County, at the most desirable facility. Based on the formula from the Guidelines for Growth, Wilson County has a need of 123 additional nursing home beds. An aging and rapidly growing population combined with the fact that the facility is fully occupied, has a wait list of at least 56 people and the aforementioned county need, present a clear and present need for additional beds. The additional beds in turn present the need to expand the current facility to meet the current and projected demands of the population.

**Existing Resources:** The Pavilion-THS's existing facility has 60 dually certified nursing home beds with space enough to add 6 more beds. There are 4 nursing homes in Wilson County including The Pavilion-THS. Of the 4 nursing homes, 3 primarily provide long term care typically associated with nursing homes. Lebanon Health and Rehabilitation is a Medicare only facility and focuses more on short term care, catering to patients recovering from surgery or illness and who typically remain in the facility for less than six months. According to the 2010 Joint Annual Reports, each of the 3 long term care nursing homes had an average annual census at or above 90 percent, while Lebanon Health and Rehab had an average annual census of approximately 86 percent.

**Project Cost:** Construction costs are estimated to be $169.64 per square foot; the total estimated project cost is $1,823,092.75

**Funding:** Applicant anticipates securing a Construction Line of Credit from Pinnacle Financial Partners in an amount not to exceed the lesser of $1,500,000.00 or eighty percent of the project cost. Applicant also expects that its mortgage bank will release a $325,000.00 reserve based on its first mortgage of the facility if necessary.

**Financial Feasibility:** The additional 24 beds are expected to generate enough revenue to cover any additional cost to the facility for operating said beds. The applicant expects that its recent Medicare approval will draw a larger number of that type of resident and provide an increased flexibility to accept residents for all levels of care, this combined with the high demand for service as evidenced by the facility's waiting list indicates the financial feasibility of the project.

**Staffing:**

| Anticipated Staff for the Addition | Wages | Prevailing wage* (Median) |
|---|---|---|
| 2-3 Licensed Nurses | $16.00-$19.00/hour | $17.30/hour |
| 5-6 Certified Nurse Assistants | $10.00-$11.00/hour | $10.74/hour |
| 1-2 Housekeeper/Laundry | $8.00/hour | $9.68/hour |

| | | |
|---|---|---|
| 1-2 Physical/Occupational Therapy | $40.00-$50.00/hour | $36.67/hour |

* Tennessee Department of Labor & Workforce Development, 2009 Quarterly Census of Employment and Wages

**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.**

The addition to the Pavilion will be a single story, wood framed building with systems and finishes to match the existing phase one facility, including a full sprinkler system. The new addition will encompass 8,341 square feet and have a maximum additional occupancy of 22 residents. This will essentially be a copy of one of the wings of the existing facility containing resident rooms, nursing areas, assisted bathing area and resident common living spaces. The facility as a whole is designed to provide a residential home-like environment for its residents, while at the same time maximizing resident safety and independence. Rooms in the addition will all be semi-private, the facility as a whole will retain six private rooms. Each private room has its own bath, and semi-private rooms will have shared baths. The semi-private rooms feature half-wall separation of sleeping areas instead of the traditional curtain separation. This will create a more residential dormitory room setting, rather than a clinical or institutional environment. There will be common dining and living areas within the addition which will contribute to the level of privacy for the residents who may seek a less institutionalized experience. The estimated construction cost will be $169.64 per square foot; the total estimated project cost is $1,823,092.75

**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.**

The applicant is seeking approval for 24 skilled nursing beds under the bed pool. The Pavilion-THS currently has 60 beds, all dually certified. There would be no change to the services currently provided. The expansion will merely increase the size of the facility and its population of residents and employees, the facility will continue to strive to provide the highest level of services possible.

***The reasons for change in bed allocations*** Beds would not be allocated for uses other than those already existing at the facility, the facility merely intends to increase its bed count. The Pavilion-THS has been operating in its new facility for over two years and has maintained an occupancy rate over 90 percent since March of 2010. As the occupancy rate clearly reflects, the new facility is more attractive to potential admittees than the former facility and has a waiting list of at least 56 new admittees who would be able to be served if the bed count is increased.

Additionally, there are new beds needed in Wilson County. According to the nursing home bed need formula in the Guidelines for Growth, 123 additional beds are necessary to fulfill the need in Wilson County.

***The impact the bed change will have on the existing service*** The bed change will allow the Pavilion-THS to take in more admittees without disrupting service to its current admittees because the new beds will be located in a newly constructed wing to the current facility and additional staff will be hired to accommodate the increased bed count. The combination of the new facility, its proximity to UMC Hospital and the effective management of Stein and Associates, LLC, has led to a level of service that has kept the facility operating near capacity for its entire existence and created a substantial waiting list of potential new admittees, the same level of service will be maintained for the beds in the new addition to the building.

A significant number of nursing home patients are currently leaving Wilson County for nursing home care. According to the Department of Health Joint Annual Report for Nursing Homes in 2008, of the 368 Wilson County residents receiving nursing home care, 91 were receiving nursing home care outside of Wilson County, and 277 were receiving care in Wilson County, an out-migration of 25 percent. This project will allow more Wilson County residents to stay in the county for nursing home care in more desirable facilities.

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

N/A. no new services are being proposed in this application. The facility currently offers and intends to continue to offer the following service: Hospice care through separately licensed hospice agencies (Alive Hospice, Gentiva, Odyssey).

**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**

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

N/A. This certificate of need does not propose to change the location or replace an existing facility; it is a request for additional beds and an expansion of an existing facility.

**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:**

N/A. there is no major medical equipment involved in this project.

**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.**

N/A. there is no fixed-site major medical equipment involved in this project

**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.**

N/A. There is no mobile major medical equipment involved in this project.

**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.**

N/A. there is no major medical equipment or mobile major medical equipment involved in this project.

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

A copy of a plot plan is attached as Attachment B, III, A.

**(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.**

There is no public mass transportation in Lebanon. The site is approximately 2.5 miles from the station for the Nashville Star commuter rail line. The site is easily accessible by car, located approximately 3.8 miles from US Interstate 40 and off Baddour Parkway, a bypass road from highway 70. The site is also less than half a mile from University Medical Center, the area hospital.

**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.**

A copy of the floor plan is attached as Attachment B, IV.

**V. For a Home Health Agency or Hospice, identify:**
N/A.

**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.**

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

## 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)."**

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

## 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.**

Two of the categories are applicable to this application:
(1) Nursing Home Services, and
(2) Construction, Renovation, Expansion, And Replacement of Health Care Institutions

**NURSING HOME SERVICES (Guidelines for Growth p. 11- 12)**

**Public Chapter No. 1112, Senate Bill No. 2463, which passed during the 1998 legislative session, amended and changed the code sections establishing the bed need formula that the Health Facilities Commission must follow when granting certificates of need for nursing home beds in Tennessee. During a fiscal year (July 1-June 30), the Commission shall issue no more than the designated number of Medicare skilled nursing facility beds for applicants filing for a certificate of need. The number of Medicare skilled nursing facility beds issued shall not exceed the allocated number of beds for each applicant. The applicant must also specify in the application the skilled services to be provided and how the applicant intends to provide such services.**

**GUIDELINES FOR NURSING HOME BEDS**

**A. Need**

1. **The need for nursing home beds shall be determined by applying the following population-based statistical methodology:**

**County bed need = .0005 times population of the county sixty-five (65) years of age and under; plus,**
**0.0120 x population age 65-74; plus,**
**0.0600 x population age 75-84; plus,**
**0.1500 x population age 85 and over.**

Applying the Tennessee Department of Health's population projections for 2014, the result is as follows:

| | |
|---|---|
| 0.0005 x 103,102 = | 51.551 |
| 0.0120 x 9231 = | 110.772 |
| 0.0600 x 4053 = | 243.18 |
| 0.1500 x 1555 = | 233.25 |
| | 638.753 |

Total Need = 639 (rounded)

Total current = 516

NET NEW BEDS NEEDED = 123

2. **The need for nursing beds shall be projected two years into the future from the current year, as calculated by the Department of Health, Division of Information Resources.**

As reflected above, applying the population projections for 2014 by the Department of Health, there is a total need for 639 nursing home beds in Wilson County for the year 2014.

3. **The source of the current supply and utilization of licensed and CON approved nursing home beds shall be the inventory of nursing home beds maintained by the Department of Health.**

According to the Joint Annual Reports for 2010 maintained by the Department of Health, there is a total supply of 516 beds in Wilson County. According to this formula, there is a need for an additional 123 beds in Wilson County for the year 2014. As of the filing of this application and according to the Tennessee Health Services and Development Agency website, the most recent nursing home bed pool stats indicate that there are 115 available beds remaining in the July 1, 2011 – June 30, 2012, 125 bed pool.

4. **"Service Area" shall mean the county or counties represented on an application as the reasonable area to which a health care institution intends to provide services and/or in which the majority of its service recipients reside. A majority of the population of a service area for any nursing home should reside within 30 minutes travel time from that facility.**

The proposed service area for this project is Wilson County Tennessee. Over 78% of The Pavilion – THS's patients are residents of Wilson County according to the 2010 Joint Annual Report of Nursing Homes p. 18. The service area as described above is within 30 minutes drive time of the facility.

5. **The Health Facilities Commission may consider approving new nursing home beds in excess of the need standard for a service area, but the following criteria must be considered:**

    a. **All outstanding CON projects in the proposed service area resulting in a net increase in beds are licensed and in operation, and**

These criteria need not be met, because there is a need for an additional 123 beds in the service area. In granting this application, the Agency would not be approving beds in excess of the need formula. Nevertheless, this exception guideline is met, because there are no outstanding CON's for nursing home beds in the service area.

b. **All nursing homes that serve the same service area population as the applicant have an annualized occupancy in excess of 90%.**

These exception criteria need not be met, because there is a need for an additional 123 beds in the service area. In other words, in granting this application, the Agency would not be approving beds in excess of the need formula.

**B. Occupancy and Size Standards:**

1. **A nursing home should maintain an average annual occupancy rate for all licensed beds of at least 90 percent after two years of operation.**

This guideline is met. The occupancy rate has been above 90 percent since March 2010. The facility opened in its current location in December 2009; at the beginning of February 2010 the Pavilion had 41 residents and ended that month with a total of 46. By March 2010 there were a total of 55 residents for 60 licensed beds, from that time to the present the monthly occupancy rate for the Pavilion has remained above 90 percent. Due to the limited amount of time the facility has been operating at its new facility, the occupancy rates are based on direct reports from the facility and applicant expects that the Joint Annual Report for 2011 would support this statistic.

2. **There shall be no additional nursing home beds approved for a service area unless each existing facility with 50 beds or more has achieved an average annual occupancy rate of 95 percent. The circumstances of any nursing home, which has been identified by the Regional Administrator, as consistently noncomplying with quality assurance regulations shall be considered in determining the service areas, average occupancy rate.**

This guideline is substantially met. The applicant has maintained an average occupancy rate of 95 percent since April 2010 and expects the Joint Annual Report for 2011 to support this statistic. Quality Care Health Center achieved a reported average annual occupancy of 96 percent according to its Joint Annual Report for 2010. Lebanon Health and Rehabilitation Center is a Medicare only facility and focuses more on short term care, catering to patients recovering from surgery or illness and who typically remain in the facility for less than six months, resulting in an average annual occupancy of 90 percent according to the Joint Annual Report for 2008, which is the highest rate it has achieved according to the available data. Mt. Juliet Health Care Center reported average annual occupancy of 91 percent according to its Joint Annual Report for 2008 and again in 2010, which are the highest rates it has achieved according to the available data. Mt. Juliet Health Care Center was built in 1994 and has not reported any major renovations since that time. Although Mt. Juliet Health Care Center averages 90 percent annual occupancy, it faces difficulty in achieving an average annual occupancy rate of 95 percent because it has almost twice the capacity of the applicant but may not be as appealing to patients who seek a more residential community atmosphere, such as that provided by the applicant's facility and other out of county facilities.

3. **A nursing home seeking approval to expand its bed capacity must have maintained an occupancy rate of 95 percent for the previous year.**

This guideline has been met. In April 2010 the occupancy rate for the Pavilion-THS reached 95 percent for 60 licensed beds, from that time to the present, the monthly occupancy rate for the Pavilion-THS has remained at or above 95 percent.

4. **A free-standing nursing home shall have a capacity of at least 30 beds in order to be approved. The Health Facilities Commission may make an exception to this standard. A facility of less than 30 beds may be located in a sparsely populated rural area where the population is not sufficient to justify a larger facility. Also, a project may be developed in conjunction with a retirement center where only a limited number of beds are needed for the residents of that retirement center.**

This guideline is met. The current facility has a total of 60 beds.

## CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS (Guidelines for Growth p. 23)

1. **Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.**
   The Guidelines relative to the addition of nursing home beds are addressed in the immediately preceding responses to these Guidelines.

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

   N/A. The existing facility is not being relocated or replaced.

   a. **The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.**
      N/A.
   b. **The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.**
      N/A.

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.**

   The Pavilion-THS has been operating in its new facility for over two years and has maintained an occupancy rate over 95 percent since April of 2010. As the occupancy rate clearly reflects, the new facility is more attractive to potential admittees than the old facility which has caused a rise in demand and has resulted in a waiting list of at

least 56 new admittees who would be able to be served if the building is expanded and the bed count increased.

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

The physical plant's condition is too small to meet demand. The Pavilion-THS has a waiting list of at least 56 people and there is only space enough for 6 additional beds in the current facility. With the proposed expansion the Pavilion-THS will be able to house 22 beds in addition to the previously mentioned 6 for a maximum of 28 new beds, this application seeks a total of 24 new beds, which would allow some flexibility in designating the number of private rooms in the facility while assuring the availability of private rooms for residents who desire that level of service. The expansion will essentially be a copy of one of the wings of the existing facility containing resident rooms, nursing areas, a therapy area, assisted bathing area, household living area and resident common living spaces.

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

N/A. There is not a proposed change of site for this facility.

[END OF RESPONSES TO GUIDELINES FOR GROWTH]

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

The applicant does not have any long range construction plans beyond this project

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.).**

The proposed service area is Wilson County. According to the 2010 Joint Annual Report, over 78 percent of the Pavilion-THS's patients were residents of Wilson County. A map of the service area is attached as Attachment C, Need, 3.

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

In 2010 Wilson County had a population of approximately 113,993. According to the U.S. Census Bureau estimate, the population 65 & over made up 12.2 percent of Wilson County's population. Wilson County ranked 69th in Tennessee counties for nursing home beds per 1,000 population 65 & older in 2008 (TACIR County profile). Wilson County, like all areas of the

state, has a need for high quality, locally accessible long term care in a desirable and resident community style facility which is the purpose of this proposal.

**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.**

There are 516 nursing home beds in Wilson County; 456 are dually certified (88% of the total beds) and the remaining 60 are Medicare certified only. The large proportion of dually certified beds means that those beds can be filled with Level I or Level II patients. Medicaid is the primary payor of Level I care for Medicaid eligible enrollees, and secondary payor for Level II care (pays for Level II only after Medicare has been exhausted).

In 2009, Level I days accounted for 79 percent of total nursing home patient days in Wilson County. Level I patients have significantly longer average length of stay than do Level II patients and consequently tend to tie up beds longer per patient. Since most Medicaid patients are placed in beds by their families we do not have a source of first hand confirmation of a need for Medicaid beds, as we do from the hospital confirming a need for additional Level II beds, but the high rate of occupancy of nursing home beds in Wilson County combined with the significant number of additional beds needed indicates a high need for beds for Medicaid patients. Approval of 24 dually certified beds will likely open up more of the currently existing 60 dually certified beds to Medicaid patients thus contributing to the needs of low-income groups in the area.

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.**

There are 4 licensed nursing homes in Wilson County, including the applicant, the Pavilion-THS. Utilization data for those facilities for 2008, 2009 and 2010, the most recent years of data publicly available, is reflected below:

**UTILIZATION OF WILSON COUNTY NURSING HOMES 2008 - 2010**

| Facility | Beds | Level I Days | Level I Mix | Level II Days | Level II Mix | Total Days | Annual Occupancy |
|---|---|---|---|---|---|---|---|
| **2010** | | | | | | | |
| The Pavilion-THS | 60 | 20,027 | 100% | 0 | 0% | 20,027 | 91% |
| Mt. Juliet H.C. Ctr. | 106 | 29,086 | 83% | 5,924 | 17% | 35,010 | 91% |
| Quality Care Health Ctr. | 290 | 79,985 | 79% | 21,714 | 21% | 101,699 | 96% |
| Lebanon Health & Rehab Ctr. | 60 | 3,200 | 17% | 15,554 | 83% | 18,754 | 86% |
| **Total / Avg.** | 516 | 132,298 | 75% | 43,192 | 25% | 175,490 | 93% |
| Source: 2010 Joint Annual Reports | | | | | | | |

**UTILIZATION OF WILSON COUNTY NURSING HOMES 2008 - 2010**

| Facility | Beds | Level I Days | Level I Mix | Level II Days | Level II Mix | Total Days | Annual Occupancy |
|---|---|---|---|---|---|---|---|
| **2009** | | | | | | | |
| The Pavilion-THS | 60 | 6,973 | 100% | 0 | 0% | 6,973 | 31% |
| Mt. Juliet H.C. Ctr. | 106 | 29,497 | 88% | 3,877 | 12% | 33,374 | 86% |
| Quality Care Health Ctr. | 290 | 75,323 | 85% | 13,042 | 15% | 88,365 | 84% |
| Lebanon Health & Rehab Ctr. | 60 | 5,413 | 30% | 12,701 | 70% | 18,114 | 83% |
| **Total / Avg.** | 516 | 117,206 | 76% | 29,620 | 24% | 146,826 | 80% |
| Source: 2009 Joint Annual Reports | | | | | | | |

**UTILIZATION OF WILSON COUNTY NURSING HOMES 2008 - 2010**

| Facility | Beds | Level I Days | Level I Mix | Level II Days | Level II Mix | Total Days | Annual Occupancy |
|---|---|---|---|---|---|---|---|
| **2008** | | | | | | | |
| The Pavilion-THS | 22* | 2,098 | 100% | 0 | 0% | 2,098 | 26% |
| Mt. Juliet H.C. Ctr. | 106 | 28,190 | 80% | 7,164 | 20% | 35,354 | 91% |
| Quality Care Health Ctr. | 290 | 77,621 | 78% | 21,600 | 22% | 99,221 | 94% |
| Lebanon Health & Rehab Ctr. | 60 | 8,158 | 41% | 11,617 | 59% | 19,775 | 90% |
| **Total / Avg.** | 478 | 116,067 | 75% | 40,381 | 25% | 156,448 | 89% |
| *setup and staffed | | | | | | | |
| Source: 2008 Joint Annual Reports | | | | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

The following Table shows the number of total beds and Medicare certified beds and the Medicare and Medicaid payor mix for each of the existing nursing homes in Wilson County for 2010:

| Facility | Total Beds | Skilled Beds* | Medicare Payor Mix** | Medicaid Payor Mix** |
|---|---|---|---|---|
| The Pavilion-THS | 60 | 60 | 0% | 70% |
| Mt. Juliet Health Care | 106 | 106 | 37% | 41% |
| Quality Health Care | 290 | 290 | 19% | 67% |
| Lebanon Health & Rehab | 60 | 60 | 92% | 0% |
| * Includes all certified Level II beds, including dually certified | | | | |
| ** Medicare and Medicaid payor mix is based on net revenues from each program dived by total net patient revenue as reported in the 2010 Joint Annual Reports. | | | | |

The following Table shows the count as to Medicare-only and Medicaid/Medicare (dually certified) bed count for the above table.

| Facility | Total Beds | Dually Certified Beds | Medicare Only Beds | Medicaid Only Beds ("NF") |
|---|---|---|---|---|
| The Pavilion-THS | 60 | 60* | 0 | 0 |
| Mt. Juliet Health Care | 106 | 106 | 0 | 0 |
| Quality Health Care | 290 | 290 | 0 | 0 |
| Lebanon Health & Rehab | 60 | 0 | 60 | 0 |
| *Effective December 17, 2010, all 60 of the Pavilion-THS's beds were dually certified | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

The following tables show admission and discharge data from each of the 4 licensed nursing homes in Wilson County, including the applicant, the Pavilion-THS. Said data for those facilities reflect the years 2010, 2009 and 2008, the most recent years of data publicly available.

**ADMISSIONS DATA**

| **The Pavilion-THS** | | Year | | |
|---|---|---|---|---|
| | | 2010 | 2009 | 2008 |
| Source | | | | |
| Home (Private Residence) | | 12 | 4 | 2 |
| Private Home With Home Health Services | | 0 | 0 | 0 |
| Home And Community Based Services | | 0 | 0 | 0 |
| Home for the Aged | | | 0 | 0 |
| Assisted Living Facility | | 9 | 1 | 0 |
| Other Nursing Home | | 29 | 27 | 7 |
| Hospital | | 17 | 0 | 1 |
| Transfers within facility | To Medicaid/TennCare Level I from Medicaid/TennCare Level II | 0 | 0 | 0 |
| | To Medicaid/TennCare Level I from Medicare SNF | 0 | 0 | 0 |
| | To Medicaid/TennCare Level II from TennCare Level I | 0 | 0 | 0 |
| | To Medicaid/TennCare Level II from Medicare SNF | 0 | 0 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level I | 0 | 0 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level II | 0 | 0 | 0 |
| Other (please specify) | to Medicaid level I from Hospice | 0 | 0 | 0 |
| | **Source of Admission Total** | **67** | **32** | **10** |
| Source: 2010, 2009, 2008 Joint Annual Reports | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

**ADMISSIONS DATA**

| **Lebanon Health and Rehab Center** | | Year | | |
|---|---|---|---|---|
| | | 2010 | 2009 | 2008 |
| Source | | | | |
| Home (Private Residence) | | 4 | 8 | 0 |
| Private Home With Home Health Services | | 0 | 7 | 7 |
| Home And Community Based Services | | 0 | 0 | 0 |
| Home for the Aged | | 0 | 0 | 0 |
| Assisted Living Facility | | 0 | 2 | 0 |
| Other Nursing Home | | 0 | 0 | 7 |
| Hospital | | 624 | 470 | 477 |
| Transfers within facility | To Medicaid/TennCare Level I from Medicaid/TennCare Level II | 0 | 0 | 0 |
| | To Medicaid/TennCare Level I from Medicare SNF | 0 | 0 | 0 |
| | To Medicaid/TennCare Level II from TennCare Level I | 0 | 0 | 0 |
| | To Medicaid/TennCare Level II from Medicare SNF | 0 | 0 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level I | 0 | 0 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level II | 0 | 0 | 0 |
| Other (please specify) | to Medicaid level I from Hospice | 0 | 0 | 0 |
| | **Source of Admission Total** | **628** | **487** | **484** |
| Source: 2010, 2009, 2008 Joint Annual Reports | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

**ADMISSIONS DATA**

| **Mt. Juliet Health Care Center** | | Year | | |
|---|---|---|---|---|
| | | 2010 | 2009 | 2008 |
| Source | | | | |
| Home (Private Residence) | | 0 | 3 | 2 |
| Private Home With Home Health Services | | 0 | 0 | 2 |
| Home And Community Based Services | | 0 | 0 | 0 |
| Home for the Aged | | | 0 | 0 |
| Assisted Living Facility | | 1 | 3 | 0 |
| Other Nursing Home | | 17 | 14 | 7 |
| Hospital | | 183 | 179 | 125 |
| Transfers within facility | To Medicaid/TennCare Level I from Medicaid/TennCare Level II | 0 | 0 | 0 |
| | To Medicaid/TennCare Level I from Medicare SNF | 56 | 35 | 71 |
| | To Medicaid/TennCare Level II from TennCare Level I | 1 | 0 | 0 |
| | To Medicaid/TennCare Level II from Medicare SNF | 0 | 2 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level I | 29 | 16 | 24 |
| | To Medicare SNF from Medicaid/TennCare Level II | 0 | 0 | 0 |
| Other (please specify) | to Medicaid level I from Hospice | 0 | 1 | 0 |
| | **Source of Admission Total** | **287** | **253** | **231** |
| Source: 2010, 2009, 2008 Joint Annual Reports | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

**ADMISSIONS DATA**

| **Quality Health Care Center** | | Year | | |
|---|---|---|---|---|
| | | 2010 | 2009 | 2008 |
| Source | | | | |
| Home (Private Residence) | | 37 | 27 | 42 |
| Private Home With Home Health Services | | 11 | 19 | 14 |
| Home And Community Based Services | | 2 | 1 | 0 |
| Home for the Aged | | 0 | 0 | 0 |
| Assisted Living Facility | | 6 | 5 | 10 |
| Other Nursing Home | | 42 | 41 | 88 |
| Hospital | | 299 | 327 | 386 |
| Transfers within facility | To Medicaid/TennCare Level I from Medicaid/TennCare Level II | 56 | 123 | 151 |
| | To Medicaid/TennCare Level I from Medicare SNF | 74 | 191 | 104 |
| | To Medicaid/TennCare Level II from TennCare Level I | 45 | 78 | 121 |
| | To Medicaid/TennCare Level II from Medicare SNF | 6 | 17 | 13 |
| | To Medicare SNF from Medicaid/TennCare Level I | 9 | 7 | 2 |
| | To Medicare SNF from Medicaid/TennCare Level II | 2 | 0 | 0 |
| Other (please specify) | to Medicaid level I from Hospice | 0 | 0 | 0 |
| | **Source of Admission Total** | **589** | **836** | **931** |
| Source: 2010, 2009, 2008 Joint Annual Reports | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

**DISCHARGE DATA**

| **The Pavilion-THS** | | Year | | |
|---|---|---|---|---|
| | | 2010 | 2009 | 2008 |
| Source | | | | |
| Home (Private Residence) | | 2 | 0 | 1 |
| Private Home With Home Health Services from other source | | 1 | 0 | 0 |
| Private Home with Home Health Services from this Facility | | 0 | 0 | 0 |
| Home And Community Based Services (HCBS) waiver program | | 0 | 0 | 0 |
| Home for the Aged | | 0 | 0 | 0 |
| Assisted Living Facility | | 2 | 0 | 0 |
| Other Nursing Home | | 1 | 2 | 0 |
| Hospital (Bed held for return) | | 0 | 0 | 0 |
| Hospital (did not return) | | 7 | 1 | 0 |
| Residential Hospice | | 1 | | 0 |
| Transfers within facility | To Medicaid/TennCare Level I from Medicaid/TennCare Level II | 0 | 0 | 0 |
| | To Medicaid/TennCare Level I from Medicare SNF | 0 | 0 | 0 |
| | To Medicaid/TennCare Level II from TennCare Level I | 0 | 0 | 0 |
| | To Medicaid/TennCare Level II from Medicare SNF | 0 | 0 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level I | 0 | 0 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level II | 0 | 0 | 0 |
| Other (please specify) | | 0 | 0 | 0 |
| | **Discharge Destination Total (not including deaths)** | **14** | **3** | **1** |
| Source: 2010, 2009, 2008 Joint Annual Reports | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

**DISCHARGE DATA**

| **Lebanon Health and Rehab Center** | | Year | | |
|---|---|---|---|---|
| | | 2010 | 2009 | 2008 |
| Source | | | | |
| Home (Private Residence) | | 0 | 332 | 0 |
| Private Home With Home Health Services from other source | | 370 | 0 | 267 |
| Private Home with Home Health Services from this Facility | | 0 | 0 | 0 |
| Home And Community Based Services (HCBS) waiver program | | 0 | 0 | 0 |
| Home for the Aged | | 0 | 0 | 0 |
| Assisted Living Facility | | 38 | 22 | 27 |
| Other Nursing Home | | 45 | 28 | 49 |
| Hospital (Bed held for return) | | 107 | 0 | 53 |
| Hospital (did not return) | | 17 | 118 | 58 |
| Residential Hospice | | 0 | 0 | 0 |
| Transfers within facility | To Medicaid/TennCare Level I from Medicaid/TennCare Level II | 0 | 0 | 0 |
| | To Medicaid/TennCare Level I from Medicare SNF | 0 | 0 | 0 |
| | To Medicaid/TennCare Level II from TennCare Level I | 0 | 0 | 0 |
| | To Medicaid/TennCare Level II from Medicare SNF | 0 | 0 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level I | 0 | 0 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level II | 0 | 0 | 0 |
| Other (please specify) | | 0 | 0 | 0 |
| | **Discharge Destination Total (not including deaths)** | **577** | **500** | **454** |
| Source: 2010, 2009, 2008 Joint Annual Reports | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

**DISCHARGE DATA**

| **Mt. Juliet Health Care Center** | | Year | | |
|---|---|---|---|---|
| | | 2010 | 2009 | 2008 |
| Source | | | | |
| Home (Private Residence) | | 12 | 1 | 0 |
| Private Home With Home Health Services from other source | | 61 | 48 | 45 |
| Private Home with Home Health Services from this Facility | | 0 | 0 | 0 |
| Home And Community Based Services (HCBS) waiver program | | 0 | 0 | 0 |
| Home for the Aged | | 0 | 0 | 0 |
| Assisted Living Facility | | 26 | 10 | 30 |
| Other Nursing Home | | 12 | 9 | 8 |
| Hospital (Bed held for return) | | 33 | 82 | 0 |
| Hospital (did not return) | | 42 | 21 | 29 |
| Residential Hospice | | 0 | 0 | 0 |
| Transfers within facility | To Medicaid/TennCare Level I from Medicaid/TennCare Level II | 0 | 0 | 0 |
| | To Medicaid/TennCare Level I from Medicare SNF | 43 | 43 | 52 |
| | To Medicaid/TennCare Level II from TennCare Level I | 0 | 0 | 1 |
| | To Medicaid/TennCare Level II from Medicare SNF | 0 | 10 | 0 |
| | To Medicare SNF from Medicaid/TennCare Level I | 36 | 27 | 31 |
| | To Medicare SNF from Medicaid/TennCare Level II | 0 | 0 | 0 |
| Other (please specify) | to hospice from Medicaid level I | 0 | 5 | 0 |
| | **Discharge Destination Total (not including deaths)** | **265** | **256** | **196** |
| Source: 2010, 2009, 2008 Joint Annual Reports | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

**DISCHARGE DATA**

| **Quality Health Care Center** | | Year | | |
|---|---|---|---|---|
| | | 2010 | 2009 | 2008 |
| Source | | | | |
| Home (Private Residence) | | 16 | 56 | 42 |
| Private Home With Home Health Services from other source | | 33 | 53 | 25 |
| Private Home with Home Health Services from this Facility | | 0 | 0 | 0 |
| Home And Community Based Services (HCBS) waiver program | | 2 | 2 | 1 |
| Home for the Aged | | 5 | 0 | 0 |
| Assisted Living Facility | | 8 | 8 | 2 |
| Other Nursing Home | | 14 | 33 | 5 |
| Hospital (Bed held for return) | | 135 | 154 | 152 |
| Hospital (did not return) | | 107 | 26 | 198 |
| Residential Hospice | | 1 | 0 | 0 |
| Transfers within facility | To Medicaid/TennCare Level I from Medicaid/TennCare Level II | 55 | 123 | 127 |
| | To Medicaid/TennCare Level I from Medicare SNF | 73 | 191 | 104 |
| | To Medicaid/TennCare Level II from TennCare Level I | 45 | 78 | 62 |
| | To Medicaid/TennCare Level II from Medicare SNF | 6 | 17 | 17 |
| | To Medicare SNF from Medicaid/TennCare Level I | 9 | 6 | 2 |
| | To Medicare SNF from Medicaid/TennCare Level II | 2 | 0 | 0 |
| Other (please specify) | to hospice from Medicaid level I | 0 | 0 | 0 |
| | **Discharge Destination Total (not including deaths)** | **511** | **747** | **737** |
| Source: 2010, 2009, 2008 Joint Annual Reports | | | | |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

## 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.**

A completed Project Costs Chart is attached on the following page.

- **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.**

A letter form the architect supporting estimated construction costs is attached as Attachment C, Economic Feasibility, 1.

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

## PROJECT COSTS CHART

A. Construction and equipment acquired by purchase:

| | | |
|---|---|---|
| 1. | Architectural and Engineering Fees | 40,000 |
| 2. | Legal, Administrative (Excluding CON Filing Fee), Consultant Fees | 10,000 |
| 3. | Acquisition of Site | 0 |
| 4. | Preparation of Site | 29,000 |
| 5. | Construction Costs | 1,414,992 |
| 6. | Contingency Fund | 100,000 |
| 7. | Fixed Equipment (Not included in Construction Contract) | 0 |
| 8. | Moveable Equipment (List all equipment over $50,000) | 100,000 |
| 9. | Other (Specify) N/A | 0 |

2012 APR 13 AM 11 25

B. Acquisition by gift, donation, or lease:

| | | |
|---|---|---|
| 1. | Facility (inclusive of building and land) | 0 |
| 2. | Building only | 0 |
| 3. | Land only | 0 |
| 4. | Equipment (Specify) N/A | 0 |
| 5. | Other (Specify) N/A | 0 |

C. Financing Costs and Fees:

| | | |
|---|---|---|
| 1. | Interim Financing | 62,508 |
| 2. | Underwriting Costs | 0 |
| 3. | Reserve for One Year's Debt Service | 62,500 |
| 4. | Other (Specify) N/A | 0 |

| | | |
|---|---|---|
| D. | Estimated Project Cost (A+B+C) | 1,819,000 |
| E. | CON Filing Fee | 4,092.75 |
| F. | Total Estimated Project Cost (D+E) | 1,823,092.75 |

**TOTAL** 1,823,092.75

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.)***

**_x_ 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**

**___ E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

**___ 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.**

The total estimated project cost is $1,823,092.75 which is similar to other projects of this size. Mountainview Rehabilitation and Nursing Center in Franklin County, Tennessee, applied for a Certificate of Need in 2005, Project Number CN05054-025. There the applicant intended to add 20 new dually certified beds from the 2004/2005 SNF pool and add 7,800 square feet of new construction at an estimated construction cost of $887,250 or approximately $113.75 per square foot, for a total project cost of 1,349,655.00.

Woodcrest at Blakeford at Green Hills in Davidson County, Tennessee, applied for a Certificate of Need in 2003, Project Number CN-0304-021. There the applicant intended to add 30 level II Medicare only beds and build a 13,050 square foot addition at a cost of $1,499,124.00 or approximately $115.00 per square foot.

The applicant, the Pavilion-THS, intends to add 24 dually certified skilled nursing home beds from the 2011-2012 bed pool and build an 8,341 square foot addition to the currently existing facility at an estimated cost of $1,823,092.75. The estimated construction cost is $1,414,992.00 or approximately $169.64 per square foot, for a total project cost of $1,823,092.75, which is reasonable when compared to the similar approved projects listed above.

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).**

A completed Historical Data Chart is attached on the following page.

A completed Projected Data Chart is attached on the following page.

SUPPLEMENTAL- #1
June 4, 2012
10:12 am

## HISTORICAL DATA CHART

2012 JUN 4 AM 10 13

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

| | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|
| A. Utilization Data (Patient days) | 3,857 | 13,457 | 21,404 |
| B. Revenue from Services to Patients | | | |
| 1. Inpatient Services | $443,527 | $1,757,944 | $3,865,930 |
| 2. Outpatient Services | 0 | 0 | 0 |
| 3. Emergency Services | 0 | 0 | 0 |
| 4. Other Operating Revenue (Specify)Medicare Part B | 0 | 0 | 0 |
| **Gross Operating Revenue** | **$443,527** | **$1,757,944** | **$3,865,930** |
| C. Deductions from Gross Operating Revenue | | | |
| 1. Contractual Adjustments | 0 | 0 | $1,409 |
| 2. Provision for Charity Care | 0 | 0 | 0 |
| 3. Provisions for Bad Debt | 0 | $155,069 | $9,176 |
| **Total Deductions** | **$0** | **$155,069** | **$10,585** |
| **NET OPERATING REVENUE** | **$443,527** | **$1,602,875** | **$3,855,345** |
| D. Operating Expenses | | | |
| 1. Salaries and Wages | $975,603.71 | $1,644,913.00 | $2,258,525.00 |
| 2. Physician's Salaries and Wages | $14,750.00 | $33,000.00 | $45,000.00 |
| 3. Supplies | $125,850.22 | 205,328.25 | $130,325.00 |
| 4. Taxes | $18,715.67 | $52,350.00 | $57,779.00 |
| 5. Depreciation | $0 | $152,167.00 | $237,563.00 |
| 6. Rent | $6,918.46 | $0 | $7,684.00 |
| 7. Interest, other than Capital | $0 | $0 | $0 |
| 8. Management Fees: | | | |
| a. Fees to Affiliates | $0 | $0 | $0 |
| b. Fees to Non-Affiliates | $0 | $0 | $0 |
| 9. Other Expenses (See Attached) | | | |
| **Total Operating Expenses** | **$1,433,940.97** | **$2,623,743.50** | **$3,467,626.00** |
| E. Other Revenue (Expenses) – Net (Specify) | $(680,126.00) | $(2,925.00) | $(3,438.00) |
| **NET OPERATING INCOME (LOSS)** | **$(310,288.00)** | **$(862,875.00)** | **$401,742.00** |
| F. Capital Expenditures | | | |
| 1. Retirement of Principal | $0 | $0 | $66,476.65 |
| 2. Interest | $139,528.42 | $116,921.00 | $170,361.00 |
| **Total Capital Expenditures** | **$139,528.42** | **$116,921.00** | **$236,837.65** |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | **$(449,816.00)** | **$(979,796.00)** | **$401,742.00** |
| | $(449,816.00) | $(1,096,717.00) | $164,904.00 |

SUPPLEMENTAL- #2
June 4, 2012
10:12 am

2012 JUN 4 AM 10 13

**HISTORICAL DATA CHART**

| 9. Other Expenses (Specify) | 2009 | 2010 | 2011 |
|---|---|---|---|
| Raw Food | $39,949.05 | $165,587.00 | $230,491.00 |
| Contract Therapy | $0 | $0 | $0 |
| Pharmacy | $3,507.95 | $3,100.00 | $63,171.00 |
| Quality of Care Fee | $94,340.00 | $99,623.00 | $133,500.00 |
| Utilities | $44,574.63 | $112,794.00 | $121,248.00 |
| Contract Expense/Consultants | $10,332.94 | $19,832.25 | $31,859.00 |
| Professional Fees | $1,904.54 | $29,400.00 | $40,981.00 |
| Insurance | $64,969.36 | $55,372.00 | $65,406.00 |
| Employee Benefits | $1,655.16 | $32,173.00 | $27,153.00 |
| Miscellaneous | $30,869.28 | $18,104.00 | $16,941.00 |

SUPPLEMENTAL- #2
June 4, 2012
10:12 am

## PROJECTED DATA CHART

2012 JUN 4 AM 10 13

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

| | | Year 1 | Year 2 |
|---|---|---|---|
| A. | Utilization Data (Patient Days) | 28,036 | 29,324 |
| B. | Revenue from Services to Patients | | |
| 1. | Inpatient Services | $6,711,089.60 | $7,313,380.72 |
| 2. | Outpatient Services | 0 | 0 |
| 3. | Emergency Services | 0 | 0 |
| 4. | Other Operating Revenue (Specify)Vending | $2,373.60 | $2,326.13 |
| | **Gross Operating Revenue** | **$6,713,463.20** | **$7,315,706.85** |
| C. | Deductions from Gross Operating Revenue | | |
| 1. | Contractual Adjustments | $930,000.00 | $973,600.00 |
| 2. | Provision for Charity Care | 0 | 0 |
| 3. | Provisions for Bad Debt | $12,000.00 | $12,000.00 |
| | **Total Deductions** | **$942,000.00** | **$985,600.00** |
| **NET OPERATING REVENUE** | | **$5,771,463.20** | **$6,330,106.85** |
| D. | Operating Expenses | | |
| 1. | Salaries and Wages | $2,609,206.37 | $2,755,971.42 |
| 2. | Physician's Salaries and Wages | $45,000.00 | $45,000.00 |
| 3. | Supplies | $142,539.94 | $147,528.84 |
| 4. | Taxes | $60,600.00 | $61,620.00 |
| 5. | Depreciation | $266,784.00 | $267,858.00 |
| 6. | Rent | $7,257.00 | $7,511.00 |
| 7. | Interest, other than Capital | $0 | $0 |
| 8. | Management Fees: | | |
| | a. Fees to Affiliates | $240,000.00 | $240,000.00 |
| | b. Fees to Non-Affiliates | $90,000.00 | $90,000.00 |
| 9. | Other Expenses (See Attached) | | |
| | **Total Operating Expenses** | **$4,707,546.40** | **$5,052,860.85** |
| E. | Other Revenue (Expenses) -- Net (Barber & Beauty) | $(2,287.35) | $(2,241.60) |
| **NET OPERATING INCOME (LOSS)** | | **$1,061,629.45** | **$1,275,004.40** |
| F. | Capital Expenditures | | |
| 1. | Retirement of Principal | $149,562.10 | $155,654.86 |
| 2. | Interest | $304,637.90 | $298,545.14 |
| | **Total Capital Expenditures** | **$454,200.00** | **$454,200.00** |
| **NET OPERATING INCOME (LOSS) less CAPITAL EXPENDITURES** | | **$607,429.45** | **$820,804.40** |

**SUPPLEMENTAL- #3**
**June 4, 2012**
**10:12 am**

**PROJECTED DATA CHART**

2012 JUN 4 AM 10 14

9. Other Expenses (Specify)

| | | |
|---|---|---|
| Raw Food | $189,884.69 | $210,254.07 |
| Contract Therapy | $336,477.00 | $473,213.45 |
| Pharmacy | $141,090.34 | $157,311.50 |
| Quality of Care Fee | $177,796.50 | $184,019.38 |
| Utilities | $120,535.50 | $122,384.48 |
| Contract Expense/Consultants | $26,183.26 | $27,099.67 |
| Professional Fees | $29,753.70 | $30,795.08 |
| Insurance | $123,369.00 | $127,686.92 |
| Employee Benefits | $87,084.00 | $90,131.94 |
| Miscellaneous | $13,985.10 | $14,475.12 |

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

The average charges as calculated from the Projected Data Chart are reflected below.

| | Year 1 | Year 2 |
|---|---|---|
| Average Gross Charge | $211.95 per patient day | $223.20 per patient day |
| Average Deduction | $0.36 per patient day | $0.33 per patient day |
| Average Net Charge | $211.59 per patient day | $222.87 per patient day |

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.**

| Payor Source | Current Rates | | Proposed Rates | |
|---|---|---|---|---|
| | Actual | Budget | Year 1 | Year 2 |
| Private Payor (Average) | 191.17 | 187.50 | 187.20 | 196.56 |
| Medicaid | 166.25 | 162.75 | 167.83 | 176.19 |
| Medicare (Average) | 169.55 | 389.06 | 353.60 | 371.28 |

The facility has recently been approved to start accepting Medicare residents and local physicians have expressed a desire to utilize the Pavilion-THS to provide skilled nursing care after hospitalization. Currently the facility has a waiting list and does not always have the bed space available to accommodate the needs of the physicians. It is anticipated that these additional beds will allow the facility to have the flexibility to accept these residents and provide the transitional rate that the physicians are looking for as the residents progress towards a return to their home. As a result, the applicant anticipates a higher utilization of Medicare days than the facility has historically experienced. Although increases in the private room rates are expected to be no more than cost of living, the overall revenue per patient day will increase from historical levels due to the reimbursement provided by Medicare on the skilled residents.

**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).**

The following is a comparison of the charges of two Wilson County nursing homes as reported on the 2010 Joint Annual Reports:

Quality Care

| | |
|---|---|
| Medicare Skilled (Ave. Daily Charge) | $179.00 |
| Medicaid Level I | $135.00 |
| Private Level I (one resident per room) | $150.00 |

Mt. Juliet Health Care

| | |
|---|---|
| Medicare Skilled (Avg. Daily Charge) | $177.00 |
| Medicaid Level I | $177.00 |
| Private Level I (one resident per room) | $188.00 |

Utilization and rates are comparable with those of other nursing homes in the area. The occupancy rate of 96 percent is reasonable based on the current waiting list, occupancy of other skilled nursing facilities in Wilson County and the demand for skilled nursing beds expressed by local physicians.

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

The current utilization rates demonstrate the need for the additional beds at the applicant's facility. The Pavilion-THS currently has a waiting list which demonstrates that there would be enough demand to justify the cost related to the additional beds. In addition, the facility has obtained certification to participate in Medicare which will allow the facility to accept residents that it was previously unable to accept. Local physicians and hospital discharge planners have already expressed an interest in placing residents at the facility if beds were available. The shift in the patient mix to more Medicare residents and strong demand will ensure that the addition will be financially viable.

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

Based on the projected financial data and historical and projected utilization data, the facility should be able to generate sufficient cash flow to support the project. Due to uncertainties related to funding of Medicare and Medicaid, the reimbursement rates were kept at the current rates and only a shift in payor sources were reflected in the census mix based on the recent Medicare

certification. The Medicare mix of less than 20 percent is reasonable based upon inquires that the facility has already received since achieving Medicare certification.

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.**

The facility currently participates in Medicaid Level 1 and Medicare. Since obtaining Medicare certification, the facility has contacted the state about receiving certification of Level II residents for Medicaid. During the first year after the addition of 24 beds, the facility anticipates the following Medicare/Medicaid breakdown:

| Payor Source | Estimated Revenue | Percentage of Revenue |
|---|---|---|
| Private | $1,234,958 | 21% |
| Medicaid | $2,817,651 | 49% |
| Medicare | $1,728,480 | 30% |

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.**

A copy is attached as Attachment C, Economic Feasibility-10. Note that the most recent reporting period covers the prior owner of the facility Community Progress Committee a not for profit Tennessee corporation.

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.**

The current facility was completed in December 2009 and had reached capacity for approved beds by March 2010 and currently has a waiting list of at least 56 people. In deciding to expand, the applicant desired to maintain its current level of service by replicating the already existing

wing of the facility. In so doing, the residents of the new wing would have the same benefits enjoyed by those in the existing wing including increased privacy, alternate socializing areas, more dining area choices, and an overall higher quality of service than the alternative.
The applicant did not find the alternative of creating an addition with a smaller footprint to be practicable. For example, the new wing could have been made without the open community areas, utilizing that space instead for residents rooms connected to the facility by a hallway. A smaller addition may have reduced the overall cost of the project but would have eliminated what the applicant feels are the strengths of its existing wing mentioned above.

**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.**

Modernization is not practical and new construction is necessary because the existing facility was completed in December 2009 and is currently too small to meet Wilson County's demand for new nursing home beds based on the projected need for the county and the wasting list of potential new residents.
The maximum number of beds the applicant can add to the existing facility is 6. Given the need for 123 additional beds in the county the applicant feels that it would be inefficient to propose adding only those 6 beds at this point and then waiting until the next review period to apply for the addition to the facility and additional beds proposed in this Certificate of Need.

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

## 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.**

Alive Hospice
Caris Healthcare
Direct Medical Supply
First Choice Medical
Hendricks Counseling
Hometown Respiratory
Lee Medical
Odyssey/Gentiva
Quality Mobile X-Ray
Rx Med
Signature Labs
Stein Ancillary Services
Sunrise Dental
University 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.**

The addition to the facility and the increase in beds will have a positive effect on the health care system. The Pavilion-THS provides care for 60 residents at any one time and currently has a waiting list of at least 56 people. Continuing its high level of service by expanding the size of the facility and adding beds, the Pavilion-THS seeks to fulfill its resident's best interests and provide care for a greater number of those who need it. The expanded facility will provide an alternative to those families who have been forced to seek care outside of Wilson County.

The 4 nursing homes in Wilson County operating near capacity combined with the need for 123 additional nursing home beds and a growing and aging population will not duplicate services or result in nursing homes having to compete for a diminishing potential resident population, on the contrary the beds will provide a partial relief at best for the significant demand for new nursing home beds in the county.

Clearly the living arrangements, care and design of applicant's facility which will be replicated in the proposed addition are what people desire and need. To the extent other facilities may be minimally impacted, such impact is due to a clear shift in demand from older institutional style facilities to the residential community style offered by the applicant.

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.**

Current Staffing Pattern

The facility operates three shifts per day: 6am-2pm, 2pm-10pm, and 10pm-6am. The present staffing pattern is 27.5 direct care FTE's for 220 direct care hours with 8 administrative hours resulting in a direct care/administrative staffing ratio of 3.8, which is representative of a typical weekday.

The chart below displays the current staffing pattern.

| | 6am-2pm | 2pm-10pm | 10pm-6am |
|---|---|---|---|
| CMA | 0 | 0 | 0 |
| CNA | 7.5 | 6 | 4 |
| LPN/LVN | 4 | 2 | 2 |
| RN | 1 | 1 | 0 |
| Direct Care Staffing Ratio | 1.66 | 1.2 | .8 |
| Administrative | 1 | 0 | 0 |
| Direct Care/Admin Staffing Ratio 3.8 | | | |

| Anticipated Staff for the Addition | Wages | Prevailing wage* (Median) |
|---|---|---|
| 2-3 Licensed Nurses | $16.00-$19.00/hour | $17.30/hour |
| 5-6 Certified Nurse Assistants | $10.00-$11.00/hour | $10.74/hour |
| 1-2 Housekeeper/Laundry | $8.00/hour | $9.68/hour |
| 1-2 Physical/Occupational Therapy | $40.00-$50.00/hour | $36.67/hour |

* Tennessee Department of Labor & Workforce Development, 2009 Quarterly Census of Employment and Wages

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.**

The applicant expects to hire 10 to 15 additional staff, of that number applicant anticipates most will be LN's or LNA's. The applicant does not foresee any difficulty in filling these positions.

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.***

The applicant understands all such licensing and certification requirements and will comply with the same. The applicant has an onsite Administrator, Joey Njezik and also has a Management Company both of whom affirm a thorough understanding of licensing certification.

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.).**

The Pavilion-THS has collaborated with Tennessee Technology Center's Hartsville campus to provide an environment to facilitate the clinical aspect of that institution's Practical Nursing Program. The Pavilion-THS also works with Cumberland University in training students in that institution's 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.**

The applicant understands all such licensing and certification requirements and will comply with the same. The applicant has an onsite Administrator, Joey Njezik and also has a Management Company both of whom affirm a thorough understanding said requirements.

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

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

**Accreditation:** N/A

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.**

The Pavilion-THS is in good standing with the Board for Licensing Health Care Facilities. A copy of the license is attached as Attachment C, Orderly Development, 7, c.

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.**

A copy of the most recent survey/deficiency statement and the approved Plan of Correction are attached as Attachment C, Orderly Development, 7, d.

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.**

None.

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.**

None.

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.**

If the project is approved, 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.

## 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.**

The Publication of Intent was in the April 10, 2012 edition of the Lebanon Democrat. A copy of the full page of the newspaper in which the notice of intent appeared is attached.

## 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.**

An extended period of validity is not requested at this time.

**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.**

A completed Projected Completion Forecast Chart is attached on the next page.

**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.**

N/A.

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

## PROJECT COMPLETION FORECAST CHART

2012 APR 13 AM 11 26

**Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c):** 7/26/2012

**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.**

| Phase | DAYS REQUIRED | Anticipated Date (MONTH/YEAR) |
|---|---|---|
| 1. Architectural and engineering contract signed | 5 | 8/12 |
| 2. Construction documents approved by the Tennessee Department of Health | 95 | 10/12 |
| 3. Construction contract signed | 100 | 11/12 |
| 4. Building permit secured | 110 | 11/12 |
| 5. Site preparation completed | 140 | 12/12 |
| 6. Building construction commenced | 141 | 12/12 |
| 7. Construction 40% complete | 225 | 03/13 |
| 8. Construction 80% complete | 309 | 05/13 |
| 9. Construction 100% complete (approved for occupancy) | 351 | 07/13 |
| 10. *Issuance of license | 381 | 08/13 |
| 11. *Initiation of service | 471 | 11/13 |
| 12. Final Architectural Certification of Payment | 476 | 11/13 |
| 13. Final Project Report Form (HF0055) | 506 | 12/13 |

*** 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.**

## ATTACHMENTS

| | |
|---|---|
| Corporate Charter and Certificate of Corporate Existence | Attachment A, 3 |
| Organizational Documentation | Attachment A, 4 |
| Management Agreement | Attachment A, 5 |
| Deed/Lease Agreement | Attachment A, 6 |
| Plot Plan | Attachment B, III (A) |
| Floor Plan | Attachment B, IV |
| Map of Service Area | Attachment C, Need, 3 |
| Architect Letter in Support of Estimated Construction Costs | Attachment C, Economic Feasibility 1 |
| Type of Funding | Attachment C, Economic Feasibility 2 |
| Financial Statements | Attachment C, Economic Feasibility 10 |
| Copy of Current License | Attachment C, Orderly Development, 7, c |
| Deficiency Statement/Approved Plan of Correction | Attachment C, Orderly Development, 7, d. |
| Proof of Publication | Attachment C, Orderly Development, Proof of Publication |

**AFFIDAVIT**

STATE OF TENNESSEE 2012 APR 13 AM 11 26

COUNTY OF WILSON

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

G. Frank Lannom
SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of April, 2012 a Notary Public in and for the County/State of Wilson, Tennessee.

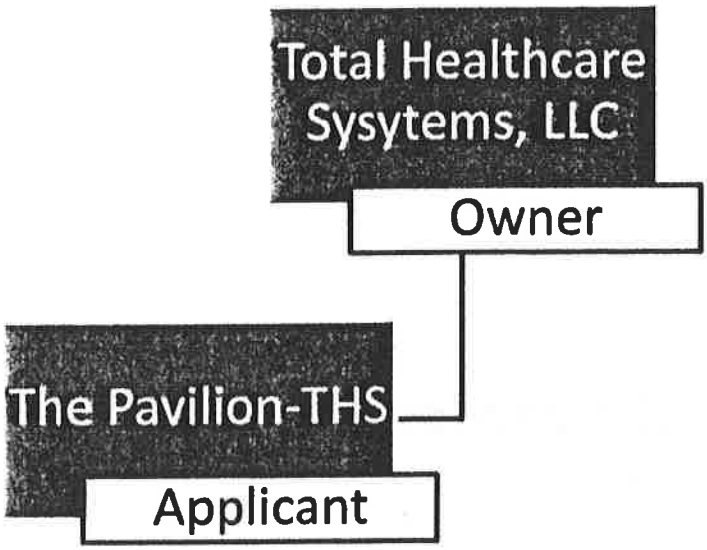
Carmen Belcher
NOTARY PUBLIC

My commission expires, 7-6-2015

CARMEN BELCHER
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

**For Section A, Item 4, Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart.**

OWNERSHIP STRUCTURE ORGANIZATIONAL CHART




**Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant.**
Total Healthcare Systems, LLC is a Tennessee limited liability company and owner of the facility.

**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.**
Gordon Bone (52% ownership interest), Hal Bone (24% ownership interest), Sue Ann Bone (24% 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.**
Neither the applicant nor the applicant's owner has a financial interest in any other health care institution in Tennessee.

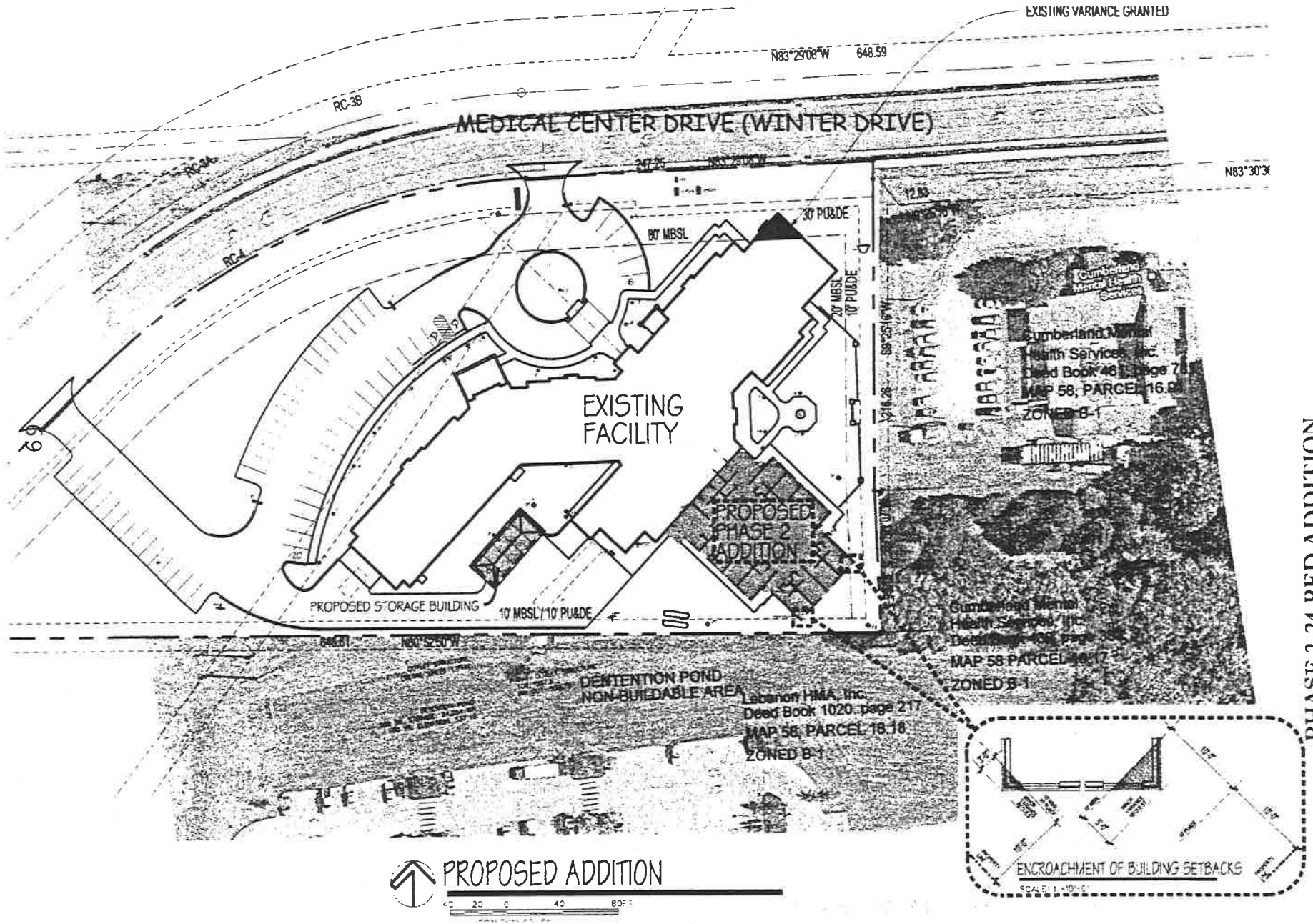
**At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.**
N/A.

# Attachment A, 5

**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.**

Stein and Associates, LLC, has been managing similar facilities for the past 11 years. The management company is a limited liability corporation with 3 owners being James Stein (40% ownership interest) Paul Stein (40% ownership interest) Randy Cartwright (20% ownership interest) Stein and Associates has had a management agreement with the owners of THS for the past 10 years

# Attachment B, III (A)




3.68 TOTAL ACRES

MANOUS DESIGN

PHASE 2-24 BED ADDITION

THE PAVILION

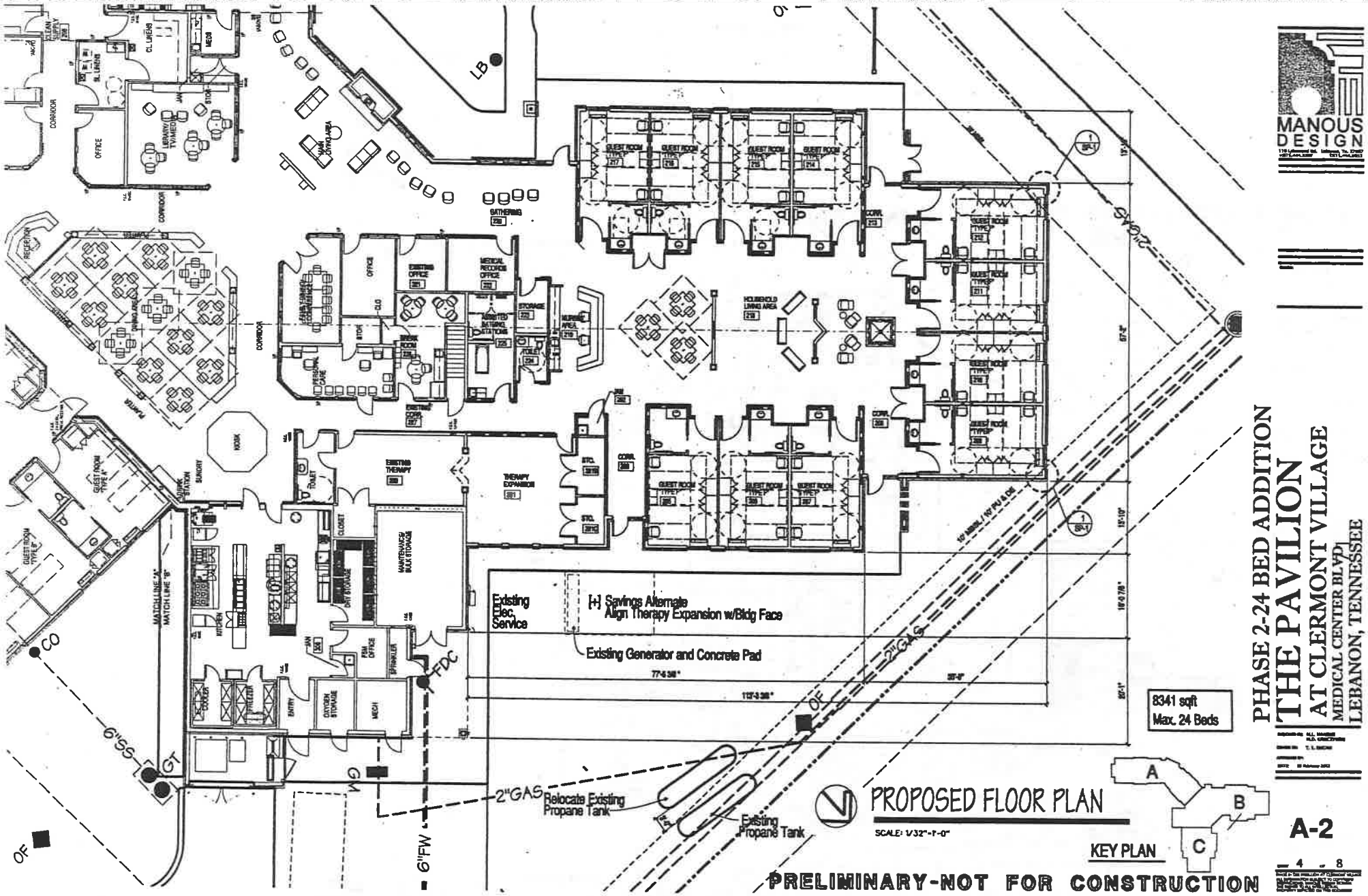
AT CLERMONT VILLAGE

MEDICAL CENTER BLVD

LEBANON, TENNESSEE

SP-2

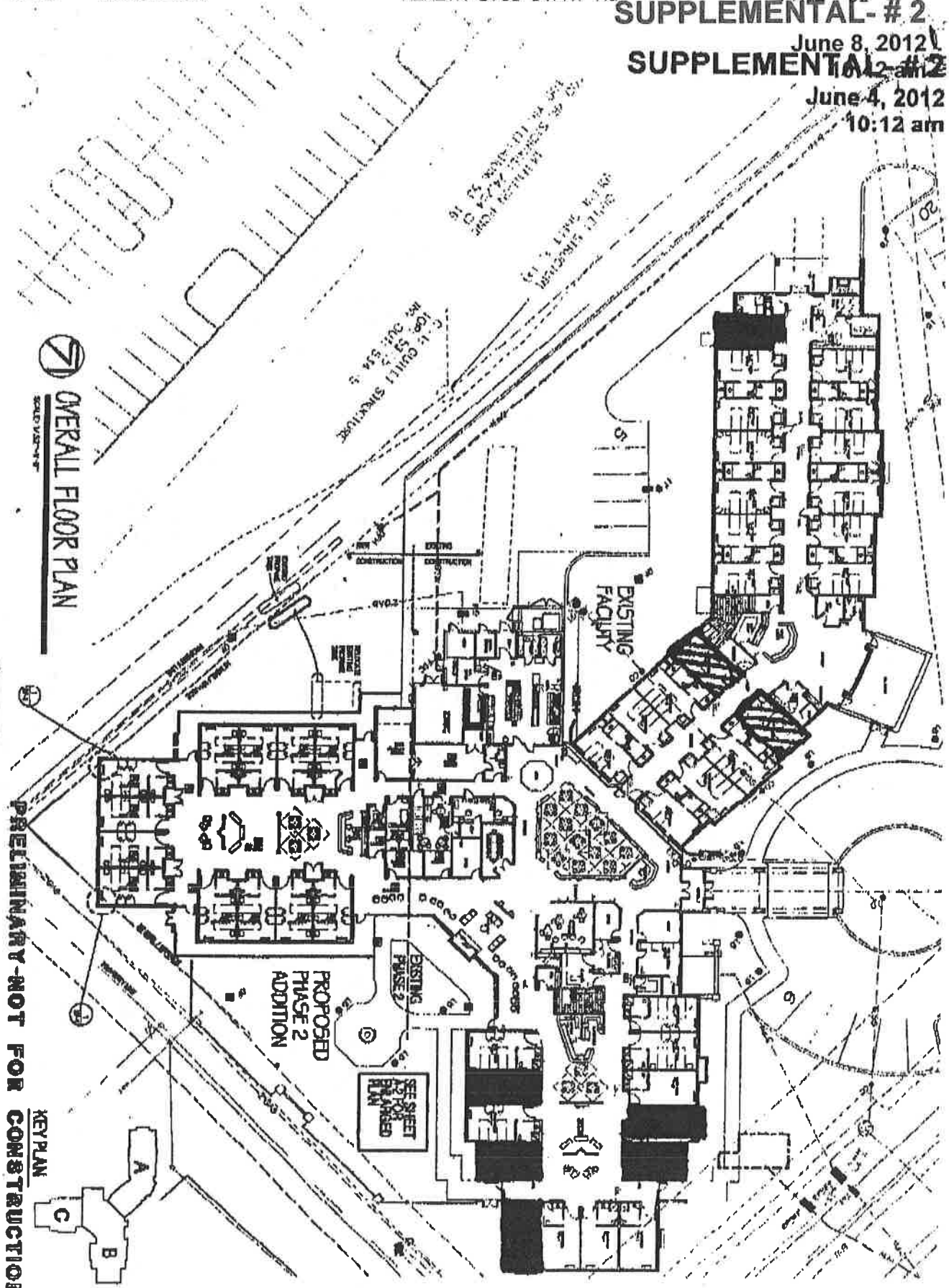
# Attachment B, IV




All rooms will be double occupancy

SUPPLEMENTAL- # 2
June 8, 2012
10:12 am

SUPPLEMENTAL- # 2
June 4, 2012
10:12 am




Private Room

Converted from Private to Semi-Private Room

PHASE 2-24 BED ADDITION

# THE PAVILION

AT CLERMONT VILLAGE

MEDICAL CENTER BLVD.

LEBANON, TENNESSEE

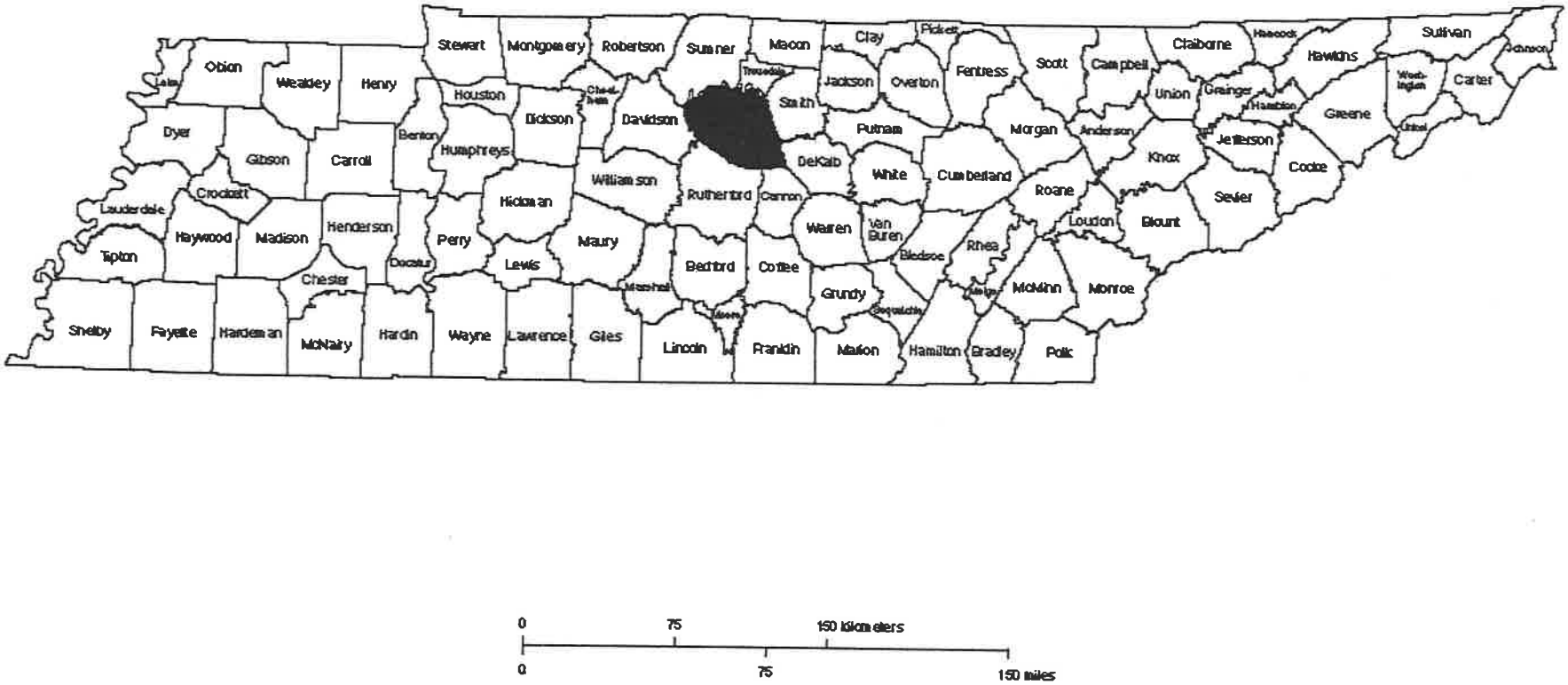
A-1

MANOUS DESIGN

# Attachment C, Need, 3

# TENNESSEE

## The Pavilion-THS's Service Area
### Shaded Grey




0 75 150 kilometers

0 75 150 miles

# Attachment C, Economic Feasibility 1

SUPPLEMENTAL- #2
June 4, 2012
10:12 am

MANOUS DESIGN

110 Lakewood Drive
Lebanon, TN 37087
615.444.6207 p
615.444.0853 f

April 27, 2012

Alex Bird
Lannom and Williams, PLLC.
137 Public Square
Lebanon, Tennessee 37087

Re: Pavilion, Phase II Addition

Dear Mr. Bird,

Per your request, I have reviewed the detailed construction cost estimate for the Phase II Addition of the Pavilion prepared by Horizon Construction & Development, LLC (Horizon).

Phase II of the facility will be the identical construction type in terms of structure, exterior cladding, interior finishes and MPE systems. The building pad for Phase II was prepared during the initial site construction.

Phase II will contains approximately 8,350 s.f. as well as a 20' x 50' maintenance and storage structure. The facility will contain resident rooms, common areas, nursing station, storage, mechanical space, public toilets and an expansion of the therapy space. I believe that Horizon's proposed budget of $165 s.f. is more than adequate to construct the facility as designed and previously constructed in Phase I.

The design and construction documents will meet all current requirements of the Tennessee Department of Health applicable to a skilled nursing facility. The project will be designed to meet the 2006 IBC, the 2006 Life Safety Code, the 2006 International Fire Code, 2004 NC Handicapped Code, and the 2006 AIA Design Guidelines for Health Facilities. No products specified for this facility will contain hazardous material or asbestos.

If you have any further questions or require additional information, please do not hesitate to contact me.

Respectfully,

Michael L. Manous, R.A.
President

# Attachment C, Economic Feasibility 2

# TERM SHEET
Prepared for
## Pavilion-THS, LLC
and
## Total Healthcare Systems, LLC
February 7, 2012

---

**The following is intended to create a baseline for discussions that will hopefully culminate in the issuance of a formal loan commitment to make a loan.**

| | |
|---|---|
| **Borrower:** | The Pavilion-THS, LLC and Total Healthcare Systems, LLC. |
| **Purpose:** | To finance the addition of 24 skilled nursing beds at The Pavillion-THS. |
| **Facility and Amount:** | Construction Line of Credit converting to a Permanent Term Loan in an amount not to exceed the lesser of $1,500,000 or eighty percent of the cost to add 24 skilled nursing beds. |
| **Rate:** | Interest shall accrue at the 30-day LIBOR plus 4.5%. |
| **Fee:** | .25% due at Closing. |
| **Prepayment Penalty:** | To be negotiated if Borrower elects a fixed rate option. |
| **Payment:** | Interest only for the first twelve months; Beginning in the thirteenth month and continuing each month thereafter, Borrower shall make monthly principal payments equal to the then outstanding principal balance divided by 180 plus monthly interest payments. |
| **Maturity:** | Construction Loan Period shall expire 12 months after Closing.<br><br>The Permanent Term Loan shall mature five (5) years from the date the Construction Loan Period expires. |
| **Collateral:** | First Deed of Trust with fixture filing in favor of the Pinnacle Financial Partners on The Pavilion-THS. |
| **Guarantors:** | Total Healthcare Systems, LLC shall guarantee the Credit Facility. |
| **Loan Agreement:** | The existing Loan Agreement by and between Borrower and Pinnacle National Bank shall be amended to reflect the new Credit Facility contemplated herein. |
| **Other:** | Borrower shall be responsible for the payment of costs including but not limited to appraisal, survey, title searches, title insurance policy, environmental study, recording taxes, UCC fees, and legal counsel whether or not the loan actually closes. The Borrower will provide insurance on the collateral with the Pinnacle Financial Partners named as loss payee. |

150 3rd Avenue South
Suite 900
Nashville, TN 37201
www.pnfp.com

SUPPLEMENTAL- #5
June 4, 2012
10:12 am

**Department of Health & Human Services**
**Centers for Medicare & Medicaid Services**
**61 Forsyth St., Suite. 4T20**
**Atlanta, Georgia 30303-8909**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

February 1, 2011

Ms. Rebecca Gay Lane, Administrator
The CPC Pavilion
1406 Medical Center Drive
Lebanon, Tennessee 37087

Re: SNF CMS Certification Number (CCN): **44-5500**

Dear Ms. Lane:

This letter is to inform you that your skilled nursing facility has been found to meet the Requirements for Participation in the Health Insurance for the Aged and Disabled Program (Medicare).

The effective date of certification is **December 17, 2010** and the fiscal year end date is December 31. The Medicare provider number is shown above. This number should be entered on all forms and correspondence pertaining to the Medicare Program.

It is most important to note that this certification is contingent upon your obtaining approval from the Office for Civil Rights (OCR). If this approval is not obtained, Medicare reimbursement will be recouped as of the effective date of certification.

The State Survey Agency previously advised you of any deficiencies found during the latest survey. If any deficiencies were cited, your plan of correction was considered in making the determination of compliance. In accordance with established Program procedures, the Survey Agency will verify that your plan of correction was implemented, and that compliance was achieved and maintained.

This Medicare certification is for:

**60-** Dually certified beds located in rooms: **Semi-private rooms: 101-112, 203-208, 301-303, 306-308, 311, 313 and Private rooms: 113, 201-202, 304-305, 309-310 and 312.**

**Cahaba GBA (10301)** will serve as your fiscal intermediary. They have been notified of your certification, by copy of this letter.

You are advised to report any major changes in staffing, services, or other significant characteristics which potentially could affect your facility's compliance, to the State Survey Agency for action as deemed necessary. Pursuant to this, Section 1819(d) (B) of the Social Security Act requires you to report any changes involving ownership, Management Company, Director of Nursing, and Administrator.

If you believe that this determination is incorrect in any respect, you may ask that it be reconsidered. Your request must be submitted in writing to this office within 60 days of receipt of this letter. You may submit with your request for reconsideration any information you believe to be pertinent to the determination.

Should you have any questions concerning this matter, please contact Alpalena Hartsfield at (404) 562-7434.

Sincerely,

Alpalena Hartsfield
for Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

**NOTE TO THE FISCAL INTERMEDIARY:**
**THIS LETTER REPLACES THE CMS-2007, PROVIDER TIE-IN NOTICE.**

# THE PAVILION - CPC
# (AN OPERATING UNIT OF
# COMMUNITY PROGRESS COMMITTEE, INC.)

## FINANCIAL STATEMENTS AND
## INDEPENDENT AUDITORS' REPORT

## YEARS ENDED JUNE 30, 2011 AND 2010

## TABLE OF CONTENTS


| | Page |
|---|---|
| Independent Auditors' Report | 3 |
| Financial Statements | |
| Statements of Financial Position | 4 |
| Statements of Activities | 5 |
| Statements of Functional Expenses | 6 - 7 |
| Statements of Cash Flows | 8 |
| Notes to Financial Statements | 9 - 15 |

DVF Dempsey Vantrease & Follis PLLC
Certified Public Accountants & Consultants

# INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
Community Progress Committee, Inc.

We have audited the accompanying statements of financial position of The Pavilion - CPC (an operating unit of Community Progress Committee, Inc., a Tennessee not-for-profit corporation) as of June 30, 2011 and 2010, and the related statement of activities, functional expenses and cash flows for the years then ended. These financial statements are the responsibility of the Organization's management. 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 of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statement is free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statement. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above presents fairly, in all material respects, the financial position of The Pavilion - CPC as of June 30, 2011 and 2010, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Dempsey Vantrease & Follis PLLC

Murfreesboro, Tennessee
September 16, 2011



630 South Church Street • Murfreesboro, Tennessee 37130
P 615-893-6666 F 615-893-8047 www.dvf-pllc.com

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)

2012 APR 13 AM 11 26

STATEMENTS OF FINANCIAL POSITION

| | June 30, 2011 | June 30, 2010 |
|---|---|---|
| **ASSETS** | | |
| CURRENT ASSETS | | |
| Cash and equivalents | $ 516,034 | $ 349,568 |
| Patient receivables (less allowance for doubtful accounts of $100,000 and $180,000 for 2011 and 2010, respectively.) | 403,958 | 151,952 |
| Prepaid expenses and other assets | 9,235 | 20,957 |
| Total current assets | 929,227 | 522,477 |
| PROPERTY AND EQUIPMENT | 5,657,752 | 5,813,600 |
| OTHER ASSETS | | |
| Intangible asset | 173,698 | 173,698 |
| Financing costs, less accumulated amortization | 26,114 | 33,078 |
| Total other assets | 199,812 | 206,776 |
| TOTAL ASSETS | $ 6,786,791 | $ 6,542,853 |
| **LIABILITIES AND NET DEFICIT** | | |
| CURRENT LIABILITIES | | |
| Accounts payable | $ 130,468 | $ 130,688 |
| Accrued expenses | 231,943 | 173,090 |
| Current maturities, long-term obligation | 253,501 | 245,139 |
| Due to related party | 3,434,807 | 3,283,368 |
| Other current liabilities | 11,066 | 8,960 |
| Total current liabilities | 4,061,785 | 3,841,245 |
| NOTES PAYABLE, less current maturities | 5,056,916 | 5,266,308 |
| NET DEFICIT | | |
| Unrestricted | (2,331,910) | (2,564,700) |
| TOTAL LIABILITIES AND NET DEFICIT | $ 6,786,791 | $ 6,542,853 |

See notes to financial statements.

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)

STATEMENTS OF ACTIVITIES

| | June 30, 2011 | June 30, 2010 |
|---|---|---|
| REVENUES | | |
| Net patient revenues | $ 3,867,339 | $ 1,757,944 |
| Other facility revenues | 3,438 | 2,925 |
| Total revenues | 3,870,777 | 1,760,869 |
| EXPENSES | | |
| Program services | 3,452,031 | 2,683,624 |
| Management and general | 185,956 | 173,962 |
| Total expenses | 3,637,987 | 2,857,586 |
| CHANGE IN UNRESTRICTED NET DEFICIT | 232,790 | (1,096,717) |
| UNRESTRICTED NET DEFICIT, Beginning of year | (2,564,700) | (1,467,983) |
| UNRESTRICTED NET DEFICIT, End of year | $ (2,331,910) | $ (2,564,700) |

See notes to financial statements.

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)
STATEMENT OF FUNCTIONAL EXPENSES

FOR THE YEAR ENDING JUNE 30, 2011

| | Program Services | Management and General | Fund-Raising | Total |
|---|---|---|---|---|
| Salaries and wages | $ 1,988,233 | $ 94,874 | $ - | $ 2,083,107 ✓ |
| Other employee benefits | 25,857 | 1,296 | - | 27,153 ✓ |
| Payroll tax expenses | 167,047 | 8,371 | - | 175,418 ✓ |
| Professional fees | - | 40,981 | - | 40,981 ✓ |
| Supplies | 108,997 | 5,462 | - | 114,459 ✓ |
| Telephone | 8,076 | 405 | - | 8,481 ✓ |
| Postage and shipping | 710 | 36 | - | 746 ✓ |
| Equipment rental and maintenance | 85,404 | 4,280 | - | 89,684 ✓ |
| Travel | - | 508 | - | 508 ✓ |
| Interest | 162,232 | 8,129 | - | 170,361 ✓ |
| Depreciation | 219,595 | 11,004 | - | 230,599 ✓ |
| Amortization | 6,632 | 332 | - | 6,964 ✓ |
| Advertising | 481 | - | - | 481 ✓ |
| Bad debt expense | 9,176 | - | - | 9,176 ✓ |
| Housekeeping | 32,115 | - | - | 32,115 |
| Dues and subscriptions | 10,887 | 546 | - | 11,433 ✓ |
| Insurance | 62,285 | 3,121 | - | 65,406 ✓ |
| Bank charges | - | 1,230 | - | 1,230 ✓ |
| Licenses and penalties | 31,859 | - | - | 31,859 ✓ |
| Training expense | 3,289 | - | - | 3,289 ✓ |
| Property and provider taxes | 191,279 | - | - | 191,279 ✓ |
| Food and supplies | 230,491 | - | - | 230,491 ✓ |
| Utilities | 107,386 | 5,381 | - | 112,767 ✓ |
| Total | $ 3,452,031 | $ 185,956 | $ - | $ 3,637,987 |

See notes to financial statements.

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)
STATEMENT OF FUNCTIONAL EXPENSES

FOR THE YEAR ENDING JUNE 30, 2010

| | Program Services | Management and General | Fund-Raising | Total |
|---|---|---|---|---|
| Salaries and wages | $ 1,458,749 | $ 94,874 | $ - | $ 1,553,623 ✓ |
| Other employee benefits | 29,587 | 2,586 | - | 32,173 ✓ |
| Payroll tax expenses | 116,700 | 7,590 | - | 124,290 ✓ |
| Professional fees | - | 15,600 | - | 15,600 ✓ |
| Supplies | 140,667 | 9,785 | - | 150,452 ✓ |
| Telephone | 5,277 | 367 | - | 5,644 ✓ |
| Postage and shipping | 313 | 22 | - | 335 ✓ |
| Equipment rental and maintenance | 29,970 | 2,085 | - | 32,055 ✓ |
| Travel | - | 5,043 | - | 5,043 ✓ |
| Interest | 109,317 | 7,604 | - | 116,921 ✓ |
| Depreciation | 135,761 | 9,444 | - | 145,205 ✓ |
| Amortization | - | 6,962 | - | 6,962 ✓ |
| Advertising | 643 | - | - | 643 ✓ |
| Bad debt expense | 155,069 | - | - | 155,069 ✓ |
| Housekeeping | 21,406 | - | - | 21,406 ✓ |
| Dues and subscriptions | 3,734 | 260 | - | 3,994 ✓ |
| Insurance | 51,771 | 3,601 | - | 55,372 ✓ |
| Bank charges | - | 1,170 | - | 1,170 ✓ |
| Licenses | 1,800 | - | - | 1,800 ✓ |
| Training expense | 5,119 | - | - | 5,119 ✓ |
| Provider taxes | 151,973 | - | - | 151,973 ✓ |
| Food and supplies | 165,587 | - | - | 165,587 ✓ |
| Utilities | 100,181 | 6,969 | - | 107,150 ✓ |
| Total | $ 2,683,624 | $ 173,962 | $ - | $ 2,857,586 |

See notes to financial statements.

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)

STATEMENTS OF CASH FLOWS

| | June 30, 2011 | June 30, 2010 |
|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES:** | | |
| Change in unrestricted net assets | $ 232,790 | $ (1,096,717) |
| Adjustments to reconcile change in unrestricted net assets to net cash provided by (used for) operating activities | | |
| Depreciation and amortization | 237,563 | 152,167 |
| Provision for doubtful accounts | 9,176 | 155,069 |
| Increase in assets: | | |
| Patient receivables | (261,182) | (254,317) |
| Prepaid expenses | 11,722 | (10,558) |
| Increase in liabilities: | | |
| Accounts payable | (220) | 357,602 |
| Accrued expenses | 58,853 | 110,298 |
| Other current liabilities | 2,106 | 2,803 |
| Net Cash Provided by (used for) Operating Activities | 290,808 | (583,653) |
| **CASH FLOWS FROM INVESTING ACTIVITIES -** | | |
| Capital expenditures | (74,751) | (2,182,023) |
| **CASH FLOWS FROM FINANCING ACTIVITIES:** | | |
| Proceeds from note payable | - | 1,905,000 |
| Principal payments on note payable | (201,030) | - |
| Payment on Line of Credit | - | (43,554) |
| Net activity - due to related party | 151,439 | 911,049 |
| Net Cash Provided by (used for) Financing Activities | (49,591) | 2,772,495 |
| **NET INCREASE IN CASH AND EQUIVALENTS** | 166,466 | 6,819 |
| **CASH AND EQUIVALENTS, Beginning of year** | 349,568 | 342,749 |
| **CASH AND EQUIVALENTS, End of year** | $ 516,034 | $ 349,568 |
| Supplemental disclosure of cash flow information | | |
| Cash paid during the year for interest | $ 179,301 | $ 191,907 |

See notes to financial statement.

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)

NOTES TO FINANCIAL STATEMENTS

JUNE 30, 2011 AND 2010

## NOTE A – NATURE OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

### Nature of Organization

The financial statements include the accounts of The Pavilion - CPC, (the "Facility") an operating unit of Community Progress Committee, Inc. (the "Community"), a Tennessee not-for-profit corporation, located in Lebanon, Tennessee for the years ended June 30, 2011 and 2010. Other operations of Community are not included in these financial statements.

### Basis of Accounting

The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

### Basis of Presentation

Financial statement presentation follows the requirements of the Financial Accounting Standards Board in its Accounting Standards Codification (FASB ASC) 958, *Financial Statements of Not-for-Profit Organizations.* Under ASC 958 the Organization is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

### Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

### Property and Equipment

Property and equipment are recorded at cost or fair value at the date of gift. Depreciation is computed using the straight-line method over the estimated useful life of the asset. Expenditures for maintenance, repairs and renewals are charged to operations as incurred, and betterments greater than $1,000 are capitalized. The building is depreciated over 30 years, building improvements over 15 years and furniture and equipment over 7 years.

## NOTE A – NATURE OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Intangible asset

The intangible asset is recorded at cost or fair value at the time of purchase. In accordance with the *Financial Accounting Standards Board in its Accounting Standards Codification (FASB ASC) 350, Intangibles – Goodwill and Other*, intangible assets deemed to have indefinite lives are not amortized but subjected to annual tests of impairment.

### Net Patient Revenues

The Facility is a 60 bed long-term care center managed by Stein and Associates, LLC under an annual renewable management agreement.

The Facility receives payments for services provided to certain patients under the state Medicaid program and during the year ended June 30, 2011 became eligible to accept patients and receive payments from the Federal Medicare program. During the years ending June 30, 2011 and 2010 62% and 55%, respectively, of the net patient revenues were from participation in the state Medicaid program. Revenues under the federal Medicare program were approximately 11% during the year ending June 30, 2011. Patient revenues under the Medicaid program are based in part on cost reimbursement principles which govern reimbursement of current year costs. Amounts earned under this program are subject to review by the third party payors. Revenues under the Medicare Program are based on the prospective payment system.

As of June 30, 2011 and 2010 approximately 91% and 65%, respectively, of the patient receivables are due from such programs. The allowance for doubtful account is estimated and recorded based on the historical bad debt experience and management's judgment. In the opinion of management, adequate provision has been made for any adjustments that may result from reviews by the state Medicaid program. Differences between estimated provisions and final settlements are reflected in operations of the year finalized. The Facility considers all patient receivable accounts greater than 60 days old to be past due. The Facility does not charge interest on past due patient accounts.

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)

NOTES TO FINANCIAL STATEMENT

JUNE 30, 2011 AND 2010

## NOTE A – NATURE OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Federal Income Taxes

The Community is an exempt organization under Internal Revenue Service Code Section 501(c)(3) accordingly, no provision for income taxes has been made in these financial statements. The Community accounts for uncertainties in income tax law under the Financial Accounting Standards Board (FASB) Accounting Standards Codification 740-10. ASC 740-10 prescribes a comprehensive model for the financial statement recognition, measurement, presentation and disclosure of uncertain tax positions taken or expected to be taken in income tax returns. ASC 740-10 requires that the tax effects of a position be recognized only if it is "more-likely-than-not" to be sustained by the taxing authority as of the reporting date. If the tax position is not considered "more-likely-than-not" to be sustained, then no benefits of the position are to be recognized. The Community has estimated that there are no unrecognized tax positions as of June 30, 2011 and 2010. At June 30, 2011, the Community's tax returns related to fiscal years ended June 30, 2008 through June 30, 2010 remain open to examination by the tax authorities.

### Cash and Equivalents

For purposes of the statements of cash flows the Facility considers all highly liquid debt instruments with a maturity of three months or less to be cash equivalents.

### Concentration of Credit Risks

The Facility's credit risks primarily relate to cash and equivalents and patient receivables. Cash and equivalents are primarily held in bank accounts. The Facility maintains several bank accounts at one bank. Accounts at an institution are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 for June 30, 2011. Cash at these institutions exceeded federally insured limits. As of June 30, 2011 and 2010 the amount in excess of the FDIC limit was approximately $325,000 and $130,000, respectively.

The Facility's credit risk, also, relates to patient receivables. Patient receivables consist primarily of amount s due from patients (funded through the Tennessee Medicaid program, Medicare program and private payers) in the state of Tennessee. The Facility performs continual credit evaluations of its patients. Management does not believe that there is significant credit risks associated with these governmental programs.

### Reclassification

Certain reclassifications in the 2010 amounts were made to conform to 2011 classifications.

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)

NOTES TO FINANCIAL STATEMENT

JUNE 30, 2011 AND 2010

## NOTE B - PROPERTY AND EQUIPMENT

Property and Equipment consists of the following as of June 30, 2011 and 2010:

| | 2011 | 2010 |
|---|---|---|
| Land and improvements | $ 1,065,158 | $ 1,065,158 |
| Building and improvements | 4,293,629 | 4,244,869 |
| Furniture and equipment | 674,769 | 648,778 |
| | 6,033,556 | 5,958,805 |
| Less accumulated depreciation | (375,804) | (145,205) |
| | $ 5,657,752 | $ 5,813,600 |

Depreciation totaled $230,599 and $145,205 during the years ending June 30, 2011 and 2010.

The Facility capitalized interest costs directly associated with the construction of the new building which was opened in December 2009. Interest capitalized during the year ended June 30, 2010 totaled $90,498 with total accumulated capitalized interest of $114,950. No additional interest was capitalized during the year ended June 30, 2011. The capitalized interest is included in "building and improvements" within property and equipment on the Statement of Financial Position.

## NOTE C – INTANGIBLE ASSET

The intangible asset is a certificate of need which the Facility has the rights totaling $173,698 as of both June 30, 2011 and 2010. The certificate of need allows the facility to operate a nursing home. This certificate of need was used to open and operate the new facility. The intangible asset is tested for impairment on an annual basis. No impairment loss was recognized during the years ended June 30, 2011 and 2010.

## NOTE D – ACCRUED EXPENSES

Accrued expenses are composed of the following as of June 30, 2011 and 2010:

| | 2011 | 2010 |
|---|---|---|
| Payroll and related expenses | $ 119,843 | $ 116,590 |
| Professional fees | 14,300 | 13,800 |
| Interest | 6,572 | 15,512 |
| Property taxes | 82,218 | 23,980 |
| Other expenses | 9,010 | 3,208 |
| Total | $ 231,943 | $ 173,090 |

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)

NOTES TO FINANCIAL STATEMENT

JUNE 30, 2011 AND 2010

## NOTE E – NOTES PAYABLE

Notes payable are composed of the following as of June 30, 2011 and 2010:

| | 2011 | 2010 |
|---|---|---|
| Note payable to bank with monthly principle and interest payments totaling $11,041 with a balloon payment of February 2013, interest at 6.25%. Collateralized by certain real estate and personally guaranteed by one of the board members. | $ 1,447,103 | $ 1,490,238 |
| Note payable to bank with monthly principle and interest payments totaling $24,512 with a balloon payment in March 2015, interest variable based on the 30-day LIBOR + 2.0%(interest at June 30, 2010 was 2.35%), collateralized by certain real estate. | 3,863,314 | 4,021,209 |
| | 5,310,417 | 5,511,447 |
| Less: current maturities of notes payable | (253,501) | (245,139) |
| Notes payable, less current maturities | $ 5,056,916 | $ 5,266,308 |

Aggregate maturities of notes payable are as follows:

| Year Ending June 30, | |
|---|---|
| 2012 | $ 253,501 |
| 2013 | 1,621,862 |
| 2014 | 221,249 |
| 2015 | 3,213,805 |
| | $ 5,310,417 |

## NOTE E – MINIMUM ANNUAL LEASE COMMITMENTS

The Facility's leases were finalized in the current year and have no active lease commitments as of June 30, 2011 and 2010.

During both years ending June 30, 2011 and 2010 the Facility incurred rent expense totaling approximately $19,000.

THE PAVILION - CPC
(AN OPERATING UNIT OF COMMUNITY PROGRESS COMMITTEE, INC.)

NOTES TO FINANCIAL STATEMENTS

JUNE 30, 2011 AND 2010

## NOTE E - RELATED PARTY TRANSACTIONS

During the years ended June 30, 2011 and 2010 the Facility borrowed additional funds of $151,440 and $911,049, respectively, from the Community for capital purchases, administrative services and other expenses incurred by the Facility. As of June 30, 2011 and 2010 $3,434,808 and $3,283,368, respectively, is due to related party.

The Facility incurred costs totaling $381,262 during the year ended June 30, 2010 to Horizon Construction and Development Company, Inc., a related party by common control, which has been capitalized as building costs with the remaining balance due of $45,000 located in Accounts Payable on the Statement of Financial Position as of June 30, 2010. No additional costs were incurred during the year ended June 30, 2011.

## NOTE F - COMMITMENTS AND CONTINGENCIES

### Management Agreement

Community has entered into a management agreement with Stein and Associates, LLC to operate and manage the Facility. Payment of the management fee is subordinate to the regular monthly payments of debt service on the notes payable.

### Health Care Regulations

The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicaid fraud and abuse. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Facility is in compliance with fraud and abuse as well as other applicable government laws and regulations.

### Letters of Credit

The Company entered into two letters of credit totaling $45,000 which expired on December 31, 2010.

## NOTE G – RESTRICTED CASH AND EQUIVALENTS

Certain cash and equivalents are held for resident trust accounts which are restricted for resident use. As of June 30, 2011 and 2010 these restricted cash and equivalent balances totaled $8,263 and $6,157, respectively.

## NOTE H – SUBSEQUENT EVENT

On December 14, 2010 the Community Progress Committee, Inc. entered into an agreement with a third party to sell all the assets of the Facility and in turn assumed the liabilities of the Facility. The asset purchase agreement was approved by the Tennessee Attorney General in August 2011. Subsequent events have been evaluated through September 16, 2011, which is the date the financial statements were available to be issued.

The Pavilion

Most Recent Income Statement

(October 2011)

Date: Dec 7, 2011
Time: 13:48:03 CT
User: Sarah Garner

**The Pavilion - CPC**
**PPD Income Statement**
**10/1/2011 to 10/31/2011**



Include Adjustment Periods: NO  Include Closing Periods: NO

| | CURRENT PERIOD | | | | | YEAR TO DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day |
| **Income** | | | | | | | | | | |
| **Room & Board** | | | | | | | | | | |
| **Private Pay** | | | | | | | | | | |
| 3000-10 ROOM & BOARD - PRIVATE PAY | 54,550 | 54,750 | (200) | 186.81 | 187.50 | 240,302 | 235,688 | 4,615 | 191.17 | 187.50 |
| **TOTAL Private Pay** | 54,550 | 54,750 | (200) | 186.81 | 187.50 | 240,302 | 235,688 | 4,615 | 191.17 | 187.50 |
| **Medicaid** | | | | | | | | | | |
| 3000-20 ROOM & BOARD - MEDICAID | 218,509 | 214,016 | 4,493 | 166.17 | 162.75 | 874,784 | 857,855 | 16,929 | 166.25 | 162.75 |
| **TOTAL Medicaid** | 218,509 | 214,016 | 4,493 | 166.17 | 162.75 | 874,784 | 857,855 | 16,929 | 166.25 | 162.75 |
| **Medicare Part A** | | | | | | | | | | |
| 3000-30 ROOM & BOARD - MED PART A | 39,915 | 96,400 | (56,485) | 165.62 | 400.00 | 132,930 | 301,525 | (168,595) | 169.55 | 389.06 |
| **TOTAL Medicare Part A** | 39,915 | 96,400 | (56,485) | 165.62 | 400.00 | 132,930 | 301,525 | (168,595) | 169.55 | 389.06 |
| **Private Insurance** | | | | | | | | | | |
| **TOTAL Private Insurance** | 0 | 0 | 0 | - | - | 0 | 0 | 0 | - | - |
| **VA** | | | | | | | | | | |
| **TOTAL VA** | 0 | 0 | 0 | - | - | 0 | 0 | 0 | - | - |
| **Managed Care** | | | | | | | | | | |
| 3000-60 ROOM & BOARD - MANAGED CARE | 0 | 0 | 0 | - | - | 1,155 | 1,400 | (245) | 165.00 | 200.00 |
| **TOTAL Managed Care** | 0 | 0 | 0 | - | - | 1,155 | 1,400 | (245) | 165.00 | 200.00 |
| **Medicare Part B** | | | | | | | | | | |
| **TOTAL Medicare Part B** | 0 | 0 | 0 | - | - | 0 | 0 | 0 | - | - |
| **TOTAL Room & Board** | 312,974 | 365,166 | (52,193) | 169.36 | 197.60 | 1,249,171 | 1,396,468 | (147,297) | 170.89 | 191.04 |
| **Contractual Allowance** | | | | | | | | | | |
| **Medicaid Contractual Allowance** | | | | | | | | | | |
| 3100-20 CONTRA ALLOW - MEDICAID | (4,305) | 0 | (4,305) | (3.27) | 0.00 | (17,045) | 0 | (17,045) | (3.24) | 0.00 |
| **TOTAL Medicaid Contractual Allowance** | (4,305) | 0 | (4,305) | (3.27) | 0.00 | (17,045) | 0 | (17,045) | (3.24) | 0.00 |
| **Med A Contractual Allowance** | | | | | | | | | | |
| 3100-30 CONTRA ALLOW - MED A, R, & B | 51,866 | 0 | 51,866 | 215.21 | 0.00 | 212,950 | 0 | 212,950 | 271.62 | 0.00 |
| **TOTAL Med A Contractual Allowance** | 51,866 | 0 | 51,866 | 215.21 | 0.00 | 212,950 | 0 | 212,950 | 271.62 | 0.00 |
| **Managed Care Contractual Allowance** | | | | | | | | | | |
| 3100-60 CONTRA ALLOW - MANAGED CARE | 0 | 0 | 0 | - | - | 1,029 | 0 | 1,029 | 147.06 | 0.00 |
| **TOTAL Managed Care Contractual Allowance** | 0 | 0 | 0 | - | - | 1,029 | 0 | 1,029 | 147.06 | 0.00 |
| **Med A Ancillary Contractual Allowance** | | | | | | | | | | |
| 3110-30 CONTRA ALLOW - MED A ANC | (57,406) | 0 | (57,406) | (238.20) | 0.00 | (202,869) | 0 | (202,869) | (258.76) | 0.00 |
| **TOTAL Med A Ancillary Contractual Allowance** | (57,406) | 0 | (57,406) | (238.20) | 0.00 | (202,869) | 0 | (202,869) | (258.76) | 0.00 |
| **Med B Contractual Allowance** | | | | | | | | | | |
| 3110-40 CONTRA ALLOW - MED B | (996) | 0 | (996) | - | - | (22,780) | 0 | (22,780) | - | - |

Date: Dec 7, 2011
Time: 13:48:06 CT
User: Sarah Garner

**The Pavilion - CPC**
**PPD Income Statement**
**10/1/2011 to 10/31/2011**



| | CURRENT PERIOD | | | | | YEAR TO DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day |
| **Med B Contractual Allowance (con't)** | | | | | | | | | | |
| **TOTAL Med B Contractual Allowance** | (996) | 0 | (996) | - | - | (22,780) | 0 | (22,780) | - | - |
| **Mngd Care Ancillary Contractual Allowance** | | | | | | | | | | |
| 3110-35 CONTRA ALLOW - MNGD CARE ANCIL | 0 | 0 | 0 | - | - | (1,363) | 0 | (1,363) | - | - |
| **TOTAL Mngd Care Ancillary Contractual Allowance** | 0 | 0 | 0 | - | - | (1,363) | 0 | (1,363) | - | - |
| **TOTAL Contractual Allowance** | (10,841) | 0 | (10,841) | - | - | (30,078) | 0 | (30,078) | - | - |
| **Ancillary Income** | | | | | | | | | | |
| **OT** | | | | | | | | | | |
| 4000-30 OT MEDICARE A | 23,250 | 0 | 23,250 | 12.58 | 0.00 | 69,780 | 0 | 69,780 | 9.55 | 0.00 |
| 4000-40 OT MEDICARE B | 740 | 0 | 740 | 0.40 | 0.00 | 30,840 | 0 | 30,840 | 4.19 | 0.00 |
| 4000-60 OT MANAGED CARE | 0 | 0 | 0 | 0.00 | 0.00 | (3,760) | 0 | (3,760) | (0.51) | 0.00 |
| **TOTAL OT** | 23,990 | 0 | 23,990 | 12.98 | 0.00 | 96,660 | 0 | 96,660 | 13.22 | 0.00 |
| **PT** | | | | | | | | | | |
| 4010-10 PT PRIVATE PAY | 540 | 0 | 540 | 0.29 | 0.00 | 540 | 0 | 540 | 0.07 | 0.00 |
| 4010-30 PT MEDICARE A | 19,950 | 0 | 19,950 | 10.80 | 0.00 | 60,270 | 0 | 60,270 | 8.24 | 0.00 |
| 4010-40 PT MEDICARE B | 1,860 | 0 | 1,860 | 1.01 | 0.00 | 45,860 | 0 | 45,860 | 6.27 | 0.00 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 4010-60 PT MANAGED CARE | 0 | 0 | 0 | 0.00 | 0.00 | 1,000 | 0 | 1,000 | 0.14 | 0.00 |
| **TOTAL PT** | **22,350** | **0** | **22,350** | **12.09** | **0.00** | **107,670** | **0** | **107,670** | **14.73** | **0.00** |
| **ST** | | | | | | | | | | |
| 4020-30 ST MEDICARE PART A | 2,100 | 0 | 2,100 | 1.14 | 0.00 | 16,350 | 0 | 16,350 | 2.24 | 0.00 |
| 4020-40 ST MEDICARE PART B | 2,275 | 0 | 2,275 | 1.23 | 0.00 | 17,255 | 0 | 17,255 | 2.36 | 0.00 |
| **TOTAL ST** | **4,375** | **0** | **4,375** | **2.37** | **0.00** | **33,605** | **0** | **33,605** | **4.60** | **0.00** |
| **Medical Supplies** | | | | | | | | | | |
| **TOTAL Medical Supplies** | **0** | **0** | **0** | **0.00** | **0.00** | **0** | **0** | **0** | **0.00** | **0.00** |
| **Drug Revenue** | | | | | | | | | | |
| 4060-40 DRUG REV MED A | 10,819 | 0 | 10,819 | 5.85 | 0.00 | 50,771 | 0 | 50,771 | 6.95 | 0.00 |
| 4060-60 DRUG REV MNGD CARE | 0 | 0 | 0 | 0.00 | 0.00 | 343 | 0 | 343 | 0.05 | 0.00 |
| **TOTAL Drug Revenue** | **10,819** | **0** | **10,819** | **5.85** | **0.00** | **51,114** | **0** | **51,114** | **6.99** | **0.00** |
| **Oxygen** | | | | | | | | | | |
| **TOTAL Oxygen** | **0** | **0** | **0** | **0.00** | **0.00** | **0** | **0** | **0** | **0.00** | **0.00** |
| **X-Ray** | | | | | | | | | | |
| 4080-30 X-RAY MEDICARE PART A | 503 | 0 | 503 | 0.27 | 0.00 | 2,700 | 0 | 2,700 | 0.37 | 0.00 |
| **TOTAL X-Ray** | **503** | **0** | **503** | **0.27** | **0.00** | **2,700** | **0** | **2,700** | **0.37** | **0.00** |
| **Lab** | | | | | | | | | | |
| 4090-30 LAB REV - MED PART A | 784 | 0 | 784 | 0.42 | 0.00 | 2,998 | 0 | 2,998 | 0.41 | 0.00 |
| **TOTAL Lab** | **784** | **0** | **784** | **0.42** | **0.00** | **2,998** | **0** | **2,998** | **0.41** | **0.00** |
| **Incontinent Supplies** | | | | | | | | | | |
| **TOTAL Incontinent Supplies** | **0** | **0** | **0** | **0.00** | **0.00** | **0** | **0** | **0** | **0.00** | **0.00** |

**Date: Dec 7, 2011**
**Time: 13:48:06 CT**
**User: Sarah Garner**

**The Pavilion - CPC**
**PPD Income Statement**
**10/1/2011 to 10/31/2011**



| | CURRENT PERIOD | | | | | YEAR TO DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day |
| **Enteral Supplies** | | | | | | | | | | |
| 4200-10 ENTERAL SUPPLIES PVT | 488 | 0 | 488 | 0.26 | 0.00 | 1,737 | 0 | 1,737 | 0.24 | 0.00 |
| **TOTAL Enteral Supplies** | **488** | **0** | **488** | **0.26** | **0.00** | **1,737** | **0** | **1,737** | **0.24** | **0.00** |
| **IV Therapy** | | | | | | | | | | |
| **TOTAL IV Therapy** | **0** | **0** | **0** | **0.00** | **0.00** | **0** | **0** | **0** | **0.00** | **0.00** |
| **OTC Pharmacy** | | | | | | | | | | |
| **TOTAL OTC Pharmacy** | **0** | **0** | **0** | **0.00** | **0.00** | **0** | **0** | **0** | **0.00** | **0.00** |
| **Miscellaneous Income** | | | | | | | | | | |
| 1300-00 REFUNDS DUE/CLEARING ACCT | 3,622 | 0 | 3,622 | 1.96 | 0.00 | (12,122) | 0 | (12,122) | (1.66) | 0.00 |
| 1400-00 BAD DEBT | 3 | 0 | 3 | 0.00 | 0.00 | 716 | 0 | 716 | 0.10 | 0.00 |
| 1500-00 BAD DEBT RECOVERY | 0 | 0 | 0 | 0.00 | 0.00 | 401 | 0 | 401 | 0.05 | 0.00 |
| 4520-00 MEAL INCOME | 198 | 0 | 198 | 0.11 | 0.00 | 798 | 0 | 798 | 0.11 | 0.00 |
| 4540-00 TELEPHONE INCOME | 352 | 0 | 352 | 0.19 | 0.00 | 1,408 | 0 | 1,408 | 0.19 | 0.00 |
| 4550-00 INTEREST INCOME | 63 | 0 | 63 | 0.03 | 0.00 | 325 | 0 | 325 | 0.04 | 0.00 |
| 4570-00 MISCELLANEOUS INCOME | 62 | 0 | 62 | 0.03 | 0.00 | 299 | 0 | 299 | 0.04 | 0.00 |
| **TOTAL Miscellaneous Income** | **4,299** | **0** | **4,299** | **2.33** | **0.00** | **(8,177)** | **0** | **(8,177)** | **(1.12)** | **0.00** |
| **TOTAL Ancillary Income** | **67,608** | **0** | **67,608** | **36.58** | **0.00** | **288,306** | **0** | **288,306** | **39.44** | **0.00** |
| **TOTAL Income** | **369,740** | **365,166** | **4,574** | **200.08** | **197.60** | **1,507,400** | **1,396,468** | **110,932** | **206.21** | **191.04** |
| **Expenses** | | | | | | | | | | |
| **Nursing Administration** | | | | | | | | | | |
| 5100-00 SALARIES - DON | 6,188 | 6,200 | (12) | 3.35 | 3.35 | 24,063 | 24,800 | (737) | 3.29 | 3.39 |
| 5100-01 SALARY - MDS PLUS NURSE | 2,947 | 3,260 | (313) | 1.59 | 1.76 | 11,047 | 13,041 | (1,995) | 1.51 | 1.78 |
| 5100-03 VAC/SICK/HOLID/PTO-NRSG ADMIN | 0 | 375 | (375) | 0.00 | 0.20 | 1,428 | 1,500 | (72) | 0.20 | 0.21 |
| 5100-04 PAYROLL TAXES - NURSING ADMIN | 709 | 600 | 109 | 0.38 | 0.32 | 2,714 | 2,400 | 314 | 0.37 | 0.33 |
| 5100-05 NURSES NOTES AND FORMS | 0 | 100 | (100) | 0.00 | 0.05 | 247 | 400 | (153) | 0.03 | 0.05 |
| 5100-07 MEDICAL DIRECTOR FEES | 3,750 | 3,750 | 0 | 2.03 | 2.03 | 12,500 | 15,000 | (2,500) | 1.71 | 2.05 |
| 5100-09 MDS TRAINING/SEMINARS/CONF | 0 | 25 | (25) | 0.00 | 0.01 | 119 | 100 | 19 | 0.02 | 0.01 |
| **TOTAL Nursing Administration** | **13,594** | **14,310** | **(717)** | **7.36** | **7.74** | **52,118** | **57,241** | **(5,123)** | **7.13** | **7.83** |
| **Nursing Services** | | | | | | | | | | |
| 5200-00 SALARIES - REGISTERED NURSES | 5,795 | 4,500 | 1,295 | 3.14 | 2.44 | 18,934 | 18,000 | 934 | 2.59 | 2.46 |
| 5200-01 SALARIES - LICENSED NURSES | 38,609 | 39,500 | (891) | 20.89 | 21.37 | 157,317 | 158,000 | (683) | 21.52 | 21.61 |
| 5200-02 SALARIES - NURSE AIDES | 51,980 | 49,500 | 2,480 | 28.13 | 26.79 | 200,477 | 198,000 | 2,477 | 27.42 | 27.09 |
| 5200-03 SALARY - RESTORATIVE NURSE | 3,132 | 3,100 | 32 | 1.69 | 1.68 | 12,212 | 12,400 | (188) | 1.67 | 1.70 |
| 5200-04 VAC/SICK/HOLID/PTO -NURSING | 3,258 | 3,000 | 258 | 1.76 | 1.62 | 19,329 | 12,000 | 7,329 | 2.64 | 1.64 |
| 5200-05 PAYROLL TAXES - NURSING | 8,275 | 8,300 | (25) | 4.48 | 4.49 | 32,895 | 33,200 | (305) | 4.50 | 4.54 |
| 5200-07 EQUIPMENT RENTAL - NURSING | 40 | 50 | (10) | 0.02 | 0.03 | 40 | 200 | (160) | 0.01 | 0.03 |
| 5200-08 NURS SUPPLIES - DIRECT CARE | 4,148 | 4,250 | (102) | 2.24 | 2.30 | 16,222 | 17,910 | (1,688) | 2.22 | 2.45 |
| 5200-09 DRUGS NON CHARGABLE- OTC FLOOR | 1,409 | 554 | 855 | 0.76 | 0.30 | 2,742 | 1,762 | 980 | 0.38 | 0.24 |
| 5200-10 PERSONAL HYGIENE | 1,611 | 998 | 613 | 0.87 | 0.54 | 4,440 | 3,938 | 501 | 0.61 | 0.54 |
| 5200-11 MEDICAL WASTE | 30 | 322 | (292) | 0.02 | 0.17 | 1,128 | 1,288 | (160) | 0.15 | 0.18 |
| 5200-12 NOURISHMENTS & SUPPLEMENTS | 423 | 370 | 54 | 0.23 | 0.20 | 1,793 | 1,224 | 569 | 0.25 | 0.17 |
| 5200-13 UNDERPADS AND DISPOSALS | 1,443 | 1,848 | (405) | 0.78 | 1.00 | 11,518 | 7,310 | 4,208 | 1.58 | 1.00 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 5200-19 PURCHASED NURSING EQUIPMENT | 0 | 1,308 | (1,308) | 0.00 | 0.71 | 4,636 | 5,233 | (598) | 0.63 | 0.72 |

**Date: Dec 7, 2011**
**Time: 13:48:06 CT**
**User: Sarah Garner**

**The Pavilion - CPC**
**PPD Income Statement**
**10/1/2011 to 10/31/2011**



| | CURRENT PERIOD | | | | | YEAR TO DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day |
| **Nursing Services (con't)** | | | | | | | | | | |
| **TOTAL Nursing Services** | 120,152 | 117,601 | 2,552 | 65.02 | 63.64 | 483,681 | 470,465 | 13,216 | 66.17 | 64.36 |
| **Nursing - Medicare** | | | | | | | | | | |
| 5300-03 NURS SUPPLIES MCR CERTIFIED | 0 | 400 | (400) | 0.00 | 0.22 | 1,233 | 1,600 | (367) | 0.17 | 0.22 |
| **TOTAL Nursing - Medicare** | 0 | 400 | (400) | 0.00 | 0.22 | 1,233 | 1,600 | (367) | 0.17 | 0.22 |
| **Medical Records** | | | | | | | | | | |
| 5400-00 SALARIES - MEDICAL RECORDS | 2,286 | 2,184 | 102 | 1.24 | 1.18 | 10,036 | 8,736 | 1,300 | 1.37 | 1.20 |
| 5400-01 VAC/SICK/HOLID/PTO MED RECORDS | 226 | 84 | 142 | 0.12 | 0.05 | 477 | 336 | 141 | 0.07 | 0.05 |
| 5400-02 PAYROLL TAXES - MED RECORDS | 175 | 175 | 0 | 0.09 | 0.09 | 782 | 700 | 82 | 0.11 | 0.10 |
| 5400-03 SUPPLIES - MED RECORDS | 0 | 350 | (350) | 0.00 | 0.19 | 388 | 1,400 | (1,012) | 0.05 | 0.19 |
| **TOTAL Medical Records** | 2,687 | 2,793 | (106) | 1.45 | 1.51 | 11,682 | 11,172 | 510 | 1.60 | 1.53 |
| **Dietary** | | | | | | | | | | |
| 5500-00 SALARIES - DIETARY SUPERVISOR | 3,802 | 3,618 | 184 | 2.06 | 1.96 | 14,764 | 14,472 | 292 | 2.02 | 1.98 |
| 5500-01 SALARIES - DIETARY STAFF | 11,535 | 10,700 | 835 | 6.24 | 5.79 | 46,187 | 42,800 | 3,387 | 6.32 | 5.85 |
| 5500-02 VAC/SICK/HOLID/PTO-DIETARY | 82 | 427 | (345) | 0.04 | 0.23 | 1,352 | 1,707 | (355) | 0.18 | 0.23 |
| 5500-03 PAYROLL TAXES - DIETARY | 1,241 | 1,300 | (59) | 0.67 | 0.70 | 5,116 | 5,200 | (84) | 0.70 | 0.71 |
| 5500-04 SUPPLIES - DIETARY | 1,142 | 1,000 | 142 | 0.62 | 0.54 | 4,981 | 4,000 | 981 | 0.68 | 0.55 |
| 5500-06 RAW FOOD | 9,913 | 10,164 | (251) | 5.36 | 5.50 | 41,556 | 40,205 | 1,351 | 5.68 | 5.50 |
| 5500-07 ENTERAL FEEDINGS | 421 | 380 | 41 | 0.23 | 0.21 | 1,365 | 1,520 | (155) | 0.19 | 0.21 |
| 5500-08 TRAINING/SEMINARS/CONFERENCES | 0 | 0 | 0 | 0.00 | 0.00 | 178 | 0 | 178 | 0.02 | 0.00 |
| **TOTAL Dietary** | 28,135 | 27,589 | 546 | 15.22 | 14.93 | 115,499 | 109,904 | 5,595 | 15.80 | 15.03 |
| **Laundry** | | | | | | | | | | |
| 5600-00 SALARIES - LAUNDRY SUPERVISOR | 0 | 2,198 | (2,198) | 0.00 | 1.19 | 5,702 | 8,792 | (3,090) | 0.78 | 1.20 |
| 5600-01 SALARIES - LAUNDRY STAFF | 5,054 | 3,677 | 1,376 | 2.73 | 1.99 | 18,713 | 14,710 | 4,003 | 2.56 | 2.01 |
| 5600-02 VAC/SICK/HOLIDAY/PTO - LAUNDRY | 0 | 172 | (172) | 0.00 | 0.09 | 451 | 688 | (237) | 0.06 | 0.09 |
| 5600-03 PAYROLL TAXES - LAUNDRY | 463 | 380 | 83 | 0.25 | 0.21 | 1,696 | 1,520 | 176 | 0.23 | 0.21 |
| 5600-04 LINEN AND BEDDING | 1,005 | 100 | 905 | 0.54 | 0.05 | 2,593 | 400 | 2,193 | 0.35 | 0.05 |
| 5600-05 SUPPLIES - LAUNDRY | 444 | 625 | (181) | 0.24 | 0.34 | 2,634 | 2,500 | 134 | 0.36 | 0.34 |
| **TOTAL Laundry** | 6,965 | 7,152 | (188) | 3.77 | 3.87 | 31,790 | 28,609 | 3,181 | 4.35 | 3.91 |
| **Housekeeping** | | | | | | | | | | |
| 5700-00 SALARIES - HOUSEKEEPING STAFF | 6,388 | 5,250 | 1,138 | 3.46 | 2.84 | 19,221 | 21,000 | (1,779) | 2.63 | 2.87 |
| 5700-01 VAC/SICK/HOLIDAY/PTO-HSKP | 33 | 245 | (212) | 0.02 | 0.13 | 1,417 | 980 | 437 | 0.19 | 0.13 |
| 5700-02 PAYROLL TAXES - HOUSEKEEPING | 525 | 550 | (25) | 0.28 | 0.30 | 2,065 | 2,200 | (135) | 0.28 | 0.30 |
| 5700-03 SUPPLIES - HOUSEKEEPING | 2,614 | 2,350 | 264 | 1.41 | 1.27 | 10,097 | 9,400 | 697 | 1.38 | 1.29 |
| 5700-04 CONTRACT HSKPG EXPENSE | 624 | 624 | 0 | 0.34 | 0.34 | 2,495 | 2,495 | 0 | 0.34 | 0.34 |
| **TOTAL Housekeeping** | 10,185 | 9,019 | 1,166 | 5.51 | 4.88 | 35,295 | 36,075 | (780) | 4.83 | 4.94 |
| **Maintenance** | | | | | | | | | | |
| 5800-00 SALARIES - MAINTEN SUPER | 2,597 | 2,253 | 344 | 1.41 | 1.22 | 9,995 | 9,013 | 982 | 1.37 | 1.23 |
| 5800-02 VAC/SICK/HOLID/PTO-MAINTENANCE | 0 | 142 | (142) | 0.00 | 0.08 | 322 | 568 | (246) | 0.04 | 0.08 |
| 5800-03 PAYROLL TAXES - MAINT | 199 | 155 | 44 | 0.11 | 0.08 | 789 | 620 | 169 | 0.11 | 0.08 |
| 5800-05 SUPPLIES MAINTENANCE | 824 | 2,000 | (1,176) | 0.45 | 1.08 | 7,703 | 8,000 | (297) | 1.05 | 1.09 |
| 5800-06 BUIDING RENTAL/LEASE | 240 | 100 | 140 | 0.13 | 0.05 | 540 | 400 | 140 | 0.07 | 0.05 |
| 5800-07 MAINTENANCE & REPAIRS | 588 | 450 | 138 | 0.32 | 0.24 | 8,184 | 1,800 | 6,384 | 1.12 | 0.25 |
| 5800-09 UTILITIES/CABLE | 545 | 545 | 0 | 0.29 | 0.29 | 2,723 | 2,180 | 543 | 0.37 | 0.30 |

**Date: Dec 7, 2011**
**Time: 13:48:06 CT**
**User: Sarah Garner**

**The Pavilion - CPC**
**PPD Income Statement**
**10/1/2011 to 10/31/2011**



| | CURRENT PERIOD | | | | | YEAR TO DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day |
| **Maintenance (con't)** | | | | | | | | | | |
| 5800-10 PEST CONTROL | 185 | 175 | 10 | 0.10 | 0.09 | 720 | 700 | 20 | 0.10 | 0.10 |
| 5800-11 SECURITY | 135 | 135 | 0 | 0.07 | 0.07 | 540 | 540 | 0 | 0.07 | 0.07 |
| 5800-12 UTILITIES/ELECTRIC | 3,758 | 6,000 | (2,242) | 2.03 | 3.25 | 21,188 | 24,000 | (2,812) | 2.90 | 3.28 |
| 5800-14 UTILITIES/WATER AND SEWER | 1,658 | 2,800 | (1,142) | 0.90 | 1.52 | 10,497 | 11,200 | (703) | 1.44 | 1.53 |
| 5800-15 WASTE DISPOSAL | 958 | 717 | 242 | 0.52 | 0.39 | 2,450 | 2,867 | (417) | 0.34 | 0.39 |
| 5800-16 GROUNDS MAINT-LAWN CARE | 459 | 250 | 209 | 0.25 | 0.14 | 1,072 | 1,000 | 72 | 0.15 | 0.14 |
| 5800-17 DEPRECIATION BLDS AND IMPROVE | 20,445 | 20,445 | 0 | 11.06 | 11.06 | 81,781 | 81,780 | 1 | 11.19 | 11.19 |
| 5800-19 PROPERTY TAXES | 6,738 | 0 | 6,738 | 3.65 | 0.00 | 17,647 | 10,910 | 6,738 | 2.41 | 1.49 |
| 5800-20 UTILITIES/TELPHONE | 753 | 800 | (47) | 0.41 | 0.43 | 3,178 | 3,200 | (22) | 0.43 | 0.44 |
| 5800-22 FIRE SAFETY | 661 | 250 | 411 | 0.36 | 0.14 | 2,313 | 1,000 | 1,313 | 0.32 | 0.14 |
| 5800-25 AMORTIZATION EXPENSE | 319 | 320 | (1) | 0.17 | 0.17 | 1,277 | 1,280 | (3) | 0.17 | 0.18 |
| **TOTAL Maintenance** | 41,061 | 37,537 | 3,524 | 22.22 | 20.31 | 172,920 | 161,058 | 11,862 | 23.66 | 22.03 |
| **Purchased Services** | | | | | | | | | | |
| 5900-02 PHYSICAL THERAPY | 10,791 | 5,000 | 5,791 | 44.78 | 20.75 | 33,915 | 20,000 | 13,915 | 43.26 | 25.81 |
| 5900-03 SPEECH THERAPY | 415 | 500 | (85) | 1.72 | 2.07 | 4,457 | 2,000 | 2,457 | 5.69 | 2.58 |
| 5900-04 OCCUPATIONAL THERAPY | 9,546 | 5,000 | 4,546 | 39.61 | 20.75 | 29,481 | 20,000 | 9,481 | 37.60 | 25.81 |
| 5900-05 DIETARY CONSULTANT | 400 | 400 | 0 | 1.66 | 1.66 | 1,650 | 1,600 | 50 | 2.10 | 2.06 |
| 5900-06 PHARMACY CONSULTING | 240 | 240 | 0 | 1.00 | 1.00 | 720 | 960 | (240) | 0.92 | 1.24 |
| 5900-07 NON EMERGENCY TRANSPORTATION | 4 | 50 | (46) | 0.02 | 0.21 | 4 | 200 | (196) | 0.01 | 0.26 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 5900-08 PHYSICAL THERAPY PART B | 964 | 6,000 | (5,036) | 4.00 | 24.90 | 19,117 | 24,000 | (4,883) | 24.38 | 30.97 |
| 5900-09 SPEECH THERAPY PART B | 1,437 | 1,000 | 437 | 5.96 | 4.15 | 9,141 | 4,000 | 5,141 | 11.66 | 5.16 |
| 5900-10 OCCUPATIONAL THERAPY PART B | 401 | 3,000 | (2,599) | 1.66 | 12.45 | 10,833 | 12,000 | (1,167) | 13.82 | 15.48 |
| 5900-11 LAB FEES | 0 | 500 | (500) | 0.00 | 2.07 | 3,294 | 2,000 | 1,294 | 4.20 | 2.58 |
| 5900-12 OXYGEN | 754 | 400 | 354 | 3.13 | 1.66 | 2,661 | 1,600 | 1,061 | 3.39 | 2.06 |
| 5900-13 PRESCRIPTION DRUGS - MEDICARE | 13,219 | 6,025 | 7,194 | 54.85 | 25.00 | 56,680 | 19,550 | 37,130 | 72.30 | 25.23 |
| 5900-17 MEDICARE THERAPY SUPPLIES | 0 | 150 | (150) | 0.00 | 0.62 | 251 | 600 | (349) | 0.32 | 0.77 |
| 5900-18 MEDICARE X RAY EXPENSE | 280 | 150 | 130 | 1.16 | 0.62 | 2,239 | 600 | 1,639 | 2.86 | 0.77 |
| 5900-22 Dental Consulting | 0 | 50 | (50) | 0.00 | 0.21 | 98 | 200 | (102) | 0.13 | 0.26 |
| **TOTAL Purchased Services** | **38,452** | **28,465** | **9,987** | **159.55** | **118.11** | **174,541** | **109,310** | **65,231** | **222.63** | **141.05** |
| **Activities** | | | | | | | | | | |
| 6000-00 SALARIES - ACTIVITY DIRECTOR | 2,450 | 2,253 | 197 | 1.33 | 1.22 | 9,595 | 9,013 | 581 | 1.31 | 1.23 |
| 6000-01 VAC/SICK/HOLID/PTO-ACTIVITIES | 0 | 124 | (124) | 0.00 | 0.07 | 104 | 496 | (392) | 0.01 | 0.07 |
| 6000-02 PAYROLL TAXES - ACTIVITIES | 189 | 250 | (61) | 0.10 | 0.14 | 939 | 1,000 | (61) | 0.13 | 0.14 |
| 6000-03 SUPPLIES - ACTIVITIES | 253 | 200 | 53 | 0.14 | 0.11 | 812 | 800 | 12 | 0.11 | 0.11 |
| 6000-04 BARBER AND BEAUTY | 0 | 50 | (50) | 0.00 | 0.03 | 0 | 200 | (200) | 0.00 | 0.03 |
| **TOTAL Activities** | **2,892** | **2,877** | **15** | **1.57** | **1.56** | **11,450** | **11,509** | **(59)** | **1.57** | **1.57** |
| **Social Services** | | | | | | | | | | |
| 6100-00 SALARIES - SOCIAL SERVICES DI | 4,173 | 3,975 | 198 | 2.26 | 2.15 | 16,550 | 15,900 | 650 | 2.26 | 2.18 |
| 6100-02 PAYROLL TAXES - SOCIAL SERVIC | 319 | 300 | 19 | 0.17 | 0.16 | 1,266 | 1,200 | 66 | 0.17 | 0.16 |
| 6100-03 SUPPLIES - SOCIAL SERVICES | 17 | 25 | (8) | 0.01 | 0.01 | 38 | 100 | (62) | 0.01 | 0.01 |
| 6100-04 TRAINING/SEMINARS/CONFERENCES | 0 | 0 | 0 | 0.00 | 0.00 | 70 | 0 | 70 | 0.01 | 0.00 |
| **TOTAL Social Services** | **4,510** | **4,300** | **210** | **2.44** | **2.33** | **17,924** | **17,200** | **724** | **2.45** | **2.35** |
| **General & Administrative** | | | | | | | | | | |
| 6200-00 SALARIES - ADMINISTRATORS | 5,208 | 5,250 | (42) | 2.82 | 2.84 | 20,841 | 21,000 | (159) | 2.85 | 2.87 |
| 6200-01 SALARIES - ADMINISTRATIVE STA | 7,657 | 8,084 | (427) | 4.14 | 4.37 | 31,653 | 32,335 | (682) | 4.33 | 4.42 |

**Date: Dec 7, 2011**
**Time: 13:48:06 CT**
**User: Sarah Garner**

**The Pavilion - CPC**
**PPD Income Statement**
**10/1/2011 to 10/31/2011**



| | CURRENT PERIOD | | | | | YEAR TO DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day | Actual $ | Budget $ | Var $ | Actual / Day | Budget / Day |
| **General & Administrative (con't)** | | | | | | | | | | |
| 6200-02 VAC/SICK/HOLIDAY/PTO - GEN & | 714 | 392 | 322 | 0.39 | 0.21 | 1,546 | 1,567 | (21) | 0.21 | 0.21 |
| 6200-03 PAYROLL TAXES - GEN & ADMIN | 1,039 | 1,100 | (61) | 0.56 | 0.60 | 4,134 | 4,400 | (266) | 0.57 | 0.60 |
| 6200-04 HEALTH INSURANCE - CAFETERIA | 1,405 | 600 | 805 | 0.76 | 0.32 | 2,661 | 2,400 | 261 | 0.36 | 0.33 |
| 6200-05 INSURANCE - WORK COMP | 0 | 4,000 | (4,000) | 0.00 | 2.16 | 30,284 | 16,000 | 14,284 | 4.14 | 2.19 |
| 6200-06 INSURANCE - LIABILITY | 3,406 | 2,189 | 1,217 | 1.84 | 1.18 | 10,303 | 8,758 | 1,545 | 1.41 | 1.20 |
| 6200-07 INSURANCE - PROPERTY | 3,573 | 3,573 | 0 | 1.93 | 1.93 | 7,146 | 14,292 | (7,146) | 0.98 | 1.96 |
| 6200-11 INSURANCE - EMPLOYEE LIFE | (2,917) | 0 | (2,917) | (1.58) | 0.00 | (4,219) | 0 | (4,219) | (0.58) | 0.00 |
| 6200-14 BACKGROUND CHECKS | 232 | 171 | 61 | 0.13 | 0.09 | 1,045 | 683 | 362 | 0.14 | 0.09 |
| 6200-16 ACCOUNTING & AUDIT FEES | 0 | 0 | 0 | 0.00 | 0.00 | 10,000 | 0 | 10,000 | 1.37 | 0.00 |
| 6200-17 FORMS & OFFICE SUPPLIES | 421 | 400 | 21 | 0.23 | 0.22 | 2,563 | 1,600 | 963 | 0.35 | 0.22 |
| 6200-19 MINOR EQUIPMENT G & A | 131 | 150 | (19) | 0.07 | 0.08 | 663 | 600 | 63 | 0.09 | 0.08 |
| 6200-20 EQUIPMENT RENTAL G & A | 1,135 | 565 | 570 | 0.61 | 0.31 | 2,269 | 2,260 | 9 | 0.31 | 0.31 |
| 6200-21 POSTAGE | 111 | 50 | 61 | 0.06 | 0.03 | 201 | 200 | 1 | 0.03 | 0.03 |
| 6200-22 SOFTWARE SUPPORT AND EXPENSE | 1,570 | 1,580 | (10) | 0.85 | 0.85 | 8,696 | 6,320 | 2,376 | 1.19 | 0.86 |
| 6200-23 EMPLOYEE PHYSICALS | 0 | 50 | (50) | 0.00 | 0.03 | 26 | 200 | (174) | 0.00 | 0.03 |
| 6200-24 BANK AND FINANCE CHARGES | 230 | 40 | 190 | 0.12 | 0.02 | 350 | 160 | 190 | 0.05 | 0.02 |
| 6200-26 RESIDENT PERSONAL PROPERTY | 38 | 25 | 13 | 0.02 | 0.01 | 38 | 100 | (62) | 0.01 | 0.01 |
| 6200-28 EMPLOYEE/RESIDENT SATISFACTIO | 26 | 25 | 1 | 0.01 | 0.01 | 128 | 100 | 28 | 0.02 | 0.01 |
| 6200-29 ADMIN/OFFICE TRAINING/SEM/CONF | 160 | 100 | 60 | 0.09 | 0.05 | 782 | 400 | 382 | 0.11 | 0.05 |
| 6200-31 DUES/MEMBERSHIPS/SUBSRIPTIONS | 0 | 100 | (100) | 0.00 | 0.05 | 125 | 400 | (275) | 0.02 | 0.05 |
| 6200-32 PAYROLL SERVICES | 1,008 | 575 | 433 | 0.55 | 0.31 | 2,938 | 2,300 | 638 | 0.40 | 0.31 |
| 6200-34 FLOWERS/GIFTS/FUNERAL | 186 | 200 | (14) | 0.10 | 0.11 | 285 | 800 | (515) | 0.04 | 0.11 |
| 6200-36 ADVERTISING NON ALLOWABLE | 0 | 50 | (50) | 0.00 | 0.03 | 151 | 200 | (49) | 0.02 | 0.03 |
| 6200-40 MANAGEMENT EXPENSE | 27 | 7,500 | (7,473) | 0.01 | 4.06 | 27 | 30,000 | (29,973) | 0.00 | 4.10 |
| 6200-41 QUALITY ASSURANCE FEE | 11,125 | 11,125 | 0 | 6.02 | 6.02 | 44,500 | 44,500 | 0 | 6.09 | 6.09 |
| 6200-43 EMPLOYEE BENEFITS | 695 | 250 | 445 | 0.38 | 0.14 | 1,366 | 1,000 | 366 | 0.19 | 0.14 |
| 6200-44 MISCELLANEOUS EXPENSE | 0 | 0 | 0 | 0.00 | 0.00 | 24,107 | 0 | 24,107 | 3.30 | 0.00 |
| 6200-47 INTEREST - MORTGAGE 1 | 7,443 | 7,050 | 393 | 4.03 | 3.81 | 28,507 | 28,200 | 307 | 3.90 | 3.86 |
| 6200-48 INTEREST - MORTGAGE 2 | 7,485 | 7,800 | (315) | 4.05 | 4.22 | 30,541 | 31,200 | (659) | 4.18 | 4.27 |
| 6200-49 PENALTIES AND INTEREST | 1,439 | 0 | 1,439 | 0.78 | 0.00 | 1,439 | 0 | 1,439 | 0.20 | 0.00 |
| 6200-50 BANK SERVICE CHARGES | 0 | 120 | (120) | 0.00 | 0.06 | 1,391 | 480 | 911 | 0.19 | 0.07 |
| 6200-53 Document Shredding | 0 | 60 | (60) | 0.00 | 0.03 | 60 | 240 | (180) | 0.01 | 0.03 |
| 6200-55 INSURANCE - EMPLOYEE LIABILITY | 2,890 | 0 | 2,890 | 1.56 | 0.00 | 2,890 | 0 | 2,890 | 0.40 | 0.00 |
| **TOTAL General & Administrative** | **56,436** | **63,174** | **(6,738)** | **30.54** | **34.18** | **269,437** | **252,695** | **16,742** | **36.86** | **34.57** |
| **TOTAL Expenses** | **325,068** | **315,217** | **9,851** | **-** | **-** | **1,377,870** | **1,266,839** | **110,731** | **-** | **-** |
| **Net Income (Loss)** | **44,672** | **49,949** | **(5,277)** | **24.17** | **27.03** | **129,830** | **129,629** | **201** | **17.76** | **17.73** |

The Pavilion

Balance Sheet

(as of October 2011)

**Date: Dec 7, 2011**
**Time: 13:47:14 CT**
**User: Sarah Garner**

**The Pavilion - CPC**
**Balance Sheet**
**As Of 10/31/2011**



| | CURRENT PERIOD Actual $ |
|---|---|
| **Assets** | |
| 1000-00 CIB OPERATING ACCOUNT | 253,941 |
| 1000-09 PETTY CASH | 500 |
| 1000-11 CIB - TRUST | 8,263 |
| 1110-10 A/R - PRIVATE PAY | 54,890 |
| 1110-20 A/R - MEDICAID PATIENT LIABIL | 18,616 |
| 1110-40 A/R - MED B COINS FROM PRIV | 396 |
| 1115-20 A/R - MED PENDING | 12,800 |
| 1120-20 A/R - MEDICAID | 215,932 |
| 1120-25 A/R HOSPICE | 22,220 |
| 1120-30 A/R - MED A COINS FROM MEDICA | 15,723 |
| 1120-40 A/R - MED B COINS FROM MEDICA | 10,428 |
| 1130-30 A/R - MEDICARE PART A | 75,669 |
| 1140-40 A/R - MEDICARE PART B | 34,415 |
| 1150-20 A/R - MED A COINS FROM INS | 51,061 |
| 1150-30 A/R - MED B COINS FROM INS | 4,461 |
| 1160-60 A/R - MANAGED CARE | 15,375 |
| 1290-00 ALLOWANCE FOR DOUBTFUL ACCOUN | (99,976) |
| 1510-00 LAND - SNF | 1,065,158 |
| 1512-00 LAND IMPROVEMENTS | 907,227 |
| 1515-00 BUILDINGS - SNF | 3,200,471 |
| 1551-00 BUILDING IMPROVEMENTS | 3,760 |
| 1600-00 FURNITURE, FIXTURES, EQUIPMENT | 674,769 |
| 1640-00 VEHICLES | 8,126 |
| 1700-00 A/D -BUILDINGS | (200,476) |
| 1710-01 A/D - EQUIPMENT | (30,894) |
| 1710-02 A/D - BUILDING IMPROVEMENTS | (167) |
| 1710-04 ACCUMULATED AMORTIZATION | (1,277) |
| 1710-05 ACQUISITION PAVILION | 67,222 |
| 1710-06 CAPITAL INTEREST | 114,949 |
| 1710-07 CASH RESERVE | 325,608 |
| 1710-08 LEGAL & ACCT/ ACQ PAVILION | 0 |
| 1710-09 PINNACLE BANK CONST. ACCOUNT | 2,536 |
| 1810-00 PREPAID EXPENSES | 29,300 |
| 1810-01 FINANCING COSTS | 26,114 |
| 1810-02 UNDEPOSITED FUNDS | 0 |
| 1810-03 A/D FURNITURE, FIXTURES, & EQU | (149,311) |
| 1810-04 A/D LAND IMPROVEMENTS | (76,736) |
| 1810-06 INTANGIBLE ASSETS | 173,698 |
| **TOTAL Assets** | **6,834,788** |
| **Liabilities and Equity** | |
| **Liabilities** | |
| 4600-00 ACCOUNTS PAYABLE | 246,350 |
| 4600-01 A/P HORIZON | 0 |
| 4600-02 ACCOUNTS PAYABLE - CPC | (288,379) |
| 4600-03 RECEIPIENT TRUST | 8,263 |
| 4600-04 PAYROLL LIABILITY / ACCRUAL | 76,382 |
| 4600-07 GARNISHMENTS | 1,134 |
| 4600-15 DUE TO STEIN ANC SERVICES | 2,803 |
| 4600-25 CEDARSTONE BANK LOAN | 1,433,480 |
| 4600-26 DUE TO CRESTVIEW | 2,006,859 |
| 4600-27 DUE TO HOME OFFICE - CPC | 1,331,326 |
| 4600-28 DUE TO SHERWOOD | 365,000 |
| 4600-29 INSURANCE PREMIUMS WITHHELD | 15,871 |
| 4600-30 AUDIT ACCRUAL | 14,300 |
| 4600-31 PROPERTY TAX ACCRUAL | (12,599) |
| 4600-32 VACATION ACCRUAL | 26,275 |
| 4600-34 UNITED LOC INTEREST ACCRUAL | 6,572 |
| 4700-14 DIRECT DEPOSIT LIABILITY | 1,782 |
| 4900-10 PAVILION CONSTRUCT ACCT | 0 |
| 4900-11 PAVILION CONSTRUCT LOAN | 3,819,836 |

| | |
|---|---|
| **TOTAL Liabilities** | **9,055,257** |
| **Retained Earnings** | |
| 3920-00 RETAINED EARNINGS | (2,501,045) |
| **TOTAL Retained Earnings** | **(2,501,045)** |

**Date: Dec 7, 2011**
**Time: 13:47:14 CT**
**User: Sarah Garner**

**The Pavilion - CPC**
**Balance Sheet**
**As Of 10/31/2011**



| | CURRENT PERIOD |
|---|---|
| | **Actual $** |
| **Equity** | |
| **TOTAL Equity** | **0** |
| **Inter-Company** | |
| **TOTAL Inter-Company** | **0** |
| **Net Income/(Loss)** | |
| Net Income | 280,576 |
| **TOTAL Net Income/(Loss)** | **280,576** |
| **TOTAL Liabilities and Equity** | **6,834,788** |

# Attachment C,

# Orderly Development, 7, c

# Board for Licensing Health Care Facilities

State of Tennessee

License No. 0000000300

No. Beds 0060

## DEPARTMENT OF HEALTH

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

PAVILION-THS, LLC *to conduct*

*and maintain a Nursing Home* THE PAVILION

*Located at* 1406 MEDICAL CENTER DRIVE, LEBANON

*County of* WILSON *, Tennessee.*

*This license shall expire* JUNE 30 *,* 2012 *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

*In Witness Whereof, we have hereunto set our hand and seal of the State this* 18TH *day of* NOVEMBER *,* 2011 *.*

*By* Vincent J. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

*By* [illegible] MD

COMMISSIONER

105

# Attachment C,

# Orderly Development, 7, d

**Department of Health & Human Services**
**Centers for Medicare & Medicaid Services**
**61 Forsyth St., Suite. 4T20**
**Atlanta, Georgia 30303-8909**

February 1, 2011

Ms. Rebecca Gay Lane, Administrator
The CPC Pavilion
1406 Medical Center Drive
Lebanon, Tennessee 37087

Re: SNF CMS Certification Number (CCN): **44-5500**

Dear Ms. Lane:

This letter is to inform you that your skilled nursing facility has been found to meet the Requirements for Participation in the Health Insurance for the Aged and Disabled Program (Medicare).

The effective date of certification is **December 17, 2010** and the fiscal year end date is December 31. The Medicare provider number is shown above. This number should be entered on all forms and correspondence pertaining to the Medicare Program.

It is most important to note that this certification is contingent upon your obtaining approval from the Office for Civil Rights (OCR). If this approval is not obtained, Medicare reimbursement will be recouped as of the effective date of certification.

The State Survey Agency previously advised you of any deficiencies found during the latest survey. If any deficiencies were cited, your plan of correction was considered in making the determination of compliance. In accordance with established Program procedures, the Survey Agency will verify that your plan of correction was implemented, and that compliance was achieved and maintained.

This Medicare certification is for:

**60-** Dually certified beds located in rooms: **Semi-private rooms: 101-112, 203-208, 301-303, 306-308, 311, 313 and Private rooms: 113, 201-202, 304-305, 309-310 and 312.**

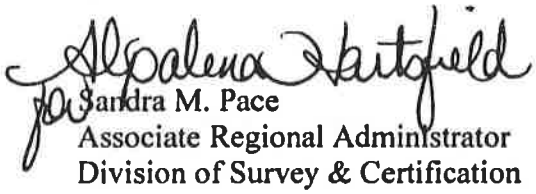
**Cahaba GBA (10301)** will serve as your fiscal intermediary. They have been notified of your certification, by copy of this letter.

You are advised to report any major changes in staffing, services, or other significant characteristics which potentially could affect your facility's compliance, to the State Survey Agency for action as deemed necessary. Pursuant to this, Section 1819(d) (B) of the Social Security Act requires you to report any changes involving ownership, Management Company, Director of Nursing, and Administrator.

If you believe that this determination is incorrect in any respect, you may ask that it be reconsidered. Your request must be submitted in writing to this office within 60 days of receipt of this letter. You may submit with your request for reconsideration any information you believe to be pertinent to the determination.

Should you have any questions concerning this matter, please contact Alpalena Hartsfield at (404) 562-7434.

Sincerely,



for Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

**NOTE TO THE FISCAL INTERMEDIARY:**
**THIS LETTER REPLACES THE CMS-2007, PROVIDER TIE-IN NOTICE.**

STATE OF TENNESSEE
**DEPARTMENT OF HEALTH**
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

**IMPORTANT NOTICE - PLEASE READ CAREFULLY**

November 24, 2010

Ms. Rebecca Gay Lane, Administrator
The Pavilion – CPC
1406 Medical Center Drive
Lebanon TN 37087

RE: 44-A122

Dear Ms. Lane:

The East Tennessee Regional Office of Health Care Facilities conducted a Health and Life Safety Code **2nd Federal Reasonable Assurance survey** on November 22 – 23, 2010. This letter to you is to serve as notice that as a result of the survey completed **November 23, 2010,** your facility was not in substantial compliance with the participation requirements of Medicare and/or Medicaid Programs. A statement of deficiencies (CMS 2567) is being provided to you with this letter.

If you do not achieve substantial compliance by **January 7, 2011,** our office will recommend to the Centers for Medicare & Medicaid Services (CMS) and/or the State Medicaid Agency that your facility be denied admittance into the Medicare program.

**Plan of Correction (POC)**

A POC for the deficiencies must be submitted by **December 4, 2010.** Failure to submit an acceptable POC by **December 4, 2010** may result in the imposition of remedies by **January 7, 2011.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents 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 systematic changes you will make to ensure that the deficient practice does not recur; and

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Based upon receipt of acceptable plan of correction for all deficiencies and verification of substantial compliance, through onsite revisit, recommendation will be made for participation in the Medicare program.

**INFORMAL DISPUTE RESOLUTION**

In accordance with 488.331, you have one opportunity to question cited deficiencies. You may request a Face to Face IDR for substandard level deficiencies, harm level deficiencies and immediate jeopardy level deficiencies. All other deficiencies will receive a desk review (telephone or written) by the Regional Office that cited the deficiency. These requests must be made within the same 10-calendar day period that you have for submitting an acceptable plan of correction and must contain additional justification as to why the deficiency(ies) should not have been written for harm level deficiencies or other deficiencies that are not substandard or immediate jeopardy. Evidence to dispute the scope and severity levels may only be submitted for substandard or immediate jeopardy deficiencies. Additional information which must be submitted with your request for an IDR is limited to no more than five (5) typed pages with a font size of no less than ten (10). If the facility is requesting a desk review in addition to a face to face IDR, the facility must submit two separate requests with their plan of correction to the State Survey Agency at the address on this letter, telephone 865-588-5656 or fax number 865-594-5739. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

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 /mad

Karen B. Kirby, R.N.
Interim Regional Administrator

KK:afl

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | | 11/23/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PAVILION, THE CPC | 1406 MEDICAL CENTER DRIVE<br>LEBANON, TN 37087 |

| (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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>During the second full survey for reassurance, conducted on November 22-23, 2010, no deficiencies were cited under 42CFR PART 482.13, Requirements for Long Term Care | F 000 | | |

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.

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9507 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 11/23/2010 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER PAVILION, THE CPC | STREET ADDRESS, CITY, STATE, ZIP CODE 1406 MEDICAL CENTER DRIVE LEBANON, TN 37087 | | |

| (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 |
|---|---|---|---|---|
| N 002 | 1200-8-6 No Deficiencies<br><br>During the second full survey for reassurance, conducted on November 22-23, 2010, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes. | N 002 | | |

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING _____ | 11/22/2010 |

NAME OF PROVIDER OR SUPPLIER
PAVILION, THE CPC

STREET ADDRESS, CITY, STATE, ZIP CODE
1406 MEDICAL CENTER DRIVE
LEBANON, TN 37087

| (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 |
|---|---|---|---|---|
| K 018<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation it was determined the facility failed to maintain the corridor doors.<br><br>The findings include:<br><br>Observation of the Resident room 113 on 11/22/10 at 7:50 AM, revealed the door was being held open with a trash can. National Fire Protection Association (NFPA) 101, 7.2.1.5.4<br><br>This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 018 | a. The trashcan was immediately moved away from the door to another location in room 113.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director has inspected all doors in the facility to know their current condition and whether they open, close, and remain open as desired without having an impediment.<br>c. Staff was inserviced on 11/29/10 by Administrator on the importance of not propping doors open or using impediments of any kind.<br>d. The Maintenance Director will audit for these practices during his observation rounds of facility. Doors that were identified as closing on their own will be realigned and adjusted by Isenhour Door Company on or before 12/16/10. | 12/16/10 |
| K 029 | NFPA 101 LIFE SAFETY CODE STANDARD | K 029 | | |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 11/22/2010 |

NAME OF PROVIDER OR SUPPLIER
PAVILION, THE CPC

STREET ADDRESS, CITY, STATE, ZIP CODE
1406 MEDICAL CENTER DRIVE
LEBANON, TN 37087

| (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 |
|---|---|---|---|---|
| K 029<br>SS=D | Continued From page 1<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the hazardous areas.<br><br>The findings include:<br><br>Observation of the attic mechanical room on 11/22/10 at 8:13 AM, revealed a penetration in the wall. National Fire Protection Association (NFPA) 101, 19.3.2.1<br><br>This findings was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 029 | a. The penetration was filled with fire caulk by the Maintenance Director on 11/24/10.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director and Administrator have surveyed the facility for any other penetrations to fill with fire caulk or drywall mud.<br>c. The staff will communicate any penetration findings within the facility to the Maintenance Director via work orders as instructed in inservice on 11/30/10 by the Maintenance Director.<br>d. The Maintenance Director will look at all walls and ceilings for penetrations during weekly preventative maintenance rounds and will report to the Administrator any findings. | 11/26/10 |
| K 052<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 | K 052 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING _____ | 11/22/2010 |

NAME OF PROVIDER OR SUPPLIER
PAVILION, THE CPC

STREET ADDRESS, CITY, STATE, ZIP CODE
1406 MEDICAL CENTER DRIVE
LEBANON, TN 37087

| (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 |
|---|---|---|---|---|
| K 052 | Continued From page 2<br><br>This STANDARD is not met as evidenced by:<br>Based on record review on 11/22/10 at 9:00 AM, it was determined the facility failed to maintain the alarm system.<br><br>The findings include:<br><br>Record review on 11/22/10 at 9:00 AM, revealed no annual testing was conducted on the alarm system. National Fire Protection Association (NFPA) 72, 7-3.1<br><br>This findings was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 052 | a. The annual testing of the alarm system was completed on 11/22/10 by ADT.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director will review the log of annual inspections to make sure all inspections/tests are complete.<br>c. The Maintenance Director has a log for annual inspections or tests that are to be completed. He will monitor this log monthly to assure no annual inspections or tests will be missed.<br>d. The Administrator will monitor the annual log monthly to maintain accountability of these practices. | ~~11/22/10~~<br>11/23/10<br>per phone with Karen Kid on 12/3/10 |
| K 054<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3<br><br>This STANDARD is not met as evidenced by:<br>Based on record review it was determined the facility failed to maintain the smoke detectors.<br><br>The finding include:<br><br>Records review on 11/22/10 at 9:15 AM, revealed | K 054 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 11/22/2010 |

NAME OF PROVIDER OR SUPPLIER: PAVILION, THE CPC

STREET ADDRESS, CITY, STATE, ZIP CODE: 1406 MEDICAL CENTER DRIVE, LEBANON, TN 37087

| (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 |
|---|---|---|---|---|
| K 054 | Continued From page 3<br>no semi or annual inspection of the smoke detectors. National Fire Protection Association (NFPA) 72, 3.2.3<br><br>This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 054 | a. The inspection of the smoke detectors was completed on 11/29/10 by D&H Electronics.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director will review the annual log to make sure all inspections and/or tests are complete.<br>c. We will add a log for the inspection of the smoke detectors to be completed by an outside source annually. The Maintenance Director will monitor this log monthly and schedule all inspections when required.<br>d. The Administrator will monitor the annual log monthly to maintain accountability of these practices. | 11/29/10 |
| K 056<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Based on records review it was determined the facility failed to maintain the sprinkler system.<br><br>The findings include:<br><br>Records review on 11/22/10 at 8:10 AM, revealed no quarterly testing was conducted on the sprinkler system. National Fire Protection Association (NFPA) 25<br><br>This finding was acknowledged by the Administrator and verified by the Director of | K 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING _____ | 11/22/2010 |

NAME OF PROVIDER OR SUPPLIER
PAVILION, THE CPC

STREET ADDRESS, CITY, STATE, ZIP CODE
1406 MEDICAL CENTER DRIVE
LEBANON, TN 37087

| (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 |
|---|---|---|---|---|
| K 054 | Continued From page 3<br>no semi or annual inspection of the smoke detectors. National Fire Protection Association (NFPA) 72, 3.2.3<br><br>This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 054 | | |
| K 056<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by: Based on records review it was determined the facility failed to maintain the sprinkler system.<br><br>The findings include:<br><br>Records review on 11/22/10 at 8:10 AM, revealed no quarterly testing was conducted on the sprinkler system. National Fire Protection Association (NFPA) 25<br><br>This finding was acknowledged by the Administrator and verified by the Director of | K 056 | a. A contract for quarterly tests to be conducted by Nashville Sprinkler Company was established on 11/30/10 with the first quarter test to be done on 1/11/11. The sprinkler system was tested on 10/14/10 to serve as its annual and fourth quarter test.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director will review the quarterly log to make sure all inspections/ tests are complete.<br>c. We will add a log for the sprinkler system to be completed quarterly by an outside source. The Maintenance Director will monitor this log and make sure all quarterly tests be completed by outside source in desired time.<br>d. The Administrator will monitor the quarterly log monthly to maintain accountability of these practices. | 11/30/10 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 11/22/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PAVILION, THE CPC | 1406 MEDICAL CENTER DRIVE<br>LEBANON, TN 37087 |

| (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 |
|---|---|---|---|---|
| K 056 | Continued From page 4<br>Maintenance conference on 11/22/10. | K 056 | | |
| K 064<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10<br><br>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the fire extinguishers.<br><br>The findings include:<br><br>(1) Observation of the attic on 11/22/10 at 8:15 AM, revealed the fire extinguisher in the front mechanical room was blocked with equipment. National Fire Protection Association (NFPA). 10, 1.6.3<br><br>(2) Observation of the attic mechanical rooms and the fire alarm room on 11/22/10 at 8:17 AM, revealed fire extinguishers were not checked monthly. NFPA 10, 4.3.1<br><br>These findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 064 | a. The boxes were immediately moved away from the fire extinguishers in the front mechanical room on 11/22/10.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director and Administrator have surveyed the facility and all fire extinguishers to make sure all fire extinguishers are clear of any blockages.<br>c. We have moved all equipment or supplies away from fire extinguishers throughout the facility. We have marked around the fire extinguishers with red paint in the front mechanical room so staff will visually see not to place things in front of fire extinguishers. All staff was inserviced on 11/29/10 by the Administrator on importance of keeping all fire extinguishers clear of any blockages and the consequences that will occur if noncompliance is observed.<br>d. The Maintenance Director will monitor all fire extinguishers on a daily basis and will report any findings to the Administrator for disciplinary action. | 11/29/10 |
| K 135<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for | K 135 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 11/22/2010 |

NAME OF PROVIDER OR SUPPLIER
PAVILION, THE CPC

STREET ADDRESS, CITY, STATE, ZIP CODE
1406 MEDICAL CENTER DRIVE
LEBANON, TN 37087

| (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 |
|---|---|---|---|---|
| K 056 | Continued From page 4<br>Maintenance conference on 11/22/10. | K 056 | | |
| K 064<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10<br><br>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the fire extinguishers.<br><br>The findings include:<br><br>(1) Observation of the attic on 11/22/10 at 8:15 AM, revealed the fire extinguisher in the front mechanical room was blocked with equipment. National Fire Protection Association (NFPA). 10, 1.6.3<br><br>(2) Observation of the attic mechanical rooms and the fire alarm room on 11/22/10 at 8:17 AM, revealed fire extinguishers were not checked monthly. NFPA 10, 4.3.1<br><br>These findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 064 | a. The Maintenance Director checked and signed off on the fire extinguishers in the attic mechanical room and the fire alarm room on 11/22/10 to bring them current.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director rechecked all fire extinguishers in the facility to make sure they were current.<br>c. The Administrator has re-educated the Maintenance Director of all the fire extinguishers in the facility and what is required when checking them. We have provided a map of all fire extinguishers in the facility with a total number and require the maintenance director to account for all in the log. The Maintenance Director will follow his monthly log for fire extinguishers and sign off each fire extinguisher for that month.<br>d. The Administrator will monitor the monthly log to keep accountability for these practices. | ~~11/22/10~~<br>11/23/10<br>per phon<br>with<br>Karen Kird<br>on 12/3/1 |
| K 135<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for | K 135 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING _____ | 11/22/2010 |

NAME OF PROVIDER OR SUPPLIER
PAVILION, THE CPC

STREET ADDRESS, CITY, STATE, ZIP CODE
1406 MEDICAL CENTER DRIVE
LEBANON, TN 37087

| (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 |
|---|---|---|---|---|
| K 135 | Continued From page 5<br>flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.<br><br>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the combustible liquids.<br><br>The findings include:<br><br>(1) Observation of the 200 and 300 hall clean supply rooms on 11/22/10 at 7:55 AM, revealed cylinders of oxygen were not secured. National Fire Protection Association (NFPA) 55, 6-6<br><br>(2) Observation of the maintenance shop on 11/22/10 at 8:12 AM, revealed a pressure washer (with gas in the tank) was stored in the room. NFPA 30, 4.4.3.6<br><br>These findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 135 | a. The Maintenance Director immediately placed the unsecured oxygen cylinder into the properly secured area.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director and Administrator surveyed the facility to make sure all oxygen cylinders are secure.<br>c. As of 11/29/10, charge nurses will check oxygen cylinders at the beginning of each shift and sign off whether they are secure on the 24-hour report.<br>d. The Director of Nursing will review each 24-hour report to make sure oxygen cylinders are remaining secured in supply rooms and will report any findings to the Administrator for disciplinary action. | 11/29/10 |
| K 147<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the electrical system. | K 147 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING _____ | 11/22/2010 |

NAME OF PROVIDER OR SUPPLIER
PAVILION, THE CPC

STREET ADDRESS, CITY, STATE, ZIP CODE
1406 MEDICAL CENTER DRIVE
LEBANON, TN 37087

| (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 |
|---|---|---|---|---|
| K 135 | Continued From page 5<br>flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.<br><br>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the combustible liquids.<br><br>The findings include:<br><br>(1) Observation of the 200 and 300 hall clean supply rooms on 11/22/10 at 7:55 AM, revealed cylinders of oxygen were not secured. National Fire Protection Association (NFPA) 55, 6-6<br><br>(2) Observation of the maintenance shop on 11/22/10 at 8:12 AM, revealed a pressure washer (with gas in the tank) was stored in the room. NFPA 30, 4.4.3.6<br><br>These findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 135 | a. The Maintenance Director immediately removed the pressure washer (with gas in the tank) and placed it in storage facility on 11/22/10.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director reviewed the maintenance shop to remove any other equipment containing gas.<br>c. The Maintenance Director will continue to monitor the facility for combustible liquids and will report to the Administrator any findings.<br>d. The Administrator will continue to monitor the facility for combustible liquids and will administer corrective actions as needed. | ~~11/22/10~~<br>11/23/10<br>per phone with Karen Kirby on 12-3-10 |
| K 147<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the electrical system. | K 147 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 11/22/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PAVILION, THE CPC | 1406 MEDICAL CENTER DRIVE<br>LEBANON, TN 37087 |

| (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 |
|---|---|---|---|---|
| K 147 | Continued From page 6<br>The findings include:<br><br>Observation of the kitchen dry storage room on 11/22/10 at 8:08 AM, revealed not all of the electrical outlets were ground fault circuit interrupters (GFCI) National Fire Protection Association (NFPA) 70, 517-20<br><br>This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. | K 147 | a. The Maintenance Director changed the electrical outlets in the kitchen dry storage to ground fault circuit interrupters (GFCI) on 11/26/10.<br>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director and Administrator surveyed the rest of the Dietary Department to make sure all electrical outlets were ground fault circuit interrupters (GFCI).<br>c. All outlets in the Dietary Department are ground fault circuit interrupters (GFCI).<br>d. All outlets in the Dietary Department are ground fault circuit interrupters (GFCI). | 11/30/10 |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN9507 | | 11/22/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PAVILION, THE CPC | 1406 MEDICAL CENTER DRIVE<br>LEBANON, TN 37087 |

| (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 |
|---|---|---|---|---|
| N 002 | 1200-8-6 No Deficiencies<br><br>Based on observation of the facility on 11/22/10 at 8:00 AM, revealed no state deficiencies. | N 002 | | |

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 22, 2010

Ms. Rebecca Gay Lane, Administrator
The Pavilion - CPC
1406 Medical Center Drive
Lebanon TN 37087

Provider #: 44-A122

Dear Ms. Lane:

The East Tennessee Regional Office of Health Care Facilities conducted a Health and Life Safety code 1st Federal Reasonable Assurance survey on October 18 – 20, 2010 to establish a "reasonable assurance period". This letter to you is to serve as notice that as a result of the survey completed October 20, 2010, your facility was found to be in compliance with the Health and Life Safety participation requirements.

Sincerely,

Karen B. Kirby

Karen B. Kirby, R.N.
Interim Regional Administrator

KK:afl

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2010
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | | 10/20/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PAVILION, THE CPC | 1406 MEDICAL CENTER DRIVE<br>LEBANON, TN 37087 |

| (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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>During the reassurance certification survey conducted on October 18 to 20, 2010, at The Pavilion, CPC, no deficiencies were cited under 42 CFR PART 482.13, Requirements for Long Term Care. | F 000 | | |

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 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: 10/21/2010
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44A122 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 10/18/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PAVILION, THE CPC | 1406 MEDICAL CENTER DRIVE<br>LEBANON, TN 37087 |

| (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 |
|---|---|---|---|---|
| K9999 | FINAL OBSERVATIONS<br><br>Based on the annual fire safety survey conducted on 10/18/10, there were no life safety deficiencies cited. | K9999 | | |

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 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.

# Attachment C, Orderly Development,

# Proof of Publication

# The Lebanon Democrat Classifieds

2012 APR 1 AM 11 27

**Ads that work pay for themselves. Ads that don't work are expensive.**

**DESCRIPTION BRINGS RESULTS!**

The LEBANON DEMOCRAT

**615-444-3952**

## BUSINESS SERVICES

**A+ HANDYMAN, HOME REPAIRS, REMODELING**
Licensed, Insured. Roger, 405-9934

***ACTION EQUIPMENT***
**Heating & Air Conditioning**
Service • Sales • Installation
Major Appliance Repair
Since 1983
Lebanon (615) 444-7927
Mt. Juliet (615) 754-5615
Hartsville (615) 767-4138
Free Service Call with Repair
Honest & Dependable
FREE ESTIMATES
Licensed & Insured
*"Big or small we can make them fall"*
Danny 478-7766 leave msg.

## PUBLIC NOTICE

## BUSINESS SERVICES

**BIG SCREEN TV REPAIR**
In home repair. 615-430-9846.

**DRIVEWAYS SCRAPED**
Gravel/top soil dirt spread, backhoe work, bushhogging. Kenny Fields 449-1599

**EXPERIENCED PAINTER & HANDYMAN LOOKING FOR WORK.**
Reasonable pricing for all your needs.
Call (H) 615-683-5178 or (Cell) 615-512-9538

**GRASSBUSTER AND LANDSCAPING**
$$ 10" cutting is FREE up to $50.00 $$
615-351-6567

**GRAVEL DELIVERED**
*Custom Spreading Available.*
Free estimates. Holes, ruts filled, 615-202-4288

**H&N CONSTRUCTION**
• Remodeling • Additions
• Pole Barns • Roofs • Decks
• Siding • Windows
•Much More
•References Available
**Free Estimates**
615-388-5783 or 615-644-4899

**HANDYMAN WORK**
No job too small. Call 615-489-9206.

**HARVEY'S LANDSCAPE & DESIGN**
Free estimates. 615-925-0610

**Landscaping/Yard Work**
Leaf Blowing - Planting - Mowing - Edging - Tilling - Weedeating - Mulch Work - Shrub Trimming -
615-579-ROOF (7663)
SCOTT 453-2647 BRUCE
SERVING THE WILSON COUNTY AREA OVER 15YRS
LICENSED & INSURED

## PUBLIC NOTICE

**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 Development Agency, that: The Pavilion-THS Nursing Home owned by: Total Healthcare Systems, LLC with an ownership type of LLC and to be managed by Stein & Associated, LLC intends to file an application for a Certificate of Need for the applicant, The Pavilion-THS, is a licensed 80 bed nursing home located at 1406 Medical Center Drive, Lebanon, Wilson County, Tennessee 37087. The applicant proposes to build an addition to the currently existing facility. The applicant also seeks approval for the addition of 24 skilled nursing beds from the nursing home bed pool. All 24 beds will be dually certified for Medicaid and Medicare. The expanded facility will have a total of 84 licensed beds. The facility currently provides care for private-pay, Medicare Level II, and Medicaid Level I and II residents. There would be no change to the services currently provided. The estimated project cost is $1,823, 092.75.

The anticipated date of filing the application is April 13, 2012. The contact person for this project is G. Frank Lannom, Attorney who may be reached at: Lannom & Williams, PLLC, 137 Public Square, Lebanon, TN 37087, 615-444-3995.

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
500 Deaderick Street, Suite 850
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 prior to the consideration of the application by the Agen-

## BUSINESS SERVICES

**SPRING SPECIAL**
**Mower Repair at your home.**
Blades Sharpened, Oil Changed, Tuneups, Etc. 615-449-3695

***THE MUSIC LAB***
•Lessons • Recording
• Voice • Songwriting
*615-708-8651*

ROOFING
**HEARTLAND ROOFING, LLC**
615-443-2252
www.heartlandroofing.com

**YOU CALL, I'LL FIX!!**
• Alternators/Starters
• Belts
• Engine Rebuild
• Gaskets
• Brakes
• Hose Replacement
• Oil Change
• Tune-ups and other things.
**Call 615-547-9271.** and ask, will let you know how much and set up a time to come over.
**YOU BUY PARTS NEEDED.**
Serious Inquiries Only
NADC Student

## APPLIANCES FOR SALE

**APPLIANCE REPAIR**
*Action Equipment Service*
We Service All Major Appliances
Lebanon 615-444-7927
Mt. Juliet 615-754-5615

## BUSINESS SERVICES

## APPLIANCES FOR SALE

**H.G. APPLIANCE SALES & SERVICE, 216-1809**

## MISC. WANTED

**BUYING BASEBALL CARDS.**
Call 754-5350.

**I PAY TOP DOLLAR $$ FOR JUNK CARS, TRUCKS, VANS, BUSES & DUMPTRUCKS. 615-504-2023.**

**RECYCLING**
We recycle all types of metal. We sell recycled auto parts. 443-3608

## HELP WANTED

**CAREGIVER NEEDED**
Caregiver needed for male patient. Needs caregiver willing and able to give "full care". 12 hour shifts available day and night. Must pass drug screening and background check. Call 449-5362.

NEW Today!

***Concrete Finisher Needed***
with experience, must have own transportation, call 615-444-7380

**DAVID'S PIZZA**
is now hiring for a part-time waitress position. Apply in person.

**FLORAL DESIGNER**
16-38 hours, experience preferred, over 21. Apply in person only. NO phone calls. Sunshine Flowers

**FULL TIME EXPERIENCED**
Farm Employee. Hourly wage +benefits. Send resume to: tnganden1234@yahoo.com

Ford
1673 West Main St.
Lebanon, TN 37087
www.TonyBatesFord.com
615-444-8221
*Home of "We will trade for anything that don't eat".*

## BUSINESS SERVICES

## HELP WANTED

**HELPER NEEDED ON DRILL RIG**
plumbing and mechanical experience helpful. Year round work, average 50+ hours weekly. Prefer CDL but must have clean MVR. Must be able to pass drug testing. Wage DOE. Watson Co. Inc, 9133 Twelve Corners Rd Lascassas, Tn. 615-273-2849

**All Roads to Success Start With TTC**
18.5-Day Class A CDL Training
Job Placement Assistance Available
Transportation Training Center
1301 Gallatin Pike South
615-

## MEDICAL

**EXPERIENCED CAREGIVERS/ CNA'S NEEDED**
dependable, enthusiastic to provide in-home care for seniors. Call (615) 822-9165

## BUSINESS OPPORTUNITY

NEW Today!

**CLEANING FRANCHISE**
Mint Condition
**Start your own Janitorial Business in 2012!**
• Accounts available immediately
• Low down payment/guaranteed

**Send Resume to:**
**Kevin P. Copeland, FICF**
Managing Partner

3735 N. Mt. Juliet Road
Suite 108
Mt. Juliet, TN 37122

**Build YOUR business. We'll provide the foundation.**

Become a financial services representative w Modern Woodmen of America, one of the nation's largest fraternal financial services providers. You'll receive these career-building benefits.

- **Income** - Unlimited income potential, outstanding compensation/training progra with monthly business development allowance and extensive benefits package.
- **Impact** - Play a vital role in families' and bu nesses' financial well-being. Impact individ als and communities with fraternal progra
- **Independence** - Build a business for yourse Control your career destiny.

Modern Woodmen of America is one of the nation's largest fraternal financial services providers.

*Discover the Pathway to Leadership. Ask us about our leadership training program.*

## APARTMENTS

**1 & 2 BEDROOM APT**
utilities included. ES Properties, 453

**Apartments! Apartmen**
**1, 2 & 3 bedroom units**
• Utilities included with many u
• Weekly & monthly payment p
• Low deposits
Call 615-444-0038
Greg Dugdale Propertie

**JC Helium Boarding Ho**
facility for men, has rooms for r
for info. please call 449-5401

**LARGE 2 BDRM APARTME**
convenient, includes water & tra
Ask about our specials! 444-7

**SOUTHLAND MOTEL**
Clean & Comfortable rooms, Cabl
phone, $140/wk., taxes incl. 444-

**SUMMERFIELD APARTME**
"Your Community for Quiet Livin
615-449-8775

## HOUSE FOR REN

**2 BEDROOM**
449-0638

**3 BEDROOM, 2 BATH**
HVAC, 436 Parkside Circle, Leba
$900/mo., $500/deposit, no pe
Call Mitch, 615-418-1942.

NEW Today!

**3 BEDROOM, 2 BATH,**
no smoking , no pets, nice neighbo
$1,050 month. 364-5612

**801 SPRING MEADOWS L**
3 bedrooms, 2 full baths, 1 car ga
concrete patio, NO PETS, $875/
$500 deposit, 1 year lease, 615-58

# SUPPLEMENTAL #1

1. **Section B. Item IIA (Project Description)**

A) The applicant indicates it is certified for Medicare and Medicaid, yet the most recently submitted utilization data (2010) shows no utilization by Medicare patients. Please explain.

a. The Pavilion is certified in both Medicare and Medicaid as of December 17, 2010. They did not receive this notice until February 1, 2011. Therefore, they would not have any utilization data in 2010 for Medicare as they were not certified.

B) The applicant indicates The Pavilion-THS nursing home has a waiting list of 56 patients. Please provide a breakdown of the number of these patients would be considered Medicare skilled nursing (Level II).

b. The patients on the waiting list for The Pavilion are all long-term care applicants. The Pavilion would not be able to keep them on the wait list for skilled care because the hospitals would discharge them to another skilled nursing facility.

C) Of the 56 persons on the waiting list what is the average wait time for a bed? Average wait time for a Medicare skilled nursing patients? Average wait for a longer term patients seeking intermediate care level of care?

c. The Pavilion cannot compute the average length of stay on the wait list for a patient/resident because it is ever changing. However, first person on the list was placed on the list in November 2010 and the Pavilion continues to have others added weekly.

2. **Section B. Item IIA (Project Description) & Section C. Contribution to the Orderly of Health Care, Item. C.3. (Staffing)**

The description of the project's proposed staffing provides ranges to the proposed staffing. It would be helpful to be more specific in the listing of proposed staffing, such as: rather than 2-3 licensed nurses, perhaps 1.5 FTE licensed nurses or 2.0 FTE licensed nurses in the first year of the project and 3.0 FTE licensed nurses in the second year of the project. (FTE= Full Time Equivalent). Please revise your proposed staffing schedules accordingly.

The following table will apply to the 2 years following completion of the project:

| | 6am-2pm | 2pm-10pm | 10pm-6am |
|---|---|---|---|
| Therapist | 1 | 1 | |
| CNA | 2 | 2 | 2 |
| LPN/LVN | 1 | | 1 |
| RN | | 1 | |
| Housekeeper | 1 | | |
| Laundry | | | 1 |
| Administrative | 1 | | |

**3. Section B. Item IIA (Project Description) and Section B, Project Description Item IV (Floor Plan)**

The project description indicates the existing Pavilion THS facility has 60 dually certified nursing home beds with enough space for 6 more beds. The proposed addition will contain space for 22 new nursing home beds. The application is requesting the addition of 24 licensed nursing home beds.

A) Please indicate on the floor plan of the existing facility where the 2 additional beds will be located in the existing facility.

a. The 2 additional beds will be placed in rooms 201 & 202, marked on the attached floor plan.

B) More often than not, the HSDA is seeing nursing home requests for more private room accommodations than semi-private accommodations. It would appear that the applicant is seeking to develop a nursing facility that is almost all semi-private accommodations. Please explain the applicant's rationale.

b. The Pavilion has always focused on providing the highest standard of resident care to our residents. We feel that the physical layout of our facility lends itself quite well to addressing the needs of our residents whether they are in a semi-private or a private room. We always work with our residents and their families to accommodate the needs of each resident. The semi-private rooms create the flexibility that we need to assist in that process. There are and will continue to be times that we may not place two residents in a semi-private room for medical or psycho-social reasons.

C) What is currently and what will be the private vs. semi-private accommodations mix? Please complete the chart below.

| | Current Rooms | Current Beds | | Proposed Rooms | Proposed Beds |
|---|---|---|---|---|---|
| Semi-private Rooms | 26 | 52 | | 39 | 78 |
| Private Rooms | 8 | 8 | | 6 | 6 |
| Total Beds | | 60 | | | 84 |

**4. Section B. Item II.C.12. (Project Description)**

Your response is noted. Please provide the applicant's need to provide additional long term care services.

Based on the formula from the Guidelines for Growth, Wilson County has a need of 123 additional nursing home beds. An aging and rapidly growing population combined with the fact that the facility is fully occupied, has a wait list of at least 56 people and the aforementioned county need, present a clear and present need for additional beds, including long term care beds and services.
Historically, the large majority of residents at the Pavilion were Medicaid recipients with private payers making up the small remainder. This pattern is projected to continue even with the addition of Medicare residents.
The Pavilion has had a significant waiting list since becoming fully occupied in early 2010. The patients on the waiting list for The Pavilion are all long-term care applicants. The Pavilion would not be able to keep them on the wait list for skilled care because the hospitals would discharge them to another skilled nursing facility.

5. **Section C. Need 1.**

Please discuss how the proposed project will relate to the 5 Principals for Achieving Better Health found in the State Health Plan."

**Healthy Lives**

- Physical activity programs provided for residents of the Pavilion
  The Pavilion has a fully staffed rehabilitation department consisting of physical, occupation, and speech therapy. They have daily restorative therapy to maintain strength and range of motion.
- Recreational activity programs provided for residents of the Pavilion
  The Pavilion staffs a certified activity director that coordinates and performs activities for the residents. They utilize volunteers, churches, entertainment groups, etc. to assist in recreations in the facility. They have a facility van with a wheelchair lift to take outings from the facility.
- Nutrition plan for residents of the Pavilion
  The Pavilion provides three balanced meals per day to all residents. They have qualified staff working in this department. They have a registered dietician that reviews all diet orders from the physicians to make recommendations and follow all state and federal regulations.
- Methods used by Pavilion to provide residents with an understanding of various health issues including mental health.
  The Pavilion uses various materials to help residents and resident's families understand certain health issues. They have care plan meetings with residents and families to discuss the care being provided and answer any concerns or misunderstandings of health issues.

**Access to Care**

- Preventative care provided for the residents of the Pavilion
  Residents are being provided care daily by qualified staff. The staff will report any findings to specific personnel to begin treatment if warranted. The Pavilion performs weekly "At-Risk" meeting that covers any issue that may become an issue of care.
- Oral care provided for the residents of the Pavilion
  Staff at the Pavilion provide or assist with daily oral care to residents. The Pavilion contracts with Marquis Mobile Dental to provide needed dental care to residents.
- Mental health care provided for the residents of the Pavilion
  The Pavilion works with Dr. Putatunda, psychologist, for all clinical mental health issues. The Pavilion also works with Hendricks Counseling for weekly counseling to residents determined to need additional mental health concerns.
- Transportation services provided by the Pavilion
  The Pavilion works with transportation companies in Middle Tennessee area to provide needed transportation for residents. They coordinate these appointments and transportation.

**Economic Efficiencies**

- The Pavilion promotes screening, early detection, and follow-up care for physical, mental and substance use disorders, and oral health care

Every resident is assessed by nursing staff upon admission, evaluated by physicians monthly, care planned and updated as needed. The Pavilion utilizes ways of communication from front line staff to directors through 24-hour reporting of any changes in residents including, but not limited to physical, mental health and oral health care.

- The Pavilion uses electronic health records in order to increase gains in healthcare productivity, quality, and safety

  The Pavilion uses Point Click Care for electronic medical records and financial records.

**Quality of Care**

- The Pavilion ensures that health care delivery is safe and effective

  The Pavilion is managed by Stein & Associates which provides monthly audits of care, documentation, life safety, etc. The Pavilion also performs monthly audits internally, competency tests on staff, and all information is reviewed at monthly quality assurance meetings.
- The Pavilion ensures residents receive well-coordinated mental and physical health care across all providers, settings, and levels of care

  Every resident is assessed by nursing staff initially, evaluated by physicians, continued review of care plans, and updated as needed.

**Health Care Workforce**

- The Pavilion will retrain and upgrade the skills of its current workforce

  The Pavilion believes in continuing education. They provide monthly in-services to our staff from outside sources of product and/or services related to nursing facilities. They also send staff to continuing education seminars through THCA, Activity Association, Dietary Managers Association, etc.

6. **Section C. Need, Item 4**

Please complete the following chart:

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table.

| | Wilson County | State of TN Total |
|---|---|---|
| Total Population-Current Year -2012 | 114,437 | 6,361,070 |
| Total Population-Projected Year -2014 | 117,941 | 6,470,546 |
| Total Population-% change | 3% | 1.7% |
| Age 65 and over Population - 2012 | 13,646 | 878,496 |
| Age 65 and over Population - 2014 | 14,839 | 931,676 |
| Age 65 and over Population - % change 2012-2014 | 8% | 5.7% |
| Age 65 and over Population as % of Total Population 2014 | 13% | 14% |
| Age 65 and over Population - 2016 | 15,998 | 987,074 |
| Age 65 and over Population - % change 2012-16 | 15% | 11% |
| Age 65 and over Population as % of Total Population 2016 | 13% | 15% |
| Median Household Income | $27,814 | $23,722 |
| TennCare Enrollees | 14,013 | 1,211,113 |
| TennCare Enrollees as % of Total | 12% | 19% |
| Persons Below Poverty Level | 8,664 | 1,056,553 |
| Persons Below Poverty Level as % of Total | 7.6% | 16.5% |

**The Tennessee Department of Health's Population Projections 2010-2020 should be used for the population projections, the US Census Bureau and the State of Tennessee Bureau of TennCare websites will be helpful in gathering the other demographic statistics.**

7. **Section C. Need, Item 5**

Please complete the following charts.

**Wilson County Nursing Homes Historical Utilization -2008**

| Nursing Home | Licensed Beds | Medicare-Certified beds | Medicare/Medicaid-dually certified beds | SNF Medicare ADC | SNF Medicaid ADC | SNF-All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|---|
| The Pavilion -THS | 42 | 0 | 0 | $0 | $0 | $0 | $147 | $147 | 24% |
| Mount Juliet Health Care Center | 106 | 0 | 106 | $164 | $164 | $164 | $164 | $164 | 93% |
| Quality Care Health Center | 290 | 0 | 290 | $174 | $174 | $182 | $135 | $159 | 96% |
| Lebanon Health and Rehab Center | 60 | 60 | 0 | $443 | $0 | $0 | $196 | $278 | 80% |
| Total | 498 | 60 | 396 | $260 | $169 | $173 | $161 | $187 | 73% |

**Wilson County Nursing Homes Historical Utilization -2009**

| Nursing Home | Licensed Beds | Medicare-certified beds | Medicare/Medicaid-dually certified beds | SNF Medicare ADC | SNF Medicaid ADC | SNF-All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|---|
| The Pavilion -THS | 60 | 0 | 0 | $0 | $0 | $0 | $163 | $163 | 48% |
| Mount Juliet Health Care Center | 106 | 0 | 106 | $172 | $172 | $172 | $178 | $174 | 93% |
| Quality Care Health Center | 290 | 0 | 290 | $179 | $179 | $187 | $140 | $164 | 92% |
| Lebanon Health and Rehab Center | 60 | 60 | 0 | $464 | $0 | $0 | $196 | $285 | 88% |
| Total | 516 | 60 | 396 | $272 | $176 | $180 | $169 | $197 | 80% |

**Wilson County Nursing Homes Historical Utilization -2010**

| Nursing Home | Licensed Beds | Medicare-certified beds | Medicare/Medicaid-dually certified beds | SNF Medicare ADC | SNF Medicaid ADC | SNF-All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|---|
| The Pavilion -THS | 60 | 0 | 60 | 0 | 0 | 0 | $179 | $179 | 98% |
| Mount Juliet Health Care Center | 106 | 0 | 106 | $177 | $177 | $177 | $181 | $179 | 89% |
| Quality Care Health Center | 290 | 0 | 290 | $179 | $179 | $187 | $140 | $164 | 91% |
| Lebanon Health and Rehab Center | 60 | 60 | 0 | $466 | $0 | $211 | $211 | $262 | 88% |
| Total | 516 | 60 | 396 | $274 | $178 | $192 | $178 | $196 | 92% |

**8. Section C. Need, Item 6**

Please provide the details regarding the methodology used to project patient days, average daily census etc. during the first year of operation and patient days, average daily census etc. during the second year of operation. The methodology must include detailed assumptions, methodology and calculations. Providing only statements such as "based on the applicant's experience" will not be considered an adequate response.

The Pavilion Utilization Assumptions:
Utilization rates for the last six months of 2011 were as follows:
Medicare – 1216 days 11.13% of total census
Medicaid –7322 days 67.02% of total census
Private – 2386 days 21.84% of total census

Overall utilization was 10924 days which was 98.94% of occupied beds.

Based on the high occupancy percentage and the fact that the facility currently has a waiting list, the fill up for the 24 additional beds was accelerated with the facility stabilizing at an occupancy percentage of 93% within six months.
Based on the fact that the additional beds could be utilized for private and Medicare residents, the additional census was allocated to Medicare and Private with a higher percentage of the increase going to Medicare since hospitals have expressed the need for additional beds at the facility.
Based on the fact that the beds could be utilized for Medicare residents, the census for the second year remains lower than the current utilization due to the transitional nature of Medicare residents. The facility will have more open beds due to the higher volume of admissions and discharges.
The projected Data chart for the two year period after the new beds are added included Medicaid residents. The mix is based on the previous six months of census information since the Pavilion opened the Medicare beds; to base it on historical data older than that would not make sense since they would not include Medicare days. The previous six month census is attached to support the current mix of residents. The allocation is changed slightly since the Pavilion is currently turning down Medicare residents because it is bed-locked.

**The Pavilion-THS Historical and Projected Utilization**

| Year | Licensed Beds | Medicare-certified beds | Medicare/Medicaid-dually certified beds | SNF Medicare ADC | SNF Medicaid ADC | SNF-All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|---|
| 2008 | 60 | 0 | 0 | 0 | 0 | 0 | 147 | 147 | 24% |
| 2009 | 60 | 0 | 0 | 0 | 0 | 0 | 163 | 163 | 48% |
| 2010 | 60 | 0 | 0 | 0 | 0 | 0 | 179 | 179 | 98% |
| 2011 | 60 | 0 | 0 | 170 | 166 | 191* | - | 176 | ~98% |
| 2012 | 60 | 0 | 60 | x | x | x | x | x | x |
| 2013 | 60 | 0 | 60 | x | x | x | x | x | x |
| 2014 | 84 | 0 | 84 | 354 | 168 | 187* | - | 236 | 92% |
| 2015 | 84 | 0 | 84 | 371 | 176 | 197* | - | 248 | 96% |
| 2016 | 120 | x | x | x | x | x | x | x | x |

* Represents an average of SNF and NF Private pay
x Projections have not been made for these years

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.**

Historical Utilization

2008*: 26%

2009*: 31%

2010: 91%

*Statistics for these transitional years are based on setup and staffed bed occupancy of the previous facility which was replaced by the current facility in December 2009. Also by 2009, in anticipation of the newly constructed current facility the previous facility had approval for 60 beds but had physical space for only 42 beds.

Projected Utilization

Year 1: 92%

Year 2: 96%

A breakdown of projected patient days for the first two years is reflected in the table below:

| **Year 1** | | | | |
|---|---|---|---|---|
| Payor/Care Level | Patient Admissions | Days of Care | % of Total Days | Average Daily Census |
| Medicare (Level II) | 13 | 4,650 | 17% | 13 |
| Medicaid:<br>Level I<br>Level II | 46 | 16,933 | 60% | 46 |
| Private: | 18 | 6,597 | 23% | 18 |
| Total | 77 | 28,180 | 100% | 81 |

| Year 2 | | | | |
|---|---|---|---|---|
| Payor/Care Level | Patient Admissions | Days of Care | % of Total Days | Average Daily Census |
| Medicare (Level II) | 13 | 4,868 | 17% | 13 |
| Medicaid:<br>Level I<br>Level II | 49 | 17,977 | 61% | 49 |
| Private: | 18 | 6,629 | 22% | 18 |
| Total | 80 | 29,474 | 100% | 80 |

[THE REMINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

**ECONOMIC FEASIBILITY**

**9. Section C, Economic Feasibility, Item 1 (Project Cost Chart)**

Please provide documentation from a licensed architect or construction professional:

1) A general description of the project,
2) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and
3) Attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the new 2006 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities

See attached

**10. Section C, Economic Feasibility, Item 2 (Funding)**

Your response is noted. Please provide a letter from an officer of your lending institution (in your case, Pinnacle National Bank), stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan and any restrictions or conditions.

See attached

**11. Section C, Economic Feasibility, Item 3 (Reasonableness of the of the Proposed Project Costs)**

Please provide a comparison of the construction cost per square foot of the proposed project and more recently approved (e.g., 2008-2010) nursing home projects submitted to the HSDA.

The following nursing home construction cost per square foot data were received from the HSDA: New Construction, 1st Quartile - $153.05, Median - $172.75/sq ft, and 3rd Quartile $220.50/sq ft. Total Construction, 1st Quartile - $125.24, Median - $168.25/sq ft, and 3rd Quartile $176.61/sq ft. These data were compiled using the nursing home CON applications filed between 2008 to 2010. With an estimated construction cost of $169.64/ sq ft, the estimated construction cost for this project is reasonable compared to those projects included in the HSDA data.

**12. Section C, Economic Feasibility, Item 4 (Historical and Projected Data Charts)**

A) The Historical Data Chart displays significant variability over the three years presented. Please provide a narrative explanation of this variability. Examples of significant variability include Patient Days (486 in 2008 to 14,098 in 2010; Revenue $153.95/pt. day in 2008 vs. $124.86/pt. day in 2010); Expenses ($2,300.55/pt. day in 2008 vs. $194.40/pt. day in 2010); Salaries and Wages ($543,885 in 2008 vs. $1,513,136 in 2010, or $1119.10/pt. day in 2008 vs. $107.33/pt. day in 2010); Taxes $143,539 in 2008, vs., $266,245 in 2010); Other Expenses ($364, 231 in 2008 vs. $802,468 in 2010, or $749.45/pt. day in 2008 vs. $56.92/pt. day).

On the Historical Data Chart for The Pavilion there are major variances in revenue and expenses. There were several variables that caused these fluctuations:

The facility was originally operating in a smaller building and was only licensed for 42 beds with a maximum capacity of 24 beds due to the configuration of the old building. In December 2009, the newly constructed nursing facility was opened and residents were transferred from the old building to the new building and new residents began to be admitted. The licensed beds also increased from 42 to 60 beds when the new building opened.

When CPC originally purchased the building, the previous owners were in the process of having their Medicare and Medicaid provider contracts terminated by CMS. CMS then ruled that CPC would inherit the disciplinary actions that were assessed against the prior owners. As a result of this ruling, the facility operated for a period of time with a full administrative staff and nursing staff but was only caring for four residents which caused all of the 2008 per patient day (ppd) cost to be inflated.

The facility did not become Medicare certified until December 2010 and did not accept their first Medicare resident until February 2011. Medicare residents are reimbursed at a much higher rate resulting in an increase in revenue from 2010 to 2011.

During the construction period of the new building in 2009 and until the sale of the old building, certain maintenance and other property related cost, such as property taxes, were inflated since they had to be paid on both buildings

B) The Historical Data Chart reflects the fiscal years 2008-2010, while the financial statements reflect the fiscal year ending June 30, 2011. Please update the Historical Data Chart reflecting years 2009-2011.
See revised Historical Data Chart

C) Please identify the unit of measure for the utilization data.
See revised Historical Data Chart

D) The Historical Data Chart does not reflect any Deductions from Gross Revenue. Did the applicant not have any Contractual Adjustments, Bed Debts or Charity Care during these past three years? If not, please explain why. If there were any of these three revenue adjustment items in the past three years, please reflect them on a revised Historical Data Chart.
See revised Historical Data Chart

E) It is assumed that the applicant developed the Projected Data Chart for the proposed 24 additional beds. Is this correct?
Yes

F) Please develop a Projected Data Chart for the entire 84 bed proposed nursing facility.
See revised Projected Data Chart for 84 beds

G) Please provide revised Historical and Projected Data Charts on the attached forms which break out management fees. Please incorporate the three categories of Deductions from Gross Revenue in both of the Historical and Projected Data Charts
See revised Historical and Projected Data Charts

H) Please provide a separate detailed page specifying the "Other Expenses" for both revised Historical and Projected Data Charts.
See revised Historical and Projected Data Charts

**13. Section C, Economic Feasibility, Item 6**

The applicant indicates the facility was recently approved to start accepting Medicare residents and local physicians have expressed a desire to utilize The Pavilion-THS to provide skilled nursing care after hospitalization.

A) When was The Pavilion-THS approved to receive Medicare patients? Please provide a copy of the CMS approval letter.

a. The Pavilion was approved on December 17, 2010 in a letter dated February 1, 2011 from CMS to accept Medicare residents. (attached)

B) It would be helpful for the applicant to gather and provide letters of support before the HSDA meeting from local physicians who have expressed interest in utilizing The Pavilion-THS to provide skilled nursing care after hospitalization.

b. Applicant is attempting to gather this information as of the time of filing.

**SUPPLEMENTAL- #2**
**June 4, 2012**
**10:12 am**

**AFFIDAVIT**

2012 JUN 4 AM 10 14

STATE OF TENNESSEE

COUNTY OF WILSON

NAME OF FACILITY: The Pavilion, THS

I, ALEX BIRD, 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.

Alex Bird / Attorney
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31st day of May, 2012, witness my hand at office in the County of Wilson, State of Tennessee.

Alex Perrigo
NOTARY PUBLIC

My commission expires July 6, 2015.

ALEX PERRIGO
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

HF-0043

Revised 7/02

# SUPPLEMENTAL
# #2

1. **Section B. Item IIA (Project Description) & Section C. Contribution to the Orderly of Health Care, Item. C.3. (Staffing)**

   **The description of the project's proposed staffing provides ranges to the proposed staffing. It would be helpful to be more specific in the listing of proposed staffing, such as: rather than 2-3 licensed nurses, perhaps 1.5 FTE licensed nurses or 2.0 FTE licensed nurses in the first year of the project and 3.0 FTE licensed nurses in the second year of the project. (FTE= Full Time Equivalent). Please revise your proposed staffing schedules accordingly.**

   Your response is noted: Please provide your response as outlined by the following chart:

| | Current Staffing (Entire 60 bed NH) | Proposed Staffing (84 Bed NH) Year 1 After Opening | Proposed Staffing (84 Bed NH) Year 2 After Opening | Proposed Total Increase in Staffing* |
|---|---|---|---|---|
| | (in FTE's) | (in FTE's) | (in FTE's) | (in FTE's) |
| Administrative | 4 | 5 | 5 | 1 |
| RN | 3 | 4 | 5 | 2 |
| LPN/LVN | 13 | 17 | 18 | 5 |
| CNA | 26 | 35 | 35 | 9 |
| Therapist | 4 | 5 | 6 | 2 |
| Housekeeper | 4 | 5 | 5 | 1 |
| Laundry | 2.5 | 3.5 | 3.5 | 1 |

*Year 2 after Opening minus Current Staffing)

2. **Section B. Item IIA (Project Description) and Section B, Project Description Item IV (Floor Plan)**

   **The project description indicates the existing Pavilion THS facility has 60 dually certified nursing home beds with enough space for 6 more beds. The proposed addition will contain space for 22 new nursing home beds. The application is requesting the addition of 24 licensed nursing home beds.**

   **A) Please indicate on the floor plan of the existing facility where the 2 additional beds will be located in the existing facility.**

   Your response is noted.

   a) Are these the rooms with crosshatching?

   b) Are the rooms which are totally blacked out, the nursing home's private rooms?

   a) Yes, the rooms on the floor plan with crosshatching are the rooms where the 2 additional beds are expected to be located.

   b) Yes, the rooms which are totally blacked out are the home's private rooms.

In supplement to the above answers to the directed questions, the applicant would also refer to the legend attached to the bottom of the supplement #1 of Section B. Project Description Item IV (floor plan), also attached as Exhibit one to this supplement.

3. **Section C. Need, Item 5**

Please complete the following charts. ***Please note these charts are requesting utilization number not charges; that is, ADC stands for Average Daily Census, not Average Daily Charge.***

While the facility operates a skilled nursing facility, the Joint annual report lists all patients in this facility under "Level One Care/Intermediate Care" which is the correct level of compensation. In recognition of this reporting methodology, all other payors are listed under "NF ADC" in the applicable charts as opposed to "SNF-all other payors." Applicant is reviewing its reporting methods for the Joint Annual Report requirements to determine the preferred reporting method.

Total licensed occupancy is rounded to the nearest whole number. The rounding of calculations will on occasion result in an addition discrepancy of no more than 1 whole number per calculation.
All ADC calculations list Level One Care/ Intermediate Care in patient days under NF ADC, as they do not fall under Skilled Nursing Care within the Joint Annual Report.

**Wilson County Nursing Homes Historical Utilization -2008**

| Nursing Home | Licensed Beds | Medicare-Certified beds | Medicare/Medicaid-dually certified beds | SNF Medicare ADC | SNF Medicaid ADC | SNF-All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|---|
| The Pavilion -THS | 42 | 0 | 0 | 0 | 0 | 0 | 6 | 6 | *14% |
| Mount Juliet Health Care Center | 106 | 0 | 106 | 17 | 2 | 0 | 77 | 96 | 91% |
| Quality Care Health Center | 290 | 0 | 290 | 18 | 34 | 7 | 212 | 271 | 94% |
| Lebanon Health and Rehab Center | 60 | 60 | 0 | 25 | 0 | 7 | 22 | 54 | 90% |
| Total | 498 | 60 | 396 | 60 | 36 | 14 | 317 | 427 | 86% |

* Mitchell Manor owned and operated a facility which is now out of service. The facility which was likely 80 plus years old, lost Medicaid and Medicare certification resulting in all patients being removed from the facility during the approximate month of June, 2008. Shortly thereafter, this facility was purchased by the precursor to the current operating entity, Pavilion-THS. New ownership slowly integrated a small number of patients into the facility in order to regain the certifications lost under the prior ownership. The facility was not Medicaid re-certified until January 29th, 2009.

Wilson County Nursing Homes Historical Utilization -2009

| Nursing Home | Licensed Beds | Medicare-certified beds | Medicare/Medicaid-dually certified beds | SNF Medicare ADC | SNF Medicaid ADC | SNF-All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|---|
| The Pavilion -THS | 60 | 0 | 0 | 0 | 12 | 0 | 7 | 19 | **32% |
| Mount Juliet Health Care Center | 106 | 0 | 106 | 7 | 2 | 2 | 81 | 91 | 86% |
| Quality Care Health Center | 290 | 0 | 290 | 3 | 28 | 6 | 206 | 242 | 83% |
| Lebanon Health and Rehab Center | 60 | 60 | 0 | 35 | 0 | 0 | 15 | 50 | 83% |
| Total | 516 | 60 | 396 | 45 | 42 | 8 | 321 | 416 | 81% |

** The facility continued to operate only 22 of the approved beds in the facility previously known as Mitchell Manor, pending completion of the new facility now known as the Pavilion. Additional space available in the now closed facility was located in a basement which was deemed unsatisfactory for patient use and was there not utilized, thereby effecting the licensed occupancy rate. The prior owners had lost Medicaid Certification and it was not re-certified until January 29th, 2009. The new facility now known as the Pavilion was not opened until November of 2009.

Wilson County Nursing Homes Historical Utilization -2010

| Nursing Home | Licensed Beds | Medicare-certified beds | Medicare/Medicaid-dually certified beds | SNF Medicare ADC | SNF Medicaid ADC | SNF-All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|---|
| The Pavilion -THS | 60 | 0 | 60 | 0 | 36 | 0 | 17 | 53 | ***91% |
| Mount Juliet Health Care Center | 106 | 0 | 106 | 16 | 0 | 0 | 80 | 96 | 91% |
| Quality Care Health Center | 290 | 0 | 290 | 22 | 34 | 3 | 219 | 278 | 96% |
| Lebanon Health and Rehab Center | 60 | 60 | 0 | 43 | 0 | 0 | 9 | 52 | 86% |
| Total | 516 | 60 | 456 | 81 | 70 | 3 | 325 | 479 | 93% |

*** The facility transitioned from the increase in beds and the opening of the new facility in November of 2009. There was a natural progression of filling the available rooms during the first few months of 2010. The applicant would assert that an occupancy rate of approximately 98% existed within the facility after April of 2010.

**4. Section C. Need, Item 6**

**Please complete the chart providing the projected utilization for 2012 and 2013, the two intervening years between the filing of the application and the opening of the project**

**The Pavilion-THS Historical and Projected Utilization**

| Year | Licensed Beds | Medicare-certified beds | Medicare/Medicaid-dually certified beds | SNF Medicare ADC | SNF Medicaid ADC | SNF-All other Payors ADC | NF ADC | Total ADC | Licensed % Occupancy |
|---|---|---|---|---|---|---|---|---|---|
| 2008 | 60 | | | | | | | | |
| 2009 | 60 | | | | | | | | |
| 2010 | 60 | | | | | | | | |
| 2011 | 60 | | | | | | | | |
| 2012 | 60 | 0 | 60 set up and staffed | 6 | 43 | 10 | 0 | 59 | 98% |
| 2013 | 60 | 0 | 60 set up and staffed | 7 | 41 | 10 | 0 | 58 | 97% |
| 2014 | 84 | | | | | | | | |
| 2015 | 84 | | | | | | | | |

4. **Section C, Economic Feasibility, Item 2 (Funding)**

   Your response is noted. The letter from an officer of your lending institution (Pinnacle National Bank), stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan and any restrictions or conditions is noted. However, the term sheet provided notes interest in loaning the applicant "the lesser of $1,500,000 or 80% of the cost to add 24 skilled beds." The applicant's estimated cost of the project in the Project Cost Chart totals $1,823,093. Please identify and provide documentation regarding how the applicant or its owners plan and capability to fund the remainder of the project's cost.

   **Applicant calculates that it will need to provide additional funds in addition to the amounts listed in the term sheet of approximately $364,618.40. The Pavilion-THS attaches hereto printed bank statements showing two separate accounts holding cash deposits in the amounts of $327,443.66 and $119,408.96 for a total of $446,852.62. This amount is sufficient to cover any other outstanding cash to fund the remainder of the project's cost.**

2012 JUN 8 AM 10 44

## *Demand Deposit 5546262 - Total Healthcare Systems LLC*

| | Rel | Birthdate | Phone | Tax Identification |
|---|---|---|---|---|
| [01] Total Healthcare Systems LLC | * | | ********** | ********** |

Reserve Account
680 Tennessee Blvd
Lebanon TN 37087

Additional Relationships
Tax Name: [1] Total Healthcare Systems LLC

### *Summary*

| | | | |
|---|---|---|---|
| Memo Ledger Balance: | $327,443.66 | Date Opened: | Jun 06, 2012 |
| Memo Available Balance: | $327,443.66 | | |
| Current Ledger Balance: | $0.00 | | |
| Current Available Balance: | $0.00 | | |
| Interest Balance: | $0.00 | | |
| Current Statement Rate: | 0.0950% | | |
| Overdraft Limit: | $0.00 | | |
| ATM/POS Overdraft Balance: | $0.00 | | |

### *Memo Balances*

| | | | |
|---|---|---|---|
| Current Ledger Balance: | $0.00 | Current Reg CC Cash Available: | $0.00 |
| Plus Presentments: | $327,443.66 | Plus Presentments: | $327,443.66 |
| **Memo Ledger Balance:** | **$327,443.66** | **Memo Available Balance:** | **$327,443.66** |

### *Projected Float*

| Projected Date | Available Float | Expiring Holds | Projected Balance |
|---|---|---|---|
| Projected Balances do not include Presentments | | | |
| Jun 07, 2012 Thursday | | | $0.00 |
| Jun 08, 2012 Friday | | | $0.00 |
| Jun 09, 2012 Saturday | | | $0.00 |
| Jun 10, 2012 Sunday | | | $0.00 |
| Jun 11, 2012 Monday | | | $0.00 |
| Jun 12, 2012 Tuesday | | | $0.00 |

### *Interest*

| | | | |
|---|---|---|---|
| Date Accrued Through: | Jun 06, 2012 | Deposit Rate Index: | [33] ZENITH MM BUSINESS |
| Current Statement Rate: | 0.0950% | Rate Adjuster Option: | Rate Adjuster Is Not Expressed as a Percentage Variance |
| Days Into This Period: | 1 | Compounding Code: | Simple |
| Last Interest Jun 05, 2012: | $0.00 | Interest Cycle: | 25th of the Month |
| | | Interest Reporting Code: | Reportable |
| | | Withholding Code: | No Withholding |

### *Rate*

| Date | Balance Type | Rate Structure | Rate | Tier Amount | Rate |
|---|---|---|---|---|---|
| Jun 06, 2012 | Available | [1] Tiered Rate | 0.0950% | $10,000.00 | 0.1450% |
| | | | | $25,000.00 | 0.1450% |
| | | | | $50,000.00 | 0.1950% |
| | | | | $100,000.00 | 0.1950% |
| | | | | $500,000.00 | 0.2450% |

**SUPPLEMENTAL- # 2**
**June 8, 2012**
**10:42 am**



## *Demand Deposit 5469830 - Pavilion THS LLC*

| | Rel | Birthdate | Phone | Tax Identification |
|---|---|---|---|---|
| [01] Pavilion THS LLC | * | | ********** | ********** |

Operating Account
680 Tennessee Blvd
Lebanon TN 37087

Additional Relationships
Tax Name: [1] Pavilion THS LLC

## *Summary*

| | | | |
|---|---|---|---|
| Memo Ledger Balance: | $119,408.96 | Last Deposit Jun 06, 2012: | $15,011.89 |
| Memo Available Balance: | $119,408.96 | Last Check Jun 06, 2012: | $853.94 |
| Current Ledger Balance: | $119,879.71 | Date Last NSF: | Feb 03, 2012 |
| Current Available Balance: | $104,867.82 | Paid NSF Items YTD: | 5 |
| Previous Ledger Balance: | $112,303.03 | Returned NSF Items YTD: | 1 |
| Previous Available Balance: | $108,991.57 | Times Overdrawn YTD: | 1 |
| Overdraft Limit: | $1,500.00 | Date Opened: | Nov 18, 2011 |
| ATM/POS Overdraft Balance: | $0.00 | | |

## *Memo Balances*

| | | | |
|---|---|---|---|
| Current Ledger Balance: | $119,879.71 | Current Reg CC Cash Available: | $104,867.82 |
| Less Presentments: | ($470.75) | Less Presentments: | ($470.75) |
| **Memo Ledger Balance:** | **$119,408.96** | Plus Float Available Today: | $15,011.89 |
| | | **Memo Available Balance:** | **$119,408.96** |

## *Projected Float*

| Projected Date | Available Float | Expiring Holds | Projected Balance |
|---|---|---|---|
| Projected Balances do not include Presentments | | | |
| Jun 07, 2012 Thursday | $15,011.89 | | $119,879.71 |
| Jun 08, 2012 Friday | | | $119,879.71 |
| Jun 09, 2012 Saturday | | | $119,879.71 |
| Jun 10, 2012 Sunday | | | $119,879.71 |
| Jun 11, 2012 Monday | | | $119,879.71 |
| Jun 12, 2012 Tuesday | | | $119,879.71 |

## *Reg CC Balances - Repeat Overdrafter (Auto) Aug 03, 2012*

| Projected Date | Cash Balance | Check Balance | Float Balance |
|---|---|---|---|
| Projected Balances do not include Presentments | | | |
| Jun 07, 2012 Thursday | $119,879.71 | $119,879.71 | $119,879.71 |

## *Reg CC Days NSF*

| | Jun 2012 | May 2012 | Apr 2012 | Mar 2012 | Feb 2012 | Jan 2012 |
|---|---|---|---|---|---|---|
| Reg CC Days NSF: | | | | | 1 | 2 |
| Reg CC Days NSF > $4,999: | | | | | 1 | 1 |

## *Service Charge*

| | | | |
|---|---|---|---|
| Date Last Service Charge: | May 31, 2012 | Service Charge Cycle: | [30] Month-End |
| Average Ledger Balance: | $160,627.66 | Maintenance Method: | 30 |
| Average Available Balance: | $145,932.05 | Activity Method: | 30 |
| Days Into This Period: | 6 | Credit Back Method: | 30 |
| Date Minimum Balance: | Jun 05, 2012 | Credit Back Option 1: | Primary/Secondary Deposits |

2012 JUN 8 AM 10 42 SUPPLEMENTAL

Enclosures

**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF WILSON

NAME OF FACILITY: Pavilion – THS

I, Hal Bone, 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.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 7th day of June, 2012 witness my hand at office in the County of Wilson, State of Tennessee.

NOTARY PUBLIC

My commission expires 7-6, 2015

CARMEN BUTCHER STATE OF TENNESSEE NOTARY PUBLIC WILSON COUNTY

HF-0043

Revised 7/02

WEEKS & ANDERSON
*An Association of Attorneys*

**2021 RICHARD JONES ROAD, SUITE 350**
**NASHVILLE, TENNESSEE 37215-2874**
TELEPHONE 615/383-3332
FACSIMILE 615/383-3480

2012 SEP 10 AM 10: 06

KENT M. WEEKS
ROBERT A. ANDERSON

F. B. MURPHY, JR.
E. GRAHAM BAKER, JR.

DIRECT TELEPHONE NUMBER: 615/370-3380

September 6, 2012

Melanie Hill, Executive Director
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Re: The Pavilion – THS, CN1204-016
Opposition Letter

Dear Mrs. Hill:

I represent Quality Care Health Center, a nursing home located in Lebanon, Tennessee. On its behalf, I am filing this letter of opposition to the referenced CON application for the addition of twenty-four (24) nursing home beds.

There is no need for the addition of nursing home beds in Wilson County based on occupancy rates of existing facilities. The project is not economically feasible, projecting an average cost per new bed in excess of $75,962, nor will the addition of these nursing home beds contribute to the orderly development of health care in the area.

I and representatives from Quality Care Health Center will attend the September 26, 2012 meeting of the Health Services and Development Agency to more fully discuss the reasons for our opposition.

Sincerely,

Graham

E. Graham Baker, Jr.
/np

c: G. Frank Lannom, Esq.

BRADLEY ARANT BOULT CUMMINGS LLP

Michael D. Brent
*Partner*
Direct: (615) 252-2361
Fax: (615) 252-6361
mbrent@babc.com

2012 SEP 11 AM 10: 09

September 7, 2012

**VIA email and US Mail**
Ms. Melanie Hill
Tennessee Health Services & Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Re: Opposition to The Pavilion-THS (CN1204-016)

Dear Melanie:

On behalf of Mt. Juliet Health Care Center, Inc, d/b/a Mt. Juliet Health Care Center, we respectfully oppose the above referenced request of The Pavilion-THS for the addition of 24 new nursing home beds. We, along with other representatives of Mt. Juliet Health Care Center, intend to be present at the Agency meeting on September 26, 2012 to further express our opposition, as we do not believe the application meets the applicable requirements as to need, orderly development and other factors.

If you have any questions or need anything further, please do not hesitate to contact me.

Very truly yours,

BRADLEY ARANT BOULT CUMMINGS, LLP

Michael D. Brent

MDB/

CC: Frank Lannom, Esq. (via US Mail)
Graham Baker, Esq. (via eMail)
Jeff Parrish, Esq. (via eMail)

7/2955293.1

Lebanon
Health & Rehabilitation Center

September 11, 2012

Ms. Melanie Hill, Executive Director
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Re: Opposition to The Pavilion – THS
(CN1204-016)

Dear Ms. Hill:

On behalf of SSC Lebanon Operating Company LLC d/b/a Lebanon Health and Rehabilitation Center, a skilled nursing facility operating in Lebanon, Tennessee, I am writing to respectfully oppose the above-referenced request of The Pavilion-THS to expand by an additional 24 nursing home beds. I intend to be present, along with other representatives of Lebanon Health and Rehabilitation Center, at the Agency meeting on September 26, 2012 to further express our opposition to this project. We do not believe the occupancy rates for the existing facilities in the area support the addition of new beds.

If you have any questions, please do not hesitate to contact me.

Sincerely,

KBD

Kerry B. Dickerson, MBA
Administrator
Lebanon Health and Rehabilitation Center

731 Castle Heights Court ■ Lebanon, Tennessee 37087 ■ 615-444-4319 ■ Fax: 615-444-4393

**CERTIFICATE OF NEED**
**REVIEWED BY THE DEPARTMENT OF HEALTH**
**DIVISION OF HEALTH STATISTICS**
615-741-1954

**DATE:** August 31, 2012

**APPLICANT:** The Pavilion-THS
1406 Medical Center Drive
Lebanon, Tennessee 37087

**CONTACT PERSON:** G. Frank Lannom, Esquire
137 Public Square
Lebanon, Tennessee 37087

**COST:** $1,823,093

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

**SUMMARY:**

The applicant, The Pavilion-THS, a licensed 60-bed nursing home located at 1406 Medical Center Drive, Lebanon (Wilson County), Tennessee, seeks Certificate of Need (CON) approval for the addition to the currently existing facility and for approval for the addition of 24 skilled nursing home beds from the nursing home bed pool. All 24 beds will be dually certified for Medicaid and Medicare. The expanded facility will have a total of 84 licensed beds; 78 semi-private and 6 private beds. The facility currently provides care for private-pay, Medicare Level II, and Medicaid Level I and II residents. There will be no change to the services currently provided.

The addition to The Pavilion will be a single story, wood framed building with systems and finishes to match the existing phase one facility, including a full sprinkler system. The estimated square foot cost for the project is $169.64 which compares favorably with HSDA new construction cost data that ranges from $153.05 to $220.50 per square foot. The new addition will encompass 8,341 square feet and have a maximum additional capacity of 22 residents. This will essentially be a copy of one of the wings of the existing facility containing resident rooms, nursing areas, assisted bathing area, and resident common living spaces. The additional two beds will result from the conversion of two existing private rooms to semi-private rooms. Rooms in the addition will all be semi-private, the facility as a whole will retain six private rooms. Each private room has its own bath, and semi-private rooms will have shared baths. The semi-private rooms feature half-wall separation of sleeping areas instead of traditional curtain separation. This will create a more residential dormitory room setting, rather than a clinical or institutional environment. There will be a common dining and living area within the addition which will contribute to the level of privacy for the residents who may seek a less institutionalized experience.

The facility owner and operator, Total Healthcare Systems, LLC, is a Tennessee limited liability company. Total Healthcare Systems, LLC has an ongoing management agreement with Stein and Associates, LLC. Stein and Associates currently manage the facility and will continue the same following approval of the CON and completion of the facility expansion.

The total estimated project cost is $1,823,092.75 and will be financed through a commercial loan from Pinnacle Financial Partners as detailed in a letter from the President in Supplemental 1. In addition, the applicant states in Supplemental 2, that they calculate they will need additional funds

in addition to the amounts listed on the terms sheet of approximately $364,618.40. The Pavilion-THS attaches in Supplemental 2, printed bank statements from Pinnacle Bank showing two separate accounts holding cash deposits in the amounts of $327,443.66 and $119,408.96 for a total of $446,853.62. The applicant states this amount is sufficient to cover other outstanding cash to fund the remainder of the project's cost.

## GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

**NEED:**
The applicant's service area is Wilson County.

The following charts illustrate the 2012 and 2016 total population projections and age 65 and older population projections for the applicant's service area.

**Service Area Total Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Wilson | 114,437 | 121,203 | 5.9% |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

**Service Area Age 65 and Older for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Wilson | 13,646 | 15,998 | 17.2% |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

The following chart illustrates the 2010 nursing home utilization for Wilson County.

**Wilson County Nursing Home Utilization 2010**

| Nursing Home | Licensed Beds | SNF Beds-Medicare | SNF/NF Beds-Dually Certified | NF Beds-Medicaid | NF-ADC (Medicaid/ Level I Only) | SNF Medicare Level II ADC | NF-ADC | Licensed Occupancy |
|---|---|---|---|---|---|---|---|---|
| The Pavilion | 60 | 0 | 60 | 0 | 4 | 0 | 55 | 91.4% |
| Quality Care Health Center | 290 | 0 | 290 | 0 | 176 | 22 | 219 | 96.1% |
| Lebanon Health and Rehab. Center | 60 | 60 | 0 | 0 | 0 | 43 | 9 | 85.6% |
| Mount Juliet Health Care Center | 106 | 0 | 106 | 0 | 55 | 16 | 80 | 90.5% |
| **Total** | **516** | **60** | **456** | **0** | **235** | **81** | **363** | **93.2%** |

Source: *Joint Annual Report of Nursing Homes 2010,* Tennessee Department of Health, Division of Health Statistics

Licensed Beds-Total beds in a nursing home licensed by the Tennessee Department of Health.
SNF Beds, Medicare Skilled Nursing or TennCare/Level II beds where the payor source is either Medicare or Skilled Medicaid.

SNF/NF Beds, Dually Certified-Medicare Skilled Nursing or TennCare/Level II and Intermediate Care or TennCare/Level I beds where the payor source is either Medicare or Medicaid.

NF Beds-Medicaid-Intermediate Care or TennCare/Level I beds where the payor source is Medicaid

Licensed Only Beds Non Certified-Skilled Nursing and Intermediate Care beds. Payor source is

private pay.

SNF Medicare/Level II ADC-Average Daily Census for skilled patients whose payor source is Medicare. Average Daily Census is calculated by taking Medicare skilled/Level II patient days and dividing it by the number of days in a year (365) resulting in an average daily census.

NF-ADC-Average Daily Census for Level I/Intermediate Care patients.

Facility Occupancy-Occupancy rate for the total nursing home facility. Occupancy Rate is calculated by taking total patient days and dividing it by the number of beds available in a year.

Source: The definitions and presentation are done in accordance with Health Services and Development Agency Members and Staff requirements, October 2006.

**Chart Summary**

There are 516 licensed beds in Wilson County, of which 60 beds are SNF Beds-Medicare, 456 beds are SNF-NF Beds-Dually Certified, and 232 beds are NF Beds-Medicaid. The average daily census (ADC) of NF-Medicaid/Level I Only beds is 0, the ADC for SNF Medicare Level II beds is 81, and the ADC for NF Beds is 363. The 2010 average licensed occupancy is 93.2% for the Wilson County agencies.

*Note to Agency Members: Of interest, one possible explanation for the occupancy of intermediate care patients in beds certified for skilled care is the legal precedent established in the Linton Ruling, a Tennessee lawsuit settled in 1990. HSDA deputy legal counsel provides a summary of the Linton Ruling as follows: "Mildred Lea Linton, a nursing home resident, represented a class of plaintiffs who alleged that Tennessee's nursing home bed certification policy, in which fewer than all beds within a particular wing or floor could be available for Medicaid recipients, violated the Medicaid Act. Ms. Linton's nursing home apportioned only 40 of its 87 intermediate care facility beds as Medicaid beds. When Medicaid officials reduced Ms. Linton's care eligibility from skilled to intermediate, Ms. Linton's nursing home informed her that it was decertifying her Medicaid bed and would not likely have available any Medicaid beds. The District Court found that Tennessee's "limited bed policy" violated the Medicaid Act, and the state was instructed to submit a remedial plan, which, among other provisions, required Medicaid providers to certify all available, licensed nursing home beds within their facilities and to admit residents on a first-come, first-serve basis."*

There are 516 nursing home beds in Wilson County; 456 are dually certified (88% of the total beds) and the remaining 60 are Medicare certified only. The applicant states the large proportion of dually certified beds means that those beds can be filled with Level I or Level II patients. Medicaid is the primary payor of Level I care for Medicaid eligible enrollees, and secondary payor for Level II care (pays for Level II only after Medicare has been exhausted).

The applicant reports that in 2009, Level I days accounted for 79% of total nursing home patient days in Wilson County. Level I patients have significantly longer average length of stay than do Level II patients, and consequently tend to tie up beds longer per patient. Since most Medicaid patients are placed in beds by their families, the applicant does not have a source of first hand conformation of a need for Medicaid beds as they do from the hospital confirming a need for additional Level II beds, but the high rate of occupancy of nursing home beds needed indicates a high need for beds for Medicaid patients. The applicant states approval of 24 dually certified beds will likely open up more of the currently existing 60 dually certified beds to Medicaid patient thus contributing to the needs of the low income groups in the area.

The current building is quite new, opening in late 2009, with the only significant flaw being that it is now too small to meet the current and projected demand for nursing home beds in Wilson County, at the most desirable facility. The applicant ``notes that prior to being built in 2009, this operation was located in a 50 year old former private home that was in steep decline wit it was

bought by Community Progress Committee, Inc. who constructed the current facility and moved the residents there in late 2009. Community Progress Committee contracted with the management company Stein and Associates to rehabilitate the former facility and then manage the new facility once it opened. Community Progress Committee, Inc. subsequently sold the facility to the current owner Total healthcare Systems, LLC who continues to contract with Stein and Associates, LLC to provide the high level of care the facility residents have come to expect.

Based on the formula from the Guidelines for Growth, Wilson County has a need of 123 additional nursing home beds. An aging and rapidly growing population combined with the fact that the facility is fully occupied; the facility has a wait list of at least 56 people. Coupled with the aforementioned county need; there is pa clear and present need for additional beds. The Pavilion states that the patients on the waiting list are all long-term care applicants. The applicant states they would not be able to keep them on the waiting list for skilled care because the hospitals would discharge them to another skilled facility. The additional beds in turn present the need to expand the current facility to meet the current and projected demands of the population. The Pavilion-THS has been operating in its new facility for over two years and has maintained an occupancy rate over 90% since March 2010.

The Pavilion-THS's existing facility has 60 dually certified nursing home beds with enough space to add 6 more beds. There are 4 nursing homes in Wilson County including The Pavilion-THS. Of the 4 nursing homes, 3 primarily provide long-term care typically associated with nursing homes. Lebanon Health and Rehabilitation is a Medicare only facility and focuses more on short term care, catering to patients recovering from surgery or illness and who typically remain in the facility for less than 6 months. According to the 2010 Joint Annual Report of Nursing Homes, each of the 3 long-term care nursing homes had an average occupancy of 90%, while Lebanon health and Rehabilitation had an average of approximately 86%.

The applicant is seeking approval for 24 skilled nursing beds under the bed pool. These beds will all be semi-private. The applicant's rational for requesting more semi-private beds is that they believe the physical layout of their facility lends itself quite well to addressing the needs of their residents whether they are in a semi-private or a private room. The applicant states they always work with their residents and their families to accommodate the needs of each resident. The semi-private rooms create the flexibility that the applicant needs to assist in that process. The applicant reports there are and will continue to be times that they may not be able to place two residents in a semi-private room for medical and psycho-social reasons.

According to the applicant, the bed change will allow The Pavilion-THS to take in more admittees without disrupting service to its current admittees because the new beds will be located in a newly constructed wing to the current facility and additional staff will be hired to accommodate the increased bed count. The combination of the new facility, its proximity to UMC Hospital, and the effective management of Stein and Associates, LLC, has led to a level of service that has kept the facility operating near capacity for its entire existence and created a substantial waiting list of potential admittees. The same level of service will be maintained for the beds in the new addition to the building.

The applicant reports a significant number of nursing home patients are currently leaving Wilson County for nursing home care. The applicant cites the 2008 Joint Annual Report of Nursing Homes reports, of the 368 Wilson County residents receiving nursing home care, 91 were receiving care outside of Wilson County, and 277 were receiving care in Wilson County, an out-migration of 25%. The applicant believes this project will allow more Wilson County residents to stay in the county for nursing home care in more desirable facilities.

The applicant projects 28,036 patient days in year one and 29,324 patient days in year two of the project.

**TENNCARE/MEDICARE ACCESS:**
The applicant states they currently participate in Medicaid Level I and Medicare. The applicant contracts with AmeriGroup and United Healthcare Community Plan. The applicant states that since obtaining Medicare certification on December 17, 2010, the facility has contacted the State about receiving certification of Level II residents for Medicaid.

The following chart illustrates the TennCare enrollees in the applicant's service area.

**TennCare Enrollees in the Proposed Service Area**

| County | 2012 Population | TennCare Enrollees | % of Total Population |
|---|---|---|---|
| Wilson | 114,437 | 14,067 | 12.3% |

Source: *Tennessee Population Projections 2000-2020,* February 2008 Revision Tennessee Department of Health, Division of Health Statistics and *Tennessee TennCare Management Information System, Recipient Enrollment,* Bureau of TennCare

The applicant estimates Medicaid revenues of $2,817,651 or49% of total gross revenue and Medicare revenues of $1,728,480 or 30% of total gross revenues.

**ECONOMIC FACTORS/FINANCIAL FEASIBILITY:**
In the Project Costs Chart, the total estimated project cost is $1,823,092.75, which includes $40,000 for architectural and engineering fees; $10,000 for legal, administrative, and consulting fees; $29,000 for preparation of site; $1,414,992 for construction costs; $100,000 for contingency fund; $100,000 for moveable equipment; $62,500 for interim financing; and $4,092.75 for CON filing fees.

On the Historical Data Chart located in Supplemental 1, the applicant reports 3,857, 13,457, and 21,404 in 2009, 2010, and 2011 with gross operating revenues of $443,527, $1,757,944, and $3,855,345 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $443,527, $1,602,875, and $3,855,345 each year. The applicant reported a net operating income/(loss) ($449,816), ($41,096,717), and $164,904 each year, respectively.

In the Projected Data Chart, the applicant projects 28,036 patient days in year one and 29,324 patient days in year two with gross operating revenues of $6,713,463.20 and $7,315,706.85 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $5,771,463.20 and $6,330,106.85 each year. The applicant projects management fees to affiliates in years one and two of $240,000 and management fees to non-affiliates of $90,000 in year one and two of the project. The applicant project a net operating income of $607,429.45 in year one and $820,804.40 in year two of the project.

The applicant projects an average daily charge in year one of $211.95, with average deduction of $0.36, resulting in an average net charge of $211.59. In year two, the applicant projects an average gross charge of $223.20, with an average deduction of $0.33, resulting in an average net charge of $222.87. The applicant compares average daily charge with Quality Care and Mt. Juliet Health Care on page 40 of the application.

The applicant did not find the alternative of creating an addition with a smaller footprint to be practical. The residents of the new wing will have the same benefits enjoyed by those in the existing wing. The new wing could be built without the same benefits thus reducing the overall cost of the project, but the applicant feels they need to maintain the strengths of the existing wing in the new addition.

The applicant reports that modernization is not practical and new construction is necessary because the existing facility was completed in December of 2009 and is currently too small to meet

Wilson County's demand for new nursing home beds based on the projected need for the county and the waiting list for new residents.

The maximum number of beds the applicant can add to the existing facility is 6. Given the need for 123 additional beds in the county, the applicant feels that it would be inefficient to propose adding only those 6 beds at this point and then waiting until the next review period to apply for the addition to the facility and additional beds in this CON.

**CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:**
The applicant provides a listing of health care providers, hospitals, home care organizations, alliances and/ or networks with which they currently or plan to have contractual or working relationships on page 43 of the application.

According to the applicant, the addition to the facility and increase in beds will have a positive effect on the health care system. The Pavilion-THS provides care for 60 residents at any one time and currently has a waiting list of at least 56 people. Continuing its high level of service by expanding the size of the facility and adding beds, The Pavilion-THS seeks to fulfill its resident's best interest and provide care for a greater number of those who need it. The expanded facility will provide an alternative to those families who have been forced to seek care outside of Wilson County.

The 4 nursing homes in Wilson County are cooperating near capacity combined with a need for 123 addition nursing home beds and a growing and aging population. This project will not duplicate services or result in nursing homes having to compete for a diminishing potential resident population. On the contrary, the additional beds will provide a partial relief at best for the significant demand of new nursing home beds in the county.

The applicant believes the living arrangements and care and design of their facility which will be replicated in the proposed addition are what people desire and need. To the extent other facilities may be minimally impacted, such impact is due to a clear shift from older institutional style facilities to the residential community style offer by this project.

The applicant provides a current and proposed year one and year two staffing chart in Supplemental 2.

The Pavilion-THS has collaborated with Tennessee Technology Center's Hartsville campus to provide an environment to facilitate the clinical aspect of that institution's Practical Nursing Program.

The Pavilion-THS is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities. The applicant was surveyed for Life Safety Code Standards On 11/22/2010 and deficiencies were noted. On 11/23/2010 a second full survey was conducted and no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.

## SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

## NURSING HOME SERVICES

Public Chapter No. 1112, Senate Bill No. 2463, which passed during the 1998 legislative session, amended and changed the code sections establishing the bed need formula that the Health Facilities Commission must follow when granting certificates of need for nursing home beds in Tennessee. During a fiscal year (July 1-June 30), the Commission shall issue no more than the

designated number of Medicare skilled nursing facility beds for applicants filing for a certificate of need. The number of Medicare skilled nursing facility beds issued shall not exceed the allocated number of beds for each applicant. The applicant must also specify in the application the skilled services to be provided and how the applicant intends to provide such services.

A. Need

1. According to TCA 68-11-108, the need for nursing home beds shall be determined by applying the following population-based statistical methodology:

   County bed need = .0005 x pop. 65 and under, plus
   .0120 x pop. 65-74, plus
   .0600 x pop. 75-84, plus
   .1500 x pop. 85, plus

   *The Division of Health Statistics calculated the Wilson County bed need to 639 beds. Currently there are 516 licensed beds in Wilson County resulting in a need for 123 additional beds.*

2. The need for nursing home beds shall be projected two years into the future from the current year, as calculated by the Department of Health.

   *The Division of Health Statistics used the 2012 population projected to 2014 to calculate the bed need.*

3. The source of the current supply and utilization of licensed and CON approved nursing home beds shall be the inventory of nursing home beds maintained by the Department of Health.

   *The Division of Health Statistics calculated the Wilson County bed need to 639 beds. Currently there are 516 licensed beds in Wilson County resulting in a need for 123 additional beds. The applicant states HSDA's website shows there are 115 available beds remaining in the July 1, 2011-June 30, 2012, 125 bed pool.*

4. Service Area" shall mean the county or counties represented on an application as the reasonable area to which a health care institution intends to provide services and/or in which the majority of its service recipients reside. A majority of the population of a service area for any nursing home should reside within 30 minutes travel time from that facility.

   *The proposed service area is Wilson County. Over 78% of The Pavilion-THS's patients are residents of Wilson County. The service area is within 30 minutes drive time of the facility.*

5. The Health Facilities Commission may consider approving new nursing home beds in excess of the need standard for a service area, but the following criteria must be considered:

   a. All outstanding CON projects in the proposed service area resulting in a net increase in beds are licensed and in operation, and

      *There are no outstanding CON's for nursing home beds in the service area.*

   b. All nursing homes that serve the same service area population as the applicant have an annualized occupancy in excess of 90%.

## *Wilson County Nursing Home Utilization 2010*

| *Nursing Home* | *Licensed Beds* | *SNF Beds-Medicare* | *SNF/NF Beds-Dually Certified* | *NF Beds-Medicaid* | *NF-ADC (Medicaid/ Level I Only)* | *SNF Medicare Level II ADC* | *NF-ADC* | *Licensed Occupancy* |
|---|---|---|---|---|---|---|---|---|
| *The Pavilion* | *60* | *0* | *60* | *0* | *4* | *0* | *55* | *91.4%* |
| *Quality Care Health Center* | *290* | *0* | *290* | *0* | *176* | *22* | *219* | *96.1%* |
| *Lebanon Health and Rehab. Center* | *60* | *60* | *0* | *0* | *0* | *43* | *9* | *85.6%* |
| *Mount Juliet Health Care Center* | *106* | *0* | *106* | *0* | *55* | *16* | *80* | *90.5%* |
| ***Total*** | ***516*** | ***60*** | ***456*** | ***0*** | ***235*** | ***81*** | ***363*** | ***93.2%*** |

*Source: Joint Annual Report of Nursing Homes 2010, Tennessee Department of Health, Division of Health Statistics*

*Only Lebanon Health and Rehabilitation Center is below 90% occupancy at 85.6%. The county average occupancy is 93.2%.*

## CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

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

   *The Guidelines relative to the addition of nursing home bed is addressed above.*

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.

      *This criterion is not applicable. This project is not for a replacement or relocation.*

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

      *This criterion is not applicable. This project is not for a replacement or relocation.*

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.

      *The Pavilion-THS has been operating in its new facility for over two years and has maintained an occupancy rate over 95% since April 2010. As the occupancy rate clearly reflects, the new facility is more attractive to potential admittees than the old facility which caused a rise in demand and has resulted in a waiting list of at least 56 new admittees who would be able to be served if the new building is expanded.*

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

*The applicant states the physical plant's condition is too small to meet demand. This application seeks a total of 24 new beds, which would allow some flexibility in designating the number of private rooms in the facility while assuring the availability of private rooms for residents who desire that level of service. The expansion will essentially be a copy of one of the existing wings of the facility.*

**HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING**
**SEPTEMBER 26, 2012**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | Southern Sports Medicine Surgery Center |
| PROJECT NUMBER: | CN1204-019 |
| ADDRESS: | 127 Saundersville Pike, Suite A<br>Hendersonville, (Sumner County), TN 37075 |
| LEGAL OWNER: | Southern Sports Surgical, LLC<br>570 Hartsville Pike<br>Gallatin, (Sumner County), TN 37066 |
| OPERATING ENTITY: | Southern Sports Medicine Institute, LLC<br>570 Hartsville Pike<br>Gallatin, (Sumner County), TN 37066 |
| CONTACT PERSON: | Thomas Gautsch, M.D.<br>(615) 452-3320 |
| DATE FILED: | April 13, 2012 |
| PROJECT COST: | $3,355,533 |
| FINANCING: | Commercial Loan and Lease |
| PURPOSE OF REVIEW: | Relocation of an approved, but unimplemented, Certificate of Need for the establishment of an ambulatory surgical treatment center (ASTC) and expansion of its designated use from single specialty to multi-specialty |

DESCRIPTION:

Southern Sports Medicine Surgery Center seeks approval for the relocation of an approved, but unimplemented Certificate of Need for the establishment of an ambulatory surgical treatment center and expansion of the designated use of its previously approved single specialty ASTC (CN1104-013A) to include multi-specialty services. The proposed project will relocate from 1163 Nashville Pike, Gallatin (Sumner

County), TN to 127 Saundersville Pike, Suite A, Hendersonville, (Sumner County), Tennessee. *See the Plot Plan in Attachment B.III.* The relocated, unimplemented ASTC is proposed to be housed in a single story building immediately adjacent to the relocated orthopaedic surgical practice of Southern Sports Medicine Institute (SSMI), which also plans to move to Hendersonville from its current location at 570 Hartsville Pike, Gallatin, Tennessee. The project will contain approximately 6,200 square feet including 2 operating rooms and one procedure room, a three (3) station pre-operative preparation/holding area, a six (6) station primary post-operative recovery area and a three (3) station secondary recovery area; and support areas including instrument cleaning and reprocessing area, supply and equipment storage, and staff locker rooms and lounge, and a reception and waiting area, as previously approved in CN1104-013A. *See the Floor Plan in Attachment B.IV.* The applicant indicates the facility would be open for operation at least 250 days/year, 8 hours/day. If this Certificate of Need application is granted, the applicant indicates it will surrender CN1104-013A.

Service Specific Criteria and Standard Review

**AMBULATORY SURGICAL TREATMENT CENTER**

1. **The need for an ambulatory surgical treatment center shall be based upon the following assumptions:**
   a. **An operating room is available 250 days per year, 8 hours per day.**

      *The applicant's operating rooms will be available at least 250 days per year, eight hours per day.*

   b. **The average time per outpatient surgery case is 60 minutes.**

      *The applicant anticipates that its average time per surgery case will be over 60 minutes. The applicant's surgical cases are mainly orthopaedic surgeries which on average take longer than typical cases found in a multispecialty surgery center. See pages 15-19 of the original application for the applicant's explanation of how many of their cases will require more than 60 minutes.*

   c. **The average time for clean up and preparation between outpatient surgery cases is 30 minutes.**

      *The applicant's clean up time will on average not exceed 30 minutes.*

d. **The capacity of a dedicated, outpatient, general-purpose operating room is 80% of full capacity. That equates to 800 cases per year.**

*The applicant believes that its operating rooms will function at utilization levels in excess of the time utilization equivalent of 800 sixty-minute cases per year. The average surgical time for all outpatient cases of the applicant surgeons is approximately 110 minutes. See pages 15-19 of the original application for the applicant's explanation of how many of their cases will require more than 60 minutes.*

e. **Unstaffed operating rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity**

*There are no unstaffed operating/procedure rooms in the two existing ambulatory surgical treatment centers located in the applicant's service area, Sumner County.*

2. **"Service Area" shall mean the county or counties represented by the applicant as the reasonable area to which the facility intends to provide services and/or in which the majority of its service recipients reside.**

*The applicant identifies Sumner County as the proposed project's service area. 79% of the patients in the physicians' practice associated with the proposed project reside in Sumner County.*

*It appears that this application meets the criterion.*

3. **The majority of the population of a service area for an ambulatory surgical treatment center should reside within 30 minutes travel time to the facility.**

*The applicant states that all of Sumner County is within 30 minutes travel time to Hendersonville and this facility.*

*It appears that this application meets the criterion.*

4. **All applicants should demonstrate the ability to perform a minimum of 800 operations and/or procedures per year per operating room and/or procedure room. This assumes 250 days x 4 surgeries/procedures x .80.**

*The applicant projects in the supplemental response 1,269 operating room cases by the second year of operation. Based on the assumptions above, the minimum standard for two operating rooms which applies here would be 1,600 cases. It would appear that the criterion has not been met. However, the discussion on pages 14-19 of the original application regarding the type of surgeries performed by the surgeons of Southern Sports Medicine Institute presents the case that their cases require considerably more time than 60 minutes per surgical case (averaging 103 minutes per case). The volume of these types of surgeries combined with the time requirements per case exceed the annual operating time equivalent for 800 cases per year per room which average 60 minutes per case. Thus, it would appear that the application does meet this criterion.*

*The applicant is projecting 431 procedure room cases by the second year of operation. It appears that the applicant does not meet the criterion's minimal standard of 800 procedures per year.*

5. **A certificate of need (CON) proposal to establish a new ambulatory surgical treatment center or to expand the existing services of an ambulatory surgical treatment center shall not be approved unless the existing ambulatory surgical services within the applicant's service area or within the applicant's facility are demonstrated to be currently utilized at 80% of service capacity. Notwithstanding the 80% need standard, the Health Services and Development Agency may consider proposals for additional facilities or expanded services within an existing facility under the following conditions: proposals for facilities offering limited-specialty type programs or proposals for facilities where accessibility to surgical services is limited.**

*There are two existing ASTCs in Sumner County: one is a single-specialty ophthalmology ASTC and the other a multi-specialty ASTC. The two facilities combined have 3 operating rooms and 3 procedure rooms. Their combined utilization in 2011, per the Joint Annual Report, was*

*5,663 procedures. Eighty percent capacity of six operating/procedure rooms is 4,800 procedures. Since neither of the two hospitals in Sumner County report having dedicated outpatient operating rooms, the 80% capacity figures for these facilities cannot be calculated.*

*It appears that this application meets the criterion.*

6. **A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must specify the number of projected surgical operating rooms to be designated for ambulatory surgical services.**

*The applicant plans to have two (2) operating rooms and one (1) procedure room in the ASTC designated for ambulatory surgical services.*

*It appears that this application meets the criterion.*

7. **A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the proposed project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

*The applicant provides projected utilization for the first eight quarters after project completion on page 23 of the original application. On page 16 and page 19 of the original application, the applicant provides the methodology for projections which includes current procedures performed by Drs. Gautsch and Grutter and projecting forward an approximate 20% growth over 4 years, projections for another orthopedic surgeon to be added in 18 months and pain management procedures for a nonsurgical musculoskeletal care specialist who joined Southern Sports Medicine Institute in August 2011.*

*It appears that this application meets the criterion.*

8. **A CON proposal to establish an ambulatory surgical treatment center or to expand the existing services of an ambulatory surgical treatment center must project patient origin by percentage and county of residence. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

*The applicant has selected a service area of Sumner County. Approximately 79% of the physicians' practice patients reside in Sumner County. The ASTCs patient origin is based on the practice's patient origin.*

*It appears that this application meets the criterion.*

SUMMARY:

The applicant, Southern Sports Surgical, LLC, (SSS) is currently owned by Thomas Gautsch, M.D. and Paul Grutter, M.D., both of whom practice together in a successful orthopaedic surgery practice, Southern Sports Medicine Institute (SSMI) in Gallatin (Sumner County), Tennessee. The applicant, Southern Sports Surgical, LLC, (SSS) is a Tennessee limited liability corporation organized in the state of Tennessee on April 7, 2011 for the purpose of establishing an ASTC associated with the practice of Southern Sports Medicine Institute (SSMI). SSMI's ownership currently consists of Thomas L. Gautsch, M.D. (50%) and Paul W. Grutter, M.D. (50%). Both physicians are also owners of Southern Sports Surgical, LLC, (SSS), each with 50% ownership proportions. The applicant indicates management services to SSS will be provided by SSMI. The facility in which both the practice, SSMI, and the ambulatory surgical treatment center, SSS, will operate will be developed by Southern Sports Holdings, LLC, (SSH) which is owned by Thomas L. Gautsch, M.D. (50%) and Paul W. Grutter, M.D. (50%). At the time of the application's filing, the proposed site was owned by Southern Sports Holdings, LLC, which has signed a purchase agreement for the Saundersville Road site in Hendersonville. Both the medical practice, SSMI, and the ASTC, SSS, will lease their separate spaces in the building. SSS and SSH have also executed an option to lease for 10 years agreement. *Note to Agency members: A copy of the organization chart illustrating the above relationships is provided in Attachment A. Item 4.*

The applicant has future plans to expand the ownership of SSS, to include other surgeons by dilution of shares. Additionally, the applicant has discussed its willingness to offer an ownership position in the center to area hospitals. However,

other than a potential future agreement, no current agreement exists at this time. Although the proposed project will initially be managed by Southern Sports Medicine, PLLC (*the official name of the orthopaedic surgical practice which does business as Southern Sports Medicine Institute*), the applicant states with rapidly evolving healthcare and changing reimbursement models, contracting with a larger ASTC management company may be beneficial for the ASTC and its patients in the future. Ownership may also be offered to that management company, if deemed appropriate.

Southern Sports Surgical, LLC successfully sought and was approved for CN1104-013A on August 24, 2011 for the establishment of a single specialty orthopedic ambulatory surgical treatment center (ASTC), containing 6,200 square feet including two (2) operating rooms, one (1) procedure room, a pre-post holding area and support space in Gallatin. CN1104-013A has not been implemented.

Southern Sports Surgical, LLC is now seeking a certificate of need to expand services to multi-specialty, as well as relocate to Sumner County's largest population center, "without *(in the applicant's words)* changing significantly" from the approved two (2) operating room, one (1) procedure room CON, except with modifications, which the applicant feels improves on the approved project. The applicant further describes the proposed project as follows:

1) The proposed project will include ASTC services for multiple specialties, including at least Orthopedic Surgery and all of its subspecialties, including Spine, Sports and Hand surgery, appropriate to the outpatient setting, and the full spectrum of Pain Management procedures of whatever specialty, Orthopedic, Sports Medicine, Spine, Neuro, or Anesthesia, with allowance for other surgical specialty utilization of the facility as well.

2) The initial Certificate of Need project CN1104-013A was granted for a 1.4 acre lot with [Gallatin] city site restrictions and requirements that resulted in the ASTC being located on the second floor of the medical office building. A larger, 2.9 acre lot has now been put under contract in Hendersonville, which will allow the previously granted ASTC floor plan to be moved to the ground level with minimal modification, create more parking, improve patient access, ingress and egress, and ease of future expansion.

3) Additionally, initial project and the only currently existent Sumner County multi-specialty ASTC are both located in Gallatin, the second largest population center in Sumner County. There is no multi-specialty ASTC or granted CON in the Hendersonville region of Sumner County, the largest and fastest growing population center in Sumner County.

4) The site is also considerably closer, by both distance and travel time, to one of the two local hospitals than that previously granted, facilitating faster transfer of patients, if necessary.

*Further details can be found on pages 4-8 of the original application.*

The applicant cites several reasons for the need for an additional ASTC:

1) Continuous population growth and projected growth in Sumner County, increasing the need for healthcare facilities such as ambulatory surgical treatment facilities
2) Currently there are only two ambulatory surgical treatment centers in Sumner County: one is limited to only ophthalmology cases and unavailable for orthopaedic patients, while the other ASTC only has two operating rooms for a multi-specialty ASTC and is operating at over 1,100 patients per room
3) A comparison of populations and ASTC operating rooms in counties closest in population to Sumner County demonstrates a relative lack of ASTC access for residents of Sumner County. Sumner County with 3 ASTC operating rooms (OR) for its 160,645 residents equates to 1.2 OR per 100,000 residents. The average in the sixteen (16) most similarly populated counties is one ASTC OR per every 15,061 residents. *The applicant has provided the details of its sixteen (16) county ASTC OR/ population analysis on pages 5 and 6 of the application.*
4) The cost effectiveness of ASTCs compared to hospital based outpatient surgery department (HOPD) has been demonstrated by the MedPac's March 2009 Report to Congress which reported that Medicare payments to ASTCs were substantially lower than payments to hospitals for the great majority of similar outpatient procedures. The applicant states by utilizing ASTCs rather than hospital outpatient surgery departments, Medicare and Medicaid, private insurances and patients save billions of dollars annually.
5) The applicant quotes the MedPac March 2009 Report to Congress as citing ASTCs:
   a) providing greater patient convenience than hospital outpatient departments in terms of their locations, ability to schedule surgery more quickly and shorter waiting times
   b) for most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower for ASTC's than for hospital outpatient

departments (*Note to Agency members: The federal Medicare/Medicaid terminology ASC (i.e., ambulatory surgery center) equates to the State of Tennessee's terminology of ASTC (i.e., ambulatory surgical treatment center).*

c) physicians may find it more convenient and efficient to perform procedures in ASTCs because they often have customized surgical environments and specialized staffing

d) additional advantages for ASCs relative to hospital outpatient surgeries include greater convenience to patients and providers, decreased program spending, and beneficiary cost sharing on a per service basis.

6) If the CON is granted, the applicant indicates surgeons of allied and varied other specialties will also be offered surgical privileges, with the option of ownership shares in the proposed ASTC. The applicant states the expansion of allowed surgical services will provide potentially greater utilization of its operating rooms and procedure rooms, and thereby enhance the economic stability and viability of the project into the future.

The applicant is planning to continue to serve the growing orthopaedic/musculoskeletal care needs for Sumner County through growth of the medical practice as well as developing a single location for both the orthopedic practice and the ambulatory surgical treatment center. Both of the SSMI practice's surgeons specialize in arthroscopic ligamentous repair and reconstruction of major joints predominantly the shoulder, knee and elbow. They also provide as part of their orthopedic practice some pain relieving injections. A non-surgical musculoskeletal care specialist, Dr. Jeffrie Kindred, joined the practice in August 2011 and a third surgeon is expected to join the practice in 18 months, respectively. Dr. Kindred is a primary care, fellowship trained, non-surgical musculoskeletal specialist trained in and routinely performs fluoroscopically and ultrasound guided injections into affected nerves, muscles, tendons and joints. The two current physician members of the medical practice already perform over 800 such procedures per year without benefit of the use of fluoroscopic and ultrasound guidance, due to lack of availability. The applicant indicates fluoroscopic and ultrasound guidance of these injections has already been shown clinically superior and more consistently accurate and so current patients will benefit from that availability. Patients requiring imaging assisted injections are referred to Nashville pain management centers. Dr. Kindred has been able to add an additional dimension pain management to the orthopedic practice. One or two additional pain management specialist physicians are planned to be added to the practice in the future. The applicant intends to perform orthopaedic surgical cases in the proposed ASTC's operating rooms and pain management procedures which the physicians consider to be part of their orthopaedic practice in the procedure room.

The applicant indicates its primary service area will be Sumner County from which the Southern Sports Medicine Institute drew 79% of its patients. According to the Department of Health's Division of Health Statistics, the population of the service area county is estimated to be 162,422 in 2012 and is expected to increase by 5.2% to 170,883 by 2016. The age 65+ proportion of the service area population in 2012 is 20,947 (12.9% of the total population) and is projected to grow by 15.4% to 24,163 in 2016 (14.1% of the total population). Service area residents enrolled in TennCare on November 15, 2011 equal 14.2% of the population, according to the Bureau of TennCare. The statewide proportion of the population enrolled in TennCare is 19.1%

Based on the Joint Annual Reports submitted to the Department of Health, there are currently two ambulatory surgical treatment centers licensed within Sumner County. Of these, the Green Surgery Center is licensed to perform only ophthalmologic procedures. The other ASTC within the applicant's declared service area, Patient Partners Surgery Center, is licensed as a multi-specialty ASTC and has two (2) operating rooms and two (2) procedure rooms. According to the 2011 Joint Annual Report, its largest service is endoscopy (56% of the 4,402 total patients), followed by otolaryngology (25.4%) general surgery (7.6%) and orthopedics (5.4%, or 241 cases and 364 procedures). The 2011 operating/procedure room utilization calculates to 1,101 patients per room and 1,907 procedures per room, as compared to the *Guidelines for Growth's* minimum utilization standard of 800 surgical cases/procedures per operating room.

The applicant's physicians do not feel with only two operating rooms, Patient Partners Surgery Center has additional operating room time available to accommodate their surgical time needs. They currently do not perform many cases at Patient Partners Surgery Center, preferring to perform their surgical cases at Sumner Regional Medical Center, which is across the street from their practice's current location.

*Note to Agency members: See the applicant's calculations of surgical time needs on pages 16-19 of application. The applicant explains on page 18 that their surgeries of the shoulder and knee (90% of their surgeries) require on average 132 minutes per surgery, including time to perform the surgery (average of 101 minutes/case), as well as room clean up and preparation time for the next surgery (30 minutes per case). Utilizing the applicant's demonstrated operating times and applying them with the applicant's projected surgical case volume, the applicant projections of 167,508 operating room minutes per year exceeds the minimum standard of 144,000 operating room minutes/year, which is the operating room time to which the Guidelines for Growth standard of 800 cases/per room/year computes.*

Below are the available capacity and utilization of the ambulatory surgical treatment center (excluding eye surgery) and hospital operating rooms in Sumner County:

| | 2008 | | 2009 | | 2010 | | 2011 | | |
|---|---|---|---|---|---|---|---|---|---|
| ASTC/Hospital | Oper. Rms | Cases | Oper. Rms | Cases | Oper. Rms | Cases | Oper. Rms | Cases | % of Total |
| Patient Partners Surgery Center | 2 | | 2 | | 2 | | 2 | | |
| Orthopedic | | 627 | | 475 | | 456 | | 241 | 5.5% |
| **Total Outpatient Surgeries** | | **4,651** | | **4,084** | | **5,109** | | **4,402** | **100%** |
| | | | | | | | | | |
| Sumner Regional Medical Center | 8 | | 8 | | 7 | | 6 | | |
| Inpatient Surgeries | | 1,066 | | 1,562 | | 1,713 | | 1,879* | 38% |
| **Outpatient Surgeries** | | **3,597** | | **3,306** | | **3,373** | | **3,007*** | **62%** |
| Total | | 4,663 | | 4,868 | | 5,086 | | 4,886* | 100% |
| Hendersonville Med. Center | 8 | | 8 | | 8 | | 8 | | |
| Inpatient Surgeries | | 1,082 | | 1,148 | | 1,188 | | 1,177* | 29.7% |
| **Outpatient Surgeries** | | **2,583** | | **3,034** | | **2,993** | | **2,779*** | **70.3%** |
| Total | | 3,665 | | 4,182 | | 4,181 | | 3,956* | 100% |
| Portland Medical Center | 2 | | 0 | Closed | 0 | Closed | 0 | Closed | Closed |
| Inpatient Surgeries | | 15 | | 0 | | 0 | | 0 | - |
| **Outpatient Surgeries** | | **265** | | **0** | | **0** | | **0** | - |
| Total | | 280 | | 0 | | 0 | | 0 | - |
| Sumner County Totals | 20 | | 18 | | 17 | | 16 | | |
| Inpatient Surgeries | | 2,163 | | 2,710 | | 2,901 | | 3,056* | 23.0% |
| **Outpatient Surgeries** | | **11,096** | | **10,424** | | **11,475** | | **10,188*** | **77.0%** |
| Total | | 13,259 | | 13,134 | | 14,376 | | **13,244*** | 100% |
| Cases per OR | | 663 | | 730 | | 848 | | 828 | |

*Provisional

Sources: TN Dept. of Health: Joint Annual Reports: ASTCs: 2008-2011 *Final;* Hospitals 2009-2010 *Final,* 2011 *Provisional*

The applicant points out while the number of outpatient surgeries continues to grow, the number of operating rooms in which to perform them has been reduced over the past four years with the closing of Portland Medical Center, with its two operating rooms, and the reduction of two OR's at Sumner Regional Medical Center. The applicant also demonstrates that the number of cases per operating room has risen 25% over the past three years. *Note to Agency members: Excluding eye surgeries, the number of outpatient surgeries constitutes almost 77% of the total surgeries performed in the County's operating rooms. The proportion of outpatient surgeries at Sumner Regional Medical Center is 62%, and the proportion of outpatient surgeries at Hendersonville Medical Center is 77%.*

Projections indicate the facility will perform 1,000 cases (746 surgical cases and 254 procedure room cases) in the first year of operation and 1,700 cases in the second year (1269 surgical cases and 431 procedure room cases). *Note to Agency members: Although the*

*applicant is asking for multi-specialty designation, the utilization projections provided for the application are based on surgical cases and pain management cases generated only by the members of the Southern Sports Medicine Institute's practice.*

The projected Average Gross Charge per "Surgery" case is $5,200, with average deductions from revenue reducing the Average Net Revenue collected to $1,766 per case. The projected Average Gross Charge per "Pain Management" case encounter is $760, with average deductions from revenue reducing the Average Net Revenue collected to $299 per case. Net operating income less capital expenditures (NOI) of ($68,140) is projected, an amount equal to approximately 1.7% of gross operating revenue during the first year of operation. NOI is expected to increase to a level of approximately 6.9% of gross operating revenue on 1,700 cases in the second year of the project, raising its net operating income less capital expenditures to $362,974.

The applicant proposes to staff the ASTC with 9.4 FTEs (5 RNs, 2 OR techs, 0.4 FTE Instrument tech and 2 clerical support staff). The SSMI surgeons planning initially to use the SSS ASTC will also utilize one to two staff members from their practice when using the ASTC. These SSMI employees will be paid by the practice and are not listed on the ASTC's payroll.

The government payor mix is expected to be 5% TennCare (or $195,468) and 22% Medicare (or $883,676) based on gross operating revenue in the first year of the project. The applicant states it intends to contract with three TennCare MCOs: TennCare Select, United Healthcare Community Group and AmeriGroup. All three of these MCOs are currently contracted with Southern Sports Medicine Institute (SSMI).

The total estimated project cost is $3,355,533. This sum is composed of $2,416,586 for a 10 year facility lease, $520,000 for fixed and moveable equipment, $100,000 in contingency, $50,414 in initial supply stock, $91,000 in architectural and engineering fees, $60,000 for legal administrative and consultant fees; $110,000 reserve for one year Debt Service and $7,533 for the CON filing fee. The applicant's architect indicates the ASTC will be designed to comply with the AIA Guidelines for the Design and Construction of Health Care Facilities as well as the International Building Codes, the NFPA Life Safety Codes, and all other applicable codes. The architect's estimated construction costs for the project is approximately $290/square foot. *See the architect's attestation letter in Attachment C Economic Feasibility – 1.*

The applicant intends to finance the project through a bank loan and capital contributions ($94,474 each) of the current members of the limited liability corporation. The first supplemental response contains a copy of a letter from the Senior Vice

President of Volunteer State Bank, indicating Volunteer State Bank's interest in providing a $5,750,000 construction and equipment loan to Southern Sports Holdings and Southern Sports Surgical, LLC. Copies of Drs. Gautsch and Grutter's Personal Financial Statements are also included in the application.

*The applicant has submitted the required corporate documentation, real estate purchase agreement, applicant option to lease, and management contract. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency's office.*

Should the Agency vote to approve this project, the CON would expire in two years.

**CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:**
There are no other Letters of Intent, denied or pending applications for this applicant.

Outstanding Certificates of Need
**Southern Sports Medicine Surgery Center, CN1104-013A**, has an outstanding Certificate of Need which is due to expire on October 1, 2014. The Certificate of Need was approved at the August 24, 2011 Agency meeting for the establishment of a single specialty Ambulatory Surgical Treatment Center (ASTC), dedicated to Orthopaedic Surgery and Musculoskeletal Care at 1163 Nashville Pike, Gallatin, (Sumner County), TN 37066. The estimated cost of the project is **$3,296,400.** *Project Status Update: The applicant has located a more desirable location in Hendersonville (Sumner County), Tennessee which is the subject of this application, CN1204-019. The applicant indicates CN1104-013A will be surrendered if this CON, CN1204-019, is granted.*

**CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:**

There are no other Letters of Intent, denied or pending applications or outstanding Certificates of Need for other Service Area entities proposing this type of ambulatory surgical treatment service.

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**
PMW 08/24/12

# LETTER OF INTENT

2012 APR 10 AM 8:40

# LETTER OF INTENT
# TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the ___Tennesean_____ which is a newspaper
(Name of Newspaper)
of general circulation in _____Sumner County_____, Tennessee, on or before ____April 10th___, 2012,
(County) (Month / day) (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

Southern Sports Surgery Center owned by: Southern Sports Surgical, LLC with an ownership type of Limited Liability Company and managed by: Southern Sports Medicine Institute, PLLC intends to file an application for a Certificate of Need for:

The establishment of a multi-specialty Ambulatory Surgical Treatment Center. Following Agency rules, the applicant seeks a new CON, but only to: (a) expand the designated use of its previously granted ASTC project CON CN1104-013A to include multi-specialty services, and (b) relocate the project to a setting more accessible to the served population. Otherwise, the application remains with the same estimated project cost of $3.3 million. The center will still contain approximately 6,200 square feet of space including 2 operating rooms, 1 procedure room, pre & post holding area and support space as previously granted. Relocated to Lot 38 (Indian Lake Village Final Plat Book 26, Page 141) Saundersville Road, Hendersonville, TN 37075, within the same service area, the project does not contain any major medical equipment and will not initiate or discontinue any other health service. If granted, the applicant will surrender CON CN1104-013A.

The anticipated date of filing the application is: April 14, 2012.

The contact person for this project is Thomas Gautsch, M.D., who may be reached at:

Southern Sports Medicine Institute
570 Hartsville Pike
Gallatin, TN, 37066
615-452-3320

_____ ____April 10th__ tgautsch@southern-sports.com
(Signature) (Date) (E-mail Address)

==========

**The Letter of Intent must be <u>filed in triplicate</u> and <u>received between the first and the tenth</u> 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**
**500 Deaderick Street, Suite 850**
**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.

==========

# ORIGINAL APPLICATION

SUPPLEMENTAL

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

2012 MAY 30 PM 3:08

Southern Sports Medicine Surgery Center
Name

127 Saundersville Road Suite A
Street or Route

Sumner
County

Hendersonville
City

TN
State

37075
Zip Code

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

Thomas Gautsch, M.D.
Name

Chief Manager
Title

Southern Sports Medicine Institute
Company Name

tgautsch@southern-sports.c
Email address

570 Hartsville Pike
Street or Route

Gallatin
City

TN
State

37066
Zip Code

Shareholder
Association with Owner

615-452-3320
Phone Number

615-745-3544
Fax Number

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

Southern Sports Surgical LLC
Name

615-442-3320
Phone Number

570 Hartsville Pike
Street or Route

Sumner
County

Gallatin
City

TN
State

37066
Zip Code

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

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

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

SUPPLEMENTAL

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

Name: Southern Sports Medicine Institute, LLC

Street or Route: 570 Hartsville Pike

County: Sumner

City: Gallatin

State: TN

Zip Code: 37066

**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 [ ]
B. Option to Purchase [ ]
C. Lease of 10 Years [✓]
D. Option to Lease [ ]
E. Other (Specify) [ ]

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

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

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

18

SUPPLEMENTAL

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 | | | | | |
| B. Surgical | | | | | |
| C. Long-Term Care Hospital | | | | | |
| D. Obstetrical | | | | | |
| E. ICU/CCU | | | | | |
| F. Neonatal | | | | | |
| G. Pediatric | | | | | |
| H. Adult Psychiatric | | | | | |
| I. Geriatric Psychiatric | | | | | |
| J. Child/Adolescent Psychiatric | | | | | |
| K. Rehabilitation | | | | | |
| 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** | | | | | |

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** to be applied for

**Certification Type**

11. **Medicaid Provider Number** to be applied for

**Certification Type**

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

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.***

**SECTION B: PROJECT DESCRIPTION**

**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:**

Description – During the August 2011 HSDA meeting Southern Sports Surgical, LLC was granted CON CN1104-013A to establish an orthopaedic ambulatory surgical treatment center (ASTC) containing approximately 6200 square feet of space, and including two (2) operating rooms, one (1) procedure room, pre/post holding area and support space. The location of the approved ASTC is 1163 Nashville Pike, Gallatin, (Sumner County), Tennessee, with an estimated project cost of $3,296,400. The expiration date for the certificate of need is October 1, 2013.

As presented at the August meeting, and as it still stands, Sumner County residents currently only have access to a solitary, two (2) operating room ASTC in our entire county of now over 165,000 people. This is the only local ASTC setting in which they could receive Orthopedic Surgical (including Spine and Hand) or Pain Management procedures. Only 2 ASTC ORs represents a significant shortage of ASTC ORs for the county and consequent lack of access to multi-specialty ASTC services for Sumner County residents, compared to residents of all other Tennessee counties of similar size. While the applicant's previously granted, but as yet un-built, CON CN1104-013A addresses the unmet orthopedic ambulatory surgical needs of the population of Sumner County, limited as it is currently to Orthopedic Surgery, it does not address the lack of access and significant deficiency that remains for patients needing other surgical specialties.

Southern Sports Surgical, LLC now seeks a certificate of need to expand services to multi-specialty, as well as move to a location more accessible to Sumner County's largest population center, without otherwise changing significantly from the approved two (2) operating room, one (1) procedure room CON except with only small modifications, which improve on the approved project.

The proposed project is to include ASTC services for multiple specialties, including at least Orthopedic Surgery and all of its subspecialties, including Spine, Sports and Hand surgery, appropriate to the outpatient setting, and the full spectrum of Pain Management procedures of whatever specialty, Orthopedic, Sports Medicine, Spine, Neuro, or Anesthesia, with allowance for other surgical specialty utilization of the facility as well. This proposed project will provide a more substantial and meaningful contribution to the orderly development of healthcare in Sumner County, so as to now expand the currently very limited access to ASTC services for patients and surgeons of varied surgical specialties, with little increase in project costs. If granted, the applicant will surrender CON CN1104-013A.

CON CN1104-013A was granted for a 1.4 acre lot address with city site restrictions and requirements that resulted in the ASTC being located on the second floor of the medical office building. Additionally, it and the only currently existent Sumner County multi-specialty ASTC are both located in Gallatin, the second largest population center in Sumner County. There is no ASTC or granted CON in the Hendersonville region of Sumner County, the largest and fastest growing population center in Sumner County.

A larger, 2.9 acre lot has now been put under contract in Hendersonville, which will allow the previously granted ASTC floor plan to be moved to the ground level with minimal modification, create more parking, improve patient access, ingress and egress, and ease of future expansion. From an orderly development standpoint, the new site is also located more appropriately for Sumner County's second multi-specialty center, both relative to the population densities and relative to the one other multi-specialty ASTC. The site is also considerably closer, by both distance and travel time, to one of the two local hospitals than that previously

granted, facilitating faster transfer of patients (in those rare cases where it might become necessary) and improving ease of Physician access. The new location is just off a major exit of Highway TN-386, the major artery thoroughfare through Sumner County, and will shorten the overall average driving time that a majority of Sumner County residents will need to travel to receive ASTC care.

With the proposed relocation and expansion of services, the estimated project costs have risen modestly from $3,296,400 to $3,355,533. The economic feasibility of the project already demonstrated and verified in the approved CON CN1104-013A application process and hearing, is conservatively based only on the projected cases, revenues and costs associated with the currently committed Surgeon owner/utilizers, Drs. Gautsch, Grutter, and Kindred to ensure the viability of the project even absent any other users than those associated with their practice. That CON application projected utilization rates of the center of 59%, 76%, and 83% in years 1,2,and 3 respectively, representing a first and second year unused case capacity of at least 410 and 340 standard 60 minute cases, more if the average surgery time of those additional cases is less than 60 minutes. If this CON is granted, surgeons of allied and varied other specialties will also be offered surgical privileges, with the option to purchase ownership shares in the ASTC. The expansion of allowed surgical services will provide potentially greater utilization of its operating rooms and procedure room, and thereby enhance the economic stability and viability of the project on into the future.

Ownership structure –The current and projected owners of Southern Sports Surgical, LLC at the time of the hearing, and their percentage ownership are: Dr. Thomas Gautsch, M.D. (50%) and Dr. Paul Grutter, M.D. (50%). The applicant plans to expand the ownership to include other surgeons by dilution of shares. Additionally, the applicant has discussed its willingness to offer an ownership position in the center to area hospitals, however other than a potential future agreement, no current agreement exists. The proposed project will initially be managed by Southern Sports Medicine, PLLC. However, with rapidly evolving healthcare and changing reimbursement models, contracting with a larger ASTC management company may be beneficial for the ASTC and its patients in the future. Ownership may also be offered to that management company if deemed appropriate.

Service Area –The service area for the project will be Sumner County, from which approximately 80% of the initial owner/utilizer's patients have historically come. Sumner County itself currently has only two licensed surgery centers. Green Surgery Center, LLC (limited to Ophthalmologic surgery only) and Patient Partners, LLC a two (2) OR multi-specialty ASTC. Both are located in Gallatin. Sumner County had a 2010 U.S. Census population of 160,645, projected now to be 169,230, based on an historic 2.4% per year, 10 year average growth. The Tennessee Department of Health projects the population of Sumner County will increase by 33.4% to 211,946 by 2030.

Need – Sumner has fewer multi-specialty ASTC ORs per person -- only 1.2 per 100,000 -- than any other TN county with ASTCs, including those with less than half its population. ORs in Sumner County are 130% above Guidelines capacity of 800 cases per OR.
Sumner County is the one of the fastest growing counties in Tennessee and the fastest growing portion of the County is the Hendersonville area. Nevertheless, with only one multi-specialty ASTC, its population has the lowest level of access to ASTC services in its own county of any County with ASTC access. Historic and continued growth of the Sumner County population in general as well as continued rapid growth of this, the largest population center, has created and will continue to create an increasing need for healthcare facilities, such as this proposed ambulatory surgical treatment facility. Currently, Sumner County has two ASTC's one of which is limited to Ophthalmology and is unavailable to patients of other specialties. The only other ASTC is multi-specialty, has only 2 ORs and is currently functioning at about 1100 cases per room. There is an objective deficiency of ASTC ORs. Additionally, a comparison of populations and ASTC operating rooms, in the 16 most populous TN Counties (Sumner is 8$^{th}$) also demonstrates a significant disparity in number of ASTC ORs and Multi-specialty ORs in Sumner County relative to other TN Counties. Sumner County has a total of only 2 Multi-Specialty ASTC ORs for all of its over 160,000 residents, or 1 multi OR per 80,322 residents. The

SUPPLEMENTAL

average in the 16 similarly populated counties is one ATSC operating room per every 17,345 residents. Put another way, ***Sumner has fewer multi-specialty ASTC ORs per person -- only 1.2 per 100,000 -- than any other county with ASTCs, including those with less than half its population***. Sumner County would require at least 7 additional Multi-specialty ATSC operating rooms, to reach the average level of access available for residents of all the other Counties with ASTCs .

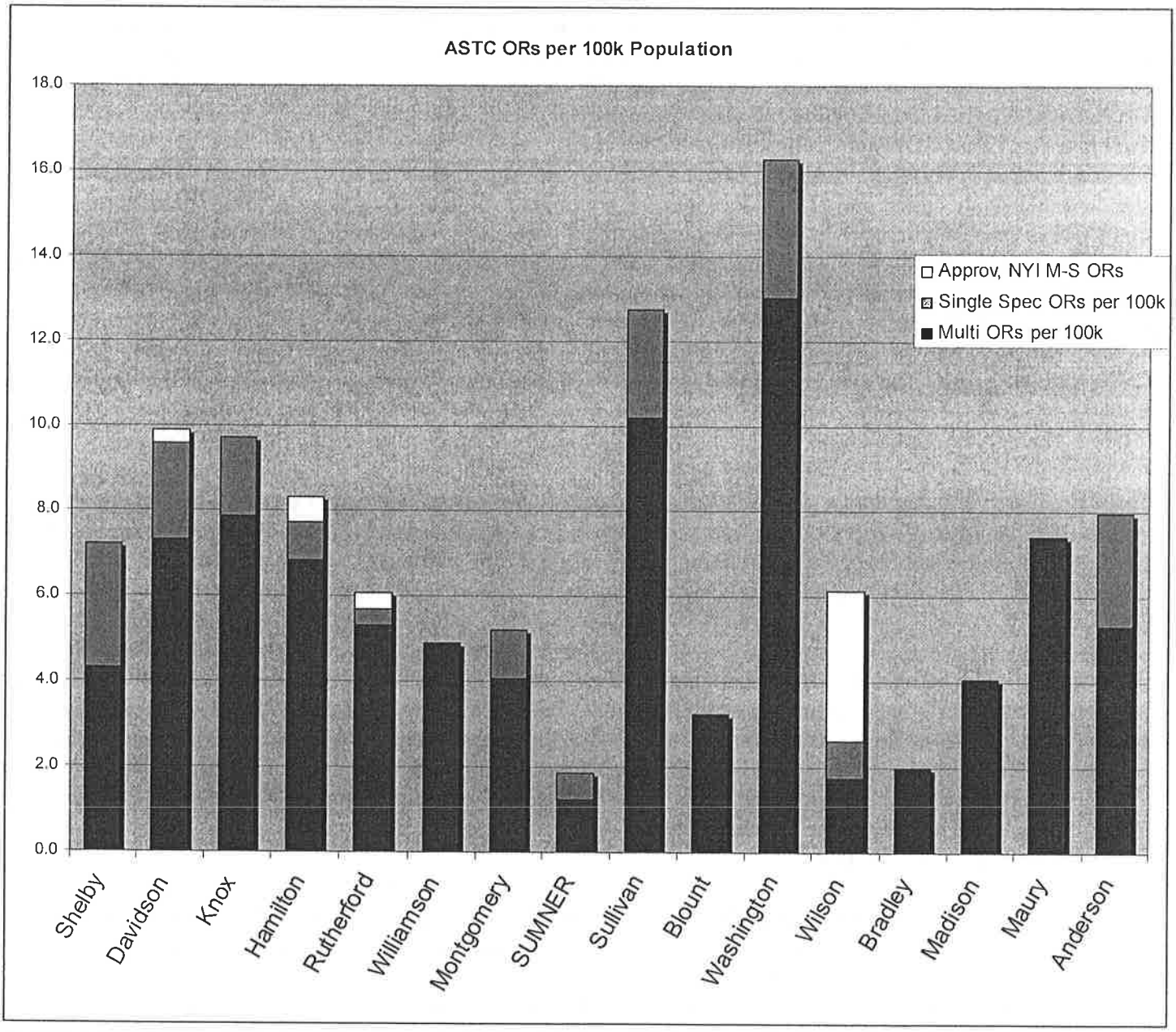



**Chart 1: Sumner County has the fewest ASTC ORs per 100,000 population of any of the comparably sized counties in TN.**

| County | 2010 Census population | Multi Specialty ASTC ORs |
|---|---|---|
| Shelby | 927,644 | 40 |
| Davidson | 626,681 | 46 |
| Knox | 432,226 | 34 |
| Hamilton | 336,463 | 23 |
| Rutherford | 262,604 | 14 |
| Williamson | 183,182 | 9 |
| Montgomery | 172,331 | 7 |
| SUMNER | 160,645 | 2 |
| Sullivan | 156,823 | 16 |
| Blount | 123,010 | 4 |
| Washington | 122,979 | 16 |
| Wilson | 113,993 | 2 (4) |
| Bradley | 98,963 | 2 |
| Madison | 98,294 | 4 |
| Maury | 80,956 | 6 |
| Anderson | 75,129 | 4 |

2012 MAY 30 PM 3:07

**ASTC ORs per 100K population**

| County | 2010 Census population | Number of ASTCs | Multi ORs per 100k | Single Spec ORs per 100k | Approv, NYI M-S ORs | Total ORs per 100k population |
|---|---|---|---|---|---|---|
| Shelby | 927,644 | 29 | 4.3 | 2.9 | - | 7.2 |
| Davidson | 626,681 | 29 | 7.3 | 2.2 | 0.3 | 9.9 |
| Knox | 432,226 | 15 | 7.9 | 1.9 | - | 9.7 |
| Hamilton | 336,463 | 10 | 6.8 | 0.9 | 0.6 | 8.3 |
| Rutherford | 262,604 | 4 | 5.3 | 0.4 | 0.4 | 6.1 |
| Williamson | 183,182 | 5 | 4.9 | 0.0 | - | 4.9 |
| Montgomery | 172,331 | 6 | 4.1 | 1.2 | - | 5.2 |
| SUMNER | 160,645 | 2 | 1.2 | 0.6 | - | 1.9 |
| Sullivan | 156,823 | 12 | 10.2 | 2.6 | - | 12.8 |
| Blount | 123,010 | 2 | 3.3 | 0.0 | - | 3.3 |
| Washington | 122,979 | 8 | 13.0 | 3.3 | - | 16.3 |
| Wilson | 113,993 | 4 | 1.8 | 0.9 | 3.5 | 6.1 |
| Bradley | 98,963 | 1 | 2.0 | 0.0 | - | 2.0 |
| Madison | 98,294 | 3 | 4.1 | 0.0 | - | 4.1 |
| Maury | 80,956 | 3 | 7.4 | 0.0 | - | 7.4 |
| Anderson | 75,129 | 3 | 5.3 | 2.7 | - | 8.0 |
| Average per 100k population | | | 5.6 | 1.2 | | 7.1 |
| Sumner Current | | | **2.0** | **1.0** | | **1.9** |
| Sumner predicted | | | **8.9** | **1.9** | | **11.4** |
| **Sumner Deficiency** | | | **(7)** | **(1)** | | **(9)** |

Existing Resources –Existing resources in Sumner County have actually diminished in the past four years despite the population growth. In 2008 the Portland Medical Center ceased its hospital operations including its surgical services and closed its operating room. This has left all of Sumner County with only 17 operating rooms, one of which is dedicated to ophthalmologic surgery only and all but two of which are in-hospital ORs.

The average surgical room utilization of all ORs combined, as generated from the 2010 service area wide utilization data from the Tennessee Department of Heath, Division of Health Statistics, is 1141 cases per room per year. This is 143% of the recommended capacity of an operating room as defined in the *Tennessee's Health: Guidelines for Growth: Criteria and Standards, 2000 Edition* of 800 cases per year.

Project Cost –$3,355,533, including $2,416,586 of 10-year total lease cost. Excluding lease payments, but including a $110,000 debt reserve and $100,000 contingency fund, the actual capital requirement to fund this project is $938,947.

Funding –Funding for the Project is part of funding of both the ASTC and the new office space. Based upon submitted financials and pro forma calculations, Volunteer State Bank has offered to fund both projects to the extent necessary to cover equipment purchases and the building project as a whole which includes both the ASTC and office spaces.

Financial Feasibility - The project costs are similar to the previously approved CON CN1104-013A which this project will replace as well as other ASTC applications recently heard by the Agency. Operationally, the facility is conservatively projected to have a positive bottom line by the second year of operation and on into the future.

Staffing – Staffing during the first year of operation is expected to be with 11 full-time and part-time staff for an equivalent of 9.4 FTE. The clinical staff will consist of 5 RN's and 3 OR Techs, with 3 full-time office personnel including a Manager.

**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:** A new building will be constructed to house the ASTC, and medical office space including the practice of Southern Sports Medicine Institute. The ASTC will occupy approximately 6200 ft.$^2$ The building will be constructed in accordance with all applicable building and safety codes and to meet all requirements for licensure and accreditation of the facility as an ASTC.

The applicant, Southern Sports Surgical LLC, will lease its space in the building. The developer of the building is Southern Sports Holdings LLC. The estimated total cost to construct the entire building is $4,571,752 ($120 per square foot for the shell, $170 per square foot for the ASTC interior build out, and $90 per square foot for the office build out) of which, approximately $1,798,00 is attributable to the ASTC, as a cost to be born by the developer. Upgrading of the building construction, hospital grade interior build-out and additional surfaces and fixtures necessary to meet the needs of the ASTC will cost an estimated $290 per square foot for the ASTC portion of the construction.

The cost per square foot for the new design and floor plans has been calculated by the architects who have both healthcare facility design and project management experience. The interior build out cost of the new design is now projected to be $190 per square foot for the ASTC (approx 6200 sqft.) The shell cost is estimated to be $120 per square foot. This is a total construction cost per square foot of $290.

$290 per square foot for construction is higher than many ASTC's had projected in their original CON applications of the past seven years, however all of those projects made application prior to several events which have had a significant impact on construction costs in the area. Hurricane Katrina had both direct and indirect influence on an increase in construction costs, which continues, given a significant need for construction personnel for the rebuilding of the regions affected. Recent years also have seen an unprecedented number of tornadoes and floods with a consequent upward effect on both labor and material costs and limited availability.

The only multispecialty ASTC in Sumner County, which is also located in Gallatin, the city of this proposed ASTC, in its CON application of 2004 projected a total construction cost of $185 per square foot. Two and a half years later in its final project report in 2007 (4 years ago), and following the influence of these economic forces between the time of its application and the time of its construction, its final project construction costs had risen to $284.50 per square foot. Based on recent similar projects, Architectural Environments, LLC has projected a $290 per square foot total construction cost for the ASTC portion of this building project.

**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.

**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.

## SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

| A. Unit / Department | Existing Location | Existing SF | Temporary Location | Proposed Final Location | Proposed Final Square Footage | | | Proposed Final Cost/ SF | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Renovated | New | Total | Renovated | New | Total |
| Waiting/reception | | | | | | 590 | 590 | | | |
| Admin Support | | | | | | .5 of 400 | 200 | | | |
| pre/post-2nd Rec | | | | | | 1640 | 1640 | | | |
| 2OR's 1Proc | | | | | | 1200 | 1200 | | | |
| Surg Support etc. | | | | | | 910 | 910 | | | |
| Bathrooms | | | | | | 350 | 350 | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| B. Unit/Depart. GSF Sub-Total | | | | | | 4890 | 4890 | | | |
| | | | | | | | | | | |
| C. Mechanical/ Electrical GSF | | | | | | 460 | 460 | | | |
| D. Circulation /Structure GSF | | | | | | 850 | 850 | | | |
| E. Total GSF | | | | | | 6200 | 6200 | | $290 | $1.798,000 |





SUPPLEMENTAL- # 1

**D. Describe the need to change location or replace an existing facility.** **SUPPLEMENTAL- # 1**

**Response:** CON CN1104-013A was granted for is a 1.4 acre lot which requires the ASTC to be located on the second floor of the medical office building. A 2.9 acre lot has been acquired which allows the ASTC to have a first floor location with improved patient access. The new location is also closer to the fastest growing and most concentrated population of Sumner County, and just off TN-386, the major artery thoroughfare through Sumner County. The new location will give patients greater ease of access than the current granted CON's location, and shorten the average distance that Sumner County residents will have to travel to receive ASTC care.

**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.**

**Response:** Not applicable.

- **b. Provide current and proposed schedules of operations.**

**Response:** Not applicable.

**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.

**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.

**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:** The requested plot plan is attached hereto with the requested information. **SUPPLEMENTAL- # 1**

**(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:** The project site is readily accessible from TN-386 by taking Exit 7, Indian Lake Blvd one block south to Saudersville Rd. The project site is located on the "northeast" corner of Cinema Drive and Saundersville Road, Hendersonville, TN 37075.

Public Transportation is not available in Sumner County.

**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:** The requested floor plan is attached hereto, as well as the plot plan showing the location of the ASTC in the building and the expansion zone immediately adjacent to the ASTC

**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.

**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.**

**Response:** From the 2010 Tennessee State health Plan the following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan:

*1. Healthy Lives*

*The purpose of the State Health Plan is to improve the health of Tennesseans. Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.*

The proposed ASTC will be an integral part of improving the health of the residents of Sumner County, Tennessee by providing access to high quality ambulatory surgery. Injuries and disease significantly impact the quality of health and quality of life of many residents of Sumner County. Improved access to ambulatory surgery in an ASTC setting dedicated to it, will provide the residents of Sumner County the ability to maintain more active healthy lifestyles with improved quality of life and decreased pain depending on their specific conditions.

*2. Access to Care*
*Every citizen should have reasonable access to health care.*
*Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.*

The proposed project expands health care access to the residents of Tennessee. The proposed ASTC provides access to high quality ambulatory orthopaedic surgery. The ASTC will be accessible to all patients of Southern Sports Medicine Institute. Southern Sports Medicine Institute provides care without regard to existing health status, employment, income, geography, or culture.

The proposed project will increase the access to care for the majority of Sumner County residents. There are some residents with existing health conditions, such as advance cardiac and pulmonary disease, which present a contraindication for ASTC care due to the associated anesthesia risks resulting from their underlying co-morbidity. These patients access to care will remain unchanged as they will continue to be taken care of in a hospital setting.

*3. Economic Efficiencies*
*The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.*

The proposed ASTC will improve the economic efficiency of ambulatory surgery in Sumner County, Tennessee. The cost effectiveness of ASTCs compared to hospital based outpatient surgery has been clearly demonstrated. The MedPac March 2009 Report, demonstrates that Medicare payments to ASTCs were substantially lower than payments to hospitals for the great majority of similar outpatient procedures. By utilizing ASTCs rather than hospital outpatient surgery departments, Medicare, Medicaid, private insurances and patients save billions of dollars annually.

The MedPac, March 2009 Report also demonstrates that for most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs. The proposed multi-specialty ASTC provides an innovative, economic and efficient method to improve the health of residents of its service area in Tennessee.

*4. Quality of Care*
*Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through*

The founding Surgeon owner utilizers of the proposed ASTC, Drs. Gautsch and Grutter are both Board Certified Orthopaedic Surgeons with fellowship training and additional subspecialty Board certifications. They were both educated at Johns Hopkins. Drs. Gautsch and Grutter understand the regulations concerning physician licensure, supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education and will work to improve their quality of care through adoption of best practices and data-driven evaluation.

*5. Health Care Workforce*
*The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.*

The proposed ASTC will contribute to the development, recruitment, and retention of a quality health care workforce which corresponds to the 5th principle in the 5 Principals for Achieving Better Health found in the State Health Plan. Southern Sports Medicine Institute, is an active, physician practice with a historic base in Sumner county. Southern Sports Medicine Institute has developed adequate professional staff and contact with nurses and other medical personnel to assure the development, recruitment and retention of a high quality healthcare work force for the proposed ASTC.

The applicant has approached and received a favorable response from the anesthesia group Sumner Anesthesia Associates, Inc. about providing anesthesia services in this proposed ASTC. They are the anesthesia group that provides anesthesia at one of Sumner County's hospitals and the two geographically closest multispecialty ASTC's. They provide anesthesia services for beneficiaries under all TennCare plans. The group's representative has expressed an enthusiastic desire to provide anesthesia services for this proposed ASTC should the CON be granted.
If circumstances were such that for some reason this group became precluded from providing the anesthesia services necessary, this ASTC would still have several options available for anesthesia. There are two very large groups that are based in Nashville which provide anesthesia services to multiple hospitals and ASTC's, including areas surrounding us, with whom we could very likely negotiate a contract. Additionally, if necessary or if it would prove advantageous, the ASTC could recruit and employ an anesthesiologist and CRNA or two to provide anesthesia as well as pain management services.

**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:**
1. The need for an ambulatory surgical treatment center shall be based upon the following assumptions:
**a. An operating room is available 250 days per year, 8 hours per day.**
**Response:** The applicant's operating room will be available at least 250 days per year, eight hours per day.
**b. The average time per outpatient surgery case is 60 minutes.**
**Response:** The applicant anticipates that its average time per surgery case will be over 60 minutes. The applicant's surgical cases are mainly orthopaedic surgeries which on average take longer than typical cases found in a multispecialty surgery center.
**c. The average time for clean up and preparation between outpatient surgery cases is 30 minutes.**

**Response:** The applicant's clean up time will not exceed 30 minutes on average, however set-up times for some reconstructive surgeries can be up to 45 minutes for set-up anesthesia, positioning and prep/draping.

**d. The capacity of a dedicated, outpatient, general-purpose operating room is 80% of full capacity. That equates to 800 cases per year.**

**Response:** The applicant believes that its operating rooms will function at utilization levels in excess of the time utilization equivalent of 800 sixty-minute cases per year.

For the purposes of this application, financial and utilization calculations are conservatively based on the committed volume of cases from its initial owner utilizers, Drs. Gautsch, Grutter and Kindred. It is also anticipated that other surgeons will utilize the center, principally in the same or allied surgical specialties including hand surgery, spine surgery, orthopedic and/or neurosurgical, sports surgery, and pain management surgeries and procedures performed by orthopedic, neurosurgical, pain management, or anesthesia specialists.

The initial owner utilizers specialize in arthroscopic ligamentous repair and reconstruction of the major joints, predominantly of the shoulder and the knee, but also including the elbow. The applicant surgeons are team physicians for a large number of Sumner County teams and athletes who are prone to such injuries. Many recreational athletes and non-athletes as well seek their care and surgical treatment for these type of injuries from the surgeons of Southern Sports Medicine Institute. Consequently, a high percentage of their surgical volume consists of surgical procedures that normally take between 90 and 150 minutes. This is equal to 150% to 250% of the Guidelines' assumed 60 minute "average time" per outpatient surgery case. The average surgical time for all outpatient cases of the applicant surgeons is approximately 110 minutes. 800 sixty-minute cases is the time equivalent of 436, 110-minute cases. Therefore, this ASTC's actual 80% capacity utilization would more correctly be projected to be 400-450 cases per OR, or 800-900 cases in 2 OR's. The applicant expects to reach this utilization threshold between year 2 and 3 of operation, much sooner with the center's use by additional surgeons.

Additionally, many of these arthroscopic shoulder and knee repair/reconstruction surgeries require additional time beyond the average for set up and patient positioning, further adding to the overall time spent on each case. The most efficient method for minimizing these set-up times between surgeries is to utilize two paired operating rooms so that one room can be cleaned and set up during the time that the other is being used for actual surgery, and then vice versa. Experience in orthopedic surgery has shown that two rooms used in tandem this way actually utilizes them both more efficiently than a single room used sequentially for these type of orthopedic cases.

The applicant is also confident that its one procedure room, which will primarily be dedicated to injection procedures, will perform in excess of 800 cases per year in year 2 and thereafter, based upon the combined rate of performance of these procedures already by the applicant surgeons, before counting the addition of another physician utilizer to the practice, and the utilization of unused capacity by other surgeons.

The above statements and calculations are illustrated more fully as follows:

The Guidelines for Growth state:

## AMBULATORY SURGICAL TREATMENT CENTERS

1. The need for an ambulatory surgical treatment center shall be based upon the following assumptions:
a. An operating room is available 250 days per year, 8 hours per day.
b. The average time per outpatient surgery case is 60 minutes.
c. The average time for clean up and preparation between outpatient surgery cases is 30 minutes.
d. The capacity of a dedicated, outpatient, general-purpose operating room is 80% of full capacity. That equates to 800 cases per year.
e. Unstaffed operating rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

Following from these assumptions, the full capacity of an ASTC OR is 1000 surgery cases per year.

1000 surgery cases per year, in 250 days per year = 4 cases per room per day.

4 surgical cases per day at an assumed average 60 minutes per case is 4 hrs of surgery per room per day.

An OR is available 8 hrs per day, therefore at full capacity, the guidelines for growth assume 4 hrs of room down time, some of which is for clean up and preparation between outpatient surgery cases (assumed to be 30 minutes per case.)

Either the guidelines assume 4- 30 minute clean-up/prep times (2 hrs), leaving an additional assumed 2 hrs of down time, perhaps an hour each for initial room set-up and terminal sterilization at the end of the day, or the guidelines mean the average time for clean up and preparation between outpatient surgery cases is 30 minutes (each). In the latter possibility, the timing of 4 surgeries = 4hrs, plus 4 set-ups =2 hrs, plus 4 clean-ups = 2 hrs accounts for all 8 hrs of the day. Which would look like this:

Guidelines for Growth
Standard OR day

Capacity 4 avg surgeries per room
250 days per year
= 1000 surgeries per room, per year

| | |
|---|---|
| 7:00 | 1st Room Set-up for the day |
| 7:30 | |
| 8:00 | 1st Surgery |
| 8:30 | |
| | 1st case Clean up |
| 9:00 | |
| | 2nd case Set-up |
| 9:30 | |
| 10:00 | 2nd Surgery |
| 10:30 | |
| | 2nd case Clean up |
| 11:00 | |
| | 3rd case Set-up |
| 11:30 | |
| 12:00 | 3rd Surgery |
| 12:30 | |
| | 3rd case Clean up |
| 13:00 | |
| | 4th case Set-up |
| 13:30 | |
| 14:00 | 4th Surgery |
| 14:30 | |
| | 4th case Clean up |
| 15:00 | |

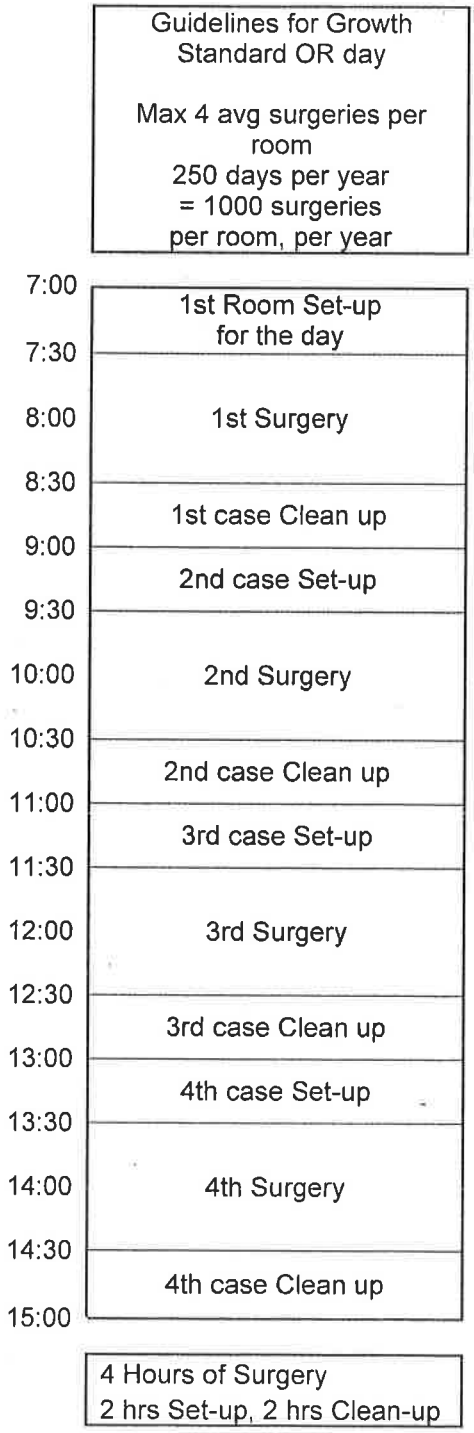
4 Hours of Surgery
2 hrs Set-up, 2 hrs Clean-up = 8 hours total

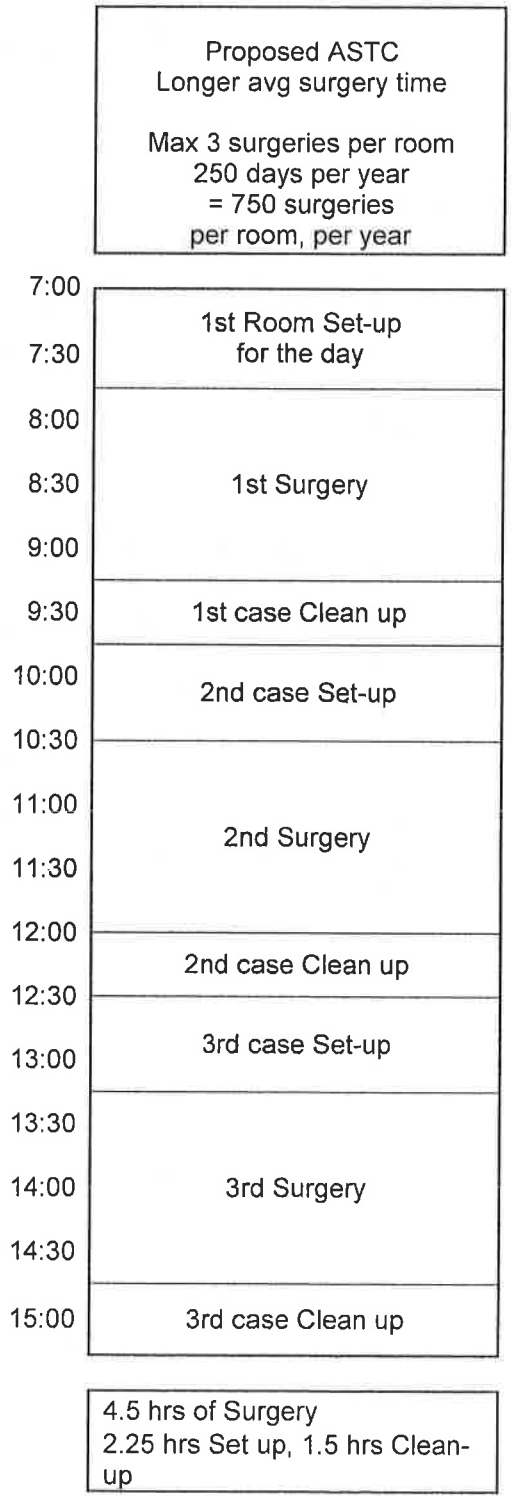
Either way, 50% of the total OR room minutes are given to surgery and 50% are given to non-surgical activities (prep, set-up, cleanup, etc.)

As stated in the application, the types of orthopedic surgery performed by Drs. Grutter and Gautsch are typically more involved both in length and complexity than the average of surgeries contemplated by the

guidelines for growth. The average length of time for Dr. Gautsch's mix of surgery in the previous three years is 110 minutes, almost twice as long as the average assumed by the guidelines. The average length of time for Dr. Grutter's surgeries is 93 minutes, 1 1/2 times the average assumed by the guidelines. Cleanup time takes just about as long as is typically assumed, however set up time is typically longer, especially for knee ligament reconstruction surgeries and all shoulder surgeries. Knee and shoulder surgeries make up approximately 90% of the surgeries that Drs. Gautsch and Grutter perform.

Since the surgical times are longer and the cleanup and set up times, while longer are not proportionately as long, it is calculated that the efficiency of this ASTC's overall utilization would be slightly better than that assumed by the guidelines however the total potential number of surgeries given their longer average length would be quite a bit less. In comparison, the projected OR utilization per operating room per day would look like this:



Southern Sports Medicine Surgery Center Surgical Volume and Time Utilization

| | | | No. of Outpatient Surgical Cases | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Physician | Ave. Time/OR case | | 2008 | 2009 | 2010 | YTD 2011 | YTD 2011 Annualized | 2012 | 2013 | 2014 | 2015 |
| Dr. Gautsch | 110 | | 394 | 374 | 293 | 143 | 344 | 364 | 384 | 400 | 400 |
| Dr. Grutter | 93 | | 0 | 69 | 251 | 125 | 300 | 340 | 360 | 380 | 400 |
| Dr. " New " | 101 | | | | | | | 69 | 251 | 300 | 340 |

Southern Sports Medicine Surgery Center **Operating Room Time Demand and Capacity**

| Ave. Time/Surgical Case | Number of Projected Annual Cases = | Annual Time (in minutes) used for surgeries | Add turnover time bet. Cases X No. of Cases | Total OR Time Required | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|
| Average Minutes/ case<br><br>101 | Total Projected Annual Cases<br><br>773, 995, 1080 | Total Minutes used for total surgical cases<br><br>1st yr: 78073<br>2nd yr: 100495<br>3rd yr: 109080 | Minutes<br><br>1st yr: 65061<br>2nd yr: 83746<br>3rd yr: 90900 | Minutes | 2013 projected minutes<br><br>143134 | 2014 projected minutes<br><br>184241 | 2015 projected minutes<br><br>199980 |
| | | Annual Total Time (in minutes) available during Scheduled Hrs of Operation * | | | 240,000 | 240,000 | 240,000 |
| | | | | % Utilization = Total OR time Required divided by Total scheduled OR time Available | **59%** | **76%** | **83%** |

*Operating Capacity = 250 days/ year X 8 hours/day X 60 minutes/ hour X 2 Operating Rooms= 240,000 minutes per year

**A) Procedure Room Utilization**

**Southern Sports Medicine Surgery Center Pain Management Volume**

| | | | No. of Pain Management Cases | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Physician | Ave. Time/OR case | | 2008 | 2009 | 2010 | YTD 2011 | YTD 2011 Annualized | 2012 | 2013 | 2014 | 2015 |
| Dr. Gautsch | | | | | | | 190 | 190 | 190 | 190 | 190 |
| Dr. Grutter | | | | | | | 64 | 64 | 64 | 64 | 64 |
| Dr. Kindred | | | | | | | | 528 | 746 | 746 | 746 |
| Dr. " New " Y | | | | | | | | | | | |
| Dr. " New " Z | | | | | | | | | | | |

**e. Unstaffed operating rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.**

**Response:** There will be no unstaffed operating rooms at this surgery center.

**2. "Service Area" shall mean the county of counties represented by the applicant as the reasonable area to which the facility intends to provide services and/or in which the majority of its service recipients reside.**

**Response:** The service area is Sumner County, although a small percentage of patients will be expected to reside in Macon, Trousdale, Davidson, and Robertson counties.

| County | % |
|---|---|
| Sumner | 79% |
| Macon | 6% |
| Trousdale | 3% |
| Davidson | 3% |
| Robertson | 2% |

**3. The majority of the population of a service area for an ambulatory surgical treatment center should reside within 30 minutes travel time to the facility.**

**Response:** All of Sumner County is within 30 minutes travel time to this facility.

**4. All applicants should demonstrate the ability to perform a minimum of 800 operations and/or procedures per year per operating room and/or procedure room. This assumes 250 days x 4 surgeries /procedures x .80.**

**Response:** A high percentage of the applicant's planned surgical volume consists of surgical procedures that normally take between 90 and 150 minutes. This is equal to 150% to 250% of the Guidelines' assumed 60 minute "average time" per outpatient surgery case. The average surgical time for all outpatient cases of the applicant's surgeons is approximately 110 minutes. 800 sixty-minute cases is the time equivalent of 436, 110-minute cases. Therefore, this ASTC's actual 80% capacity utilization would more correctly be calculated to be 400-450 cases per OR, or 800-900 cases in 2 OR's. Without counting the addition of the planned 3rd surgeon to the practice, the applicant still expects to reach this utilization threshold between year 2 and 3 of operation, much sooner with the planned addition of the 3rd surgeon.

Additionally, many of these arthroscopic shoulder and knee repair/reconstruction surgeries require additional time beyond the average for set up and patient positioning, further adding to the overall time spent on each case. The most efficient method for minimizing these set-up times between surgeries is to utilize two paired operating rooms so that one room can be cleaned and set up during the time that the other is being used for actual surgery, and then vice versa. Experience in orthopedic surgery has shown that two rooms used in tandem this way

actually utilizes them both more efficiently than a single room used sequentially for these type of orthopedic cases.

The initial center owner utilizers are very active orthopedic surgeons, Dr. Thomas Gautsch and Dr. Paul Grutter and a non-surgical musculoskeletal care specialist, Dr. Jeffrie Kindred. Another orthopedic surgeon outside of middle Tennessee is expected to relocate to Gallatin to join the practice in 12 to 18 months. Dr. Kindred who is a primary care, fellowship trained, Musculoskeletal specialists who routinely performs fluoroscopically and ultrasound guided injections and procedures on afflicted nerves, muscles, tendons, and joints.

Doctors Gautsch and Grutter historically perform well over 800 such procedures per year without benefit of the use of fluoroscopic or ultrasound guidance, due to a previous lack of availability. Flouroscopic and ultrasound guidance of these percutaneous procedures has already been shown clinically superior and more consistently accurate and so current patients will benefit from that availability.

The practice currently also plans to engage 1-2 pain management specialist physicians in the future.

**5. A certificate of need (CON) proposal to establish a new ambulatory surgical treatment center or to expand existing services of an ambulatory treatment center shall not be approved unless the existing ambulatory surgical services within the applicant's service area or within the applicant's facility are demonstrated to be currently utilized at 80% of service capacity. Notwithstanding the 80% need standard, the Health Facility Commission may consider proposals for additional facilities or expanded services within an existing facility under the following conditions: proposals for facilities offering limited-specialty type programs or proposals for facilities where accessibility to surgical services is limited.**

**Response:** This ASTC is needed as determined by the *Tennessee's Health: Guidelines for Growth: Criteria and Standards, 2000 Edition.* The 2010 service area wide utilization data generated from the Tennessee Department of Heath, Division of Health Statistics demonstrates that the 17 currently available operating rooms in Sumner County are generating an average of 1141 cases per operating room which exceeds the 800 cases per year indicated in the Guideline.

Additionally, this ASTC will be Sumner County's second multi-specialty ASTC and the only one with surgical suites specifically constructed and built out for the performance of state of the art arthroscopic reconstruction and repair procedures.

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

**(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change the proposed new site.**

**Response:** CON CN1104-013A was granted for is a 1.4 acre lot which requires the ASTC to be located on the second floor of the medical office building. A 2.9 acre lot has been acquired which allows the ASTC to have a first floor location with improved patient access. The new location is also closer to the more concentrated population of Sumner County and TN-386, the major artery thoroughfare through Sumner County. The new location will give patients greater ease of access than the current granted CON's location, and shorten the average distance that Sumner County residents will have to travel to receive ASTC care.

**(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.**

**Response:** With no increase in service costs to patients, the new location is closer to the more concentrated population of Sumner County and TN-386, the major artery thoroughfare through the County. The new location will give patients greater ease of access than the current granted CON CN1104-013A location, and shorten the average distance that Sumner County residents will have to travel to receive ASTC care. Currently many Sumner County residents are forced to leave the county for ambulatory surgical care. The proposed new site provides significant economic benefits to ambulatory surgery patients of Sumner County due to lowered travel times and costs and improved access.

**(c) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.**

**Response:** The location of CON CN1104-013 still requires considerable site preparation work for retention and drainage and leveling before construction could begin. It also is in a portion of the city's master plan with a number of encumbrances and approvals necessary, setbacks, required construction of an access road, and limited size, useable area and room for expansion. The newly proposed location has all site preparation work completed all access already present, no retention or drainage issues, potentially allowing a faster construction of the ASTC's building.

**6. A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment must specify the number of projected operating rooms to be designated for ambulatory surgical services.**

**Response:** The project proposed in this CON will contain two operating rooms and one procedure room. All operating and procedure rooms will be designated for ambulatory surgical services.

**7. A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following the completion of the completion of the proposed project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

**Response:** The conservatively projected utilization for the first eight quarters following completion of this project are set forth in the table below. These projections of utilization are based on experience of the applicants and projections from expected growth. With the addition of other physician utilizers these numbers may increase substantially.

Q1 -- 150
Q2 -- 250
Q3 -- 300
Q4 -- 300
Q5 -- 350
Q6 -- 400
Q7 – 450
Q8 – 500

| Total ASTC Volume | Q1 | Q2 | Q3 | Q4 | Year 1 | Q5 | Q6 | Q7 | Q8 | Year 2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Operating Room cases | 112 | 187 | 224 | 224 | 746 | 261 | 299 | 336 | 373 | 1269 |
| Procedure Room Cases | 38 | 63 | 76 | 76 | 254 | 89 | 102 | 114 | 127 | 431 |
| Total ASTC Cases | 150 | 250 | 300 | 300 | 1,000 | 350 | 400 | 450 | 500 | 1,700 |

**8. A CON proposal to establish an ambulatory surgical treatment center of to expand the existing services of an ambulatory surgical treatment center must project patient origin by percentages and county of residence. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

**Response:** The surgical treatment center anticipates patient origins based on experience data information from the surgeon utilizers:

| County | % |
|---|---|
| Sumner | 79% |
| Macon | 6% |
| Trousdale | 3% |
| Davidson | 3% |
| Robertson | 2% |

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

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

**(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change the proposed new site.**

**Response:** CON CN1104-013A was granted for is a 1.4 acre lot which requires the ASTC to be located on the second floor of the medical office building. A 2.9 acre lot has been acquired which allows the ASTC to have a first floor location with improved patient access. The new location is also closer to the more concentrated population of Sumner County and TN-386, the major artery thoroughfare through Sumner County. The new location will give patients greater ease of access than the current granted CON's location, and shorten the average distance that Sumner County residents will have to travel to receive ASTC care.

**(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.**

**Response:** The new location is closer to the more concentrated population of Sumner County and TN-386, the major artery thoroughfare through Sumner County. The new location will give patients greater ease of access than the current granted CON CN1104-013A location, and shorten the average distance that Sumner County residents will have to travel to receive ASTC care. Currently many Sumner County residents are forced to leave the county for ambulatory surgical care. The proposed new site provides significant economic benefits to ambulatory surgery patients of Sumner County due to travels cost and improved access.

**(c) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.**

**Response:** The location of CON CN1104-013 still requires site preparation work before construction could begin. The newly proposed location has all site preparation work completed allowing a decreased timeline for development of the ASTC.

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

**Response:**. This is a new facility. Its current long-range development plans are limited to those as set forth in this application.

**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:** The service area for this application is Sumner County. The requested service area map is attached.

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

**Response:** The demographics of the service area population will be those of Sumner County. Sumner County, Tennessee has a population of 160,645 as determined by the 2010 U.S. Census. The Tennessee Department of Health projects the population of Sumner County will increase by 33.4% to 211,946 by 2030. This rapidly growing population is also aging. Those over sixty-five are also rapidly increasing and has the highest utilization of health care services including outpatient surgical services. The demographics of Sumner County are set forth in the tables attached to this application.

| Demographic /Geographic Area | Service Area / Sumner County Total | State of TN Total |
|---|---|---|
| Total Population-Current Year -2012 | 162,422 | 6,361,070 |
| Total Population-Projected Year - 2016 | 170,883 | 6,757,165 |
| Total Population-% change | 5.21% | 6.23% |
| Age 65 & over Population - 2012 | 20,767 | 878,496 |
| Age 65 & over | 24,163 | 987,074 |

40

| Population - 2016 | | |
|---|---|---|
| Age 65 & over Population - % change | 16.35% | 12.36% |
| Age 65 & over Population as % of Total Population | 12.79% | 13.82% |
| Median Household Income | $54,916 | $51,914 |
| TennCare Enrollees | 23,028 | 1,208,209 |
| TennCare Enrollees as % of Total | 14.18% | 18.99% |
| Persons Below Poverty Level | 16,404 | 1,049,576 |
| Persons Below Poverty Level as % of Total | 10.1% | 16.5% |

Sources: The Tennessee Department of Health's Population Projections 2010-2020, US Census Bureau and the State of Tennessee Bureau of TennCare websites.

**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.**

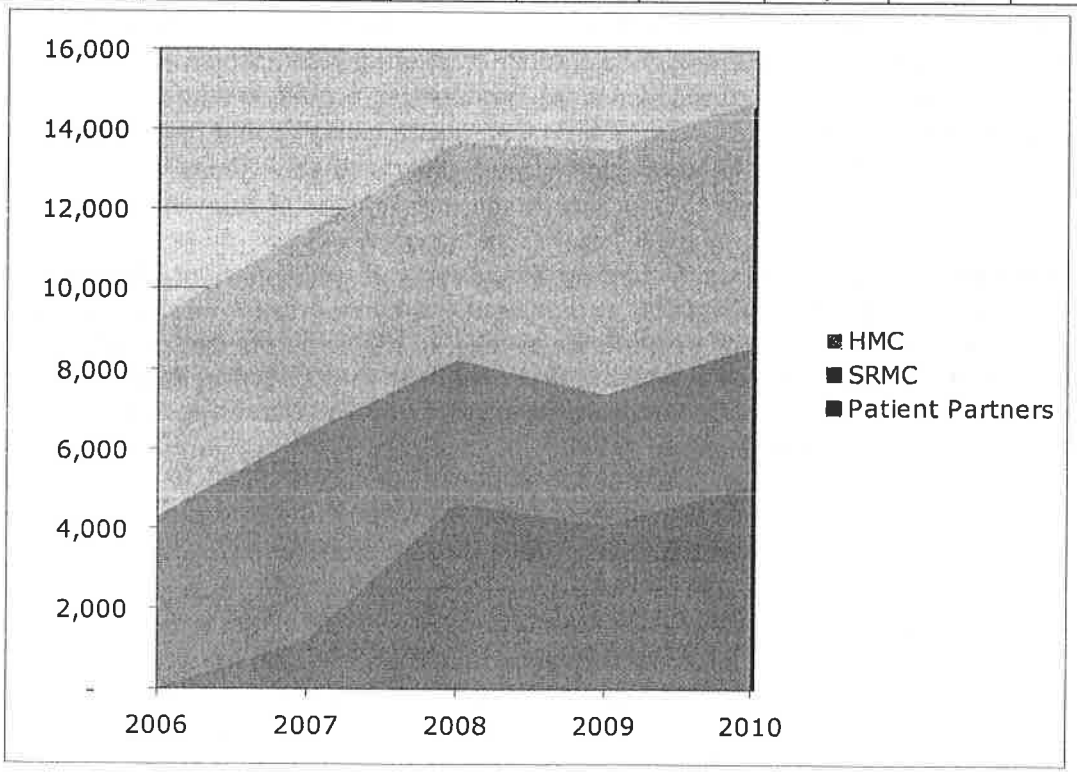
**Response:** The proposed ASTC will be accessible to all patients of Sumner and surrounding counties without regard to sex, disability, race, ethnic origin, religion or, in many urgent and emergent cases, ability to pay. It is anticipated that the population served will be typical of that of two of its utilizers, Drs. Gautsch and Grutter. They routinely see uninsured patients referred from the the Emergency rooms of both Sumner County Hospitals, the Salvus Center which serves the working uninsured of Sumner County, and has a location currently next door to their Gallatin office building, and another location in Hendersonville, near the site of this proposed facility. All initial owner utilizers of the center are participating providers with TennCare. 5.6% of Sumner County's residents are adult enrollees of TennCare. Drs. Gautsch and Grutter have long participated in the TennCare plans and their TennCare case volumes have closely paralleled adult TennCare enrollment. Patients of all socioeconomic levels in Sumner County rely on these physicians to meet their orthopedic needs.

**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:** There are four certified institutions providing ambulatory surgery in Sumner County; Green Surgery Center, Patient Partners Surgery Center, Hendersonville Medical Center, and Sumner Regional Medical Center. Apart from its own approved CON, the applicant is not aware of any other un-built but approved surgery centers in Sumner County. Green Surgery Center is an ophthalmology surgery center with only one operating room and a procedure room. Hendersonville Medical Center and Sumner Regional Medical Center are acute care hospitals, which provide outpatient surgery. Patient Partners Surgery Center is a multi-specialty ambulatory surgery treatment center with 2 ORs and 2 procedure rooms. The existing institutions reported a total of 19,389 encounters in 17 operating rooms in their 2010 Joint Annual Reports, the last year for which

complete data is available as of this writing. The Tennessee Health Guidelines for Growth defines the capacity of an ASTC room to be 800 cases/procedures per year. During 2010, the average utilization of these 17 operating rooms was 1141 encounters per room, 143% of the Guideline utilization. For the ASTC's in Sumner County the average utilization was 1738 procedures per year, 217% of the Guideline utilization.

| Provider | 2008 | | 2009 | | 2010 | | 2011 (provisional) | |
|---|---|---|---|---|---|---|---|---|
| | # OR's | Cases | # OR's | Cases | # OR's | Cases | # OR's | Cases |
| **ASTC's** | | | | | | | | |
| Patient Partners | 2 | | 2 | | 2 | | 2 | |
| Total Cases | | 4651 | | 4084 | | 5109 | | 4296 |
| Ortho Cases | | 627 | | 475 | | 456 | | 1440 |
| | | | | | | | | |
| **Hospitals** | | | | | | | | |
| HighPoint (SRMC) | 8 | | 8 | | 7 | | 7 | NF |
| Inpt Cases | | 1066 | | 1562 | | 1717 | | |
| Outpt Cases | | 3597 | | 3306 | | 3451 | | |
| Hendersonville | 8 | | 8 | | 8 | | 8 | NF |
| Inpt Cases | | 1634 | | 1769 | | 1538 | | |
| Outpt Cases | | 5461 | | 6128 | | 6127 | | |
| Portland Med Ctr | 2 | | 0 | | 0 | | 0 | |
| Inpt Cases | | 15 | | 0 | | 0 | | 0 |
| Outpt Cases | | 265 | | 0 | | 0 | | 0 |
| | | | | | | | | |
| **Total ORs available for Outpt Surgery** | 20 | | 18 | | 17 | | 17 | |
| **Total Cases** | | 16689 | | 16849 | | 19389 | | Data |
| **Total Outpt Cases** | | 13974 | | 13518 | | 15223 | | Pending |
| **Cases per OR** | | **834** | | **936** | | **1,141** | | |



**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:** This application is for a new facility. Therefore, there are no existing utilization data for the applicant. However, surgical and procedure volume for the committed utilizers of this ASTC project, is very well-known. Currently, Drs. Gautsch and Grutter perform a combined total of 200 orthopedic outpatient surgeries and 200 injection procedures average per quarter. These both are in excess of both the year 1 and year 2 projections already, which are estimated conservatively in anticipation of potential delays in establishing contracts with some payors. Based upon 2011 and the first quarter of 2012 volumes, Drs. Gautsch and Grutter are expected to produce the projected volumes on their own. This still leaves an unused capacity of at least 410 and 340 cases in years 1 and 2 for other interested surgeons. With the planned addition another orthopedic surgeon to the practice in 18 months, the actual volumes will likely be higher. The project has been sited and designed in such a way that it can easily be expanded when volumes exceed capacity. Furthermore, Drs. Gautsch and Grutter are developing the pain management aspects of their orthopedic practice in preparation for the addition of one or more pain management specialists. The utilization of the procedure room will be in large part by Dr. Kindred, a fellowship trained non-surgical musculoskeletal specialist, the anesthesiologists for peri-operative regional and nerve blocks, and future medical practitioners specializing in pain management.

***From the 2010 Tennessee State health Plan the following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. The proposed project fits well within the 5 Principals for Achieving Better Health in the following manner:***

***1. Healthy Lives***
***The purpose of the State Health Plan is to improve the health of Tennesseans.***
***Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.***

The proposed ASTC will be an integral part of improving the health of the residents of Sumner County, Tennessee by providing access to high quality orthopaedic ambulatory surgery. Orthopaedic injuries and disease significantly impact the quality of health and quality of life of many residents of Sumner County. Improved access to ambulatory orthopaedic surgery will provide the residents of Sumner County the ability to maintain more active healthy lifestyles with improved quality of life and decreased pain depending on their specific orthopaedic condition.

***2. Access to Care***
***Every citizen should have reasonable access to health care.***
***Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.***

The proposed project expands health care access to the residents of Tennessee. The proposed ASTC provides access to high quality ambulatory orthopaedic surgery. The ASTC will be accessible to all patients of Southern Sports Medicine Institute. Southern Sports Medicine Institute provides care without regard to existing health status, employment, income, geography, or culture.

The proposed project will increase the access to care for the majority of Sumner County residents. There are some residents with existing health conditions, such as advance cardiac and pulmonary disease, which present a contraindication for ASTC care due to the associated anesthesia risks resulting from their underlying

comorbidity. These patients access to care will remain unchanged as they will continue to be taken care of in a hospital setting.

*3. Economic Efficiencies*

***The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.***

The proposed ASTC will improve the economic efficiency of orthopaedic ambulatory surgery in Sumner County, Tennessee. The cost effectiveness of ASTCs compared to hospital based outpatient surgery has been clearly demonstrated. The MedPac March 2009 Report, demonstrates that Medicare payments to ASTCs were substantially lower than payments to hospitals for the great majority of similar outpatient procedures. By utilizing ASTCs rather than hospital outpatient surgery departments, Medicare, Medicaid, private insurances and patients save billions of dollars annually.

The MedPac, March 2009 Report also demonstrates that for most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs. The proposed single specialty orthopaedic ASTC provides an innovative, economic and efficient method to improve the orthopaedic health of residents of its service area in Tennessee.

*4. Quality of Care*

***Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.***

The proposed ASTC will be an extension of Southern Sports Medicine Institute who's main premise is excellence in orthopaedic care. Drs. Gautsch and Grutter are both Board Certified Orthopaedic Surgeons with fellowship training and subspecialty certifications. They were both educated at Johns Hopkins. Drs. Gautsch and Grutter understand the regulations concerning physician licensure, supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education and will work to improve their quality of care through adoption of best practices and data-driven evaluation.

*5. Health Care Workforce*

***The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.***

The proposed ASTC will development, recruit, and retain a quality health care workforce which corresponds to the 5th principle in the 5 Principals for Achieving Better Health found in the State Health Plan. Southern Sports Medicine Institute, is an active, physician practice with a historic base in Sumner county. Southern Sports Medicine Institute has developed adequate professional staff and contact with nurses and other medical personnel to assure the development, recruitment and retention of a high quality healthcare work force for the proposed ASTC.

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:** Projected project costs are set forth on the chart attached hereto. Calculations of the project cost have been generated by the following process: The lease rate is projected to be at the market rate of $34 per square foot with a total 10 year lease cost of $2,416,586 including yearly 3% increases.

The structure will be developed by Southern Sports Holdings, LLC, which controls the property. The applicant, Southern Sports Surgical LLC, will lease its space in the building. The developer of the building is Southern Sports Holdings LLC. The estimated total cost to construct the entire building is $4,571,752 ($120 per square foot for the shell, $170 per square foot for the ASTC interior buildout, and $90 per square foot for the office buildout) of which, approximately $1,798,00 is attributable to the ASTC, as a cost to be born by the developer. Upgrading of the building construction, hospital grade interior build-out and additional surfaces and fixtures necessary to meet the needs of the ASTC will cost an estimated $290 per square foot for the ASTC portion of the construction.

2. **Identify the funding sources for this project.**

**A. 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.)**

**XA. 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.**

## PROJECT COSTS CHART

| | | |
|---|---|---|
| A. | Construction and equipment acquired by purchase: | |
| 1. | Architectural and Engineering Fees | 91,000.00 |
| 2. | Legal, Administrative (Excluding CON Filing Fee), Consultant Fees | 60,000.00 |
| 3. | Acquisition of Site | |
| 4. | Preparation of Site | |
| 5. | Construction Costs | |
| 6. | Contingency Fund | 100,000.00 |
| 7. | Fixed Equipment (Not included in Construction Contract) | 318,000.00 |
| 8. | Moveable Equipment (List all equipment over $50,000) | 202,000.00 |
| 9. | Other (Specify) initial suppy stock | 50,414.24 |
| B. | Acquisition by gift, donation, or lease: | |
| 1. | Facility (inclusive of building and land) | 2,416,585.76 |
| 2. | Building only | |
| 3. | Land only | |
| 4. | Equipment (Specify) | |
| 5. | Other (Specify) | |
| C. | Financing Costs and Fees: | |
| 1. | Interim Financing | |
| 2. | Underwriting Costs | |
| 3. | Reserve for One Year's Debt Service | 110,000.00 |
| 4. | Other (Specify) | |
| D. | Estimated Project Cost (A+B+C) | 3,348,000 |
| E. | CON Filing Fee | 7,533.00 |
| F. | Total Estimated Project Cost (D+E) | 3,296,533.00 |
| | TOTAL | 3,355,533.00 |

## PROJECTED DATA CHART

2012 MAY 30 PM 3:06

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

| | Year 2014/15 | Year 15/16 |
|---|---|---|
| A. Utilization Data (Specify unit of measure) | 1000 | 1700 |
| B. Revenue from Services to Patients | | |
| 1. Inpatient Services | $ | $ |
| 2. Outpatient Services | 4,072,240 | 5,274,080 |
| 3. Emergency Services | | |
| 4. Other Operating Revenue (Specify) | | |
| **Gross Operating Revenue** | $4,072,240 | $5,274,080 |
| C. Deductions from Gross Operating Revenue | | |
| 1. Contractual Adjustments | $2,498,388 | $2,912,712 |
| 2. Provision for Charity Care | 122,167 | 161,038 |
| 3. Provisions for Bad Debt | 58,299 | 71,741 |
| **Total Deductions** | $2,678,854 | $3,145,490 |
| **NET OPERATING REVENUE** | $1,393,386 | $2,128,590 |
| D. Operating Expenses | | |
| 1. Salaries and Wages | $443,520 | $532,224 |
| 2. Physician's Salaries and Wages | | |
| 3. Supplies | 327,850 | 462,120 |
| 4. Taxes | 42,000 | 51,684 |
| 5. Depreciation | 51,863 | 76,943 |
| 6. Rent | 210,800 | 217,124 |
| 7. Interest, other than Capital | | |
| 8. Other Expenses (Specify) see attachment | 177,449 | 210,583 |
| **Total Operating Expenses** | $1,253,482 | $1,550,678 |
| E. Other Revenue (Expenses) -- Net (Specify) | $ | $ |
| **NET OPERATING INCOME (LOSS)** | $139,904 | $577,912 |
| F. Capital Expenditures | | |
| 1. Retirement of Principal | $176,844 | $187,455 |
| 2. Interest | 31,200 | 27,483 |
| **Total Capital Expenditures** | $208,044 | $214,938 |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | $(68,140) | $362,974 |

2012 MAY 30 PM 3:06

PROJECTED DATA CHART
SECTION D, PART 8
OTHER EXPENSES

| for D8 Other Expenses : | yr 1 | yr 2 |
|---|---|---|
| Repair and maintenance | $ 25,000 | $ 30,764 |
| Purchased services | $ 25,000 | $ 27,500 |
| Utilities | $ 25,000 | $ 26,250 |
| Professional fees | $ 5,000 | $ 6,153 |
| Insurance | $ 10,000 | $ 12,306 |
| Management fee expense | $ 87,449 | $ 107,611 |
| | $ 177,449 | $ 210,583 |

**_D. Grants--Notification of intent form for grant application or notice of grant award; or**

**_E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

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

**Response:** The capital needs for this project will be met by to a commercial loan from Volunteer State Bank. Documentation is attached hereto in the letter from the Senior Vice President Volunteer State Bank.

This is for a 15,200 sqft bldg:

| | sqft | $/sqft | total |
|---|---|---|---|
| building shell | 15,200 | $ 120 | $ 1,824,000 |
| office buildout | 9,000 | $ 90 | $ 810,000 |
| ASC Buildout | 6,200 | $ 170 | $ 1,054,000 |
| | | | $ 3,688,000 |

**ASTC**

| | |
|---|---|
| | $ |
| ASTC Project Cost | 3,355,533 |
| | $ |
| minus 10 yr lease cost | (2,416,586) |
| | **$** |
| capital need | **938,947** |
| | $ |
| owner contributions | (200,000) |
| Volunteer State Bank | $ |
| Credit | (750,000) |
| | $ |
| residual credit/(need) | 11,053 |

**Real Estate**

| | |
|---|---|
| | $ |
| land | 1,141,000 |
| | $ |
| construction | 3,688,000 |
| | **$** |
| capital need | **4,571,752** |
| | $ |
| owner contributions | (685,763) |
| | $ |
| Volunteer State Bank | (5,000,000) |

| | |
|---|---|
| | $ |
| residual credit/(need) | 1,114,011 |
| | **$** |
| Total Capital Costs | **5,510,699** |
| | $ |
| Total Owner Contributions | (885,763) |
| | **$** |
| **Total financing need** | **4,624,936** |
| | **$** |
| **Financing Available** | **5,750,000** |
| | $ |
| residual credit/(need) | 1,125,064 |

**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:** These construction costs are reasonable, when compared to recent similar applications for the establishment of surgery centers.

| Project | Construction Cost | ConstructionCost per S.F. |
|---|---|---|
| Southern Sports Surgery | $1,798,000 | $290.00 |
| Patient Partners | $2,813,705 | $284.50 |
| Tennessee Pain Surgery Center | $1,900,000 | $190.00 (interior only) |
| Surgery Center of Columbia | 1,183,606 | $192.61 (interior only) |

**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:** Since this is a new institution, there are no historical data. Volume data from the practices of Drs. Gautsch and Grutter are represented. The projected data is as set forth on the Projected Data Chart.

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

**Response:** The average gross charge for a pain management procedure at this center is projected to be $760; for a surgery procedure the average gross charge is projected to be $5600. The average deduction for a surgery procedure is expected to be $3204, and the average deduction for a pain management procedure is

50

expected to be $426. The average net charge for a surgical procedure is projected to be approximately $1840, the average net charge for a pain management procedure is projected to be approximately $334.

**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:** This is a new institution. Therefore, there is no current charge schedule, and there are no adjustments to current charges. Similarly, there is no impact on existing patient charges from this project.

**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:** A comparison of common procedures with CPT codes of the proposed charge schedule for this facility, current Medicare allowable fee schedule and those of the average for all of Tennessee are provided.

| Procedure | CPT | Applicant | Medicare Allowable | Tennessee Average Charge | Tennessee Average Payment |
|---|---|---|---|---|---|
| Arthroscopy, Shoulder, cartilage repair | 29807 | 2,650 | 1,060 | 5,848 | 843 |
| Arthroscopy, Shoulder, Rotator Cuff repair | 29827 | 3,138 | 1,255 | 6,410 | 963 |
| Open Rotator Cuff Repair | 23410 | 2,945 | 1,178 | 5,584 | 913 |
| CRPP Wrist | 25606 | 1,773 | 709 | 3,828 | 545 |

"Pain Management" Procedures

| Procedure | CPT | Applicant | Medicare Allowable | Tennessee Average Charge | Tennessee Average Payment |
|---|---|---|---|---|---|
| Injection, Lower Back Joint | 64476 | 1,384 | 299 | 1495 | 230 |
| Single nerve block injection, arm nerve | 64415 | 745 | 118 | 745 | 90 |
| Multiple nerve block injections, rib nerves | 64421 | 1120 | 293 | 1120 | 223 |
| | | | | | |

Chart source: Centers for Medicare & Medicaid Services

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

**Response:** Utilization rates for this surgery center will be more than sufficient to maintain cost effectiveness, because as only the second multi-specialty ASTC in all of Sumner County, and the only one near the population center of Hendersonville, it will have utilization rates of above that already demonstrated for the approved

single specialty CON which it seeks to replace. Its utilization rates will be above those specified by the applicable portions of the state health plan.

**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:** Financial viability is ensured since the applicant conservatively projects that this project will generate a positive cash flow and profitability within the first two years of operations based on the projected cases of already identified utilizing surgeons, with the expectation that once granted, several other surgeons will also join the project.

**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:** The applicant project will participate in both Medicare and TennCare/Medicaid. Furthermore, the applicant surgeons serve medically indigent patients as well. The utilization for these programs is expected to mirror that Southern Sports Medicine Institute, LLC, which is currently 22% Medicare, 5% TennCare/Medicaid. The TennCare utilization at this practice hit 24% in October, 2004. Changes in TennCare enrollments and utilization rules have seen a decrease in Sumner County of Tenncare adult enrollees, the potential patients of this project. 5.6% of the Sumner County population are adult enrollees of TennCare. In year one of the applicant's operations, the applicant anticipates charging $195,468 to TennCare/Medicaid and $883,676 to Medicare.

**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:** This surgery center does not yet have a balance sheet or income statement. The most recent balance sheet and income statement for Southern Sports Medicine Institute is attached.

**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:** The applicant considered the alternative of building a surgery center comprised only of procedure rooms. This alternative was rejected because the availability of an operating room is integral to the practice of Southern Sports Medicine Institute.

**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:** The applicant considered modernization of their present office building as well as sharing arrangements. The current office building is of insufficient size to house a surgery center, physicians practices, MRI and physical therapy both due to the size of the building as well as available lot size for patient parking. One of the main tenets of this surgery center is its ability to provide economical access to excellence

in orthopaedic care from one location. Providing physician diagnosis, treatment, digital radiography, MRI and treatment options including physical therapy and same-day surgery procedures in one location improves care for our patients including the elderly and indigent. Sharing arrangements create a burden of travel for our patients, which is considerable especially for the elderly and indigent. Additionally this new proposed site improves upon the currently approved site in myriad ways as already outlined in this application.

**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:** The applicant anticipates having transfer agreements with Hendersonville Medical Center and/or Sumner Regional Medical Center as well as contracting with all managed care organizations. Owner utilizers of the center as well as committed Anesthesiologists are contracted providers with the TennCare MCO's serving Sumner County. Owner utilizers are on the medical staff of both Hendersonville Hospital and Sumner Regional Medical Center and anticipate remaining on their staffs.

**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:** At present, Sumner County's over 165,000 residents only have local access to a solitary 2 operating room ASTC in the whole of the county. Significant numbers of residents are therefore traveling outside of the county for cost effective ASTC care. As the cost burden increasingly shifts towards patients with larger average deductibles, co-pays and out of pocket expenditures, cost alone is driving patients away from Hospital facilities for outpatient surgeries. With the availability of a second multi-specialty ASTC in Sumner County, it is anticipated that there will be a potential modest reduction in the number of outpatient cases that are performed in inpatient hospital ORs at the two closest hospitals, but most probably, the reduction will be far less than the utilization of this facility, as patients who are already going out of the County for cost effective, ASTC care will no longer have to travel outside of the county for that service.

**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:** There is no current staffing pattern for this project. The anticipated initial staffing will be with combined FT and PT staff of 11 individuals for 9.24 Full Time Equivalents. Staffing will include: one Manager/Billing supervisor, five registered nurses, three operating room technicians and two clerical/support personnel. Salaries for these staffers will be comparable to prevailing wage patterns in Sumner County.

Tennessee Department of Labor prevailing wage information indicates that the range of hourly wages in the Nashville SMSA is as follows: entry level - $18.42; average - $26.50; experienced - $30.54. The applicant plans to pay RNs $30-32.00/hour.

Proforma Personnel

Costs

| | Hourly | Staff | Days per | hours per | Annual |
|---|---|---|---|---|---|

| | Rate | | week | week | | |
|---|---|---|---|---|---|---|
| | $ | | | | | $ |
| Pre-op Admit (RN) | 32.00 | 1 | 4 | | 32 | 49,152 |
| | $ | | | | | $ |
| Recovery (RN) | 32.00 | 2 | 4 | | 64 | 98,304 |
| | $ | | | | | $ |
| Circulator (RN) | 32.00 | 2 | 4 | | 64 | 98,304 |
| | $ | | | | | $ |
| OR Tech | 20.00 | 2 | 4 | | 64 | 61,440 |
| | $ | | | | | $ |
| Instrument Tech | 15.00 | 1 | 4 | | 32 | 23,040 |
| | $ | | | | | $ |
| Scheduler/Med recs | 14.00 | 1 | 5 | | 40 | 26,880 |
| | $ | | | | | $ |
| Manager/Billing 1 | 30.00 | 1 | 5 | | 40 | 57,600 |
| | $ | | | | | $ |
| Billing 2 | 15.00 | 1 | 5 | | 40 | 28,800 |
| | | | | | | **$** |
| **Total Personnel** | | 11 | | | 376 | **443,520** |
| | | | FTE | 9.4 | | |

2012 MAY 30 PM 3:06

**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:** The Manager, Southern Sports Medicine Institute is a well established, large business with a historic base in Sumner County. As such, Southern Sports Medicine Institute has developed adequate professional staff and contact with nurses and other personnel to SOS to assure sufficient staff are available at all times.

**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:** The applicant has reviewed and understands the licensing requirements for ATSC of the Board of Licensing Healthcare Facilities. Applicant Surgeons are on the medical staff at both Sumner County Hospitals, Hendersonville Medical Center and Sumner Regional Medical Center, and other institutions. Additionally, the applicant understands the regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

**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:** Southern Sports Medicine Institute is currently active in physical therapist education by providing clerkships for physical therapy students. The Anesthesia group that will staff the center is actively involved in the training of CRNA students.

**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:** The applicant has reviewed and understands the licensure requirements of the Tennessee Department of Health for ASTCs, as well as applicable Medicare requirements.

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

Licensure: The applicant anticipates licensure by the Tennessee Board for Licensing Healthcare Facilities.

Accreditation: The applicant will seek accreditation by the Joint Commission and/or AAAHC

**(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:** Not applicable.

**(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:** Not applicable.

**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:** Not applicable.

**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 are no civil or criminal judgments for fraud or theft against any person or entity involved with this application. Please see attached

**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:** The applicant will provide the requested data to the HSDA or any other state or federal reviewing agency as required.

SUPPLEMENTAL- # 1

# PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): Jul 2012

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.

| Phase | DAYS REQUIRED | Anticipated Date (MONTH/YEAR) |
|---|---|---|
| 1. Architectural and engineering contract signed | 30 | Aug 2012 |
| 2. Construction documents approved by the Tennessee Department of Health | 120 | Nov 2012 |
| 3. Construction contract signed | 150 | Dec 2012 |
| 4. Building permit secured | 180 | Jan 2013 |
| 5. Site preparation completed | 270 | Apr 2013 |
| 6. Building construction commenced | 285 | May 2013 |
| 7. Construction 40% complete | 405 | Sep 2013 |
| 8. Construction 80% complete | 525 | Dec 2013 |
| 9. Construction 100% complete (approved for occupancy | 645 | Apr 2014 |
| 10. *Issuance of license | 660 | May 2014 |
| 11. *Initiation of service | 670 | May 2014 |
| 12. Final Architectural Certification of Payment | 685 | Jun 2014 |
| 13. Final Project Report Form (HF0055) | 700 | Jun 2014 |

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

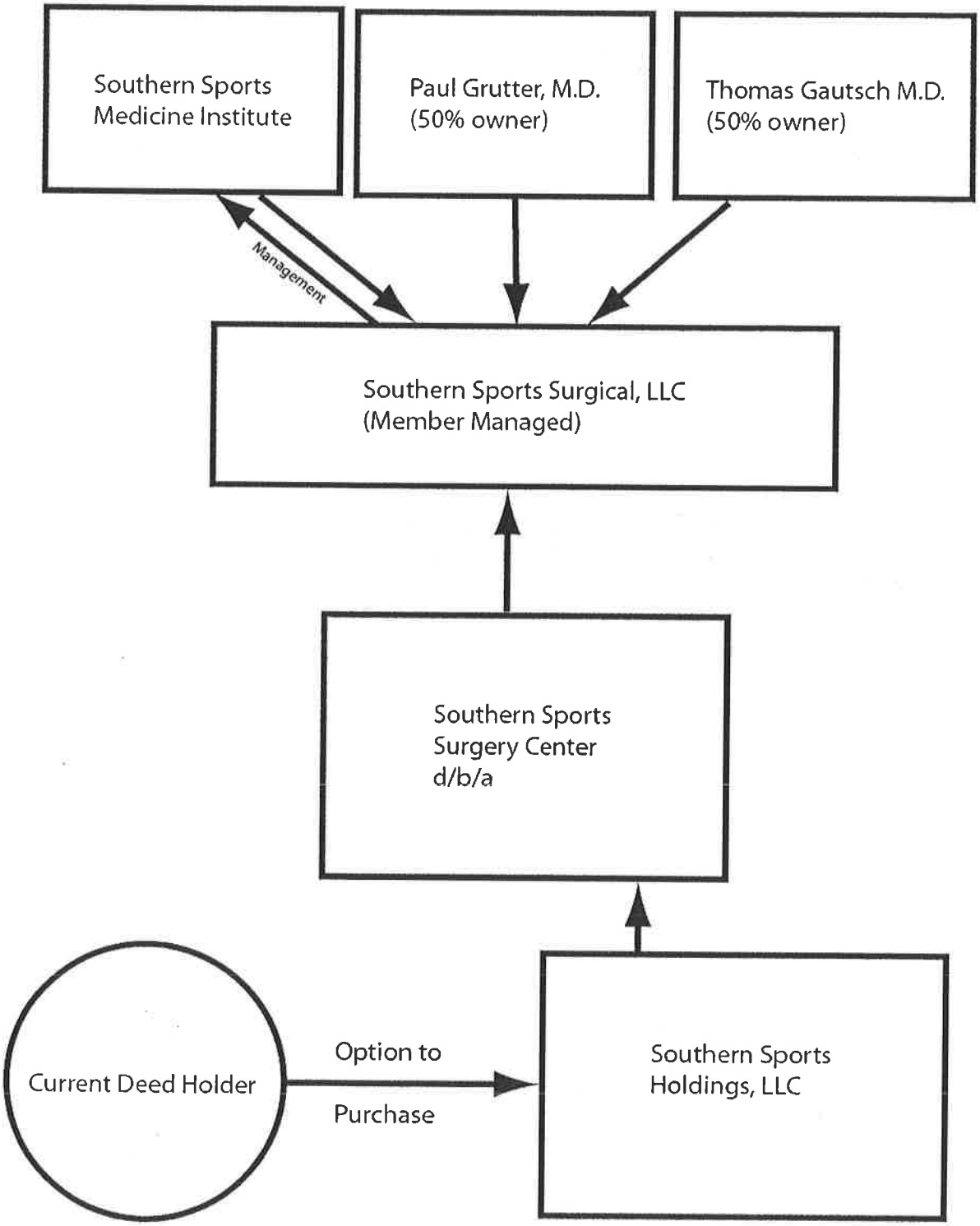
**Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.**

3.C ORGANIZATION CHART
SECTION A ITEM 4

SUPPLEMENTAL- # 1

# Southern Sports Surgery Center

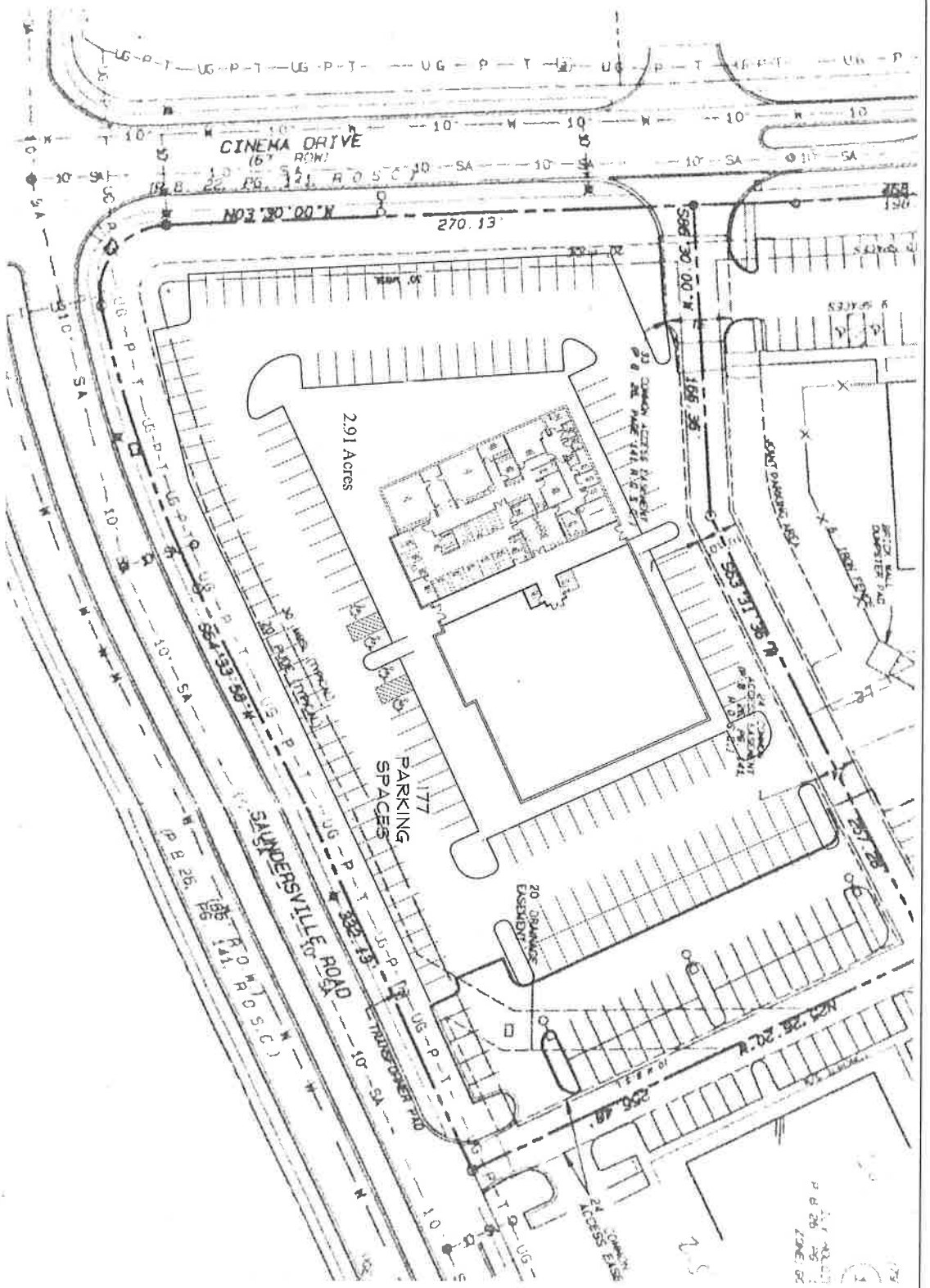
2012 MAY 30 PM 3:05




58

ATTACHMENT B.III.(A)1
COPY OF PLOT PLAN

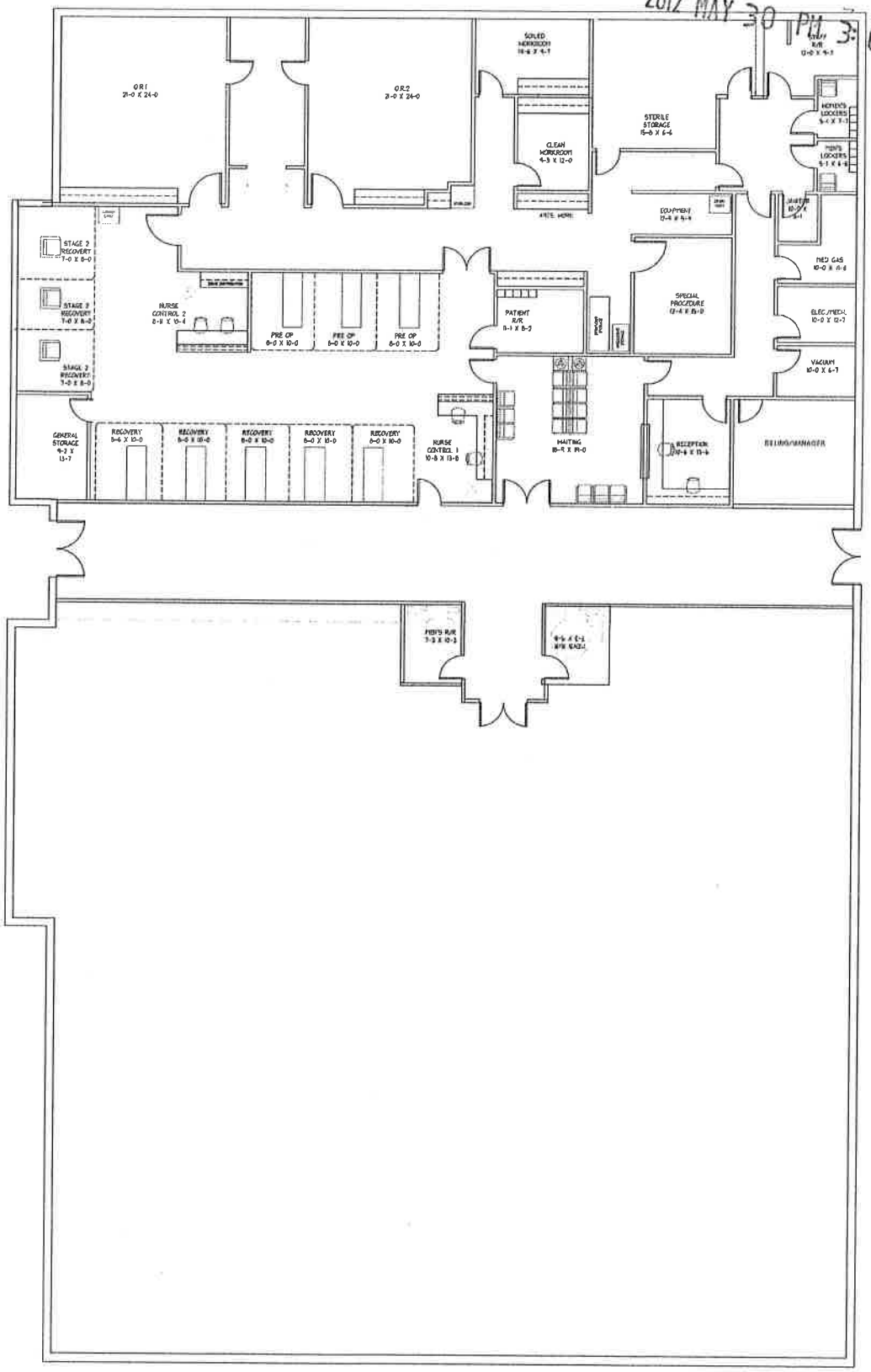
BBLMedical Facilities



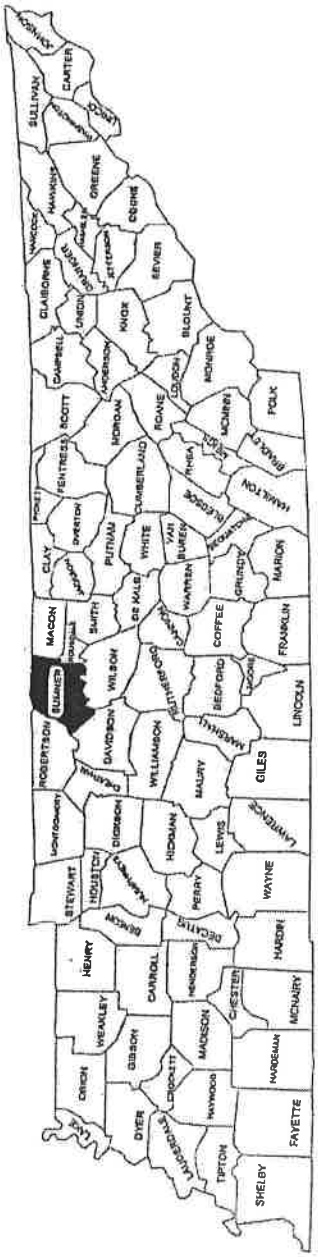

PRELIMINARY SITE PLAN
SOUTHERN SPORTS MEDICINE INSTITUTE
3-27-2012

ATTACHMENT B.IV
COPY OF FLOOR PLAN

2012 MAY 30 PM 3:05



ATTACHMENT C. NEED – 3
MAP OF SERVICE AREA




# Southern Sports Surgical Service Area Map

ATTACHMENT C, ECONOMIC FEASIBILITY – 1
HEALTH CARE ARCHITECT LETTER

SUPPLEMENTAL

ARCHITECTURAL ENVIRONMENTS, PLLC
6 CADILLAC DRIVE . SUITE 290
BRENTWOOD, TN 37027
T - 615-620-4420 . F - 615-620-4425
www.aenashville.com

June 1, 2012

Dr. Thomas Gautsch
Southern Sports Medicine
570 Hartsville Pike
Gallatin, TN. 37066

RE: Southern Sports Holdings, LLC

Dear Dr. Gautsch:

The proposed ambulatory surgery center for Southern Sports Holdings, LLC will be designed to comply with the AIA Guidelines for Design and Construction of Health Care Facilities as well as the International Building Codes, the NFPA Life Safety Codes, and all other applicable codes. In this early design phase, the surgery suite will be located within this one story facility with the primary access through a centrally located building entrance. There will also be additional access via a minimum of two egress points.

Based off the preliminary design of the proposed ambulatory surgery center that our office prepared for you with an approximate square footage of 6,200 sf, an approximate construction budget of $120 per square foot for the shell construction and $170 per square foot for the interior build-out of the ASC should be expected. The land and equipment cost for this ambulatory surgery center would be budgeted separately.

This estimated construction budget is based on our previous experience with ambulatory surgery centers in the State of Tennessee. Combined with this knowledge, as well as, knowledge of current trends in construction costs, we feel this budgetary figure is adequate at this stage of the project.

Sincerely,

David McGill

**SUPPLEMENTAL- # 1**

ARCHITECTURAL ENVIRONMENTS, PLLC
6 CADILLAC DRIVE , SUITE 290
BRENTWOOD, TN 37027
T - 615-620-4420 F - 615-620-4425
www.aenashville.com

May 25, 2012

Dr. Thomas Gautsch
Southern Sports Medicine
570 Hartsville Pike
Gallatin, TN. 37066

2012 MAY 30 PM 3:05

RE: Southern Sports Holdings, LLC

Dear Dr. Gautsch:

Architectural Environments, PLLC has been retained to aid in the programming and design of a surgery center to be located in Gallatin, TN. Our firm has been actively involved with the design of medical facilities since its founding in 1991. These facilities would include hospitals, diagnostic facilities, rehabilitation facilities, and ambulatory surgery centers in addition to other types of medically related projects. Our firm has provided design services for these types of facilities throughout the southeastern United States. We have been involved with numerous medical facilities and we have completed 62 in 2010 alone.

Sincerely,

David McGill

6 Cadillac Drive Suite 290 Brentwood, TN 37027 Phone 615-620-4420 Fax 615-620-4425

ATTACHMENT C, ECONOMIC FEASIBILITY – 2
FINANCING LETTER

# Volunteer State Bank

323 East Main Street
Hendersonville, TN 37075
(615) 824-6542
Fax (615) 824-7237

May 23, 2012

Dr. Thomas Gautsch, Chief Manager
Dr. Paul Grutter
Southern Sports Surgical LLC/Southern Sports Holdings LLC,
570 Hartsville Pike
Gallatin, TN 37066

Dear Drs. Gautsch and Grutter

Volunteer State Bank would like to express an interest in becoming involved in your future medical office building and ASTC projects. The center is to be built on an unaddressed site on the northeast corner of Cinema Drive and Saundersville Road in Hendersonville, TN. The projected request is for approximately $5.75 million for construction, equipment, and working capital relative to Southern Sports Surgical Center. Volunteer State Bank will be working towards a term sheet in the near future. The rate and term of the construction portion of the loan will be subject to credit strength and loan to value. Currently, rates for such a project are in the range of 5.0-6.5%. These rates are subject to many factors including the term of the loan and the credit worthiness of the borrowers. The term would be up to 18 month construction with permanent financing of up to 25 years with a call feature. The equipment portion would be 60-84 months fixed at approximately 6.5%. This is just a guideline of rates and terms. Final approval of this request is subject to review of up to date financials, plans, etc. by Volunteer State Bank's loan committee and Board of Directors.

This letter is not to be construed as a commitment for financing. If there are any questions pertaining to the details of Volunteer State Banks intentions in this matter, please feel free to call me directly.

Sincerely,

Keith Whitley, SVP
NMLS#552199
Office 615-824-4973
Cell 615-417-1000
kwhitley@volstatebank.com

ATTACHMENT C, ECONOMIC FEASIBILITY – 10

Personal Financial Statement
Paul and Tracy Grutter

Gallatin, TN 37066
5/10/12

| Assets | | Amount in Dollars |
|---|---|---|
| Non-qualified assests-cash, securities | $ | 160,303 |
| Cash - savings accounts | | 79,350 |
| Securities - stocks / bonds / mutual funds | | 34,361 |
| Life insurance *(cash surrender value)* | | 41,001 |
| Personal property *(autos, jewelry, etc.)* | | 98,000 |
| Retirement Funds *(eg. IRAs, 401k)* | | 192,545 |
| Real estate *(market value)* Residence @ Rozella Way | | 1,855,500 |
| Other assets *(specify)* Business- Southern Sports Medicine | | |
| 3 x EBITDA = $ 1,450,000 | | 1,450,000 |
| Total Assets | $ | 3,911,060 |

| Liabilities | | Amount in Dollars |
|---|---|---|
| Current Debt *(Credit cards, Accounts)* | $ | - |
| Notes payable *(describe below)* | | - |
| Taxes payable | | - |
| Real estate mortgages *(describe)* *Residence @ Rozella Way* | | 1,339,230 |
| Total Liabilities | $ | 1,339,230 |
| Net Worth | $ | 2,571,830 |

Signature: Date:

Signature: Date:

# SUPPLEMENTAL- # 1

Personal Financial Statement
Thomas and Michele Gautsch
652 Northridge Drive
Gallatin, TN 37066
5/1/2012

| Assets | | Amount in Dollars |
|---|---|---|
| Cash - checking accounts | | $ 41,812 |
| Cash - savings accounts | | 15,277 |
| Certificates of deposit | | - |
| Securities - stocks / bonds / mutual funds | | 728,732 |
| Notes & contracts receivable | | - |
| Life insurance *(cash surrender value)* | | 156,500 |
| Personal property *(autos, jewelry, etc.)* | | 174,500 |
| Retirement Funds *(eg. IRAs, 401k)* | | 176,965 |
| Real estate *(market value)* Residence @ | 652 Northridge Drive | 1,145,469 |
| Other assets *(specify)* Property @ | 1165 Nashville Pike | 900,000 |
| Other assets *(specify)* Property @ | 544 Hartsville Pike | 365,000 |
| Other assets *(specify)* Property @ | 570 Hartsville Pike | 625,000 |
| Other assets *(specify)* Property @ | 1145 Napoleon St. #204 | 226,500 |
| Other assets *(specify)* Business- | Southern Sports Medicine | |
| A/R = $ 193,935.65 | | |
| Hard Assets = $ 200,000 | | |
| 3 x EBITDA = $ 2,100,000 | | 2,100,000 |
| **Total Assets** | | **$ 6,655,755** |

| Liabilities | Amount in Dollars |
|---|---|
| Current Debt *(Credit cards, Accounts)* | $ 38,000 |
| Notes payable *(describe below)* | 195,000 |
| Taxes payable | - |
| Real estate mortgages *(describe)* *Residence @ 652 Northridge* | 693,000 |
| Other liabilities *(specify)* 1165 Nashville Pike | 500,248 |
| Other liabilities *(specify)* 544 Hartsville Pike | 292,550 |
| Other liabilities *(specify)* 570 Hartsville Pike | 560,655 |
| Other liabilities *(specify)* 1145 Napoleon St. #204 | 181,200 |
| **Total Liabilities** | **$ 1,718,798** |
| | |
| **Net Worth** | **$ 4,936,957** |

| Signature: | Date: |
|---|---|

| Signature: | Date: |
|---|---|

ATTACHMENT C
ORDERLY DEVELOPMENT OF HEALTH CARE – 1
TRANSFER AGREEMENT

ATTACHMENT C,
CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF
HEALTH CARE – 9

# Paul Grutter, M.D.

2012 MAY 30 PM 3:04

*Diplomate, American Board of Orthopaedic Surgery*
*Fellow, American Academy of Orthopaedic Surgeons*
*Fellowship Trained: Johns Hopkins (Shoulder & Elbow Surgery)*
*ABOS Subspecialty Certification: Sports Medicine*


May 12, 2012

State of Tennessee
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgical, LLC

Dear Sir or Madam:

As an applicant on this project, I, Paul Grutter, MD, attest that there are no final orders or judgments entered in any state or county by a licensing agency or court against my professional licenses.

I also attest that there are no final civil or criminal judgments for fraud or theft against me.

Respectfully,

Paul Grutter, M.D.

570 Hartsville Pike • Gallatin, TN 37066 • Phone: (615) 452-3320 • Fax: (615) 452-2668
www.DrGrutter.com

*Thomas L. Gautsch, M.D., F.A.C.S.*
*Specializing in Shoulder and Knee Surgery*

*Diplomate, American Board of Orthopaedic Surgeons*

*Fellow, American Academy of Orthopaedic Surgeons*

*Fellow, American College of Surgeons*

*Board Certified, Fellowship Trained, Specialist in Arthroscopic Surgery, Minimally Invasive Surgery, Microscopic Surgery and Total Joint Replacement in the treatment of:*

*Sports Injuries*

*Shoulder Problems*

*Knee Problems*

May 12, 2012

State of Tennessee
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgical, LLC

Dear Sir or Madam:

As an applicant on this project, I, Paul Grutter, MD, attest that there are no final orders or judgments entered in any state or county by a licensing agency or court against my professional licenses.

I also attest that there are no final civil or criminal judgments for fraud or theft against me.

Respectfully,

Thomas Gautsch, M.D.

*H. Michael Lee, P.T.*
*Physical Therapist*

*570 Hartsville Pike • Gallatin, TN 37066 • (615) 452-3326 • Fax (615) 452-9665*

ATTACHMENT C
PROOF OF PUBLICATION

Page 1 in Office of

Continued to next column

0101540571

## 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. SS 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Southern Sports Surgery Center owned by: Southern Sports Surgical, LLC with an ownership type of Limited Liability Company and managed by: Southern Sports Medicine Institute, PLLC intends to file an application for a Certificate of Need for: The establishment of a multi-specialty Ambulatory Surgical Treatment Center. Following Agency rules, the applicant seeks a new CON, but only to: (a) expand the designated use of its previously granted ASTC project CON CN1104-013A to include multi-specialty services, and (b) relocate the project to a setting more accessible to the served population. Otherwise, the application remains with the same estimated project cost of $3.3 million. The center will still contain approximately 6,200 square feet of space including 2 operating rooms, 1 procedure room, pre & post holding area and support space as previously granted. Relocated to Lot 38 (Indian Lake Village Final Plat Book 26, Page 141) Saundersville Road, Hendersonville, TN 37075, within the same service area, the project does not contain any major medical equipment and will not initiate or discontinue any other health service. If granted, the applicant will surrender CON CN1104-013A. The anticipated date of filing the application is: April 14, 2012. The contact person for this project is Thomas Gautsch, M.D., who may be reached at: Southern Sports Medicine, 570 Hartsville Pike, Gallatin, TN, 37066; 615-452-3320. 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
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. Ss 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.

Continued to next column

of Trust, said prop-
rty being real es-
te situated in
Sumner County,
Tennessee, and be-
ng more particular-
y described as fol-
ows:
A certain tract or
parcel of land in
Sumner County,
tate of Tennessee,
escribed as fol-
ws, to wit:
eing Lot No. 204 on
e Plan of Tyree
oods Subdivision,
ction 5, of record
Plat Book 10, Page
9.
LSO KNOWN AS:
59 Winding Way
rive, White House,
ennessee 37188
The HB
588 letter was
ailed to the
orrower(s) pur-
uant to Tennessee
ode Annotated 35-
-117. This sale is
ubject to all mat-
ers shown on any
pplicable recorded
lat; any unpaid tax-
s; any restrictive
ovenants, ease-
ents, or setback
nes that may be
pplicable; any stat-
tory rights of re-
emption of any
overnmental agen-
y, state or federal;
ny prior liens or en-
umbrances as well
s any priority cre-
ted by a fixture fil-
g; and to any mat-
r that an accurate
urvey of the prem-
es might disclose.
addition, the fol-
wing parties may
aim an interest in
e above-
eferenced property:
wendolyn E.
Waddell; Paul
Waddell;
quivantage, Inc.;
Sumner County Am-
bulance Service;
John C. Austin, MD
The sale
held pursuant to this
Notice may be re-
scinded at the Suc-
cessor Trustee's op-

Continued to next column

and conditions of a Deed of Trust Note dated May 26, 2005, and the Deed of Trust of even date securing the same, recorded May 31, 2005, at Book 2257, Page 718 in Office of the Register of Deeds for Sumner County, Tennessee, executed by Pamela Lee Gary Lee and Pam Lee, conveying certain property therein described to Richard A. Northcutt as Trustee for Mortgage Electronic Registration Systems, Inc., as a separate corporation that is acting solely as a nominee for First Horizon Home Loan Corporation D/B/A First Tennessee Home Loans; and the undersigned, Wilson & Associates, P.L.L.C., having been appointed Successor Trustee.
NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable; and that an agent of Wilson & Associates, P.L.L.C., as Successor Trustee, by virtue of the power, duty, and authority vested in and imposed upon said Successor Trustee will, on May 2, 2012 on or about 2:00 P.M., at the Sumner County Courthouse, Gallatin, Tennessee, offer for sale certain property hereinafter described to the highest bidder FOR CASH, free from the statutory right of redemption, homestead, dower, and all other exemptions which are expressly waived in the Deed of Trust, said property being real estate situated in Sumner County,

Continued to next column

government, county, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. In addition, the following parties may claim an interest in the above-referenced property: Pamela Lee; Gary Lee; Pam Lee
The sale held pursuant to this Notice may be rescinded at the Successor Trustee's option at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. W&A No. 931 220500
DATED April 5, 2012
WILSON & ASSOCIATES, P.L.L.C.,
Successor Trustee
INSERTION DATES:
April 10, 2012
April 17, 2012
April 24, 2012
FOR SALE INFORMATION, VISIT WWW.MYFIR.COM and WWW.REALTYTRAC.COM

0101540529

## NOTICE OF TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms, and conditions of a Deed of Trust Note dated January 30, 2003, and the Deed of Trust of even date securing the same, recorded February 4, 2003, at Book 1647, Page 342 in Office of the Register of Deeds for Sumner County, Tennessee, executed by Kevin G.

Continued to next column

P.M., at the Sumner County Courthouse, Gallatin, Tennessee, offer for sale certain property hereinafter described to the highest bidder FOR CASH, free from the statutory right of redemption, homestead, dower, and all other exemptions which are expressly waived in the Deed of Trust, said property being real estate situated in Sumner County, Tennessee, and being more particularly described as follows:
Land in Sumner County, Tennessee, described as follows, to wit:
A certain lot or parcel of land situated in the Fifth Civil District of Sumner County, Tennessee, being Lot No. 49 on the Plan of Hendersonville Lakefront Estates, as of record in Plat Book 1, Page 117.
ALSO KNOWN AS: 223 Harbor Drive, Hendersonville, Tennessee 37075
The HB 3588 letter was mailed to the borrower(s) pursuant to Tennessee Code Annotated 35-5-117. This sale is subject to all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory rights of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose.

Continued to next column

WWW.MYFIR.COM and WWW.REALTYTRAC.COM

0101538714

## NOTICE OF TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms, and conditions of a Deed of Trust Note dated May 27, 1999, and the Deed of Trust of even date securing the same, recorded June 1, 1999, at Book 979, Page 559 in Office of the Register of Deeds for Sumner County, Tennessee, executed by Donald L. Schuff and Theresa Schuff, conveying certain property therein described to T. Michael Logan, Williamson County, TN as Trustee for Suntrust Bank, Nashville, N.A.; and the undersigned, Wilson & Associates, P.L.L.C., having been appointed Successor Trustee.
NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable; and that an agent of Wilson & Associates, P.L.L.C., as Successor Trustee, by virtue of the power, duty, and authority vested in and imposed upon said Successor Trustee will, on April 25, 2012 on or about 2:00 P.M., at the Sumner County Courthouse, Gallatin, Tennessee, offer for sale certain property hereinafter described to the highest bidder FOR CASH, free from the statutory right of redemption, homestead, dower, and all other exemptions

Continued to next column

covenants, ease-
ments, or setback
lines that may be
applicable; any stat-
utory rights of re-
demption of any
governmental agen-
cy, state or federal;
any prior liens or en-
cumbrances as well
as any priority cre-
ated by a fixture fil-
ing; and to any mat-
ter that an accurate
survey of the prem-
ises might disclose.
In addition, the fol-
lowing parties may
claim an interest in
the above-
referenced property:
Donald L. Schuff;
Theresa Schuff
The sale held pur-
suant to this Notice
may be rescinded at
the Successor Trust-
ee's option at any
time. The right is re-
served to adjourn
the day of the sale
to another day, time,
and place certain
without further pub-
lication, upon an-
nouncement at the
time and place for
the sale set forth
above. W&A No. 791
218448
DATED March 29,
2012
WILSON & ASSOCI-
ATES, P.L.L.C.,
Successor Trustee
INSERTION DATES:
April 3, 2012
April 10, 2012
April 17, 2012
OR SALE INFORMA-
TION, VISIT
WWW.MYFIR.COM
a n d
WWW.REALTYTRAC.
COM

0101538677

## NOTICE OF TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms, and conditions of a Deed of Trust Note dated June 15, 2006, and the Deed of Trust of even date

Continued to next column

P.M., at the Sumner County Courthouse, Gallatin, Tennessee, offer for sale certain property hereinafter described to the highest bidder FOR CASH, free from the statutory right of redemption, homestead, dower, and all other exemptions which are expressly waived in the Deed of Trust, said property being real estate situated in Sumner County, Tennessee, and being more particularly described as follows:
Land in Sumner County, Tennessee, being Lot No. 10 as shown on the Plan of Cedar Grove Subdivision, of record in Plat Book 13, page 362.
ALSO KNOWN AS: 103 Lynnwood Court, Portland, Tennessee 37148
The HB 3588 letter was mailed to the borrower(s) pursuant to Tennessee Code Annotated 35-5-117. This sale is subject to all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory rights of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. In addition, the following parties may claim an interest in the above-referenced property: Enora Key

Continued to next column

WHEREAS, default has occurred in the performance of the covenants, terms, and conditions of a Deed of Trust Note dated April 7, 2008, and the Deed of Trust of even date securing the same, recorded April 10, 2008, at Book 2943, Page 767 in Office of the Register of Deeds for Sumner County, Tennessee, executed by Daniel Zilbut and Daniela Zilbut, conveying certain property therein described to Craig E. Newby as Trustee for JPMorgan Chase Bank, N.A.; and the undersigned, Wilson & Associates, P.L.L.C., having been appointed Successor Trustee.
NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable; and that an agent of Wilson & Associates, P.L.L.C., as Successor Trustee, by virtue of the power, duty, and authority vested in and imposed upon said Successor Trustee will, on May 2, 2012 on or about 2:00 P.M., at the Sumner County Courthouse, Gallatin, Tennessee, offer for sale certain property hereinafter described to the highest bidder FOR CASH, free from the statutory right of redemption, homestead, dower, and all other exemptions which are expressly waived in the Deed of Trust, said property being real estate situated in Sumner County, Tennessee, and being more particular-

Continued to next column

SUPPLEMENTAL- # 1

**AFFIDAVIT** 2012 MAY 30 PM 3:04

STATE OF TENNESSEE

COUNTY OF SUMNER

NAME OF FACILITY: Southern Sports Medicine Surgery Center

I, THOMAS L. GAUTSCH, 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.

Thomas L. Gautsch, M.D. Chief Manager

Sworn to and subscribed before me, a Notary Public, this the 30th day of May, 2012, witness my hand at office in the County of Sumner, State of Tennessee.

NOTARY PUBLIC

TONI M. STEPHENS STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF SUMNER

My commission expires 1-27 2015.

HF-0043

Revised 7/02

# SUPPLEMENTAL

SUPPLEMENTAL

2012 JUN -5 AM 9: 12

June 5, 2012

Philip M. Wells, FACHE
Health Planner III

RE: Certificate of Need Application CN1204-019
Southern Sports Medicine Surgery Center

Dear Mr. Wells:

Attached please find answers to your second set of supplemental questions and additional requested information for the CON application of Southern Sports Medicine Surgery Center.

If there is anything still lacking, or you require additional information please don't hesitate to contact me.

Sincerely,

Thomas L. Gautsch, M.D.
Chief Manager
contact person
Southern Sports Surgical, LLC

---

1. **Section A, Section A, Applicant Profile, Item 4**

   Please provide a copy of the applicant facility's Corporate Charter, or Articles of Organization.

   **Response:** Please see the attached Articles of Organization for Southern Sports Surgical, LLC.

2. **Section A, Section A, Applicant Profile, Item 5**

   Please provide a copy of the applicant facility's management agreement.

   **Response:** Please see the attached Management Agreement.

3. **Section B, Item II A. (Project Description) & Section C, Need Item 1b (Specific Criteria –ASTC)**

   Besides The members of the practice of the Southern Sports Institute (Drs. Gautsch, Grutter and Kindred), the applicant indicates it is anticipated that other surgeons will utilize the center. In order to substantiate the interest by other physicians who may be interested in practicing at the center, the Agency reviewers appreciate receiving letters of support which identify interest

potential volumes of cases for which the physicians would anticipate utilizing the proposed facility. Please provide those as they become available before the Agency meeting.

2012 JUN -5 AM 9: 12

**Response:** We will provide them as they become available.

4. **Section C, Need Item 1 (Specific Criteria -ASTC)**

Does the applicant have in mind a group of anesthesiologists who would be interested and have the capability to provide anesthesia services to the ASTC? If so, please provide a letter of interest from the group which also described their willingness to provide services to TennCare beneficiaries.

**Response:** The applicant has approached and received a favorable response from the anesthesia group Sumner Anesthesia Associates, Inc. about providing anesthesia services in this proposed ASTC. They are the anesthesia group that has long provided anesthesia at one of Sumner County's hospitals and one of its ASTCs. They provide anesthesia services for beneficiaries under all TennCare plans. The group's representative has expressed an enthusiastic desire to provide anesthesia services for this proposed ASTC should the CON be granted. Please see his attached letter.

If circumstances were such that for some reason this group became precluded from providing the anesthesia services necessary, this ASTC would still have several options available for anesthesia. There are two very large groups that are based in Nashville which provide anesthesia services to multiple hospitals and ASTC's, including areas surrounding us, with whom we could very likely negotiate a contract. Additionally, if necessary or if it would prove advantageous, the ASTC could recruit and employ an anesthesiologist and CRNA or two to provide anesthesia as well as pain management services.

5. **Section C. Economic Feasibility Item 1**

The architect's letter misidentifies the location of the project as a second story project. Please resubmit a corrected letter which properly identifies the project location.

**Response:** Please see the attached revised letter that accurately reflects the project location.

6. **Section C. Economic Feasibility Item 2 (Funding)**

Your response is noted. It is noted that Volunteer State Bank will be funding both the ASTC project and the Southern Sports Institute office project. Since the project will be funded from a bank loan and cash reserves from the two principles in the project, please identify and clarify the proportion of costs which will be funded by each source for the ASTC project.

| Source of Funding | Anticipated Total Project Capital Cost ASTC and Office Space | Anticipated Total ASTC Project Capital Cost | Total Amount of Funding for Total ASTC and Office Space Project by Funding Source | Amount of Funding from various funding sources to be committed to ASTC Project |
|---|---|---|---|---|
| Volunteer State Bank | | | $ 4,624,936 | $ 750,000 |
| Dr. Gautsch | | | $ 715,763 | $ 94,473.50 |
| Dr. Grutter | | | $ 170,000 | $ 94,473.50 |

SUPPLEMENTAL

| | | | | |
|---|---|---|---|---|
| Total ASTC Capital Cost & Funding | $ 5,510,699 | $ 938,947 | $ 5,510,699 | $ 938,947 |

7. **Section C. Economic Feasibility Item 4 (Projected Data Chart) and Item 5 (Average Gross Charges, Average Deductions from Revenue, and Average Net Charges**

The calculations of Average Gross Charges, Average Deductions from Revenue, and Average Net Charges with volumes do not match the Projected Gross Operating Revenues Deductions from Revenue, and Average Net Revenues in the Projected Data Chart. Please review and resubmit synchronous numbers.

Example:

Surgery Gross Operating Revenues = Projected Surgery Volume X Average Gross Surgery Charge
+ Pain Gross Operating Revenues = Projected Pain Volume X Average Gross Pain Charge
Total Gross Operating Revenues = Projected Total Volume X Average Gross Charge

Surgery Deductions from Revenues = Projected Surgery Volume X Average Deduction from Gross Surgery Charge
+ Pain Deductions from Revenues = Projected Pain Volume X Average Deduction from Gross Pain Charge
Total Deductions from Revenues = Projected Total Volume X Average Deductions from Revenues

Surgery Net Operating Revenues = Projected Surgery Volume X Average Net Surgery Charge
+ Pain Net Operating Revenues = Projected Pain Volume X Average Net Pain Charge
Total Net Operating Revenues = Projected Total Volume X Average Net Charge

**Response:** The Project's Average Gross Charge is expected to be $4,072, Average Deductions from Revenue $2679, Average Net Charges $1,393.

The Project's Average Gross Surgery Charge is expected to be $5,200, Average Surgery Deductions from Revenue $3,434, Average Surgery Net Charges $1,766.

The Project's Average Gross "Pain" Charge is expected to be $760, Average "Pain" Deductions from Revenue $461, Average "Pain" Net Charges $299.

Updated comparison of common procedures with CPT codes of the proposed charge schedule for this facility, current Medicare allowable fee schedule and those of the average for all of Tennessee are provided.

| Procedure | CPT | Applicant | Medicare Allowable | Tennessee Average Charge | Tennessee Average Payment |
|---|---|---|---|---|---|
| Arthroscopy, Shoulder, cartilage repair | 29807 | 5,725 | 1,496 | 5,913 | 809 |
| Arthroscopy, Shoulder, Rotator Cuff repair | 29827 | 4,446 | 1,537 | 7,097 | 1,166 |
| Open Rotator Cuff Repair | 23420 | 6,824 | 1,611 | 8,760 | 1,289 |
| ORIF Wrist Fracture | 25607 | 5,900 | 1,911 | 6,150 | 1,565 |
| Carpal Tunnel Release | 64721 | 2,200 | 932 | 2,350 | 764 |
| Neuroplasty ulnar nerve at elbow | 64718 | 2,200 | 932 | 2,637 | 765 |
| Vertebroplasty | 22520 | 6,824 | 1,611 | 8,469 | 1,314 |

"Pain Management" Procedures

| Procedure | CPT | Applicant | Medicare Allowable | Tennessee Average Charge | Tennessee Average Payment |
|---|---|---|---|---|---|
| Injection, Lower Back Joint | 64476 | 1,384 | 299 | 1,495 | 230 |
| Single nerve block injection, arm nerve | 64415 | 600 | 140 | 615 | 106 |
| Multiple nerve block injections, rib nerves | 64421 | 1,120 | 279 | 1,156 | 218 |
| Implant Spine stimulator | 63650 | 7,593 | 4,434 | 9,278 | 3,635 |

Chart source: Centers for Medicare & Medicaid Services

8. **Section C. Contribution to Orderly Development, Item 3 (Staffing)**

Your response is noted. However, the number of full time equivalent staffing numbers on page 34 and page 35 do not match. Please correct and resubmit synchronous numbers.

**Response:** There is no current staffing pattern for this project. The anticipated initial staffing will be with a combined staff of 8 Part-Time and 3 Full-time individuals for a combined 9.4 Full Time Equivalents. Staffing will include: one Manager/Billing supervisor, five registered nurses, three operating room technicians and two clerical/support personnel. Salaries for these staffers will be comparable to prevailing wage patterns in Sumner County.

Tennessee Department of Labor prevailing wage information indicates that the range of hourly wages in the Nashville SMSA is as follows: entry level - $18.42; average - $26.50; experienced - $30.54. The applicant plans to pay RNs $30-32.00/hour.

Proforma Personnel Costs

| | | Hourly Rate | Staff | Days per week | hours per week | | Annual |
|---|---|---|---|---|---|---|---|
| Pre-op Admit (RN) | $ | 32.00 | 1 | 4 | 32 | $ | 49,152 |
| Recovery (RN) | $ | 32.00 | 2 | 4 | 64 | $ | 98,304 |
| Circulator (RN) | $ | 32.00 | 2 | 4 | 64 | $ | 98,304 |
| OR Tech | $ | 20.00 | 2 | 4 | 64 | $ | 61,440 |
| Instrument Tech | $ | 15.00 | 1 | 4 | 32 | $ | 23,040 |
| Scheduler/Med recs | $ | 14.00 | 1 | 5 | 40 | $ | 26,880 |
| Manager/Billing 1 | $ | 30.00 | 1 | 5 | 40 | $ | 57,600 |
| Billing 2 | $ | 15.00 | 1 | 5 | 40 | $ | 28,800 |
| **Total Personnel** | | | 11 | | 376 | **$** | **443,520** |
| | | | | FTE 9.4 | | | |

SECTION C, NEED ITEM 1
ANESTHESIA GROUP
LETTER OF INTEREST
AND SUPPORT

SUPPLEMENTAL

2012 JUN -5 AM 9: 13

Sumner
**Anesthesia Associates, Inc.**
300 Steamplant Rd.
Suite 240
Gallatin, Tennessee 37066

(615) 451-3571

May 29, 2012

Ms. Melanie Hill
State of Tennessee
Health Services and Development Agency
500 Deaderick St, Ste. 850
Nashville, TN 37243

Re: Southern Sports Medicine Surgery Center, CN – 1104 – 013

Dear Ms. Hill,

This letter is in support of Dr. Thomas Gautsch and his request for a certificate of need for his proposed office and surgery center. I have been closely associated with Dr. Gautsch for over 15 years and have provided anesthesia services for him over this time. Through out this time, his reputation and skills are beyond reproach.

In our discussions, we have agreed in principle to provide anesthesia services for Dr. Gautsch when his certificate of need is approved. As we also provide the post-operative nerve blocks for the majority of his procedures, this would allow us to take advantage of the ancillary procedure roam that would be available. We also have experience in chronic pain management which may allow us the opportunity to use this area for certain types of diagnostic procedures. We would be willing to participate in Tenncare at this surgery facility.

Sumner Anesthesia Associates support Dr. Gautsch in his request for a surgery center certificate of need.

Sincerely,

Mark Carter, M.D.

Mark Carter, M.D.
Chief of Anesthesiology

SUPPLEMENTAL

2012 JUN -5 AM 9: 13

**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF SUMNER

NAME OF FACILITY: Southern Sports Medicine Surgery Center, CN1204-019

I, THOMAS L. GAUTSCH, M.D 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.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 1st day of June, 2012, witness my hand at office in the County of Sumner, State of Tennessee.

NOTARY PUBLIC

My commission expires 1-27, 2015.

HF-0043

Revised 7/02

**Hendersonville Medical Center**

TRISTAR HEALTH SYSTEM

2012 SEP 11 PM 2 54

September 10, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Board of Trustees member at Hendersonville Medical Center. I am aware that several of our Medical Staff members have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We support our hospital and medical staff in the belief that a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Charles Lea
Union University

355 New Shackle Island Road • Hendersonville, TN 37075 • 615-338-1000
www.tristarhealth.com

2012 SEP 11 PM 2 52

September 6, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Radiologist physician practicing medicine in the Hendersonville area of Sumner County. I am aware that other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We support our colleagues in the belief that a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Webb Earthman, MD

**Hendersonville Medical Center**

TRISTAR HEALTH SYSTEM

2012 SEP 11 PM 2 54

September 10, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Board of Trustees member at Hendersonville Medical Center. I am aware that several of our Medical Staff members have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We support our hospital and medical staff in the belief that a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Tracy Callister, M.D.

355 New Shackle Island Road • Hendersonville, TN 37075 • 615-338-1000

www.tristarhealth.com

**Hendersonville Medical Center**

2012 SEP 11 PM 2 54

TRISTAR HEALTH SYSTEM

September 10, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Board of Trustees member at Hendersonville Medical Center. I am aware that several of our Medical Staff members have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We support our hospital and medical staff in the belief that a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Kelli Fischer

Kelli Fischer
Fischer Family Dentistry

**Hendersonville Medical Center**

2012 SEP 11 PM 2 54 TRI-STAR HEALTH SYSTEM

September 11, 2012

Melanie M. Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Medicine Surgery Center
CN1204-019

Dear Ms. Hill:

Tri-Star Hendersonville Medical Center ("HMC") wishes to state its opposition to the above-referenced certificate of need application. Approximately one year ago, the HSDA granted a CON to this orthopedic physician group to establish an ASTC in Gallatin, limited to orthopedic surgical procedures. Without taking any significant step to implement the approved ASTC, this same group is now proposing to move the proposed ASTC to Hendersonville and expand it to a multi-specialty surgery center.

HMC did not oppose the original application, in that the scope of the services and the location of the facility seemed appropriate to meet the needs of the practice and its patients. The proposal in this application, however, would greatly expand the scope of the services, locate the facility in close proximity to HMC, and thus negatively impact the operations and services of HMC. The proposal does not represent the orderly development of health care facilities and services, and HMC respectfully urges the HSDA to deny the application. It should be noted that even if this application is denied, Southern Sports Medicine will still be able to implement the original CON and open its ASTC in Gallatin.

Sincerely,

Regina Bartlett

Regina Bartlett, CEO

355 New Shackle Island Road • Hendersonville, TN 37075 • 615-338-1000
www.tristarhealth.com

**Hendersonville Medical Center**

2012 SEP 11 PM 2 54

TRISTAR HEALTH SYSTEM

September 10, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Board of Trustees member at Hendersonville Medical Center. I am aware that several of our Medical Staff members have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We support our hospital and medical staff in the belief that a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Ken Wilber

Ken Wilber

355 New Shackle Island Road • Hendersonville, TN 37075 • 615-338-1000
www.tristarhealth.com

**Hendersonville Medical Center**

TRISTAR HEALTH SYSTEM

2012 SEP 11 PM 2:54

September 10, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Board of Trustees member at Hendersonville Medical Center. I am aware that several of our Medical Staff members have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We support our hospital and medical staff in the belief that a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Nell Nestor, MD

355 New Shackle Island Road • Hendersonville, TN 37075 • 615-338-1000
www.tristarhealth.com

2012 SEP 11 PM 2 54

September 6, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am an Obstetric/Gynecology physician practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Brett Branson, MD

September 6, 2012

2012 SEP 11 PM 2 54

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Gastroenterologist practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Randy Howard, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am Emergency Room physician practicing medicine in the Hendersonville area of Sumner County. I am aware that other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We support our colleagues in the belief that a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Duane Harrison, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am an Obstetric/Gynecology physician practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Brent Nason, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Cardiologist practicing medicine in the Hendersonville area of Sumner County. I am aware that other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We support our colleagues in the belief that a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Don Russo, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am an Obstetric/Gynecology physician practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Jill Steier MD

Jill Steier, MD

2012 SEP 11 PM 2 53

September 6, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Gastroenterologist practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

William Norris, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Anesthesiologist practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Steven Dickerson, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Obstetric/Gynecology physician practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Tamie Babb, MD

2012 SEP 11 PM 2 53

September 6, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am an Obstetric/Gynecology physician practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Brandon Riggan, MD

2012 SEP 11 PM 2 53

September 6, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Plastic Surgeon practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Jeffrey Jones, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Thoracic Surgeon practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Chad Swan, MD

2012 SEP 11 PM 2 53

September 11, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am an Anesthesiologist practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and dishcartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Kenneth Lanyon, MD

2012 SEP 11 PM 2 53

September 6, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a General Surgeon practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Tom Taylor MD 9/5/12

Tom Taylor, MD

2012 SEP 11 PM 2 53

September 6, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Vascular Surgeon practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Patrick Meacham, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a General Surgeon practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

W. Gerald Davis

William Davis, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Pulmonologist practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Clyde Southwell, MD

September 6, 2012

2012 SEP 11 PM 2 53

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am a Podiatrist practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Stanley Embree, DPM

2012 SEP 11 PM 2 52

September 6, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Southern Sports Surgery Center
CN1204-019

Dear Ms. Hill:

I am an Orthopedic Surgeon practicing medicine in the Hendersonville area of Sumner County. I and other colleagues in the area have engaged in serious discussions with the leadership of Hendersonville Medical Center about the prospects of partnering in the development and operation of a multi-specialty ambulatory surgery center in Hendersonville. We were surprised and disheartened to learn of the CON application proposing to move an approved but not yet built physician owned ASC approved for Gallatin to Hendersonville in close proximity to the hospital.

We continue to believe a joint hospital-physician ASC would better meet the needs of the area and hold significant benefits compared to the physician-owned model proposed in this application. Especially if the population and demographics of the area will not support two surgery centers, it is important that any such facility approved for Hendersonville be structured in a manner that will be the most efficient and effective. For those reasons, I urge the Health Services and Development Agency to deny this application.

Thank you for your time and for your consideration of these concerns.

Sincerely,

Robert Fogolin, MD

**CERTIFICATE OF NEED**
**REVIEWED BY THE DEPARTMENT OF HEALTH**
**DIVISION OF HEALTH STATISTICS**
615-741-1954

**DATE:** August 31, 2012

**APPLICANT:** Southern Sports Surgery Center
Lot 38, Indian Lake Village, Saundersville Road
Hendersonville, Tennessee 37075

**CONTACT PERSON:** Dr. Thomas Gautsch
Southern Sports Medicine Institute
570 Hartsville Pike
Gallatin, Tennessee 37066

**COST:** $3,355,533

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

**SUMMARY:**

The applicant, Southern Sports Surgery Center, located in Hendersonville (Sumner County), Tennessee, seeks Certificate of Need (CON) approval for the establishment of a multi-specialty ambulatory surgical treatment center (ASTC). The applicant seeks a new CON to expand the designated use of its previously granted ASTC project CN1104-013A to include multi-specialty services, and relocate the project to a setting more accessible to the served population. The applicant states this application remains within the same estimated project cost of $3.3million. The center will contain approximately 6,200 square feet of space including 2 operating rooms, 1 procedure room, pre and post holding area and support space as previously granted. The project is being relocated to lot 38, Indian Lake Village, Saundersville Road, within the same service area. The project does not contain any major medical equipment and will not initiate or discontinue any other health service. If the new CON is granted, the applicant will surrender CN1104-013A.

The applicant states the cost per square foot is $290 per square foot. Calculations of the project cost have been generated by the following process: The lease rate is projected to be at the market rate of $34 per square foot with a total 10 year lease cost of $2,416,586 including yearly 3% increases.

The structure will be developed by Southern Sports Holdings, LLC, which controls the property. The applicant, Southern Sports Surgical, LLC, will lease its space in the building. The developer of the building is Southern Sports Holdings, LLC. The estimated total cost to construct the entire building is $4,571,752 ($120 per square foot for the shell, $170 per square foot for the ASTC interior build out, and $90 peer square foot for the office build out) of which approximately $1,798,000 is attributable to the ASTC, as a cost to be borne by the developer. Upgrading of the building construction, hospital grade interior build out and additional surfaces and fixtures necessary to meet the needs of the ASTC will cost an estimated $290 per square foot for the ASTC part of the construction.

Southern Sports Medicine Surgery Center is owned by Southern Sports Surgical, LLC. The current and projected owners of Southern Sports Surgical, LLC are Dr. Thomas Gautsch, M.D. (50% ownership) and Dr. Paul Grutter, M.D. (50% ownership). The applicant states they plan to expand ownership to include other surgeons by dilution of shares. Additionally, the applicant has

discussed its willingness to offer an ownership in the center to area hospitals, however other than a potential future agreement, no current agreement exists. The proposed project will initially be managed by Southern Sports Medicine, PLLC. The applicant provides an organizational chart on page 30 of the application. However, the applicant states with rapidly evolving healthcare and changing reimbursement models, contracting with a larger ASTC management company may be beneficial for the ASTC and its patients in the future. Ownership may also be offered to that management company if deemed appropriate.

The total estimated project cost is $3,355,533 and will be funded through a commercial loan from Volunteer State Bank and cash reserves from the two principals. Documentation from the Senior Vice President of Volunteer State Bank is provided in Supplemental 1, Attachment C, Economic Feasibility 2. Additionally, the applicant provides a breakout of each principal's cash reserve contribution and Volunteer State Bank's funding for both the office space project and the ASTC project is Supplemental 2, page 2.

## GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

**NEED:**
The applicant's service area will be Sumner County from which approximately 80% of Southern Sports Medicine Institute's patients have historically come.

**Service Area Total Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Sumner | 162,422 | 170,883 | 5.2% |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

The following chart illustrates the service area hospital surgical utilization.

**Service Area Hospital Utilization, 2010**
**Surgery Procedures**

| Hospital | ORs | Inpatient Procedures | Outpatient Procedures |
|---|---|---|---|
| Sumner Regional Medical Center | 7 | *12,555* | *3,945* |
| Hendersonville Medical Center | 8 | *8,217* | *13,719* |

*Source: Joint Annual Report of Hospitals, 2010 Tennessee Department of Health, Division of Health Statistics*

The following chart illustrates ASTC utilization in Sumner County.

**2011 Utilization for Sumer County ASTCs**

| Facility | ORs | Procedure Rooms | Procedures |
|---|---|---|---|
| Patient Partners, LLC | 2 | 2 | 7,627 |
| Green Surgery Center * | 1 | 1 | 1,096 |

Source: *Joint Annual Report of Ambulatory Surgical Treatment Centers 2011,* Tennessee Department of Health, Division of Health Statistics
*Ophthalmology Only

The proposed project is to include ASTC services for multiple specialties, including at least orthopedic surgery and all its sub-specialties, including spine, sports and hand surgery, appropriate to the outpatient setting, and the full spectrum of pain management procedures of whatever specialties, orthopedic, sports medicine, spine, neuro, or anesthesia, with allowance for other surgical specialty utilization of the facility as well. The applicant states this proposed project will provide a more substantial and meaningful contribution to the orderly development of healthcare

in Sumner County, so as to now expand the currently very limited access to the ASTC services for patients and surgeons of varied specialties, with little increase in project costs.

A larger 2.9 acre lot has now been put under contract in Hendersonville, which will allow the previously granted ASTC floor plan to be moved to the ground level with minimal modification, create more parking, improve patient access, ingress and egress, and ease of future expansion. From the orderly development standpoint, the new site is also located more appropriately for Sumner County's second multi-specialty center, both relative to the population densities and relative to one other multi-specialty ASTC. The site is also considerably closer to one of the two local hospitals that the previous site, facilitating faster transfer of patients and physician access. The new location is just off a major exit of Highway TN-386, the major artery thoroughfare through Sumner County, and will shorten driving time that a majority of Sumner County residents will need to travel to receive ASTC care.

According to the applicant, Sumner County has fewer multi-specialty ASTC ORs per person-only 1.2 per 100,000 than any other Tennessee county with ASTC, including those with less than half its population. The applicant reports that ORs in Sumner County are 130% above Guidelines capacity of 800 cases per OR.

The applicant reports Sumner County is one of the fastest growing counties in Tennessee and the fastest growing portion of the county is the Hendersonville area. Nevertheless, with only one multi-specialty ASTC, its population has the lowest level of access to ASTC services in its own county of any county with ASTC access. Historic and continued growth of the Sumner County population in general as well as continued rapid growth of the largest population center, has and will continue to create an increasing need for healthcare facilities such as the proposed ASTC. Currently, Sumner County has two ASTC's, one of which is limited to ophthalmology and is unavailable to patients of other specialties. The only other ASTC is multi-specialty, has only 2 ORs and is currently functioning at about 1,100 cases per room.

The applicant believes there is an objective deficiency of ASTC ORs. Additionally, a comparison of populations and ASRC operating rooms in the 16 most populous Tennessee counties (Sumner is 8$^{th}$) also demonstrates a significant disparity in the number of ASTC ORs in Sumner County relative to other Tennessee counties. Sumner County has a total of only two multi-specialty ASTC ORs for all of it's over 160,000 residents, or 1 multi-specialty OR per 80,322 residents. The average in the 16 similarly populated counties is one ASTC OR per every 17,345 residents. Put another way, Sumner County has fewer multi-specialty ASTC ORs per person, only 1.2 per 100,000, than any other county with ASTCs, including those with less than half its population. Sumner County would require at least 7 additional multi-specialty ASTC ORs to reach the average level of access available for residents of all other counties with ASTCs.

The applicant reports that existing resources have actually diminished in the last 4 years despite the population growth. In 2008, Portland Medical Center ceased its hospital operations including its surgical services and closed its operating rooms. This left Sumner County with only 17 operating rooms, one of which is dedicated to ophthalmologic surgery only and all but two of which are in hospital ORs. The applicant states the average surgical room utilization of all ORs combined in 2010 was 1,141 cases per room per year. The applicant states this is 143% of the recommended capacity of an operating room as defined in the Tennessee's Health: Guidelines for Growth: Criteria and Standards, 2000 Edition Specific Criteria for ASTCs of 800 cases per year.

The applicant projects 1,000 cases in year one and 1,700 in year two of the project.

**TENNCARE/MEDICARE ACCESS:**

The applicant states they will participate in the TennCare and Medicare programs. The applicant ASTC plans to contract with BlueCross Blue Shield, United HealthCare, TennCare Select, AmeriChoice, and AmeriGroup. The utilization for these programs is expected to mirror Southern

Sports Medicine Institute, LLC, which is 5% Medicare and 22% TennCare. In year one the applicant states they anticipate charging $195,468 to TennCare and $883,676 to Medicare.

The following chart illustrates the TennCare enrollees in the applicant's service area.

**TennCare Enrollees in the Proposed Service Area**

| County | 2012 Population | TennCare Enrollees | % of Total Population |
|---|---|---|---|
| Sumner | 162,422 | 22,937 | 14.1% |

Source: *Tennessee Population Projections 2000-2020,* February 2008 Revision Tennessee Department of Health, Division of Health Statistics and *Tennessee TennCare Management Information System, Recipient Enrollment,* Bureau of TennCare

**ECONOMIC FACTORS/FINANCIAL FEASIBILITY:**

In the Project Costs Chart located in Supplemental 1, the total estimated project cost is $3,355,533, which includes $91,000 for architectural and engineering fees; $60,000 for legal, administrative, and consultant fees; $100,000 for contingency fund; $318,000 for fixed equipment; $202,000 for moveable equipment; $50,414.24 for initial supply stock; $2,416,585.76 for facility; $110,000 for reserve for one year's debt service; and $7,533 for CON filing fees.

This is an application for a new ASTC so there is no Historical Data Chart.

In the Projected Data Chart located in Supplemental 1, The applicant projects 1,000 cases in year one and 1,700 cases in year two with gross operating revenues of $4,072,240 and $5,274,080 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $1,393,386 and $2,128,590 each year. The applicant projects a net operating income/(loss) of ($66,140) in year one and $362,974 in year two.

In Supplemental 2, the applicant states the project's average gross charge is expected to be $4072, with an average deduction of $2,679, resulting in an average net charge of $1,393.

The project's average gross surgery charge is expected to be $5,200, with an average deduction of $3,434, resulting in an average net charge of $1,766.

The project's average gross pain charge is expected to $760, with an average deduction of $461, resulting in an average net charge of $299.

The applicant provides a comparison of common procedures with CPT codes of the proposed charge schedule for this facility, current Medicare allowable fee schedule, and those of the average for all of Tennessee on pages 3 and 4 of Supplemental 2.

The applicant considered the alternative of building a surgery center comprised only of procedure rooms. This alternative was rejected because of the availability of an operating room is integral to the practice of Southern Sports Medicine.

The applicant also considered modernization of their present office building as well as sharing arrangements. The current office building is of insufficient size to house a surgery center, physicians' practices, MRI and physical therapy both due to the size of the building as well as available lot size for patient parking. One of the main tenets of this surgery center is its ability to provide economical access to excellence in orthopedic care from one location. Providing physician diagnosis, treatment, digital radiography, MRI, and treatment options including physical therapy and same-day surgery procedures in one location improves care for their patients including the elderly and indigent. Sharing arrangements can create a burden of travel for patients, which is considerable especially for the indigent and elderly. Additionally, this new proposed site improves upon the currently approved site in myriad ways as outlined in the application.

**CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:**
The applicant anticipates having transfer agreements with Hendersonville Medical Center and/or Sumner Regional Medical Center as well as contracting with all managed care organizations. The owners who will utilize the center are on the medical staff of both hospital staffs.

According to the applicant, at present,Sumner County's over 165,000 residents have local access to a solitary 2 operating room ASTC in the whole county. Significant numbers of residents are therefore traveling outside of the county for cost effective ASTC care. As the cost burden increasingly shifts towards patients with larger average deductibles, co-pays and out of pocket expenditures, cost alone is driving patients away from hospital facilities for outpatient surgeries. With the availability of a second multi-specialty ASTC in Sumner County, it is anticipated that there will be a potential modest reduction in the number of outpatient cases performed in inpatient hospital ORs at the two closest hospitals, but most probably, the reduction will be far less than the utilization of this facility, as patients who are already going out of the County for cost effective ASTC care will no longer have to travel outside the county for that service.

The applicant states their anticipated initial staffing will be with combined full and part-time staff of 11 individuals for 9.24 FTEs. Staffing will include one manager/billing supervisor, five registered nurses, three operating room technicians, and two clerical/support personnel.

The applicant will seek licensure from the Tennessee Department of Health, Board for Licensing Healthcare Facilities and seek accreditation from Joint Commission and or AAAHC.

## SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

## AMBULATORY SURGICAL TREATMENT CENTERS

1. The need for an ambulatory surgical treatment center shall be based upon the following assumptions:

   a. An operating room is available 250 days per year, 8 hours per day.

      *The applicant states the operating room will be available 250 days a year, eight hours per day.*

   b. The average time per outpatient surgery case is 60 minutes.

      *The applicant states they anticipate that the average time per surgery case will be over 60 minutes. The applicant's surgical cases are mainly orthopedic surgeries which on average take longer than typical cases found in a multi-specialty surgery center.*

   c. The average time for clean up and preparation between outpatient surgery cases is 30 minutes.

      *The applicant states their clean up time will not exceed 30 minutes on average, however, set up times for some reconstructive surgeries can be up to 45 minutes for set-up anesthesia, positioning, and prep/draping.*

   d. The capacity of a dedicated, outpatient, general-purpose operating room is 80% of full capacity. That equates to 800 cases per year.

      *The applicant believes that its operating rooms will function at utilization levels in excess of the time utilization equivalent of 800 sixty-minute cases per year.*

*For the purpose of this application, the applicant states financial and utilization calculations are conservatively based on the committed volume of cases from its initial owners/utilizers, Drs. Gautsch, Grutter, and Kindred. It is also anticipated that other surgeons will utilize the center, principally in the same allied surgical specialties including hand surgery, spine surgery, orthopedic and/or neurosurgical, sports surgery, and pain management surgeries and procedures performed by orthopedic, neurosurgical, pain management, or anesthesia specialists.*

*The initial owners/utilizers specialize in arthroscopic ligamentous repair and reconstruction of major joints, predominantly of the shoulder and the knee, but also including the elbow. The applicant surgeons are team physicians for a large number of Sumner County teams and athletes who are prone to such injuries. Many recreational athletes and non-athletes as well seek their care and surgical treatment for these types of injuries from the surgeons of Southern sports Medicine. Consequently, a high percentage of their surgical volume consists of surgical procedures that normally take between 90 and 150 minutes. This is equal to 150%- 250% of the Guidelines' assumed 60 minute "average time" per outpatient surgery case. The average surgical case time for all outpatient cases of the applicant surgeons is 110 minutes. The applicant states 800 sixty minute cases is the time equivalent of 436 110 minute cases. Therefore, this ASTC's actual 80% capacity utilization would more correctly be projected to be 400-450 cases per OR, or 800-900 cases in two ORs. The applicant expects to reach this utilization threshold between year 2 and 3 of operation, much sooner with the center's use by additional surgeons.*

*Additionally, many of these arthroscopic shoulder and knee repair/reconstruction surgeries require additional time for set up beyond the average for set up and patient positioning, further adding to the overall time spent on each case. The most efficient method for minimizing these set up times between surgeries is to utilize two paired operating rooms so that one room can be cleaned and set up during the time the other is being used for actual surgery, and vice versa. Experience in orthopedic surgery has shown that two rooms used in tandem this way actually utilizes them both more efficiently than a single room used sequentially for these types of orthopedic cases.*

*The applicant reports they are also confident that its one procedure room, which will be primarily dedicated to injection procedures, will perform in excess of 800 cases per year in year two and thereafter, based upon the combined rates of performance already by the applicant surgeons, before counting the addition of another physician utilizer to the practice, and utilization of unused capacity by other surgeons.*

*The applicant states the above statements and calculations based on Guidelines 1.a. through 1.e. are illustrated more fully by the following:*

- *Following these assumptions, the full capacity of an ASTC OR is 1,000 surgery cases a year*
- *1,000 surgery cases per year, 250 day per year= 4 cases per room per day;*
- *4 surgical cases per day at an assumed average 60 minutes per case is 4 hours of surgery per room per day;*
- *An OR is available 8 hours per day, therefore at full capacity, the guidelines for growth assume 4 hours of down time, some of which is for clean up and preparation between outpatient surgery cases (assumed to be 30 minutes per case).*

*The applicant provides an example of what the above assumption would look like for a standard OR surgery day on page 17 of Supplement 1.*

*Either way, 50% of the total OR room minutes are given to surgery and 50% are given to non-surgical activities.*

*As stated by the applicant in this project application, the types of orthopedic surgery performed by Dr. Grutter and Dr. Gautsch are typically more involved in both length and complexity than the average of surgeries contemplated by the Guidelines for Growth. The average length of time for Dr. Gautsch's mix of surgery in the previous three years is 110 minutes, almost twice as long as the average assumed by the Guidelines. Cleanup time takes about as long as is typically assumed, however set up time is typically longer, especially for knee ligament reconstruction surgeries and shoulder surgeries. Knee and shoulder surgeries make up approximately 90% of surgeries that Drs. Gautsch and Grutter perform.*

*According to the applicant, since the surgical times are longer and the cleanup times and set up times, while longer are not proportionately as long, it is calculated that the efficiency of the ASTC's overall utilization would be slightly better than that assumed by the Guidelines, however the total number of surgeries given their longer average length would be quite less. The applicant provides a comparison of their assumptions for a standard OR day and the proposed ASTC with longer average surgery time on page 18 of Supplemental 1.*

e. Unstaffed operating rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

*The applicant states their will be no unstaffed operating rooms at the surgery center.*

2. "Service Area" shall mean the county or counties represented by the applicant as the reasonable area to which the facility intends to provide services and/or in which the majority of its service recipients reside.

*The applicant states their service area is Sumner County, although a small percentage of patients will reside in other contiguous counties.*

3. The majority of the population of a service area for an ambulatory surgical treatment center should reside within 30 minutes travel time to the facility.

*The applicant reports all of Sumner County is within 30 minutes drive time to the facility.*

4. All applicants should demonstrate the ability to perform a minimum of 800 operations and/or procedures per year per operating room and/or procedure room. This assumes 250 days x 4 surgeries/procedures x .80.

*The average surgical case time for all outpatient case of the applicant surgeons is 110 minutes. The applicant states 800 sixty minute cases is the time equivalent of 436 110 minute cases. Therefore, this ASTC's actual 80% capacity utilization would more correctly be projected to be 400-450 cases per OR, or 800-900 cases in two ORs. Without considering the addition of a planned 3rd surgeon to the practice, the applicant still expects to reach this utilization threshold between year two and 3 of operation, much sooner with the planned addition of the 3rd surgeon.*

*Additionally, many of these arthroscopic shoulder and knee repair/reconstruction surgeries require additional time for set up beyond the average for set up and patient positioning, further adding to the overall time spent on each case. The most efficient method for minimizing these set up times between surgeries is to utilize two paired operating rooms so that one room can be cleaned and set up during the time the other is being used for actual surgery, and vice versa. Experience in orthopedic surgery has shown that two rooms used in*

*tandem this way actually utilizes them both more efficiently than a single room used sequentially for these types of orthopedic cases.*

*The initial owners/utilizers are very active orthopedic surgeons, Dr. Gautsch and Dr. Grutter, and a non-surgical musculoskeletal care specialist, Dr. Kindred. Another orthopedic surgeon outside of Middle Tennessee is expected to relocate to Gallatin to join the practice in 12 to 18 months. Dr. Kindred is a primary care, fellowship trained musculoskeletal care specialist who routinely performs fluoroscopically ultrasound guided injections and procedures on affiliated nerves, muscles, tendons, and joints.*

*Drs. Gautsch and Grutter historically performed well over 800 such procedures per year without benefit of fluoroscopic or ultrasound guidance due to previous availability. Fluoroscopic and ultrasound guidance of these percutaneous procedures has already been shown clinically superior and more consistently accurate and so current patients will benefit from that availability.*

*The practice currently plans to engage 1-2 pain management specialist physicians in the future.*

5. A certificate of need (CON) proposal to establish a new ambulatory surgical treatment center or to expand the existing services of an ambulatory surgical treatment center shall not be approved unless the existing ambulatory surgical services within the applicant's service area or within the applicant's facility are demonstrated to be currently utilized at 80% of service capacity. Notwithstanding the 80% need standard, the Health Facilities Commission may consider proposals for additional facilities or expanded services within an existing facility under the following conditions: proposals for facilities offering limited-specialty type programs or proposals for facilities where accessibility to surgical services is limited.

*The applicant states Sumner County has only 17 operating rooms, one of which is dedicated to ophthalmologic surgery only and all but two of which are in hospital ORs. The applicant states the average surgical room utilization of all ORs combined in 2010 was 1,141 cases per room per year.*

*Additionally, this ASTC will be Sumner County's second multi-specialty ASTC and the only one with surgical suites specifically constructed and built out for performance of state of the art arthroscopic reconstruction and repair procedures.*

***Service Area Hospital Utilization, 2010***
***Surgery Procedures***

| Hospital | ORs | Inpatient Procedures | Outpatient Procedures |
|---|---|---|---|
| Sumner Regional Medical Center | 7 | 12,555 | 3,945 |
| Hendersonville Medical Center | 8 | 8,217 | 13,719 |

*Source: Joint Annual Report of Hospitals, 2010 Tennessee Department of Health, Division of Health Statistics*

***2011 Utilization for Sumer County ASTCs***

| Facility | ORs | Procedure Rooms | Procedures |
|---|---|---|---|
| Patient Partners, LLC | 2 | 2 | 7,627 |
| Green Surgery Center * | 1 | 1 | 1,096 |

*Source: Joint Annual Report of Ambulatory Surgical Treatment Centers 2011, Tennessee Department of Health, Division of Health Statistics*

6. A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment must specify the number of projected surgical operating rooms to be designated for ambulatory surgical services.

*This project will contain 2 operating rooms and one procedure room and will be designated for ambulatory surgical services.*

7. A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following the completion of the proposed project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

   *The applicant projects in year one, Q1-150, Q2-250; Q3-300; and Q4-300. In year two, the applicant projects Q1-350, Q2-400, Q3-450, and Q4-500.*

8. A CON proposal to establish an ambulatory surgical treatment center or to expand the existing services of an ambulatory surgical treatment center must project patient origin by percentage and county of residence. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

   *The applicant projects 79% of cases from Sumner, 6% from Macon, 3% from Trousdale, 3% from Davidson, and 2% from Roberson counties*

**Applications for Change of Site**

When considering a certificate of need application, which is limited to a request for a change of site for a proposed new health care institution, the Commission may consider, in addition to the foregoing factors, the following factors:

(a) *Need.* The applicant should show the proposed new site would serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change the proposed new site.

*CN1104-013A was granted for a 1.4 acre lot which requires the ASTC to be located on the second floor of the medical office building. A larger 2.9 acre lot has now been put under contract in Hendersonville, which will allow the previously granted ASTC floor plan to be moved to the ground level with minimal modification, create more parking, improve patient access, ingress and egress, and ease of future expansion. From the orderly development standpoint, the new site is also located more appropriately for Sumner County's second multi-specialty center, both relative to the population densities and relative to one other multi-specialty ASTC. The site is also considerably closer to one of the two local hospitals than the previous site, facilitating faster transfer of patients and physician access. The new location is just off a major exit of Highway TN-386, the major artery thoroughfare through Sumner County, and will shorten driving time that a majority of Sumner County residents will need to travel to receive ASTC care.*

(b) *Economic factors.* The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

*The new location is closer to the concentrated population of Sumner County and TN-386, the major artery thoroughfare through Sumner County, and will shorten driving time that a majority of Sumner County residents will need to travel to receive ASTC care. The new location will give greater ease o access than the current granted CN1104-013A. Currently many Sumner County residents are*

*forced to leave the county for ASTC care. The proposed new site provides significant economic benefits to ASTC patients of Sumner County due to travel costs and improved access.*

(c) *Contribution to the orderly development of health care facilities and/or services.* The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.

*The location of CN1104-013A still requires site preparation work before construction could begin. The newly proposed site has all the preparation work completed allowing a decreased timeline for development of the ASTC.*

**HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING**
**SEPTEMBER 26, 2012**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | Southern Sports Medicine Surgery Center |
| PROJECT NUMBER: | CN1204-019 |
| ADDRESS: | 127 Saundersville Pike, Suite A<br>Hendersonville, (Sumner County), TN 37075 |
| LEGAL OWNER: | Southern Sports Surgical, LLC<br>570 Hartsville Pike<br>Gallatin, (Sumner County), TN 37066 |
| OPERATING ENTITY: | Southern Sports Medicine Institute, LLC<br>570 Hartsville Pike<br>Gallatin, (Sumner County), TN 37066 |
| CONTACT PERSON: | Thomas Gautsch, M.D.<br>(615) 452-3320 |
| DATE FILED: | April 13, 2012 |
| PROJECT COST: | $3,355,533 |
| FINANCING: | Commercial Loan and Lease |
| PURPOSE OF REVIEW: | Relocation of an approved, but unimplemented, Certificate of Need for the establishment of an ambulatory surgical treatment center (ASTC) and expansion of its designated use from single specialty to multi-specialty |

DESCRIPTION:

Southern Sports Medicine Surgery Center seeks approval for the relocation of an approved, but unimplemented Certificate of Need for the establishment of an ambulatory surgical treatment center and expansion of the designated use of its previously approved single specialty ASTC (CN1104-013A) to include multi-specialty services. The proposed project will relocate from 1163 Nashville Pike, Gallatin (Sumner

County), TN to 127 Saundersville Pike, Suite A, Hendersonville, (Sumner County), Tennessee. *See the Plot Plan in Attachment B.III.* The relocated, unimplemented ASTC is proposed to be housed in a single story building immediately adjacent to the relocated orthopaedic surgical practice of Southern Sports Medicine Institute (SSMI), which also plans to move to Hendersonville from its current location at 570 Hartsville Pike, Gallatin, Tennessee. The project will contain approximately 6,200 square feet including 2 operating rooms and one procedure room, a three (3) station pre-operative preparation/holding area, a six (6) station primary post-operative recovery area and a three (3) station secondary recovery area; and support areas including instrument cleaning and reprocessing area, supply and equipment storage, and staff locker rooms and lounge, and a reception and waiting area, as previously approved in CN1104-013A. *See the Floor Plan in Attachment B.IV.* The applicant indicates the facility would be open for operation at least 250 days/year, 8 hours/day. If this Certificate of Need application is granted, the applicant indicates it will surrender CN1104-013A.

Service Specific Criteria and Standard Review

**AMBULATORY SURGICAL TREATMENT CENTER**

1. **The need for an ambulatory surgical treatment center shall be based upon the following assumptions:**
   a. **An operating room is available 250 days per year, 8 hours per day.**

      *The applicant's operating rooms will be available at least 250 days per year, eight hours per day.*

   b. **The average time per outpatient surgery case is 60 minutes.**

      *The applicant anticipates that its average time per surgery case will be over 60 minutes. The applicant's surgical cases are mainly orthopaedic surgeries which on average take longer than typical cases found in a multispecialty surgery center. See pages 15-19 of the original application for the applicant's explanation of how many of their cases will require more than 60 minutes.*

   c. **The average time for clean up and preparation between outpatient surgery cases is 30 minutes.**

      *The applicant's clean up time will on average not exceed 30 minutes.*

d. **The capacity of a dedicated, outpatient, general-purpose operating room is 80% of full capacity. That equates to 800 cases per year.**

*The applicant believes that its operating rooms will function at utilization levels in excess of the time utilization equivalent of 800 sixty-minute cases per year. The average surgical time for all outpatient cases of the applicant surgeons is approximately 110 minutes. See pages 15-19 of the original application for the applicant's explanation of how many of their cases will require more than 60 minutes.*

e. **Unstaffed operating rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity**

*There are no unstaffed operating/procedure rooms in the two existing ambulatory surgical treatment centers located in the applicant's service area, Sumner County.*

2. **"Service Area" shall mean the county or counties represented by the applicant as the reasonable area to which the facility intends to provide services and/or in which the majority of its service recipients reside.**

*The applicant identifies Sumner County as the proposed project's service area. 79% of the patients in the physicians' practice associated with the proposed project reside in Sumner County.*

*It appears that this application meets the criterion.*

3. **The majority of the population of a service area for an ambulatory surgical treatment center should reside within 30 minutes travel time to the facility.**

*The applicant states that all of Sumner County is within 30 minutes travel time to Hendersonville and this facility.*

*It appears that this application meets the criterion.*

4. **All applicants should demonstrate the ability to perform a minimum of 800 operations and/or procedures per year per operating room and/or procedure room. This assumes 250 days x 4 surgeries/procedures x .80.**

*The applicant projects in the supplemental response 1,269 operating room cases by the second year of operation. Based on the assumptions above, the minimum standard for two operating rooms which applies here would be 1,600 cases. It would appear that the criterion has not been met. However, the discussion on pages 14-19 of the original application regarding the type of surgeries performed by the surgeons of Southern Sports Medicine Institute presents the case that their cases require considerably more time than 60 minutes per surgical case (averaging 103 minutes per case). The volume of these types of surgeries combined with the time requirements per case exceed the annual operating time equivalent for 800 cases per year per room which average 60 minutes per case. Thus, it would appear that the application does meet this criterion.*

*The applicant is projecting 431 procedure room cases by the second year of operation. It appears that the applicant does not meet the criterion's minimal standard of 800 procedures per year.*

5. **A certificate of need (CON) proposal to establish a new ambulatory surgical treatment center or to expand the existing services of an ambulatory surgical treatment center shall not be approved unless the existing ambulatory surgical services within the applicant's service area or within the applicant's facility are demonstrated to be currently utilized at 80% of service capacity. Notwithstanding the 80% need standard, the Health Services and Development Agency may consider proposals for additional facilities or expanded services within an existing facility under the following conditions: proposals for facilities offering limited-specialty type programs or proposals for facilities where accessibility to surgical services is limited.**

*There are two existing ASTCs in Sumner County: one is a single-specialty ophthalmology ASTC and the other a multi-specialty ASTC. The two facilities combined have 3 operating rooms and 3 procedure rooms. Their combined utilization in 2011, per the Joint Annual Report, was*

*5,663 procedures. Eighty percent capacity of six operating/procedure rooms is 4,800 procedures. Since neither of the two hospitals in Sumner County report having dedicated outpatient operating rooms, the 80% capacity figures for these facilities cannot be calculated.*

*It appears that this application meets the criterion.*

6. **A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must specify the number of projected surgical operating rooms to be designated for ambulatory surgical services.**

*The applicant plans to have two (2) operating rooms and one (1) procedure room in the ASTC designated for ambulatory surgical services.*

*It appears that this application meets the criterion.*

7. **A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the proposed project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

*The applicant provides projected utilization for the first eight quarters after project completion on page 23 of the original application. On page 16 and page 19 of the original application, the applicant provides the methodology for projections which includes current procedures performed by Drs. Gautsch and Grutter and projecting forward an approximate 20% growth over 4 years, projections for another orthopedic surgeon to be added in 18 months and pain management procedures for a nonsurgical musculoskeletal care specialist who joined Southern Sports Medicine Institute in August 2011.*

*It appears that this application meets the criterion.*

8. **A CON proposal to establish an ambulatory surgical treatment center or to expand the existing services of an ambulatory surgical treatment center must project patient origin by percentage and county of residence. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

*The applicant has selected a service area of Sumner County. Approximately 79% of the physicians' practice patients reside in Sumner County. The ASTCs patient origin is based on the practice's patient origin.*

*It appears that this application meets the criterion.*

SUMMARY:

The applicant, Southern Sports Surgical, LLC, (SSS) is currently owned by Thomas Gautsch, M.D. and Paul Grutter, M.D., both of whom practice together in a successful orthopaedic surgery practice, Southern Sports Medicine Institute (SSMI) in Gallatin (Sumner County), Tennessee. The applicant, Southern Sports Surgical, LLC, (SSS) is a Tennessee limited liability corporation organized in the state of Tennessee on April 7, 2011 for the purpose of establishing an ASTC associated with the practice of Southern Sports Medicine Institute (SSMI). SSMI's ownership currently consists of Thomas L. Gautsch, M.D. (50%) and Paul W. Grutter, M.D. (50%). Both physicians are also owners of Southern Sports Surgical, LLC, (SSS), each with 50% ownership proportions. The applicant indicates management services to SSS will be provided by SSMI. The facility in which both the practice, SSMI, and the ambulatory surgical treatment center, SSS, will operate will be developed by Southern Sports Holdings, LLC, (SSH) which is owned by Thomas L. Gautsch, M.D. (50%) and Paul W. Grutter, M.D. (50%). At the time of the application's filing, the proposed site was owned by Southern Sports Holdings, LLC, which has signed a purchase agreement for the Saundersville Road site in Hendersonville. Both the medical practice, SSMI, and the ASTC, SSS, will lease their separate spaces in the building. SSS and SSH have also executed an option to lease for 10 years agreement. *Note to Agency members: A copy of the organization chart illustrating the above relationships is provided in Attachment A. Item 4.*

The applicant has future plans to expand the ownership of SSS, to include other surgeons by dilution of shares. Additionally, the applicant has discussed its willingness to offer an ownership position in the center to area hospitals. However,

other than a potential future agreement, no current agreement exists at this time. Although the proposed project will initially be managed by Southern Sports Medicine, PLLC (*the official name of the orthopaedic surgical practice which does business as Southern Sports Medicine Institute*), the applicant states with rapidly evolving healthcare and changing reimbursement models, contracting with a larger ASTC management company may be beneficial for the ASTC and its patients in the future. Ownership may also be offered to that management company, if deemed appropriate.

Southern Sports Surgical, LLC successfully sought and was approved for CN1104-013A on August 24, 2011 for the establishment of a single specialty orthopedic ambulatory surgical treatment center (ASTC), containing 6,200 square feet including two (2) operating rooms, one (1) procedure room, a pre-post holding area and support space in Gallatin. CN1104-013A has not been implemented.

Southern Sports Surgical, LLC is now seeking a certificate of need to expand services to multi-specialty, as well as relocate to Sumner County's largest population center, "without *(in the applicant's words)* changing significantly" from the approved two (2) operating room, one (1) procedure room CON, except with modifications, which the applicant feels improves on the approved project. The applicant further describes the proposed project as follows:

1) The proposed project will include ASTC services for multiple specialties, including at least Orthopedic Surgery and all of its subspecialties, including Spine, Sports and Hand surgery, appropriate to the outpatient setting, and the full spectrum of Pain Management procedures of whatever specialty, Orthopedic, Sports Medicine, Spine, Neuro, or Anesthesia, with allowance for other surgical specialty utilization of the facility as well.

2) The initial Certificate of Need project CN1104-013A was granted for a 1.4 acre lot with [Gallatin] city site restrictions and requirements that resulted in the ASTC being located on the second floor of the medical office building. A larger, 2.9 acre lot has now been put under contract in Hendersonville, which will allow the previously granted ASTC floor plan to be moved to the ground level with minimal modification, create more parking, improve patient access, ingress and egress, and ease of future expansion.

3) Additionally, initial project and the only currently existent Sumner County multi-specialty ASTC are both located in Gallatin, the second largest population center in Sumner County. There is no multi-specialty ASTC or granted CON in the Hendersonville region of Sumner County, the largest and fastest growing population center in Sumner County.

4) The site is also considerably closer, by both distance and travel time, to one of the two local hospitals than that previously granted, facilitating faster transfer of patients, if necessary.

*Further details can be found on pages 4-8 of the original application.*

The applicant cites several reasons for the need for an additional ASTC:

1) Continuous population growth and projected growth in Sumner County, increasing the need for healthcare facilities such as ambulatory surgical treatment facilities
2) Currently there are only two ambulatory surgical treatment centers in Sumner County: one is limited to only ophthalmology cases and unavailable for orthopaedic patients, while the other ASTC only has two operating rooms for a multi-specialty ASTC and is operating at over 1,100 patients per room
3) A comparison of populations and ASTC operating rooms in counties closest in population to Sumner County demonstrates a relative lack of ASTC access for residents of Sumner County. Sumner County with 3 ASTC operating rooms (OR) for its 160,645 residents equates to 1.2 OR per 100,000 residents. The average in the sixteen (16) most similarly populated counties is one ASTC OR per every 15,061 residents. *The applicant has provided the details of its sixteen (16) county ASTC OR/ population analysis on pages 5 and 6 of the application.*
4) The cost effectiveness of ASTCs compared to hospital based outpatient surgery department (HOPD) has been demonstrated by the MedPac's March 2009 Report to Congress which reported that Medicare payments to ASTCs were substantially lower than payments to hospitals for the great majority of similar outpatient procedures. The applicant states by utilizing ASTCs rather than hospital outpatient surgery departments, Medicare and Medicaid, private insurances and patients save billions of dollars annually.
5) The applicant quotes the MedPac March 2009 Report to Congress as citing ASTCs:
   a) providing greater patient convenience than hospital outpatient departments in terms of their locations, ability to schedule surgery more quickly and shorter waiting times
   b) for most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower for ASTC's than for hospital outpatient

departments (*Note to Agency members: The federal Medicare/Medicaid terminology ASC (i.e., ambulatory surgery center) equates to the State of Tennessee's terminology of ASTC (i.e., ambulatory surgical treatment center).*

c) physicians may find it more convenient and efficient to perform procedures in ASTCs because they often have customized surgical environments and specialized staffing

d) additional advantages for ASCs relative to hospital outpatient surgeries include greater convenience to patients and providers, decreased program spending, and beneficiary cost sharing on a per service basis.

6) If the CON is granted, the applicant indicates surgeons of allied and varied other specialties will also be offered surgical privileges, with the option of ownership shares in the proposed ASTC. The applicant states the expansion of allowed surgical services will provide potentially greater utilization of its operating rooms and procedure rooms, and thereby enhance the economic stability and viability of the project into the future.

The applicant is planning to continue to serve the growing orthopaedic/musculoskeletal care needs for Sumner County through growth of the medical practice as well as developing a single location for both the orthopedic practice and the ambulatory surgical treatment center. Both of the SSMI practice's surgeons specialize in arthroscopic ligamentous repair and reconstruction of major joints predominantly the shoulder, knee and elbow. They also provide as part of their orthopedic practice some pain relieving injections. A non-surgical musculoskeletal care specialist, Dr. Jeffrie Kindred, joined the practice in August 2011 and a third surgeon is expected to join the practice in 18 months, respectively. Dr. Kindred is a primary care, fellowship trained, non-surgical musculoskeletal specialist trained in and routinely performs fluoroscopically and ultrasound guided injections into affected nerves, muscles, tendons and joints. The two current physician members of the medical practice already perform over 800 such procedures per year without benefit of the use of fluoroscopic and ultrasound guidance, due to lack of availability. The applicant indicates fluoroscopic and ultrasound guidance of these injections has already been shown clinically superior and more consistently accurate and so current patients will benefit from that availability. Patients requiring imaging assisted injections are referred to Nashville pain management centers. Dr. Kindred has been able to add an additional dimension pain management to the orthopedic practice. One or two additional pain management specialist physicians are planned to be added to the practice in the future. The applicant intends to perform orthopaedic surgical cases in the proposed ASTC's operating rooms and pain management procedures which the physicians consider to be part of their orthopaedic practice in the procedure room.

The applicant indicates its primary service area will be Sumner County from which the Southern Sports Medicine Institute drew 79% of its patients. According to the Department of Health's Division of Health Statistics, the population of the service area county is estimated to be 162,422 in 2012 and is expected to increase by 5.2% to 170,883 by 2016. The age 65+ proportion of the service area population in 2012 is 20,947 (12.9% of the total population) and is projected to grow by 15.4% to 24,163 in 2016 (14.1% of the total population). Service area residents enrolled in TennCare on November 15, 2011 equal 14.2% of the population, according to the Bureau of TennCare. The statewide proportion of the population enrolled in TennCare is 19.1%

Based on the Joint Annual Reports submitted to the Department of Health, there are currently two ambulatory surgical treatment centers licensed within Sumner County. Of these, the Green Surgery Center is licensed to perform only ophthalmologic procedures. The other ASTC within the applicant's declared service area, Patient Partners Surgery Center, is licensed as a multi-specialty ASTC and has two (2) operating rooms and two (2) procedure rooms. According to the 2011 Joint Annual Report, its largest service is endoscopy (56% of the 4,402 total patients), followed by otolaryngology (25.4%) general surgery (7.6%) and orthopedics (5.4%, or 241 cases and 364 procedures). The 2011 operating/procedure room utilization calculates to 1,101 patients per room and 1,907 procedures per room, as compared to the *Guidelines for Growth's* minimum utilization standard of 800 surgical cases/procedures per operating room.

The applicant's physicians do not feel with only two operating rooms, Patient Partners Surgery Center has additional operating room time available to accommodate their surgical time needs. They currently do not perform many cases at Patient Partners Surgery Center, preferring to perform their surgical cases at Sumner Regional Medical Center, which is across the street from their practice's current location.

*Note to Agency members: See the applicant's calculations of surgical time needs on pages 16-19 of application. The applicant explains on page 18 that their surgeries of the shoulder and knee (90% of their surgeries) require on average 132 minutes per surgery, including time to perform the surgery (average of 101 minutes/case), as well as room clean up and preparation time for the next surgery (30 minutes per case). Utilizing the applicant's demonstrated operating times and applying them with the applicant's projected surgical case volume, the applicant projections of 167,508 operating room minutes per year exceeds the minimum standard of 144,000 operating room minutes/year, which is the operating room time to which the Guidelines for Growth standard of 800 cases/per room/year computes.*

Below are the available capacity and utilization of the ambulatory surgical treatment center (excluding eye surgery) and hospital operating rooms in Sumner County:

| | 2008 | | 2009 | | 2010 | | 2011 | | |
|---|---|---|---|---|---|---|---|---|---|
| ASTC/Hospital | Oper. Rms | Cases | Oper. Rms | Cases | Oper. Rms | Cases | Oper. Rms | Cases | % of Total |
| Patient Partners Surgery Center | 2 | | 2 | | 2 | | 2 | | |
| Orthopedic | | 627 | | 475 | | 456 | | 241 | 5.5% |
| **Total Outpatient Surgeries** | | **4,651** | | **4,084** | | **5,109** | | **4,402** | **100%** |
| | | | | | | | | | |
| Sumner Regional Medical Center | 8 | | 8 | | 7 | | 6 | | |
| Inpatient Surgeries | | 1,066 | | 1,562 | | 1,713 | | 1,879* | 38% |
| **Outpatient Surgeries** | | **3,597** | | **3,306** | | **3,373** | | **3,007*** | **62%** |
| Total | | 4,663 | | 4,868 | | 5,086 | | 4,886* | 100% |
| Hendersonville Med. Center | 8 | | 8 | | 8 | | 8 | | |
| Inpatient Surgeries | | 1,082 | | 1,148 | | 1,188 | | 1,177* | 29.7% |
| **Outpatient Surgeries** | | **2,583** | | **3,034** | | **2,993** | | **2,779*** | **70.3%** |
| Total | | 3,665 | | 4,182 | | 4,181 | | 3,956* | 100% |
| Portland Medical Center | 2 | | 0 | Closed | 0 | Closed | 0 | Closed | Closed |
| Inpatient Surgeries | | 15 | | 0 | | 0 | | 0 | - |
| **Outpatient Surgeries** | | **265** | | **0** | | **0** | | **0** | **-** |
| Total | | 280 | | 0 | | 0 | | 0 | - |
| Sumner County Totals | 20 | | 18 | | 17 | | 16 | | |
| Inpatient Surgeries | | 2,163 | | 2,710 | | 2,901 | | 3,056* | 23.0% |
| **Outpatient Surgeries** | | **11,096** | | **10,424** | | **11,475** | | **10,188*** | **77.0%** |
| Total | | 13,259 | | 13,134 | | 14,376 | | **13,244*** | 100% |
| Cases per OR | | 663 | | 730 | | 848 | | 828 | |

*Provisional

Sources: TN Dept. of Health: Joint Annual Reports: ASTCs: 2008-2011 *Final;* Hospitals 2009-2010 *Final,* 2011 *Provisional*

The applicant points out while the number of outpatient surgeries continues to grow, the number of operating rooms in which to perform them has been reduced over the past four years with the closing of Portland Medical Center, with its two operating rooms, and the reduction of two OR's at Sumner Regional Medical Center. The applicant also demonstrates that the number of cases per operating room has risen 25% over the past three years. *Note to Agency members: Excluding eye surgeries, the number of outpatient surgeries constitutes almost 77% of the total surgeries performed in the County's operating rooms. The proportion of outpatient surgeries at Sumner Regional Medical Center is 62%, and the proportion of outpatient surgeries at Hendersonville Medical Center is 77%.*

Projections indicate the facility will perform 1,000 cases (746 surgical cases and 254 procedure room cases) in the first year of operation and 1,700 cases in the second year (1269 surgical cases and 431 procedure room cases). *Note to Agency members: Although the*

*applicant is asking for multi-specialty designation, the utilization projections provided for the application are based on surgical cases and pain management cases generated only by the members of the Southern Sports Medicine Institute's practice.*

The projected Average Gross Charge per "Surgery" case is $5,200, with average deductions from revenue reducing the Average Net Revenue collected to $1,766 per case. The projected Average Gross Charge per "Pain Management" case encounter is $760, with average deductions from revenue reducing the Average Net Revenue collected to $299 per case. Net operating income less capital expenditures (NOI) of ($68,140) is projected, an amount equal to approximately 1.7% of gross operating revenue during the first year of operation. NOI is expected to increase to a level of approximately 6.9% of gross operating revenue on 1,700 cases in the second year of the project, raising its net operating income less capital expenditures to $362,974.

The applicant proposes to staff the ASTC with 9.4 FTEs (5 RNs, 2 OR techs, 0.4 FTE Instrument tech and 2 clerical support staff). The SSMI surgeons planning initially to use the SSS ASTC will also utilize one to two staff members from their practice when using the ASTC. These SSMI employees will be paid by the practice and are not listed on the ASTC's payroll.

The government payor mix is expected to be 5% TennCare (or $195,468) and 22% Medicare (or $883,676) based on gross operating revenue in the first year of the project. The applicant states it intends to contract with three TennCare MCOs: TennCare Select, United Healthcare Community Group and AmeriGroup. All three of these MCOs are currently contracted with Southern Sports Medicine Institute (SSMI).

The total estimated project cost is $3,355,533. This sum is composed of $2,416,586 for a 10 year facility lease, $520,000 for fixed and moveable equipment, $100,000 in contingency, $50,414 in initial supply stock, $91,000 in architectural and engineering fees, $60,000 for legal administrative and consultant fees; $110,000 reserve for one year Debt Service and $7,533 for the CON filing fee. The applicant's architect indicates the ASTC will be designed to comply with the AIA Guidelines for the Design and Construction of Health Care Facilities as well as the International Building Codes, the NFPA Life Safety Codes, and all other applicable codes. The architect's estimated construction costs for the project is approximately $290/square foot. *See the architect's attestation letter in Attachment C Economic Feasibility – 1.*

The applicant intends to finance the project through a bank loan and capital contributions ($94,474 each) of the current members of the limited liability corporation. The first supplemental response contains a copy of a letter from the Senior Vice

President of Volunteer State Bank, indicating Volunteer State Bank's interest in providing a $5,750,000 construction and equipment loan to Southern Sports Holdings and Southern Sports Surgical, LLC. Copies of Drs. Gautsch and Grutter's Personal Financial Statements are also included in the application.

*The applicant has submitted the required corporate documentation, real estate purchase agreement, applicant option to lease, and management contract. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency's office.*

Should the Agency vote to approve this project, the CON would expire in two years.

**CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:**
There are no other Letters of Intent, denied or pending applications for this applicant.

Outstanding Certificates of Need
**Southern Sports Medicine Surgery Center, CN1104-013A**, has an outstanding Certificate of Need which is due to expire on October 1, 2014. The Certificate of Need was approved at the August 24, 2011 Agency meeting for the establishment of a single specialty Ambulatory Surgical Treatment Center (ASTC), dedicated to Orthopaedic Surgery and Musculoskeletal Care at 1163 Nashville Pike, Gallatin, (Sumner County), TN 37066. The estimated cost of the project is **$3,296,400.** *Project Status Update: The applicant has located a more desirable location in Hendersonville (Sumner County), Tennessee which is the subject of this application, CN1204-019. The applicant indicates CN1104-013A will be surrendered if this CON, CN1204-019, is granted.*

**CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:**

There are no other Letters of Intent, denied or pending applications or outstanding Certificates of Need for other Service Area entities proposing this type of ambulatory surgical treatment service.

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**
PMW 08/24/12

# HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
## SEPTEMBER 26, 2012
## APPLICATION SUMMARY

| | |
|---|---|
| NAME OF PROJECT: | Coram Alternative Site Services, Inc. d/b/a Coram Specialty Infusion Services |
| PROJECT NUMBER: | CN1205-020 |
| ADDRESS: | 2970 Sidco Drive<br>Nashville (Davidson County), Tennessee 38104 |
| LEGAL OWNER: | Coram Specialty Infusion Services, Inc.<br>555 17th Street, #1500<br>Denver (Denver County), Colorado 80202 |
| OPERATING ENTITY: | Not Applicable |
| CONTACT PERSON: | Jeffrey J. Miller, Attorney<br>(615) 251-5600 |
| DATE FILED: | May 14, 2012 |
| PROJECT COST: | $63,000.00 |
| FINANCING: | Cash Reserves |
| PURPOSE FOR FILING: | Establishment of a home care organization and the initiation of home health services limited to provision and administration only of home infusion products and related nursing services ancillary to its pharmacy |

DESCRIPTION:

Coram Alternative Site Services, Inc. d/b/a Coram Specialty Infusion Services is seeking approval to establish a home care organization and initiate home health services limited to providing and administering home infusion products and related infusion nursing services in a 38-county area in Middle Tennessee. The applicant's home office is at 2970 Sidco Drive, Nashville (Davidson County) and is the location of the applicant's licensed pharmacy services.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

**HOME HEALTH SERVICES**

1. The need for home health agencies/services shall be determined on a county by county basis.

2. In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county.

   The 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed service area.

3. Using recognized population sources, projections for four years into the future will be used.

4. The use rate of existing home health agencies in the county will be determined by examining the latest utilization rate as calculated in the Joint Annual Report of existing home health agencies in the service area.

   Based on the number of patients served by home health agencies in the service area, estimation will be made as to how many patients could be served in the future.

   *Following Steps 1-4 above the Department of Health report, which is based on 2011 data, indicates that 43,888 service area residents will need home health care in 2016; however, 75,331 patients are projected to be served in 2016 resulting in a net excess of (31,443). It appears that this application does not meet the criterion.*

5. Documentation from referral sources:

   a. The applicant shall provide letters of intent from physicians and other referral sources pertaining to patient referral.

      *The applicant provides a letter from one existing home health agency, Home Health Care of Middle Tennessee; a case manager from Cumberland Medical Center, a case manager from Vanderbilt University Medical Center; a neurologist in Hendersonville, and two neurologists in Goodletsville indicating support for the application but not necessarily intent pertaining to patient referral.*

*It appears that this application does not meet this criterion.*

b. The applicant shall provide information indicating the types of cases physicians would refer to the proposed home health agency and the projected number of cases by service category to be provided in the initial year of operation.

*The applicant provides six letters of support but do not specifically address potential number of cases to be referred.*

*It appears that this application does not meet this criterion.*

c. The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.

*Several of the support letters have indicated that there has been difficulty in finding home care providers that provide specialty infusion services.*

*It appears that this application does meet this criterion*

d. The applicant shall provide information concerning whether a proposed agency would provide services different from those services offered by existing agencies.

*The applicant points to letters of support as documentation that appropriate home infusion nursing services required by these infusion therapy patients is not readily available throughout the Middle Tennessee service area.*

*It appears that the application does meet this criterion*

6. The proposed charges shall be reasonable in comparison with those of other similar facilities in the service area or in adjoining service areas.

a. The average cost per visit by service category shall be listed.

*The applicant states that the average cost per visit is expected to be $140 in 2013. The applicant states that the average cost per visit of existing home health agencies in the service area is the $122 per visit.*

*The applicant goes on to state that adjusting for inflation the average cost per visit for existing home health agencies in 2013 would be $130.*

*It appears that the application does meet this criterion*

b. The average cost per patient based upon the projected number of visits per patient shall be listed.

*The applicant states that the average cost per patient is based upon the expected mix of patients.*

*It appears that the application does meet this criterion*

SUMMARY:

In addition to infusion services Coram Specialty Infusion Services would provide additional infusion-related services such as line maintenance, phlebotomy services, and infusion equipment repair and replacement and dressing changes on central lines and external access ports. These services will be provided by a registered nurse who is appropriately credentialed and is certified with a certified registered nurse infusion (CRNI) designation. The applicant states that the types of infusion products to be administered include: antibiotics; total parenteral nutrition (TPN); hydration; cardiac products (such as inotropic therapies); intravenous immunoglobulin (IVIG) and other similar specialty drugs; pain management; antiemetic; and steroids. The types of patients served by Coram who have demonstrated needs for infusion nursing services in the home which are otherwise unavailable from other home health agencies include the following:

- Specialty Patients Requiring IVIG -Intravenous immunoglobulin is given as a plasma protein replacement therapy for immune deficient patients who have decreased or abolished antibody production capabilities

- Alpha 1 Therapies-Alpha -1 antitrypsin infusion therapy is given to treat the genetic disorder alpha-1 antitrypsin deficiency that causes defective production of the alpha-1 antitrypsin (A1AT) leading to decreased A1AT in the blood and lungs.

- First Dose Administration-First time a prescribed infusion therapy is provided to a patient.

- Low Intervention Patients-Patient who are not homebound and do not require significant intervention; they are taught to self-administer thereby limiting the number of home skilled nursing visits.
- Three Dose Schedule Patients-Infusion therapy patients whose therapy is administered three times throughout a day.
- Rural Patients-Patients living outside urban areas where there is an abundance of major medical centers and infusion centers
- Pediatric Patients-Children requiring infusion therapy products and services.

The applicant states that the types of patients requiring these infusion services include patients with compromised immune system or auto immune disorders, transplant patients, congestive heart failure patients, patients who cannot consume nutrition or food via regular intake, hemophiliacs or patients with other blood clotting disorders, patients with progressive emphysema, and other conditions.

The applicant provides a number of reasons regarding skilled nursing access problems for their infusion therapy patients to include that in general home health agencies: do not provide therapies in excess of three hours, do not infuse blood or blood products in the home, do not take on patients that are not homebound and do not qualify for Medicare reimbursement, do not provide first dose administration, are unable to staff for patients needing three doses a day every eight hours, have difficulty in providing infusion services to patients residing in rural areas and pediatric patients. The applicant indicates that many of their patients have extended hospital stays for first dose administration and patient/family education for self-administration, and that once discharged patients requiring infusion nursing services either have to travel to the hospital or infusion therapy centers to continue receiving this service.

The applicant indicates that an infusion nursing agency would have a different typical patient profile than a typical Medicare certified home health agency. A side-by-side comparison is provided in the table below:

| Variable | Medicare Home Health Agency | Infusion Nursing Agency |
|---|---|---|
| Average Visit Duration | One to Two Hours | Up to eight hours |
| Equipment | Generally not involved | Typically includes infusion equipment |
| Payor | 80% Medicare Patients | Private Insurance mainly |
| Age | Over 70% Age 65+ | Predominately under Age 65 |
| Service Provided | 42% is skilled nursing. Balance of service includes therapy, home health aide, and medical social services. | 100% specialized skilled nursing |
| Patient Status | Homebound | *Patient may or may not be homebound |

**Applicant states that a non-homebound patient may not have reasonable geographic or financial access to reach an ambulatory infusion center, hospital, or other venue for infusion. The applicant also states that home infusion therapy is more cost effective than infusion in an institutional setting.*

The applicant was asked to provide some clarifying information by email.

- The current Coram pharmacy is both Medicare and Medicaid certified and is providing infusion products to Medicare and TennCare patients. The applicant notes that their TennCare business is very small in comparison to Medicare and commercial insurance patients.
- Regarding the proposed home health agency, the applicant indicates that it will not be a Medicare or TennCare certified home health agency; however it will provide administration for those patients but will not bill Medicare or TennCare for those services. The applicant expects that this population will be manageably small since the majority of those patients will be referred to full-service home health agencies. Situations where the applicant will provide administration to Medicare and TennCare patients are patients that the full service home health agencies won't accept, e.g., first dose administration, blood product administration patients, multiple infusion daily patients, or infusion administration that take several hours. *Note to Agency members: The applicant was asked a*

*follow-up question by email regarding payment for services to Medicare and TennCare patients and provided the following response: "Patients will be billed the standard per visit rate of $178 (average) in Year 1, and $187 (average) in Year 2. Patients that qualify for Coram's charity care policy would be written off. The Company is estimating those itemizations will bring average per visit revenue/charges to $90/visit. TennCare patients, which, as shown in the application, are a very, very small part of the Company's business, would not be billed."*

- For those Medicare and TennCare patients who are not currently able to receive infusion administration in the home, the applicant states that those patients are either staying longer in the hospital for this service, going to physician offices or infusion clinics, or returning to hospitals as outpatients.
- The applicant states for homebound patients who qualify for Medicare home health and have short term and intermittent needs, i.e., not multiple hour infusions, or multiple infusions daily, or blood products), Coram works with the following local home health agencies qualified to provide the service: Deaconess, Home Health Care of Tennessee, NHC, CareAll, Amedisys, and Suncrest.

HSDA staff contacted the Tennessee Association of Home Care (TAHC) regarding home health providers and the Tennessee Hospital Association (THA) regarding hospital-based home care providers.

TAHC indicated the following:

- TAHC membership applications on file indicate that 224 home health offices (parents and branches) offer infusion therapy services.
- Standard home health policy is that first dose should be completed in the hospital setting
- The majority of home health agencies partner with an infusion company for administration of the second dose in the home.
- The home health nurse continues to support the patient's needs with observations and reports to the physician. It is unrealistic to think that a home health provider could limit their care to only infusion therapy. Infusion may be the primary need but these are typically patients with multiple chronic illnesses and co-morbidities who need a holistic, multi-disciplinary approach to their health care
- The barriers to home infusion therapy are generally noted as staffing and adequate payment. This is a growing issue for all homecare providers as both governmental and commercial payors continue to look to provider payments to cut costs.
- Homebound status is only a Medicare issue. An infusion company would be held to the same standard if it were a Medicare-certified home health agency.

THA's response included that a "typical" home care provider does not provide infusion administration for:

- Patients requiring 6 hour therapies

- Medicare patients who are not homebound. This applies only to Medicare. Many non-Medicare patients who are not homebound are served
- Patients requiring first dose administration
- Patients requiring three doses daily

THA does go on to state that member home health agencies see patients in every county in the state and that there are pediatric programs often affiliated with pediatric hospitals such as Vanderbilt, Methodist LeBonheur, and East Tennessee Children's Hospital.

Coram Alternative Site Services is a wholly owned subsidiary of Coram Specialty Infusion Services, Inc. These entities ultimate parent is Apria Healthcare Group, Inc. According to its website Apria offers a comprehensive range of home respiratory therapy, diabetic supplies, medications and equipment, home infusion therapy and home medical equipment services. The applicant states that it has no financial interest in any other health care institution as defined by statute.

The 38 counties that consist of the applicant's proposed service area are presented in the table below:

| | | | |
|---|---|---|---|
| Bedford | Bledsoe | Cannon | Cheatham |
| Clay | Coffee | Cumberland | Davidson |
| DeKalb | Dickson | Franklin | Giles |
| Grundy | Hamilton | Hickman | Humphreys |
| Jackson | Lawrence | Lewis | Lincoln |
| Macon | Marion | Marshall | Maury |
| Montgomery | Overton | Putnam | Rhea |
| Robertson | Rutherford | Sequatchie | Smith |
| Sumner | Trousdale | Wilson | Warren |
| White | Williamson | | |

The applicant states that determination of the service area was completed based on a detailed assessment of Coram's Nashville Branch Patient Records to identify the county of residence of most of its patients. The applicant provides a patient origin chart in the first supplemental response confirming that over 85% of Coram's Nashville branch patients reside in the 38 county area.

According to the Tennessee Department of Health, the 2012 population of the service area is 2,808,944 and is expected to grow by 4.2 to 2,925,879 in 2016. Currently, there are 17.1% of service area residents who are enrolled in TennCare, as compared with the statewide proportion of 19.1%.

According to the Tennessee Department of Health, there are 88 home health agencies (HHAs) licensed to serve at least one of the service area counties. In 2011, these 88 HHAs served 71,862 patients, providing the typical variety of home health services such as nursing, physical therapy, occupational therapy, speech therapy, medical social workers, home health aide, homemaker services, etc. According to the 2000 edition of

the *Guidelines for Growth's* Need Formula for Home Health Services, the latest calculation of home health care need computes to a surplus of 31,443 patients for general home health services. The applicant acknowledges that the actual home health usage in the service area is well beyond the 1.5% of total population computation for home health need; however the applicant believes that this general guideline is not applicable to the typical patient who will be served by the applicant. The applicant states a traditional home health client is not the typical infusion patient because generally infusion patients are not elderly, not covered by Medicare, not in need of the full scope of home health service, and may not be homebound.

The applicant projects 247 patients will be served in the first year of operation producing 1,192 skilled nursing visits and 263 patients during the second year of operation producing 1,252 skilled nursing visits. The applicant bases these projections on the estimation that 17% of its pharmacy patients will need infusion skilled nursing services in the home. For a more detailed discussion on the methodology see page 52 of the original application.

The applicant provides a Historical Data Chart for the existing pharmacy operation. The applicant reports a positive net operating income of $1,102,393 in 2009, $1,757,951 in 2010, and $2,127,736 in 2011.

The applicant's Projected Data Chart for the limited home health agency projects a net operating income of $18,989 in Year 1 or a gross margin of 8.9% and net operating income of $28,050 in Year 2 or a gross margin of 12.0%. The applicant's gross charge per inpatient is projected to be approximately $860 and gross charge per nursing visit is approximately $178.

The applicant states that the licensed pharmacy participates in both Medicare and TennCare and serves medically indigent patients; however the proposed home health agency will not become Medicare/Medicaid certified because the agency will not be eligible for Medicare certification as a home health agency for the following reasons:

- Limited scope of service which means the agency would not be providing the full range of home health services as prescribed by the Medicare Conditions of Participation and;
- Its patients may not be homebound

The patients of the proposed agency will be covered by third party payors or will be medically indigent. The applicant expects that 5% of its patients will be charity care. The applicant states in the supplemental response that for patients who are homebound and are Medicare eligible for home health reimbursement, the applicant will continue its historical and current practice of trying to obtain full-service home health agency coverage. As noted earlier the applicant has worked in the past with multiple branches of

the following existing home health agencies: Deaconess, Home Health Care of Tennessee, NHC, CareAll, Amedisys, and Suncrest.

The applicant projects needing 1.75 FTE nurses to provide the service. The applicant explains in the first supplemental response that the vast majority of patients will reside in Davidson County and its immediate environs, with other less intense utilization coming from counties grouped north, east, and south of Davidson County. The applicant expects to have one employed nurse operating out of Davidson County and a pool of 3-4 nurses (compensated either on a per diem or per visit basis) residing in the three other regions to cover the additional 0.75 FTE.

The total project cost is $63,000 consisting solely of legal, administrative, consultant, and CON filing fees.

The letter from Apria Healthcare's Executive Vice President commits to funding the proposed project and notes that Apria as of December 31, 2011 had $29 million cash and cash equivalents on hand.

If approved, the applicant will obtain licensure from the Tennessee Department of Health.

*The applicant has submitted the required corporate documentation, and property documentation. HSDA staff will have a copy of these documents available for member reference at the Agency meeting. Copies are also available for review at the Health Services and Development Agency office.*

Should the Agency vote to approve this project, the CON would expire in two years.

## CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

There are no other Letters of Intent, denied or pending applications, or outstanding certificates of need for this applicant.

## CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent or outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

### Pending Applications

**VIP Home Nursing and Rehabilitation Services, LLC, CN1207-033,** has a pending application scheduled to be heard at the October 24, 2012 Agency

meeting for the relocation of the home health parent office from 501 Park Avenue, Suite B, Lebanon (Wilson County) to the current location of its Nashville branch office located at 4015 Travis Drive, Suite 102, Nashville (Davidson County). VIP Home Nursing and Rehabilitation Service, LLC is licensed to serve Bedford, Cannon, Cheatham, Clay, Cumberland, Davidson, DeKalb, Jackson, Macon, Overton, Perry, Putnam, Robertson, Rutherford, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, and Wilson Counties. Existing home care services will not be affected, and no services will be initiated or discontinued. Estimated project cost is **$111,500.**

Denied Applications

**CN1203-013D, Rainbow Home Health,** was denied at the July 25, 2012 Agency meeting. The application was for the establishment of a home care organization and the initiation of home health services in Cheatham County. Estimated project cost was **$27,950.00.** *Reason for Denial: 1) Need-There is no need due to services being adequately provided by the other agencies in the area; 2) Economic Feasibility-The project is not economically feasible due to the numbers not being justified and not showing how they feasibly provide this service; and 3) The project does not contribute to the orderly development of adequate and effective health care as it will impact the other agencies that are already in the area based upon volumes and also on staffing.*

**CN1111-045D, Rainbow Home Health,** was denied at the February 22, 2012 Agency meeting. The application was for the establishment of a home care organization and the initiation of home health services in Cheatham County. Estimated project cost was **$262,600.00.** *Reason for Denial: Applicant did not understand the need, there was a concern with the economic feasibility of the project based on the numbers provided, and the orderly development of health care was too subjective.*

**Home Care Agency of Middle Tennessee, CN1001-001D** was denied a Certificate of Need at the June 23, 2010 Agency meeting for the establishment of a home care organization and the initiation of home health care services focusing on the elderly population in a four (4) county service area including Davidson, Rutherford, Sumner, and Williamson Counties. The office of the applicant was to be located at 5115 Maryland Way, Brentwood, (Williamson County), Tennessee. The applicant planned to provide a full range of home health services, including, but not limited to, skilled nursing, home health aide, personal care, physical therapy, occupational therapy, speech therapy, and medical social services; however, the applicant sought to specialize in psychiatric nursing services. The estimated project cost was **$69,000.00.** *Reasons for Denial: 1) Need – There is not a*

*need as there are other agencies in the proposed service area that are providing home health services and also to the mentally ill patients; 2) Economic Feasibility – It is not economically feasible to have another agency; and 3) The project will not contribute to the orderly development of adequate and effective health care.*

**Maristone In Home, CN0808-053D,** was denied a Certificate of Need at the November 19, 2008 Agency meeting for the establishment of a home health agency to provide skilled nursing, physical therapy, occupational therapy, and speech therapy, home health aide, medical social worker and private duty services in Davidson, Sumner, Williamson and Wilson counties. The parent office was to be located in Nashville (Davidson County), Tennessee. The estimated project cost was **$57,000.** *Reason for Denial: Need was not demonstrated for the project.*

**AlphaCare Nursing, LLC, CN0805-032D,** was denied a Certificate of Need at the October 22, 2008 Agency meeting for the establishment of a home health organization to provide health services which include skilled nursing, rehabilitation and social services. The proposed service area included Cheatham, Davidson, Dickson, Robertson, Rutherford, Sumner and Williamson counties. The estimated project cost was **$33,980.00.** *Reason for Denial: Need was not demonstrated by the applicant for additional providers in the proposed service area.*

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**

MAF

09/11/2012

# LETTER OF INTENT

2012 MAY 10 AM 10: 05

# LETTER OF INTENT
# TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times-Free Press (Name of Newspaper) which is a newspaper of general circulation in see Exhibit A (County), Tennessee, on or before May 10 (Month / day), 2012 (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: Coram Alternate Site Services, Inc. d/b/a Coram Specialty Infusion Services, Inc., an Apria Healthcare Company (Name of Applicant) (Facility Type-Existing) owned by: Coram Specialty Infusion Services, Inc. with an ownership type of for profit corporation and to be managed by: self-managed intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

the establishment of a limited service home health agency only to provide and administer home infusion products and related infusion nursing services ancillary to its pharmacy services, by way of example and not limitation, line maintenance, phlebotomy services, infusion equipment repair and replacement, and dressing changes on central lines and external access ports within the following Tennessee counties: Bedford, Bledsoe, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Franklin, Giles, Grundy, Hamilton, Hickman, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marion, Marshall, Maury, Montgomery, Monroe, Overton, Putnam, Rhea, Robertson, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, and Wilson, from its current licensed home infusion pharmacy located at 2970 Sidco Drive, Nashville, Davidson County, Tennessee 37207 with an estimated project cost to not exceed $63,000.

The anticipated date of filing the application is: May 14, 2012

The contact person for this project is Jeffrey J. Miller (Contact Name) Attorney (Title)

who may be reached at: Harwell Howard Hyne Gabbert & Manner, P.C. (Company Name) 333 Commerce Street, Suite 1500 (Address)

Nashville (City) TN (State) 37201 (Zip Code) 615/256-0500 (Area Code / Phone Number)

(Signature) 05/10/2012 (Date) jjm@h3gm.com (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**
**500 Deaderick Street, Suite 850**
**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.

==========

HF0051 (Revised 05/03/04 – all forms prior to this date are obsolete)

2012 MAY 10 AM 10: 03

# LETTER OF INTENT
# TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the The Tennessean (Name of Newspaper) which is a newspaper of general circulation in see Exhibit A (County), Tennessee, on or before May 10 (Month / day), 2012 (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: Coram Alternate Site Services, Inc. d/b/a Coram Specialty Infusion Services, Inc., an Apria Healthcare Company (Name of Applicant) (Facility Type-Existing) owned by Coram Specialty Infusion Services, Inc. with an ownership type of for profit corporation and to be managed by: self-managed intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

the establishment of a limited service home health agency only to provide and administer home infusion products and related infusion nursing services ancillary to its pharmacy services, by way of example and not limitation, line maintenance, phlebotomy services, infusion equipment repair and replacement, and dressing changes on central lines and external access ports within the following Tennessee counties: Bedford, Bledsoe, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Franklin, Giles, Grundy, Hamilton, Hickman, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marion, Marshall, Maury, Montgomery, Monroe, Overton, Putnam, Rhea, Robertson, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, and Wilson, from its current licensed home infusion pharmacy located at 2970 Sidco Drive, Nashville, Davidson County, Tennessee 37207 with an estimated project cost to not exceed $63,000.

The anticipated date of filing the application is: May 14, 2012

The contact person for this project is Jeffrey J. Miller (Contact Name) Attorney (Title)

who may be reached at: Harwell Howard Hyne Gabbert & Manner, P.C. (Company Name) 333 Commerce Street, Suite 1500 (Address)

Nashville (City) TN (State) 37201 (Zip Code) 615/256-0500 (Area Code / Phone Number)

(Signature) 05/10/2012 (Date) jjm@h3gm.com (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**
**500 Deaderick Street, Suite 850**
**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.

==========

HF0051 (Revised 05/03/04 – all forms prior to this date are obsolete)

# ORIGINAL APPLICATION

2012 MAY 14 PM 1:49

# CORAM ALTERNATE SITE SERVICES, INC.

# CERTIFICATE OF NEED APPLICATION

# TO ESTABLISH A

# LIMITED SERVICE HOME HEALTH AGENCY

## MAY 2012

# SECTION A

# APPLICANT PROFILE

# CORAM ALTERNATE SITE SERVICES, INC.

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

2012 MAY 14 PM 1:49

Coram Alternate Site Services, Inc. d/b/a Coram Specialty Infusion Services, an Apria Healthcare Company
Name

2970 Sidco Drive
Street or Route

Davidson
County

Nashville
City

TN
State

37204
Zip Code

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

Jeffrey J. Miller
Name

Attorney
Title

Harwell, Howard, Hyne, Gabbert and Manner
Company Name

jeff.miller@h3gm.com
Email address

333 Commerce Street, Suite 1500
Street or Route

Nashville
City

TN
State

37201
Zip Code

Counsel
Association with Owner

615-251-1073
Phone Number

615-251-1059
Fax Number

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

Coram Specialty Infusion Services, Inc.
Name

303-372-8738
Phone Number

555 17th Street, #1500
Street or Route

Denver
County

Denver
City

CO
State

80202
Zip Code

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

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

**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: Not Applicable

Street or Route: 

County: 

City: 

State: 

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 7 -2/3rd Years | ✓ | | | |

**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) | | 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) Pharmacy | ✓ |

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 Health Care Service as defined in TCA § 68-11-1607(4) (Specify) Home Health-Limited Svc | ✓ | H. | Change of Location | |
| E. | Discontinuance of OB Services | | I. | Other (Specify) | |
| 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 | | | | | |
| B. Surgical | | | | | |
| C. Long-Term Care Hospital | | | | | |
| D. Obstetrical | | | | | |
| E. ICU/CCU | | | | | |
| F. Neonatal | | | | | |
| G. Pediatric | | | | | |
| H. Adult Psychiatric | | | | | |
| I. Geriatric Psychiatric | | | | | |
| J. Child/Adolescent Psychiatric | | | | | |
| K. Rehabilitation | | | | | |
| 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** | 0 | 0 | 0 | 0 | 0 |

*CON-Beds approved but not yet in service

**10. Medicare Provider Number** 0326910573

**Certification Type** Pharmacy

**11. Medicaid Provider Number** 1952418725

**Certification Type** Pharmacy

**12. If this is a new facility, will certification be sought for Medicare and/or Medicaid?** No

**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.***

## SECTION A: APPLICANT PROFILE, ADDITIONAL RESPONSES

***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.***

The Applicant is a Delaware Corporation which is a wholly owned subsidiary of Coram Specialty Infusion Services, Inc. These entities ultimate parent is Apria Healthcare Group Inc. The Applicant's confirmation of corporate existence from the Tennessee Secretary of State is included in Attachment, Section A, Item 3.1. Its By Laws are included in Attachment, Section A, Item 3.2.

***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.***

A description of the Applicant and its Organizational Chart are included in Attachment, Section A, Item 4.1. The Applicant's ultimate parent's most recently filed 10-K (annual report) with the Securities and Exchange Commission is included in Attachment, Section A, Item 4.2. The Applicant has no financial interest in any other healthcare institution (as defined by TCA §68-11-1602(7)) in Tennessee.

***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.***

Coram Alternate Site Services, Inc. is a self managed operation with its employed leadership operating the entity on a day to day basis, reporting to regional directors who ultimately report to the holding company's executive leadership and board. This question is not applicable to the Applicant.

***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.***

The Applicant's ultimate parent Apria Healthcare Group Inc. has occupied its existing building since March 1, 2011 under a Lease Agreement with the landlord, Meadows Family General Partnership. Earlier this year, the Applicant's ultimate parent assigned its rights under the Lease Agreement to Coram Alternate Site Services, Inc., the Applicant. The existing leased space is sufficiently sized to add the restricted home health services to its business lines and effectively operate the licensed pharmacy and home health services with common leadership and facilities. A copy of the Lease Agreement is included in Attachment, Section A, Item 6.1. A copy of the sublease agreement with the Applicant is included in Attachment, Section A, Item 6.2.

***For Section A, Item 13, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract with.***

Coram Alternate Site Services, Inc., and its affiliate Coram Specialty Infusion Services, Inc. have historically and will continue to contract with Tennessee Managed Care Organizations.

There are four TennCare MCOs within the state. TennCare Select and United Healthcare serve all three regions. BlueCare serves the East and West region; and Amerigroup serves the Middle Tennessee region. Currently the Applicant contracts with BlueCare and is in contract negotiations with Amerigroup on a national level. The existing contract covers the Applicant's infusion services and will be expanded to incorporate nursing services associated with the infusion products. Because the contract under negotiation with Amerigroup is national, it will include both infusion products and nursing administration of the products for markets throughout the country where these services are provided by a Coram affiliate. Upon CON approval, the Applicant will initiate discussions with TennCare Select and United HealthCare to secure additional contracts in the Middle Tennessee region.

In addition to TennCare MCOs, the Applicant contracts with a host of commercial managed care organizations that serve the region for its infusion products. These entities include, but are not limited to, the following: Aetna, Blue Cross Blue Shield of Tennessee, Blue Advantage, Carecentrix, Corizon, First Medical Management, HealthSprings of Tennessee, Humana, Medicare, TriCare, United Healthcare, Veterans Administration and Vanderbilt University. Nursing services to administer the infusion products will be added to these contracts. As necessary, additional MCOs will be added to the Applicant's contractual arrangements as its services expand.

# SECTION B

# PROJECT DESCRIPTION

# CORAM ALTERNATE SITE SERVICES. INC.

SUPPLEMENTAL
2012 MAY 31 PM 4: 16

## SECTION B: PROJECT DESCRIPTION

**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.***

The applicant is Coram Alternate Site Services, Inc., a Delaware corporation, which operates a licensed pharmacy and ambulatory infusion suite at 2970 Sidco Drive, Nashville, Tennessee ("Coram" or "Applicant"). It is both licensed by the State and accredited by The Joint Commission. These documents are included in Attachment, Section B, Project Description, Item I. This Coram branch provides home infusion products to residents throughout Middle Tennessee spanning from Crossville in the east, Chattanooga to the southeast, Gainesboro, Celina and Livingston to the northeast, Clarksville to the northwest, Waverly and Centerville to the west and Lawrenceburg to the southwest. This 38-county Middle Tennessee area represents 86 percent of the home infusion services provided by Coram from its Nashville Branch. The balance of its infusion therapy product patients is either out of state or patients initiated and transferred to the other Tennessee branches; they will not be served by the home health agency under its proposed licensure.

The Applicant is a wholly owned subsidiary of Coram Specialty Infusion Services, Inc. which has as its ultimate parent Apria Healthcare Group Inc., also a Delaware corporation. Coram's ultimate parent is controlled by its executive offices and board of directors who collectively own just three percent of the corporation's stock. The majority stockholders, totaling more than 90 percent, are various investment funds.

Through the submission of this CON application, the Applicant is seeking to establish a limited service home health agency. Specifically, with its approved home health agency license, the Applicant will only provide and administer home infusion products and related infusion nursing services. By way of example and not limitation, the related services are line maintenance, phlebotomy services, infusion equipment repair and replacement and dressing changes on central lines and external access ports. These services will be provided by a registered nurse who is appropriately credentialed and is certified with a CRNI designation (certified registered nurse infusion). These services and credentials are a unique service and not typical of the average Medicare certified home health agency available to Middle Tennesseans.

The administrator of the home health agency will be the existing general manager of the Nashville Branch, Ms. Grace Chambliss, as this service will be seamlessly added to the existing infrastructure of the Nashville Branch. Ms. Chambliss meets the home health administrator criteria as prescribed by Rules of Tennessee Department of Health, Board of Licensing, Chapter 1200-08-26.

The defined service area of the proposed home health agency is 38 counties throughout Middle Tennessee which is the geographic area in which most of the Coram infusion therapy product patients reside. Evaluation of these patients' records for the past three years identified the infusion product profile, age profile, payor profile, referral sources including place of hospitalization, and the identified hardships for these patients to receive infusion nursing services in the home. The latter factor contributed to extended lengths of stay in hospital, more costly hospital stays, increased costs to the healthcare system overall, and economic hardships on the patients and families.

The types of patients will be restricted to infusion therapy patients. Types of infusion products to be administered include: antibiotics; total parenteral nutrition (TPN); hydration; cardiac products (such as inotropic therapies); intravenous immunoglobulin (IVIG) and other similar specialty drugs; pain management; antiemetic; and steroids. The types of patients served by Coram who have demonstrated needs for infusion nursing services in the home which are otherwise unavailable from other home health agencies include the following:

- Specialty Patients Requiring IVIG and Alpha 1 Therapies
- First Dose Administration
- Low Intervention Patients
- Three Dose Schedule Patients
- Rural and Pediatric Patients

The uniqueness of its patient population drives the need for Coram to be licensed as a home health agency. Approval of Coram's restricted home health license will enable a specific subset of the population to receive a higher standard of care in a lower cost environment, thereby contributing to the orderly development of healthcare while meeting a distinct patient and community need. The underlying bases and discussions relative to the lack of access and availability of skilled infusion nursing services for this patient population is provided in response to Section C, Need: Home Health Services, Question 1 along with supporting discussions in response to the other Home Health Services, Guidelines for Growth and General Criteria related to Need. Community support for approval of this CON application is also presented herein with respect to referral sources and area home health agencies.

There is no construction associated with this project and there is no major medical equipment involved with this project. Its costs are limited to the administrative, legal and consulting costs associated with obtaining certificate of need approval and costs associated with licensure. The total cost for the project is $63,000. Its funding can be assured based on the financial statements of the ultimate parent as provided in Attachment, Section A, Item 4.2 and the letter of funding commitment included with this CON application as Attachment, Section C, Economic Feasibility, Item 2. Demonstration of Economic Feasibility and how this project makes a Contribution to the Orderly Development of Healthcare is presented in response to those sections in this application.

Operationally, the Applicant will operate the home health service as part of its existing Nashville Branch operations. Adding the nursing service to its existing product line will enhance the operation while providing its patients with a service that is historically difficult to obtain resulting in prolonged hospital stays. The financial projections which are a part of this Application demonstrate that this service is restricted in its scope, is financially feasible and generates a positive net income from operations.

## *SECTION B: PROJECT DESCRIPTION*

***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.***

Coram Alternate Site Services, Inc. occupies a single story 6,800 square foot structure at 2970 Sidco Drive, Nashville, Tennessee 37204. This existing space houses its licensed pharmacy services and includes the pharmacy, distribution warehouse, ambulatory infusion suite and administrative offices and support space. The addition of the restricted home health services will be under the existing leadership and operate from the existing leased space. Accordingly, there is no construction, renovation or modification required to implement this proposed project.

The square footage chart for the currently leased space which will house the home health service is included as Attachment, Section B, Project Description, Item II (A). Square footage was estimated from the existing floor plan as the space is currently occupied by the Applicant. There are no costs to establish the program as the home health services will be supported from the existing administrative spaces while the actual service will be provided in the client (patient) home.

## *SECTION B: PROJECT DESCRIPTION*

***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.***

This question addresses a change in bed capacity. This CON application is for a limited service home health agency. Therefore this question is not applicable to the project proposed herein.

## *SECTION B: PROJECT DESCRIPTION*

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

This question addresses the need to change location or replace an existing facility. This CON application is for a limited service home health agency. Therefore this question is not applicable to the project proposed herein.

## *SECTION B: PROJECT DESCRIPTION*

***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***

The Applicant has defined an unmet community need to provide home health services limited to infusion nursing and related services. The need for this service results from a lack of available or accessible home infusion nursing capability throughout Middle Tennessee. As a licensed pharmacy providing infusion therapy products to patients in their homes, Coram is intimately familiar with the patients throughout the region, and the hardships encountered by hospitals, physicians and patients/families in effecting a timely discharge from the hospital when hospitalization is no longer required, but the patient and family have not initiated their first infusion dose nor are they knowledgeable about the process, the infusion equipment, and the specific regimen which must be followed. Furthermore, as the pharmacy providing the infusion product to the patient, Coram's staff regularly meets with the patients and understands their skilled nursing needs, but is unable to assist in that regard as it does not have a home health license. The types of infusion patients which have compromised access and how Coram will meet their needs are discussed in response to Sections B and Section C on the following pages.

With the approval of this CON application, Coram will be able to serve a patient population in need in a more appropriate, cost effective and accessible manner, in their own home, thereby meeting a defined need while contributing to the orderly development of healthcare.

## *SECTION B: PROJECT DESCRIPTION*

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.***

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.***

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.***

This question addresses the acquisition of major medical equipment. This CON application is for a limited service home health agency. Therefore this question is not applicable to the project proposed herein.

## *SECTION B: PROJECT DESCRIPTION*

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.***

The home health service will be located at 2970 Sidco Drive, Nashville, Tennessee. This 6,800 square foot building is subject to an ongoing lease agreement between Coram and its landlord. The restricted service home health will be operated from this existing leased space. No modification, construction or renovation is required; nor is the addition of any further people to the management team.

The Site Plan and location of the leased building on the site relative to the surrounding streets and neighborhoods is included as Attachment, Section B, Project Description, Item III (A).

## *SECTION B: PROJECT DESCRIPTION*

**(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.***

Accessibility to Coram's location is not applicable as the home health services will not be provided at Coram's Nashville Branch. The purpose of this CON application is to obtain approval to provide these limited nursing services in the patient's home which will be in one of the 38 counties for which CON approval is being sought. The Coram nurse who will provide the service will reach the patient's home by private vehicle.

## *SECTION B: PROJECT DESCRIPTION*

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.***

The Floor Plan of the leased building is included as Attachment, Section B, Project Description, Item IV. This building is subject to an existing lease between the Applicant and landlord. It will not be modified within the context of this proposal as the home health service will operate from the administrative space within the building by the Branch's leadership.

## SECTION B: PROJECT DESCRIPTION

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.***

This CON application is for a limited service home health agency whereby its license will be restricted to provide only infusion nursing and related skilled services. The Applicant does not currently operate any existing home health services within the State of Tennessee. It has three pharmacy branches in the state, serving east (from Knoxville), middle (from Nashville) and west (from Memphis). This CON application seeks approval to provide limited home health services from its Nashville Branch and in the following Middle Tennessee counties:

| | | | |
|---|---|---|---|
| Bedford | Bledsoe | Cannon | Cheatham |
| Clay | Coffee | Cumberland | Davidson |
| DeKalb | Dickson | Franklin | Giles |
| Grundy | Hamilton | Hickman | Humphreys |
| Jackson | Lawrence | Lewis | Lincoln |
| Macon | Marion | Marshall | Maury |
| Montgomery | | Overton | Putnam |
| Rhea | Robertson | Rutherford | Sequatchie |
| Smith | Sumner | Trousdale | Wilson |
| Warren | White | Williamson | |

The geographic area represented by these counties spans from the Cookeville/Crossville area to the east of Nashville, to the Chattanooga area to the southeast, to Lawrenceburg in the southwest, north to the state line, south to the state line, northwest to the Clarksville area, northeast to the Gainesboro and Livingston area and west to the Centerville and Waverly area. A map depicting these counties relative to the State of Tennessee is included in Attachment, Section B, Project Description, Item V.

# SECTION C

# GENERAL CRITERIA FOR CERTIFICATE OF NEED

# CORAM ALTERNATE SITE SERVICES, INC.

## *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)."***

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

**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.***

   The criterion and standards in Certificate of Need Categories that are applicable to this project include: Home Health Services. Each of the Home Health Guidelines along with the associated responses is provided on the following pages.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

**NEED: HOME HEALTH SERVICES**

1. ***The need for home health agencies/services shall be determined on a county by county basis.***

Home Health Services are regulated under Tennessee Chapter 1200-08-26, Board of Licensing. Tennessee Code Annotated (T.C.A.) § 68-11-201 defines a Home Care Organization as one that provides home health services, home medical equipment services or hospice services to patients on an outpatient basis in either their regular or temporary place of residence. T.C.A. further defines home health services as a service provided an outpatient by an appropriately licensed health care professional or an appropriately qualified staff member of a licensed home care organization in accordance with orders recorded by a physician, and which includes one ore more of the following:

- Skilled nursing care including part time or intermittent supervision
- Physical, occupational or speech therapy
- Medical social services
- Home health aide services
- Medical supplies and medical appliances

This CON application to become approved and licensed as a home health services agency is unique in that the Applicant is only seeking CON approval to enable it to provide one of the above services – skilled nursing care – and on a limited basis for a specific subset of patients in each county. Specifically, the skilled nursing care the Applicant is seeking licensure to provide is the administration of home infusion products and related infusion nursing services. By way of example and not limitation, the related infusion nursing services are line maintenance, phlebotomy services, infusion equipment repair and replacement and dressing changes on central lines and external access ports. These services will be provided by a registered nurse who is appropriately credentialed and is certified with a CRNI designation (certified registered nurse infusion). These services and credentials are a unique service and not typical of the average Medicare certified home health agency available to Middle Tennesseans.

Need for this special service was developed by the Applicant based on its existing infusion therapy patient profiles including age, county of residence, infusion service requirement, payor, referral source, and identified hardship experiences by patients, families and their referral sources (hospitals, physicians and others) to obtain infusion nursing service in the home on a timely basis.

As an existing licensed pharmacy provider in Tennessee, the Applicant has a range of home infusion products it provides to its patients some of whom are homebound while others are not. Types of infusion products prescribed for its patients include, but are not limited to, the following:

- Antibiotics
- Total parenteral nutrition (TPN)
- Hydration
- Cardiac products (such as inotropic therapies)
- Intravenous immunoglobulin (IVIG) and other similar specialty drugs
- Pain management
- Antiemetic
- Steroids

During each of the past three years, the Applicant from its Nashville Branch has provided these types of infusion products to approximately 1,000 to 1,200 patients per year. Some of these patients received more than one infusion product (therapy). When factoring for unduplicated therapies, the number of therapy patients increase to 1,213, 1,117 and 1,545, respectively for each of the last three calendar years.

Because infusion therapy products are generally not one dose but can last over a period of time, shortest being days and longest being years, utilization is not only measured by number of patients or number of therapies, but also by patient months. Patient months are the average number of months on infusion service for the total unduplicated patient count. Following is the most recent three year activity for the Applicant's Nashville Branch:

| *Factor* | *CY 2009* | *CY 2010* | *CY 2011* |
|---|---|---|---|
| Unduplicated Patients | 1,028 | 958 | 1,288 |
| Duplicated Patients/Unduplicated Therapies | 1,213 | 1,117 | 1,545 |
| Patient Months | 1,921 | 1,869 | 2,554 |
| Average Months per Patient (length of stay) | 1.9 | 2.0 | 2.0 |
| Average Therapies per Patient | 1.2 | 1.2 | 1.2 |

On an ongoing basis, the Applicant has documented difficulties in meeting the infusion nursing needs of its infusion therapy patients. This skilled nursing access problem arises from several different associated factors, each of which is summarized in the following paragraphs.

- Specialty Patients Requiring IVIG and Alpha 1 Therapies: These immunotherapy patients receive comparatively long infusions, lasting up to 6 hours for each therapy, generally only one time per month. Because of the duration of the infusion time and only once per month requirement, existing home health agencies do not provide this service. Another challenge with these patients is some receive blood based products or

plasma derivatives which result in higher rates of patient reaction. Existing home health agencies do not generally accept these types of patients due to this reaction rate and associated liabilities. Additionally, some of these patients are not homebound and therefore would not qualify for a traditional certified home health visit. Given Medicare home health reimbursement, even if the patient is homebound, local home health agencies are not staffed or favorably inclined to provide a nursing service which lasts most of the work day for one full time equivalent. As an approved home health agency, Coram will provide this service for its immunotherapy patients which is otherwise unavailable for this population.

- First Dose Administration: Engaging a local home health agency to provide the first dose in a lengthy ongoing infusion therapy session is difficult at best as most do not have a first dose policy. Initiating infusion therapy services on a new patient requires specialized certified infusion nurses, who are not regularly employed by Medicare certified home health agencies. These patients can be acute and complex or not homebound or low intervention. By providing the first dose at home, Coram can train the patient to self administer thus avoiding ongoing home health services for some of its patients. For others, Coram will meet this need by providing the required nurse to initiate therapy, first dose administration, then either continuing to treat the patient or turning the patient to the local home health agency if ongoing nursing care is required and a local home health agency is available and qualified for the service. As an approved home health agency, Coram will be able to expeditiously provide this service to effect a timely patient discharge from the hospital.

- Low Intervention Patients: These are patients who are not homebound and therefore do not qualify for Medicare/Medicaid home health services. They need the skilled nursing visit to initiate the infusion process and then train the patient to self administer. These patients are not seen by certified home health agencies as they don't generally qualify for services. It is these types of patients that stay in hospitals longer than necessary because they have to start infusion and be trained at the hospital due to lack of qualified home health agency availability. As an approved home health agency, Coram will admit these patients and train them to self administer, thus saving the system financially by avoiding prolonged hospitalizations.

- Three Dose Schedule: Patients on certain types of infusion are on a three dose schedule, 6 AM, 2 PM and 10 PM. Because of this schedule, many of these patients stay in the hospital extra day(s) because of the availability or lack thereof for nurses to be at home for the first dose, which may be at 10PM. Many home health agencies do not provide services nights and weekends. Likely home health hours are reported as 8AM to 5 or 6 PM and not on weekends, particularly to start a new patient. This

impacts discharge dates from hospitals as well as first dose policy/training. In addition, short notice to these home health agencies for a late afternoon referral inevitably results in an extra day in the hospital. As an approved home health agency, Coram will treat these patients on an interim basis until the patient is trained to self administer or the local home health agency admits the patient.

- Rural and Pediatric Patients: It has also been Coram's experience with its infusion therapy patients, that those who reside in outlying counties – the rural areas within the 38-county service area – and pediatric patients are patients for whom it is difficult to obtain infusion nursing services. Coram will also fill this need when the situation arises.

Infusion nursing is highly specialized in protocol, equipment management, patient/family education and training and time commitment. These aspects of home care delivery are not typical with the average Medicare certified home health agency patient profile and service delivery, or with their available nurse staff. Average Medicare certified home health agencies patient profile including documentation in the Tennessee Joint Annual Report (JAR) Summary has the following characteristics:

- Homebound
- Average visit duration is one to two hours
- Equipment generally not involved
- 80 percent of the visits are Medicare patients
- 71 percent are 65 years of age and older with nearly 50 percent being 75 and older
- Of total visits statewide,
  - 38 percent are physical, occupational and speech therapy,
  - 18 percent are home health aide and homemaker services,
  - 1 percent are medical social services, and
  - Just 42 percent are skilled nursing

Infusion nursing patients, and those proposed to be served by the Coram limited service home health agency, differ from the average Medicare certified home health agency patient. Notable differences are as follows:

- The predominant age of patients is under the age of 65
- Private insurance is the dominant payor
- Specialty patient infusion visits last up to six hours one time per month for lengthy infusions of immunoglobin
- Antibiotic therapy and TPN patients can have up to three doses (infusions) per day at eight hour intervals
- Nurses require specialized understanding and protocol for infusion equipment

- The goal of infusion nursing is to train the patient to self administer with only limited follow up as needed by the nurse
- The patient may not be homebound, but may not have reasonable geographic or financial access to reach an ambulatory infusion center, hospital or other venue for infusion
- Infusion therapy in the home is more cost effective to the system than accessing the product and service in an institution (i.e. a hospital)

The needs of this highly specific patient population with unique infusion therapy requirements is not being met in the most appropriate, accessible and available means. With Coram's approval for a limited service home health agency license, these access problems can be ameliorated.

The service area definition proposed by the Applicant is defined at the county level. This was accomplished through thorough study of the Coram Nashville Branch Patient Records which includes the patients' counties of residence, referral sources (i.e. place of hospitalization) and the specialized needs as discussed above. The counties for which approval is sought, based on the patient evaluation and needs, are the following:

| | | | |
|---|---|---|---|
| Bedford | Bledsoe | Cannon | Cheatham |
| Clay | Coffee | Cumberland | Davidson |
| DeKalb | Dickson | Franklin | Giles |
| Grundy | Hamilton | Hickman | Humphreys |
| Jackson | Lawrence | Lewis | Lincoln |
| Macon | Marion | Marshall | Maury |
| Montgomery | | Overton | Putnam |
| Rhea | Robertson | Rutherford | Sequatchie |
| Smith | Sumner | Trousdale | Wilson |
| Warren | White | Williamson | |

The guideline relative to 1.5 percent of the population requiring home health services is generally not applicable to the infusion therapy population. First, the average home health agency utilization in the defined service area is greater than 2.5 percent (not 1.5 percent as noted in the Guidelines). Second, the infusion population is a limited subset of that population or not included within that population at all. This relates to the fact that some of the patients are younger, not home bound and require start up and training for self administration, but not ongoing skilled visits.

Referral sources such as hospitals and physicians support this unique initiative. Additionally, existing home health agencies within the service area note this service is unique, not competitive with existing Medicare certified home health agencies, and are a welcome addition to the delivery of care. The constituent letters of support are discussed in response to Section C, Need: Home Health Services, Question 5 and the letters are included in that section's Attachment.

## SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:

### NEED: HOME HEALTH SERVICES

2. ***In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county. The 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed service area.***

The defined service area for Coram Alternate Site Services, Inc.'s proposed home health agency includes 38 counties within Middle Tennessee. This area represents the counties where in excess of 86 percent of Coram's infusion therapy patient population resides.

In the following table is the current (2012) population as estimated by the Tennessee Office of the Governor, forecasted four years from current to 2016. Accompanying the population count is the home health formula identifying potential home health patients as a 1.5 percent general guideline applied to the total population.

| *Service Area* | *Population* | | *1.5 Percent General Guideline* | |
|---|---|---|---|---|
| *County* | *2012* | *2016* | *2012* | *2016* |
| Bedford | 48,083 | 51,282 | 721 | 769 |
| Bledsoe | 13,565 | 13,886 | 203 | 208 |
| Cannon | 14,268 | 14,805 | 214 | 222 |
| Cheatham | 42,222 | 44,357 | 633 | 665 |
| Clay | 8,201 | 8,301 | 123 | 125 |
| Coffee | 54,707 | 56,774 | 821 | 852 |
| Cumberland | 55,798 | 57,735 | 837 | 866 |
| Davidson | 602,257 | 618,202 | 9,034 | 9,273 |
| DeKalb | 19,366 | 20,024 | 290 | 300 |
| Dickson | 49,744 | 51,903 | 746 | 779 |
| Franklin | 43,112 | 44,351 | 647 | 665 |
| Giles | 30,076 | 30,638 | 451 | 460 |
| Grundy | 14,925 | 15,212 | 224 | 228 |
| Hamilton | 318,632 | 322,740 | 4,779 | 4,841 |
| Hickman | 26,100 | 27,616 | 392 | 414 |
| Humphreys | 19,067 | 19,515 | 286 | 293 |
| Jackson | 11,419 | 11,730 | 171 | 176 |
| Lawrence | 42,709 | 43,918 | 641 | 659 |
| Lewis | 12,208 | 12,599 | 183 | 189 |
| Lincoln | 34,084 | 34,940 | 511 | 524 |
| Macon | 23,208 | 24,183 | 348 | 363 |
| Marion | 28,455 | 28,787 | 427 | 432 |
| Marshall | 30,958 | 32,304 | 464 | 485 |
| Maury | 84,148 | 88,120 | 1,262 | 1,322 |
| Montgomery | 159,209 | 167,554 | 2,388 | 2,513 |
| Overton | 21,377 | 21,747 | 321 | 326 |
| Putnam | 72,489 | 75,364 | 1,087 | 1,130 |

| *Service Area County* | *Population* | | *1.5 Percent General Guideline* | |
|---|---|---|---|---|
| | *2012* | *2016* | *2012* | *2016* |
| Rhea | 31,803 | 32,809 | 477 | 494 |
| Robertson | 68,589 | 72,906 | 1,029 | 1,094 |
| Rutherford | 256,765 | 274,920 | 3,851 | 4,124 |
| Sequatchie | 14,042 | 14,701 | 211 | 221 |
| Smith | 20,104 | 20,984 | 302 | 315 |
| Sumner | 162,422 | 170,883 | 2,436 | 2,563 |
| Trousdale | 8,287 | 8,611 | 124 | 129 |
| Warren | 42,263 | 43,792 | 634 | 657 |
| White | 25,521 | 26,236 | 383 | 394 |
| Williamson | 184,323 | 200,247 | 2,765 | 3,004 |
| Wilson | 114,437 | 121,203 | 1,717 | 1,818 |
| Total | 2,808,943 | 2,925,879 | 42,133 | 43,890 |

*Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics, 2008 Revision. Per Health Statistics, this is the most updated population published by the State as of the CON submission date and to be used in this CON application dated May 2012.*

2012 MAY 31 PM 4: 16

The above computes an estimated 42,000 to 44,000 persons who are appropriate for home health services, based on the general guidelines. Actual experience within these 38 counties far exceeds the need estimate based on 1.5 percent. In fact, utilizing the actual average historical utilization within the service area increases the applicable rate to 2.58 percent. Adjusting the above from 1.5 to 2.58, results in 71,000 to 74,000 patients – 70 percent more than computed in the table.

Coram's proposal involves providing services to approximately 263 patients per year. This represents only 0.6 percent of the 42,000 to 44,000 in the table or 0.36 percent of the actual 71,000 to 74,000 identified patients if the total is inclusive of the infusion patient.

Aside from actual experience in the service area far exceeding the 1.5 computation, in the case of this CON application for a restricted home health service license, the general guideline is not applicable as the proposed patient population is not the traditional home health client, nor is the person seen for the same length of time. The population in need of infusion nursing services is generally not elderly, not covered by Medicare, not in need of the full scope of home health services and may not even be homebound. The patient, however, will be a costly addition to the healthcare system if the infusion service is provided in an institutional setting versus at home. Furthermore, part of Coram's proposal is to educate the infusion patient to enable self administration after the initial visit(s). Therefore, further reduction in costs to the healthcare system will be expected with the approval of this CON application.

## SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:

### NEED: HOME HEALTH SERVICES

3. ***Using recognized population sources, projections for four years into the future will be used.***

The defined service area for the Applicant is 39 counties within Middle Tennessee. These counties include those listed in the table below which also provides forecasted population as estimated by the Tennessee Office of the Governor, four years from current, the forecasted change between 2012 and 2016 and the percent that change represents.

| *Service Area* | *Population* | | *Change from 2012 to 2016* | |
|---|---|---|---|---|
| *County* | *2012* | *2016* | *Count* | *Percent* |
| Bedford | 48,083 | 51,282 | 3,199 | 6.7% |
| Bledsoe | 13,565 | 13,886 | 321 | 2.4% |
| Cannon | 14,268 | 14,805 | 537 | 3.8% |
| Cheatham | 42,222 | 44,357 | 2,135 | 5.1% |
| Clay | 8,201 | 8,301 | 100 | 1.2% |
| Coffee | 54,707 | 56,774 | 2,067 | 3.8% |
| Cumberland | 55,798 | 57,735 | 1,937 | 3.5% |
| Davidson | 602,257 | 618,202 | 15,945 | 2.6% |
| DeKalb | 19,366 | 20,024 | 658 | 3.4% |
| Dickson | 49,744 | 51,903 | 2,159 | 4.3% |
| Franklin | 43,112 | 44,351 | 1,239 | 2.9% |
| Giles | 30,076 | 30,638 | 562 | 1.9% |
| Grundy | 14,925 | 15,212 | 287 | 1.9% |
| Hamilton | 318,632 | 322,740 | 4,108 | 1.3% |
| Hickman | 26,100 | 27,616 | 1,516 | 5.8% |
| Humphreys | 19,067 | 19,515 | 448 | 2.3% |
| Jackson | 11,419 | 11,730 | 311 | 2.7% |
| Lawrence | 42,709 | 43,918 | 1,209 | 2.8% |
| Lewis | 12,208 | 12,599 | 391 | 3.2% |
| Lincoln | 34,084 | 34,940 | 856 | 2.5% |
| Macon | 23,208 | 24,183 | 975 | 4.2% |
| Marion | 28,455 | 28,787 | 332 | 1.2% |
| Marshall | 30,958 | 32,304 | 1,346 | 4.3% |
| Maury | 84,148 | 88,120 | 3,972 | 4.7% |
| Montgomery | 159,209 | 167,554 | 8,345 | 5.2% |
| Overton | 21,377 | 21,747 | 370 | 1.7% |
| Putnam | 72,489 | 75,364 | 2,875 | 4.0% |
| Rhea | 31,803 | 32,809 | 1,006 | 3.2% |
| Robertson | 68,589 | 72,906 | 4,317 | 6.3% |
| Rutherford | 256,765 | 274,920 | 18,155 | 7.1% |
| Sequatchie | 14,042 | 14,701 | 659 | 4.7% |
| Smith | 20,104 | 20,984 | 880 | 4.4% |
| Sumner | 162,422 | 170,883 | 8,461 | 5.2% |
| Trousdale | 8,287 | 8,611 | 324 | 3.9% |
| Warren | 42,263 | 43,792 | 1,529 | 3.6% |
| White | 25,521 | 26,236 | 715 | 2.8% |
| Williamson | 184,323 | 200,247 | 15,924 | 8.6% |

| *Service Area County* | *Population* | | *Change from 2012 to 2016* | |
|---|---|---|---|---|
| | *2012* | *2016* | *Count* | *Percent* |
| Wilson | 114,437 | 121,203 | 6,766 | 5.9% |
| Total | 2,808,943 | 2,925,879 | 116,936 | 4.2% |

*Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics, 2008 Revision. Per Health Statistics, this is the most updated population published by the State as of the CON submission date and to be used in this CON application dated May 2012.*

Given the Applicant's forecasted skilled nursing patient count and skilled nursing patient visits, it only expects to annually admit 0.0093 percent of the total population (263 / 2,808,943) based on 2012 population counts, decreasing to 0.0090 percent based on 2016 population counts.

As noted previously, this application is for a limited service (restricted) home health agency to provide infusion nursing and related services to infusion therapy patients in their home. It is a special circumstance and category of patient who does not fall within the traditional home health type patient. Accordingly, its need should be measured by the special circumstances demonstrated by the Applicant, not the traditional or general observations included in the Guidelines.

Service area maps have been prepared for this project and are included in Attachment, Section B, Project Description, Item V and Attachment C, Home Health Services, Item 3. There are two maps included. The first one is the entire state with the service area counties highlighted. The second version has the service area "zoomed in" to provide more detail at the county level.

There are no readily available infusion nursing services to meet the unique needs of the Coram infusion therapy patients. Time and time again, Coram and its referring hospitals struggle with this dilemma resulting in extended but avoidable hospital stays of these patients. Constituent input supporting this fact is presented in response to Question 5 below.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### NEED: HOME HEALTH SERVICES

4. ***The use rate of existing home health agencies in the county will be determined by examining the latest utilization rates as calculated in the Joint Annual Report of existing home health agencies in the service area. Based on the number of patients served by home health agencies in the service area, an estimate will be made as to how many patients could be served in the future.***

Home health agencies with licenses in each county do not necessarily provide services within the counties for which they are licensed. As required in the Joint Annual Reports (JAR), each home health agency is to identify its patients by county of residence. So, for example, an agency licensed in 15 counties may not have patients in all 15 counties. And, by being licensed in those 15 counties, the JAR Summary will list "licensed" agencies and "reporting" agencies indicating that although licensed each is not reporting services to residents of each county in which it is licensed.

The following table identifies the number of licenses by county along with those agencies providing reports and reporting residents by county.

| *Service Area Counties* | *Number of Home Health Agencies* | | *Agencies Not Available* |
|---|---|---|---|
| | *Licensed* | *Reporting* | |
| Bedford | 21 | 19 | 2 |
| Bledsoe | 11 | 8 | 3 |
| Cannon | 21 | 16 | 5 |
| Cheatham | 23 | 22 | 1 |
| Clay | 9 | 5 | 4 |
| Coffee | 19 | 16 | 3 |
| Cumberland | 15 | 13 | 2 |
| Davidson | 32 | 31 | 1 |
| DeKalb | 24 | 18 | 6 |
| Dickson | 20 | 17 | 3 |
| Franklin | 17 | 14 | 3 |
| Giles | 11 | 10 | 1 |
| Grundy | 18 | 16 | 2 |
| Hamilton | 15 | 17 | -2 |
| Hickman | 19 | 14 | 5 |
| Humphreys | 16 | 13 | 3 |
| Jackson | 13 | 11 | 2 |
| Lawrence | 14 | 11 | 3 |
| Lewis | 11 | 9 | 2 |
| Lincoln | 14 | 14 | 0 |
| Macon | 19 | 14 | 5 |
| Marion | 14 | 15 | -1 |
| Marshall | 17 | 13 | 4 |
| Maury | 21 | 18 | 3 |
| Montgomery | 21 | 18 | 3 |

| *Service Area Counties* | *Number of Home Health Agencies* | | *Agencies Not Available* |
|---|---|---|---|
| | *Licensed* | *Reporting* | |
| Moore | 11 | 9 | 2 |
| Overton | 13 | 11 | 2 |
| Putnam | 18 | 15 | 3 |
| Rhea | 15 | 12 | 3 |
| Robertson | 26 | 25 | 1 |
| Rutherford | 30 | 28 | 2 |
| Sequatchie | 12 | 10 | 2 |
| Smith | 18 | 13 | 5 |
| Sumner | 24 | 23 | 1 |
| Trousdale | 18 | 12 | 6 |
| Warren | 21 | 15 | 6 |
| White | 16 | 13 | 3 |
| Williamson | 26 | 26 | 0 |
| Wilson | 31 | 29 | 2 |
| Total | 714 | 613 | 101 |

*Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics.*

The total of the table does not indicate how may home health agencies are licensed within the 39 county area. The cumulative total is actually the aggregate number of counties. So in the example where one home health agency is licensed in 15 counties, it is counted 15 times in the above list. What is notable about the list is that anywhere from 1 to 6 agencies which are licensed in each county, or an average of 2.6 per county, do not actually report services to residents of those counties.

Considering just the active home health agencies and patients by county of residence, and the 2010 utilization by county, the effective use rate averages 25.2 patients per 1000 population, or 2.52 percent of the population. As shown in the following table, this ranges from a low of 1.45 percent to a high of 4.76 percent depending on the county of residence.

| *Service Area County* | *Patients Served in 2010* | *2010 Population* | *Use Rate* | *2016 Population* | *Estimated 2016 Capacity* |
|---|---|---|---|---|---|
| Bedford | 1,032 | 46,576 | 0.0222 | 51,282 | 1,136 |
| Bledsoe | 449 | 13,425 | 0.0334 | 13,886 | 464 |
| Cannon | 457 | 14,025 | 0.0326 | 14,805 | 482 |
| Cheatham | 744 | 41,241 | 0.0180 | 44,357 | 800 |
| Clay | 233 | 8,184 | 0.0285 | 8,301 | 236 |
| Coffee | 1,761 | 53,726 | 0.0328 | 56,774 | 1,861 |
| Cumberland | 1,776 | 54,840 | 0.0324 | 57,735 | 1,870 |
| Davidson | 13,847 | 595,833 | 0.0232 | 618,202 | 14,367 |
| DeKalb | 908 | 19,080 | 0.0476 | 20,024 | 953 |
| Dickson | 1,381 | 48,742 | 0.0283 | 51,903 | 1,471 |
| Franklin | 1,498 | 42,550 | 0.0352 | 44,351 | 1,561 |
| Giles | 937 | 29,855 | 0.0314 | 30,638 | 962 |
| Grundy | 600 | 14,805 | 0.0405 | 15,212 | 616 |
| Hamilton | 8,391 | 316,977 | 0.0265 | 322,740 | 8,544 |

| *Service Area County* | *Patients Served in 2010* | *2010 Population* | *Use Rate* | *2016 Population* | *Estimated 2016 Capacity* |
|---|---|---|---|---|---|
| Hickman | 594 | 25,379 | 0.0234 | 27,616 | 646 |
| Humphreys | 580 | 18,876 | 0.0307 | 19,515 | 600 |
| Jackson | 334 | 11,277 | 0.0296 | 11,730 | 347 |
| Lawrence | 1,489 | 42,163 | 0.0353 | 43,918 | 1,551 |
| Lewis | 472 | 12,044 | 0.0392 | 12,599 | 494 |
| Lincoln | 924 | 33,709 | 0.0274 | 34,940 | 958 |
| Macon | 703 | 22,746 | 0.0309 | 24,183 | 747 |
| Marion | 980 | 28,332 | 0.0346 | 28,787 | 996 |
| Marshall | 770 | 30,332 | 0.0254 | 32,304 | 820 |
| Maury | 2,502 | 82,338 | 0.0304 | 88,120 | 2,678 |
| Montgomery | 2,259 | 155,391 | 0.0145 | 167,554 | 2,436 |
| Moore | 95 | 6,285 | 0.0151 | 6,593 | 100 |
| Overton | 719 | 21,208 | 0.0339 | 21,747 | 737 |
| Putnam | 2,189 | 71,140 | 0.0308 | 75,364 | 2,319 |
| Rhea | 858 | 31,357 | 0.0274 | 32,809 | 898 |
| Robertson | 1,565 | 66,529 | 0.0235 | 72,906 | 1,715 |
| Rutherford | 5,096 | 248,172 | 0.0205 | 274,920 | 5,645 |
| Sequatchie | 375 | 13,727 | 0.0273 | 14,701 | 402 |
| Smith | 612 | 19,702 | 0.0311 | 20,984 | 652 |
| Sumner | 3,731 | 158,385 | 0.0236 | 170,883 | 4,025 |
| Trousdale | 281 | 8,154 | 0.0345 | 8,611 | 297 |
| Warren | 1,972 | 41,541 | 0.0475 | 43,792 | 2,079 |
| White | 985 | 25,189 | 0.0391 | 26,236 | 1,026 |
| Williamson | 2,588 | 177,123 | 0.0146 | 200,247 | 2,926 |
| Wilson | 2,832 | 111,199 | 0.0255 | 121,203 | 3,087 |
| Total | 69,519 | 2,762,157 | 0.0252 | 2,932,472 | 73,503 |

*Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics, 2008 Revision. Per Health Statistics, this is the most updated population published by the State as of the CON submission date and to be used in this CON application dated May 2012.*

As the table in response to Section C, Need, Question 5 indicates, there are actually 67 agencies reporting activity in 2011 in these counties. Yet, despite this number of agencies, there is a compelling need for approval of Coram's proposal for infusion nursing services. The distinct and highly specialized need with credentialed certified staff is unique when one considers the existing home health agencies serving Middle Tennessee. Their provision of services does not generally include first dose protocols or certified infusion staff, but rather focuses on Medicare clients in need of skilled, aide and therapy visits.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

**NEED: HOME HEALTH SERVICES**

5. ***Documentation from referral sources:***
   a. ***The applicant shall provide letters of intent from physicians and other referral sources pertaining to patient referral.***
   b. ***The applicant shall provide information indicating the types of cases physicians would refer to the proposed home health agency and the projected number of cases by service category to be provided in the initial year of operation.***
   c. ***The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.***
   d. ***The applicant shall provide information concerning whether a proposed agency would provide services different from those services offered by existing agencies.***

The patients to be treated by Coram will be its home infusion product patients in need of administration of the infusion product and related infusion nursing services. By way of example and not limitation, the related services are line maintenance, phlebotomy services, infusion equipment repair and replacement and dressing changes on central lines and external access ports. These services will be provided by a registered nurse who is appropriately credentialed and is certified with a CRNI designation (certified registered nurse infusion). These services and credentials are a unique service and not typical of the average Medicare certified home health agency available to Middle Tennesseans.

The types of patients will be restricted to infusion therapy patients. Types of infusion products to be administered include:

- Antibiotics
- Total parenteral nutrition (TPN)
- Hydration
- Cardiac products (such as inotropic therapies)
- Intravenous immunoglobulin (IVIG) and other similar specialty drugs
- Pain management
- Antiemetic
- Steroids

The uniqueness of this patient population that drives the need for Coram to be licensed as a home health agency includes the following infusion patients by group:

- Specialty Patients Requiring IVIG and Alpha 1 Therapies
- First Dose Administration
- Low Intervention Patients
- Three Dose Schedule Patients
- Rural and Pediatric Patients

The underlying bases and discussions relative to the lack of access and availability of skilled nursing services for this patient population are provided in response to Section X, Need: Home Health Services, Question 1. In summary, each of these patient types requires and will benefit from infusion nursing services in the home which includes patient and family education for self administration.

To estimate the number of infusion nursing patients and their related skilled visits for the forecast period, the Applicant considered the types of infusion therapy products which comprise the patient therapies for which it has physician orders, the average monthly census by type of infusion and the hardship the Applicant has encountered in various situations throughout Middle Tennessee in obtaining qualified infusion nursing services from other third parties. This affected the analysis because Coram is not intending on competing with existing available services but rather responding to a community need based on the gap in service which equates to a lack of availability or accessibility of infusion nursing services.

As noted previously, there are primary differences between two types of Coram patients. One is the more typical infusion therapy patient receiving antibiotics, TPN, pain management, cardiac and the like; the other is the specialty patient receiving immunoglobin or alpha 1 therapies. The former therapies comprise 92 percent of Coram's census; the specialty patients comprise 8 percent of the patient census. In terms of estimated requirement for infusion nursing services, it is estimated that all specialty patients will require the service each month. The reason for this utilization is these patient infusions last up to 6 hours per treatment. As such, the more traditional home health agency providing intermittent services is not generally staffed for nor compensated for under Medicare guidelines such as long nursing visits. Ongoing, Coram has significant challenges to find nursing services for these patients resulting in these patients remaining in the hospital for an unnecessary prolonged period, having the patient travel to his/her physician office for Coram to meet the patient in that setting or having the patient travel to another licensed location – all creating hardship on the patient and family.

For the balance of Coram's therapy patients, it is estimated that 10 percent of those patients will require infusion nursing provided by Coram's home health agency. Similarly, this patient estimate is based on the Applicant's assessment of its patient case load and the challenges it regularly faces in admitting a patient to the pharmacy service that can not obtain at home support to initiate the infusion therapy. Depending on the therapy, each patient will receive between two and four visits per month.

Extrapolating the above utilization assumptions and applying them to the estimated future monthly census of infusion therapy patients results in a computed approximate 17 percent of Coram's pharmacy patients requiring skilled nursing services be provided by Coram. As required by this Question, Coram herein provides the information and patient counts/visits regarding the types of cases that it will treat as part of its home infusion nursing services. All home health visits will be skilled nursing as noted in the following table:

| *Factor* | *CY 2013* | *CY 2014* |
|---|---|---|
| Number of Home Health Patients | 247 | 263 |
| | | |
| *Skilled Home Health Visits by Infusion Therapy Type* | | |
| Antibiotic Therapy | 667 | 701 |
| Total Parenteral Nutrition Therapy | 77 | 81 |
| Pain Management | 14 | 15 |
| Cardiac Treatment | 22 | 23 |
| IVIG | 132 | 139 |
| Alpha 1 | 108 | 113 |
| Viva | 65 | 68 |
| Antiemetic | 18 | 19 |
| Other | 89 | 93 |
| Total Annual Skilled Nursing Visits | 1,192 | 1,252 |

Regarding support from the provider community, the Applicant has received letters of support from existing infusion therapy referral sources who recognize the need for Coram to be licensed to realize more effective and appropriate hospital discharges. These letters include representatives of Vanderbilt University Medical Center, Cumberland Medical Center, TriStar Medical Group, and Affiliated Neurologists. Each of these hospitals which provided letters of support also have hospital based home health agencies yet they are each still seeking Coram's approval for a limited service home health agency to meet their needs. Sentiments from these letters supporting the need for this CON application's approval include the following:

*"...It is common for patients to be ready for discharge from the hospital, but the discharges become delayed as patients are required to stay in the hospital an extra day because there is no home health agency that is available to administer the patient's first dose of medication in the home (this is usually when an evening dose is required)."*

*"...Most home health agencies that have policies that prevent them from starting a first dose of a medication in the home. This requires an increase in patients' length of stay in order to give the first dose before discharge. Additionally, we may need to discharge a patient home on the weekend, but are unable to locate a home health agency that is capable of admitting and caring for the patient until Monday morning, thus incurring extra costs and length of stay for the patient."*

*"...If infusion company nurses were able to assist with administering the first dose in patients' homes, this would help alleviate discharge delays that often create financial hardship and other hardships for our patients."*

*"...I treat patients that have limited access to facilities and conditions that restrict mobility. I cannot find a home health agency that will support patients with first dosing. As a result, patients are delayed in receiving care. This delay directly affects health care costs. Coram Specialty Infusion is an expert in blood product administration. I fully support and welcome the expertise they can bring to Middle Tennessee."*

*"...As a practicing physician, it is often difficult to find the necessary agencies to provide specialty infusion to my patients in a timely manner. Many of my patients require drugs such as IVIG that require long infusion times and need special training to administer. Because of the lack of nursing agencies to provide this specialty infusion, many patients are forced to be hospitalized when home initiation would save time and money. Nursing agencies increasingly shy away from these types of patients for low reimbursement. This service is needed to ensure that patients are receiving adequate, accessible care."*

*"...By granting this Certificate of Need to Coram Healthcare you would make patient care in the home more accessible and affordable, reducing overall costs to the health care system."*

*"...As a Case Manager for a large hospital system, I experience delays in discharge of patients to home on a daily basis due to lack of home nursing. This delay costs our hospital thousands of dollars each day which could be avoided. I am writing in support of Coram Healthcare to receive a Certificate of Need for nursing in the state of Tennessee. If granted, Coram would be able to help facilitate early discharge of hospital patients to the home. ...Finding sufficient nursing services for many of these patients is often difficult and sometimes non-existent.... By allowing Coram Healthcare the ability to provide nursing many of these delays would be avoided thereby saving the hospital and patients money. These costs can run from $1500.00 per day and up."*

Furthermore given the uniqueness of the services proposed by the Applicant to the infusion therapy patients, even the area home health agencies acknowledge the need for and uniqueness of the patients to be served by Coram's limited service home health agency. Excerpts from a letter of support from Home Health Care of Middle Tennessee indicate the following:

*"...We support this effort as it does not compete with our available services and will enhance patient services in the region. Some of the patients who would benefit from home infusion services do not meet the requirement of Medicare/Medicaid home bound status. We would want Coram's home health agency to care for these types of patients and train these patients in self administration..."*

This home health agency is licensed in fourteen of the counties throughout Middle Tennessee where Coram would be licensed and provided more than 92,000 visits during 2011, making it one of the larger area home health agencies. Its position is not unlike other home health agencies which work with Coram and support this effort.

Please refer to Section C, Home Health Services, Item 5 for the letters of support provided by referral sources and these other knowledgeable parties in the service area.

It is clear from these letters that the appropriate home infusion nursing services required by these infusion therapy patients is not readily available throughout the Middle Tennessee service area. Existing agencies do not meet the needs of these patients, due to the fact that some of the services do not qualify for Medicare/ Medicaid provision meeting the conditions of participation; some of the services are so atypical of the reimbursement methodology associated with short term intermittent nursing treatment; and some of the nursing services are a relocation of in hospital care to the patient home to provide a more cost effective, patient oriented service.

Approving the Coram CON application for a restricted home health license will have a positive effect on the quality of care available to the area population, will improve the discharge options available to area hospitals, will enhance quality of care through more prompt and cost effective discharge of patients and will meet a demonstrated need for infusion nursing services throughout the region.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

**NEED: HOME HEALTH SERVICES**

6. ***The proposed charges shall be reasonable in comparison with those of other similar facilities in the service area or in adjoining service areas.***
   a. ***The average cost per visit by service category shall be listed.***
   b. ***The average cost per patient based upon the projected number of visits per patient shall be listed.***

The average cost per visit for the Applicant is forecasted to be $140 in 2013 dollars. This is based upon a mix of patients as described previously with some portion of the visits lasting up to six hours, or three times as long as the typical visit duration. Evaluating cost per visit based on the typical visit versus the six hour visit, the Applicant's estimated costs per visit are approximately $74 and $223, respectively.

In considering the cost per visit of home health agencies operating within the service area, the average cost for a skilled nursing visit for the agencies listed in response to Section C, Need, Question 5, per the 2011 Joint Annual Report Summary had a range of cost per skilled visit from a low of $32 to a high of $329. The simple average of the reported costs was $122 per visit in 2011. Adjusting for two years inflation to be presented in 2013 dollars increases this average to approximately $130 per visit.

This amount compares with the Applicant's cost per visit for the typical visit identified above and is slightly less when considering the six hour specialty patients.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

**NEED**

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

***(4) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, the Commission may consider, in addition to the foregoing factors, the following factors:***

***(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change the proposed new site.***

***(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.***

***(c) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.***

This CON application is for a limited service home health agency. Therefore this criterion does not apply.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

**NEED**

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

The Applicant is a licensed pharmacy and operates an ambulatory infusion suite serving Middle Tennessee. This project relates to its current and future operations in that it will enable more rapid hospital discharge and infusion therapy admission for patients who are otherwise ready to go home from the hospital except for availability of skilled infusion nursing services. The limited service home health license will enable Coram to more effectively and expeditiously meet the needs of its infusion therapy patients. On a long term basis, it will enable Coram to better contribute to the adequate and cost effective delivery of healthcare services in Middle Tennessee.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

**NEED**

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.).***

This CON application seeks approval to provide limited home health services (infusion nursing and related skilled services) from its Nashville Branch and in the following 39 Middle Tennessee counties:

| | | | |
|---|---|---|---|
| Bedford | Bledsoe | Cannon | Cheatham |
| Clay | Coffee | Cumberland | Davidson |
| DeKalb | Dickson | Franklin | Giles |
| Grundy | Hamilton | Hickman | Humphreys |
| Jackson | Lawrence | Lewis | Lincoln |
| Macon | Marion | Marshall | Maury |
| Montgomery | | Overton | Putnam |
| Rhea | Robertson | Rutherford | Sequatchie |
| Smith | Sumner | Trousdale | Wilson |
| Warren | White | Williamson | |

The geographic area represented by these counties spans from the Cookeville/Crossville area to the east of Nashville, to the Chattanooga area to the southeast, to Lawrenceburg in the southwest, north to the state line, south to the state line, northwest to the Clarksville area, northeast to the Gainesboro and Livingston area and west to the Centerville and Waverly area. A map depicting these counties relative to the State of Tennessee is included in Attachment, Section B, Project Description, Item V.

Determination of the service area was completed based on a detailed assessment of Coram's Nashville Branch Patient Records to identify the county of residence of most of its patients. The limited number of Nashville Branch's patients who did not live in this service area resided out of state or with a few in the eastern or western portions of the state. These in state residents who received initial services from the Nashville Branch were rapidly transferred to Coram's branches in Knoxville and Memphis and not served ongoing. This residency assessment was coupled with the location of the Branch's referral sources and its community liaison staff, all of which are dispersed throughout the defined 39 county service area.

Confirmation of this definition was also provided by the area hospitals and providers (physicians and home health agencies) who submitted letters of support in favor of this CON application. These letters are discussed in response to Section C, Need: Home Health Services, Question 5 and provided in that section's Attachments.

## SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:

### NEED

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

The defined service area for Coram's proposed limited service home health agency is 38 counties consolidated throughout Middle Tennessee. This service area definition was derived from an analysis of the patients currently being served by Coram's Nashville Branch and the geographic designation from which it currently receives its patient referrals for infusion therapy products. Patients who are referred from local hospitals to Coram's Nashville Branch who live outside these 38 counties will be referred to Coram's other branches (Knoxville and Memphis) in the state for services.

In the following table is the current (2012) population as estimated by the Tennessee Office of the Governor, forecasted four years from current to 2016.

| *Service Area County* | *Population* | | *Percent Change 2012-2016* |
|---|---|---|---|
| | *2012* | *2016* | |
| Bedford | 48,083 | 51,282 | 6.7% |
| Bledsoe | 13,565 | 13,886 | 2.4% |
| Cannon | 14,268 | 14,805 | 3.8% |
| Cheatham | 42,222 | 44,357 | 5.1% |
| Clay | 8,201 | 8,301 | 1.2% |
| Coffee | 54,707 | 56,774 | 3.8% |
| Cumberland | 55,798 | 57,735 | 3.5% |
| Davidson | 602,257 | 618,202 | 2.6% |
| DeKalb | 19,366 | 20,024 | 3.4% |
| Dickson | 49,744 | 51,903 | 4.3% |
| Franklin | 43,112 | 44,351 | 2.9% |
| Giles | 30,076 | 30,638 | 1.9% |
| Grundy | 14,925 | 15,212 | 1.9% |
| Hamilton | 318,632 | 322,740 | 1.3% |
| Hickman | 26,100 | 27,616 | 5.8% |
| Humphreys | 19,067 | 19,515 | 2.3% |
| Jackson | 11,419 | 11,730 | 2.7% |
| Lawrence | 42,709 | 43,918 | 2.8% |
| Lewis | 12,208 | 12,599 | 3.2% |
| Lincoln | 34,084 | 34,940 | 2.5% |
| Macon | 23,208 | 24,183 | 4.2% |
| Marion | 28,455 | 28,787 | 1.2% |
| Marshall | 30,958 | 32,304 | 4.3% |
| Maury | 84,148 | 88,120 | 4.7% |
| Montgomery | 159,209 | 167,554 | 5.2% |
| Overton | 21,377 | 21,747 | 1.7% |
| Putnam | 72,489 | 75,364 | 4.0% |
| Rhea | 31,803 | 32,809 | 3.2% |
| Robertson | 68,589 | 72,906 | 6.3% |
| Rutherford | 256,765 | 274,920 | 7.1% |
| Sequatchie | 14,042 | 14,701 | 4.7% |
| Smith | 20,104 | 20,984 | 4.4% |

| *Service Area County* | *Population* | | *Percent Change 2012-2016* |
|---|---|---|---|
| | *2012* | *2016* | |
| Sumner | 162,422 | 170,883 | 5.2% |
| Trousdale | 8,287 | 8,611 | 3.9% |
| Warren | 42,263 | 43,792 | 3.6% |
| White | 25,521 | 26,236 | 2.8% |
| Williamson | 184,323 | 200,247 | 8.6% |
| Wilson | 114,437 | 121,203 | 5.9% |
| Total | 2,808,943 | 2,925,879 | 4.2% |

*Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics, 2008 Revision. Per Health Statistics, this is the most updated population published by the State as of the CON submission date and to be used in this CON application dated May 2012.*

The defined service area currently has 2.8 million persons which are estimated to increase by 4.2 percent to 2.9 million within the next four years. While the increase is notable, this application is based on the demonstrated needs of the existing population for whom Coram has identified a gap in service and an access problem related to infusion nursing visits in the home. Coram's patients are quantified within the existing population of the counties identified above; the identified problem will only be exacerbated without the approval of this CON application.

While traditional Medicare certified home health agencies primarily service the elderly, this will not be the case with Coram's services as proposed via this CON application. In fact, analysis of the Coram Nashville Branch infusion patients, who will become its skilled nursing patients, for the past three years indicate the following age dispersion:

| *Age Group* | *CY 2009* | *CY 2010* | *CY 2011* |
|---|---|---|---|
| Under Age 18 | 4.4% | 4.7% | 4.5% |
| 18 to 64 | 66.6% | 68.0% | 65.8% |
| 65 to 74 | 16.7% | 17.0% | 17.0% |
| 75 and Older | 12.3% | 10.3% | 12.7% |
| Total | 100.0% | 100.0% | 100.0% |
| | | | |
| Percent Under Age 65 | 71.0% | 72.7% | 70.3% |
| Percent 65 and Older | 29.0% | 27.3% | 29.7% |

*Source: Coram Alternate Site Services, Inc. Nashville Branch Patient Records and analysis.*

In contrast with the average Medicare certified home health agency, actual age dispersion of patients obtained from the 2011 Joint Annual Report Summary indicates statewide that more than 71 percent of patients are older than age 65 (versus less than 30 percent above). More dramatic is the age distribution of the elderly. Statewide, the 75 and older home health services population accounts for nearly 50 percent of all patients; the same statistic is representative of the agencies reporting from the 38 county Coram defined service area. In contrast, only about 12 percent of Coram's patients in its Nashville Branch are 75 years of ago or older.

The patient to be served by Coram's home health infusion nursing service will be primarily under the age of 65. Furthermore, these patients will be either privately insured, self pay or uncompensated. In fact, it is not Coram's intent to obtain Medicare certification for its home health services. Rather it will rely on the available Medicare home health agencies in Middle Tennessee to meet that client's needs, unless otherwise requested. To demonstrate the difference in patient population, actual visits by payor was obtained from the 2011 Joint Annual Report Summary. This indicates that Statewide 80 percent of the home health agency visits were for Medicare and Medicare HMO clients. Within the 38 county service area and its reporting agencies, this percent is also 80 percent of visits provided to Medicare/Medicare HMO patients. This will contrast with the service proposed via this CON application which will provide no Medicare home health visits.

2012 MAR 31 PM 4:16

The service proposed to be provided by Coram is strictly limited to skilled nursing visits and specifically infusion related. Again, in analyzing the existing licensed home health agencies Statewide, fifty eight percent of those agencies' visits were not skilled nursing visits; just 42 percent were skilled nursing visits. Breakdown by type of skilled visits is not available. However, based on the Applicant's identification of difficulty accessing home infusion nursing support, it is likely that infusion nursing only comprises a very small portion of the 42 percent skilled visits. In contrast to available home health agencies, Coram will be different. It will be 100 percent skilled and of the skilled it will be 100 percent infusion nursing and related services.

As demonstrated above, the age profile, payor profile and needs of the Coram infusion nursing patient will differ dramatically from the patient served by the existing home health agencies within the 39 county service area and Statewide.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

**NEED**

***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.***

The population to be served by Coram via this CON application is unique in contrast to other home health agencies. The patient profile is derived from Coram's existing patient profile as those are the persons who will receive infusion nursing services in the home. As noted previously, Coram estimates approximately 17 percent of its ongoing census will have a need for infusion nursing services provided by Coram. These patients are specialized with special needs. They include patients with compromised immune system or auto immune disorders, transplant patients, congestive heart failure patients, patients who can not consume nutrition or food via regular intake, hemophiliacs or patients with other blood clotting disorders, patients with progressive emphysema, among others.

The specialized needs of these patients can be met via Coram's provision of infusion therapy products in the home, supported by Coram's proposed infusion nursing services which will include patient/family education for self administration. Benefits of home infusion depending on the patient include, but are not limited to, the following:

- Earlier hospital discharge, or hospital avoidance
- Positive outcomes
- Multiple drug therapies managed by experience clinicians in the home
- First dosing protocols in the home
- PICC line and IV access management
- Trended lab results
- Therapeutic drug monitoring and pharmacokinetic drug dosing
- Education materials which include pictures and written step by step instructions
- Personalized training by nurse clinicians
- Nursing visits to reassess techniques and reinforcement training as needed
- 24-hour access to Coram clinicians
- Patient service representative to act as the patient's liaison

Relative to the patient profile, Coram expects that five percent of its patients will be medically indigent with Coram providing the nursing service free of charge (charity care), other persons will not be able to afford their treatment but not considered charity care and the balance covered by either self pay or third party payor. The majority of the patients will be under the age of 65, many of whom are still working and therefore can not afford to not receive in home services and self administration education.

## SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:

### 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.***

Coram Alternate Site Services, Inc. proposes to become a restricted license home health service, and under this license only provide infusion nursing and related services in the patient home. This is unique in contrast with the Medicare certified home health agencies available in Middle Tennessee. Uniqueness is attributable to the following factors: (1) restricted license to only provide infusion nursing and related services; (2) not Medicare or Medicaid certified; (3) patients primarily under the age of 65; (4) patient may not be home bound but the service is more appropriate in the home (due to cost, compromised immune system, accessibility, education/training, etc.); (5) without availability of Coram's services, many patients remain in the hospital unnecessarily; (6) Coram's certified nurse infusion professionals; (7) Coram's education and training of Medicare certified agencies to assume the patient population when appropriate; (8) Coram's first dose policy/protocol; among others.

While this proposal is unique and therefore not directly competitive with existing licensed home agencies in the Service Area, in accordance with information requested in this question, the following table provides the names and utilization (visits) for home health agencies listed in the Joint Annual Report Summary as being existent in one of the 39 counties defined as the Coram Alternate Site Services Service Area:

| *Licensed Agency* | *Listed County* | *2009* | *2010* | *2011* |
|---|---|---|---|---|
| Heritage Home Health | Bedford | 6,291 | 6,198 | 5,240 |
| Cumberland River Homecare | Clay | 7,692 | 9,638 | 9,267 |
| Doctor's Associates Home Health | Coffee | 18,641 | 31,387 | 22,309 |
| Medical Home Health Care | Coffee | 41,031 | 26,823 | 39,467 |
| C.M.C. Home Care | Cumberland | 10,564 | 12,485 | 10,799 |
| Alere Women's and Children's Health LLC | Davidson | 610 | 349 | 888 |
| Amedisys Home Care | Davidson | 96,819 | 108,136 | 102,456 |
| Amedisys Home Health | Davidson | 32,382 | 38,725 | 41,170 |
| Amedisys of Nashville East | Davidson | 13,967 | 18,730 | 22,624 |
| Continuous Care Services, LLC | Davidson | 26,315 | 22,316 | 21,210 |
| Elk Valley Health Services, Inc. | Davidson | 0 | 54 | 5,227 |
| Friendship Home Healthcare, Inc. | Davidson | 28,114 | 24,484 | 23,498 |
| Friendship Private Duty, Inc. | Davidson | n/r | 314 | 288 |
| Gentiva Health Services | Davidson | 41,370 | 34,552 | 31,320 |
| Home Care Solutions | Davidson | 79,620 | 80,565 | n/r |
| Home Health Care of Middle Tennessee | Davidson | 69,056 | 86,360 | 92,154 |

| *Licensed Agency* | *Listed County* | *2009* | *2010* | *2011* |
|---|---|---|---|---|
| Innovative Senior Care Home Health | Davidson | n/r | n/r | 1,222 |
| Intrepid USA Healthcare Services | Davidson | 10,194 | 10,749 | 16,477 |
| Maxim Healthcare Services, Inc. | Davidson | 56 | 1,211 | 8,337 |
| Premiere Home Health, Inc. | Davidson | 1,973 | 2,524 | 3,950 |
| Suncrest Home Health | Davidson | 94,836 | 154,364 | 182,177 |
| US Bioservices | Davidson | 497 | n/r | n/r |
| Vanderbilt Community and Home Services | Davidson | 10,447 | 9,352 | 8,754 |
| Vanderbilt Home Care Services | Davidson | 20,730 | 25,240 | 21,140 |
| Willowbrook Home Health Care Agency, Inc. | Davidson | 56,853 | 61,744 | 57,255 |
| SunCrest Home Health | DeKalb | 16,908 | 35,666 | 55,373 |
| Amedisys Home Care | Franklin | 31,358 | 31,516 | 27,448 |
| Caresouth HHA Holdings of Winchester LLC | Franklin | 20,573 | 26,240 | 27,345 |
| Alere Women's and Children's Health LLC | Hamilton | 39 | 6 | 92 |
| Amedisys Home Health | Hamilton | 78,960 | 92,515 | 102,650 |
| Continucare Healthservices Inc – I | Hamilton | 24,011 | 21,674 | 17,922 |
| Continucare Healthservices Inc – II | Hamilton | 186 | 324 | 252 |
| Family Home Care | Hamilton | 5,129 | n/r | n/r |
| Gentiva Health Services | Hamilton | 8,149 | 12,328 | 13,994 |
| Guardian Home Care LLC | Hamilton | 73,305 | 97,800 | 82,144 |
| Home Care of Chattanooga | Hamilton | n/r | 5,097 | 6,377 |
| Home Care Solutions | Hamilton | 10,738 | 21,921 | n/r |
| Life Care at Home of Tennessee | Hamilton | 19,452 | 18,699 | 28,693 |
| Maxim Healthcare Services | Hamilton | 608 | 967 | 461 |
| Memorial Hospital Home Health | Hamilton | 52,290 | 58,854 | 55,856 |
| NHC Homecare | Hamilton | 8,497 | 5,950 | 4,219 |
| Hickman Community Home Care Inc. | Hickman | 2,836 | 2,651 | 2,598 |
| Deaconess Homecare (fka Elk Valley) | Lincoln | 14,176 | 15,934 | 17,798 |
| Hospital Home Health and Hospice | Lincoln | 6,359 | 5,462 | 5,226 |
| CareAll Homecare Services | Maury | 15,323 | 14,896 | 9,976 |
| Maury Regional Home Services | Maury | 16,761 | 18,922 | 21,122 |
| NHC Homecare | Maury | 80,911 | 82,678 | 73,904 |
| Quality First Home Care | Maury | 18,612 | 24,188 | 141,396 |
| A-Certive Home Health Care | Montgomery | 10,928 | n/r | n/r |
| Gateway Home Health, Clarksville | Montgomery | 16,584 | 14,772 | 17,564 |
| Suncrest Home Health of Nashville | Montgomery | n/r | n/r | 3,529 |
| Amedisys | Overton | 37,191 | 40,623 | 43,496 |
| Highland Rim Home Health Agency | Putnam | 19,915 | 17,207 | 16,398 |
| Intrepid USA Healthcare Services | Putnam | 12,497 | 13,607 | 10,866 |
| Lifeline Home Health Care | Robertson | 10,898 | 12,971 | 13,656 |
| NHC Homecare | Robertson | 20,109 | 24,629 | 22,372 |
| Amedisys Home Health | Rutherford | 17,709 | 18,999 | 16,236 |
| Amedisys Home Health Care | Rutherford | 32,177 | 51,104 | 60,105 |
| NHC Homecare | Rutherford | 90,981 | 100,034 | 96,162 |
| Sumner Homecare and Hospice LLC | Smith | 10,269 | 10,268 | 8,076 |
| Sumner Homecare and Hospice LLC | Sumner | 26,096 | 22,994 | 15,589 |
| CareAll Home Care Services | Warren | 29,283 | 33,833 | 16,066 |
| Friendship Home Health Inc. | Warren | 12,174 | 46,777 | 29,432 |
| Intrepid USA Healthcare Services | Warren | 24,387 | 18,667 | 19,336 |
| Guardian Home Care of Nashville LLC | Williamson | 24,119 | 39,209 | 43,006 |
| Home Health Care Services LLC | Williamson | 1,300 | 1,344 | 1,492 |
| Walgreens-Optioncare Inc. | Williamson | 180 | n/r | 101 |
| CareAll | Wilson | 69,239 | 68,430 | 80,438 |

| *Licensed Agency* | *Listed County* | *2009* | *2010* | *2011* |
|---|---|---|---|---|
| Deaconess Homecare (fka Elk Valley) | Wilson | 18,654 | 20,363 | 29,251 |
| Donelson Home Health | Wilson | 53,863 | 49,872 | 44,527 |
| Quality Care Home Health Agency | Wilson | 414 | 3,900 | 6,738 |

*Source: Joint Annual Report Summary for 2009, 2010 and 2011, published by the State of Tennessee.*
*n/r = not reported or listed in the report.*

As noted, while these agencies are listed, their patients are 80 percent Medicare/Medicare HMO, which Coram will not serve. They are 58 percent non-skilled or therapy visits, which Coram will not serve. They are 42 percent skilled visits of which only a small fraction if any at all are infusion type patients. Furthermore, area home health agencies have voiced support for Coram's proposal as non-competitive and appropriate for the community at large.

## SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:

### NEED

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.***

Following is the most recent three year infusion therapy product activity for the Applicant's Nashville Branch licensed pharmacy:

| *Factor* | *CY 2009* | *CY 2010* | *CY 2011* |
|---|---|---|---|
| Unduplicated Infusion Therapy Patients | 1,028 | 958 | 1,288 |
| Duplicated Patients/Unduplicated Therapies | 1,213 | 1,117 | 1,545 |
| Infusion Therapy Patient Months | 1,921 | 1,869 | 2,554 |
| Average Monthly Census | 160 | 156 | 213 |

The above patients represent the number of patients who received infusion products from Coram's Nashville Branch (licensed pharmacy) during the past three calendar years. The average length of stay (therapy product duration) of the infusion patients is approximately two months.

In the following table is the two forecasted years for the infusion product patients following completion of the project, which will be calendar years 2013 and 2014. Calendar year 2012, the current year and prior to home health licensure, is also provided for information only. The infusion nursing patients to be treated by the home health agency upon licensure are a subset of the infusion therapy patients budgeted for calendar years 2013 and 2014 in this table. The forecasted skilled nursing patients and visits and the supporting methodology follow the table.

| | *Before Project* | *After Project Completion* | |
|---|---|---|---|
| *Factor* | *CY 2012* | *CY 2013* | *CY 2014* |
| Unduplicated Infusion Therapy Patients | 1,347 | 1,435 | 1,528 |
| Duplicated Patients/Unduplicated Therapies | 1,616 | 1,721 | 1,833 |
| Infusion Therapy Patient Months | 2,668 | 2,841 | 3,026 |
| Average Monthly Census | 222 | 237 | 252 |

To estimate the number of infusion nursing patients and their related skilled visits for the forecast period, the Applicant considered the types of infusion therapy products which comprise the patient therapies and the average monthly census in the above table as well as the hardship the Applicant has encountered in various situations throughout Middle Tennessee in obtaining qualified infusion nursing services from other third parties. This affected the analysis because Coram is not intending on competing with existing

available services but rather responding to a community need based on the gap in service which equates to a lack of availability or accessibility of infusion nursing services.

As noted previously, there are primary differences between two types of Coram patients. One is the more typical infusion therapy patient receiving antibiotics, TPN, pain management, cardiac and the like; the other is the specialty patient receiving immunoglobin or alpha 1 therapies. The former therapies comprise 92 percent of Coram's census; the specialty patients comprise 8 percent of the patient census. In terms of estimated requirement for infusion nursing services, it is estimated that 100 percent of the specialty patients will require the service each month. The reason for such high utilization is these patient infusions last up to 6 hours per treatment. As such, the more traditional home health agency providing intermittent services is not generally staffed for nor compensated for under Medicare guidelines such long nursing visits. Ongoing, Coram has significant challenges to find nursing services for these patients resulting in these patients remaining in the hospital for an unnecessary prolonged period, having the patient travel to his/her physician office for Coram to meet the patient in that setting or having the patient travel to another licensed location – all creating hardship on the patient and family.

For the balance of Coram's therapy patients, it is estimated that 10 percent of those patients will require infusion nursing provided by Coram's home health agency. Similarly, this patient estimate is based on the Applicant's assessment of its patient case load and the challenges it regularly faces in admitting a patient to the pharmacy service that can not obtain at home support to initiate the infusion therapy. Depending on the therapy, each patient will receive between two and four visits per month.

Extrapolating the above utilization assumptions and applying them to the estimated monthly census of infusion therapy patients results in a computed approximate 17 percent of Coram's pharmacy patients requiring skilled nursing services be provided by Coram. In the following table are the total number of home health patients and visits for each of the first two forecast years:

| *Factor* | *CY 2013* | *CY 2014* |
|---|---|---|
| Number of Home Health Patients | 247 | 263 |
| | | |
| *Skilled Home Health Visits by Infusion Therapy Type* | | |
| Antibiotic Therapy | 667 | 701 |
| Total Parenteral Nutrition Therapy | 77 | 81 |
| Pain Management | 14 | 15 |
| Cardiac Treatment | 22 | 23 |
| IVIG | 132 | 139 |
| Alpha 1 | 108 | 113 |
| Viva | 65 | 68 |
| Antiemetic | 18 | 19 |
| Other | 89 | 93 |
| Total Annual Skilled Nursing Visits | 1,192 | 1,252 |

As noted in the above table, the forecasted patients in years one and two are 247 and 263, respectively. Visits total 1,192 in year one and 1,252 in year two. This results in an average of 4.8 visits per patient. This is yet another differentiating factor between the Medicare certified home health agency and the Coram proposed restricted service agency.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### 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; <u>documentation must be</u> provided from a contractor and/or architect that support the estimated construction costs.***

The Project Cost Chart is provided on the following page. Assumptions supporting each of the line items immediately follow the chart.

# PROJECT COST CHART

2012 MAY 14 PM 1:49

| | | | |
|---|---|---|---|
| A | Construction and equipment acquired by purchase: | | |
| 1 | Architectural and Engineering Fees | | $0 |
| 2 | Legal, Administrative (Excluding CON Fee), Consultants Fee | | $60,000 |
| 3 | Acquisition of Site | | $0 |
| 4 | Preparation of Site | | $0 |
| 5 | Construction Costs | | $0 |
| 6 | Contingency Fund | | $0 |
| 7 | Fixed Equipment (not in Construction Contract) | | $0 |
| 8 | Moveable Equipment (List all equipment over $50,000) | | $0 |
| 9 | Other (Specify) | | $0 |
| B | Construction and equipment acquired by purchase: | | |
| 1 | Facility (inclusive of land and building) | | $0 |
| 2 | Building Only | | $0 |
| 3 | Land Only | | $0 |
| 4 | Equipment (Specify) | | $0 |
| 5 | Other (Specify) | | $0 |
| C | Financing Costs and Fees | | |
| 1 | Interim Financing | | $0 |
| 2 | Underwriting Costs | | $0 |
| 3 | Reserve of One Year's Debt Service | | $0 |
| 4 | Other (Specify) | | $0 |
| D | Estimated Project Cost (A+B+C) | | $60,000 |
| E | CON Filing Fee | | $3,000 |
| F | Total Estimated Project Cost (D+E) | **TOTAL** | $63,000 |

## Project Cost Chart, Underlying Assumptions

The underlying assumptions for the Project Cost Chart on the preceding pages are summarized in the following paragraphs.

- Line A 1, Architectural and Engineering Fees: Not applicable as there is no design and construction involved in this project.
- Line A 2, Legal, Administrative, Consultants Fee: These costs represent legal, administrative and consulting associated with preparing and filing the CON application including a contingency for such costs and the home health license application fee of $1,080. There are no pre-opening costs as the existing operations have the infrastructure necessary to add the limited home health services without the additional of any support personnel or additional physical space.
- Line A 3, Acquisition of Site: Not applicable as the service will be incorporated into the existing leased space at 2970 Sidco Drive, Nashville, TN 37204.
- Line A 4, Preparation of Site: Not applicable as there is no design and construction involved in this project.
- Line A 5, Construction Costs: Not applicable as there is no design and construction involved in this project.
- Line A 6, Contingency: Not applicable as there is no design and construction involved in this project.
- Line A 7, Fixed Equipment: Not applicable as there is no design and construction involved in this project.
- Line A 8, Moveable Equipment: Not applicable as there is no addition of infrastructure to house the nurses and the infusion equipment is already owned by Coram and housed at its offices.
- Line A 9, Other: Not applicable.
- Line B 1 through 5: This is not applicable.
- Line C 1 through 4: This is not applicable as the costs of implementing the program are being funded from cash reserves.
- Line D: This is the subtotal of A, B and C above.
- Line E: This is the applicable CON application fee payable to the State of Tennessee.
- Line F: This is total project costs.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

***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

☒ E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

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

The project proposed by the Applicant will be funded from cash reserves. As demonstrated in the Historical Data Chart, the Applicant generates more than sufficient Net Operating Income to fund the minimal costs associated with establishing the limited service home health agency. Additionally, Robert Holcombe, Executive Vice President, General Counsel and Secretary, for the Applicant's ultimate parent has provided a letter indicating the project will be funded from cash reserves. This is provided in Attachment, Section C, Economic Feasibility, Item 2. Included within Attachment, Section A, Item 4.2 is the Applicant's ultimate parent's audited financial statements which clearly demonstrate adequate funding available for the project as proposed.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

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.***

The project costs for the proposed limited service home health agency are restricted to Line A 2, legal, administrative and consulting fees and Line E, the CON application fee. The existing infrastructure of the licensed pharmacy and ambulatory infusion suite located at 2970 Sidco Drive, Nashville, Tennessee will also house the home health agency. There is no construction, renovation, expansion or additional resources required to add this service as the space is fully functioning and has the management and support personnel to assume responsibility for the home health agency services.

Administrative, legal and consulting fees are based on costs incurred to prepare the CON application, anticipated costs to be incurred up through the HSDA hearing on this matter and the home health licensing fee, along with some contingency. The CON application fee is based on the minimum filing fee established by the HSDA of $3,000. Combined, total project costs are $63,000.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

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).***

The Historical Data Chart for the Existing Operation of Coram Alternate Site Services, Inc. is included on the following page. The three most recent years of operation are calendar years 2009, 2010 and 2011. This chart presents the existing utilization and financial information for the licensed pharmacy operation discussed herein as the Nashville Branch. As shown on the Historical Data Chart, the Nashville Branch generates positive net income sufficient to support the implementation of the home health service proposed via this CON application.

Following the Historical Data Chart is the Projected Data Chart. This chart provides the utilization and financial information for calendar years 2013 and 2014, the first two full years of operation of the new service. As instructed the Projected Data Chart included herein on page 61 presents only the proposed new service – the limited service home health agency. Immediately following the Projected Data Chart is a list of the assumptions supporting the projection.

The forecasted utilization and financial performance of the existing licensed pharmacy operation (without the home health agency) is provided as an addendum to this application and included in Attachment, Section C, Economic Feasibility, Item 4.

SUPPLEMENTAL

## HISTORICAL DATA CHART - EXISTING NASHVILLE OPERATIONS

2012 MAY 31 PM 4:15

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in: January (month)

| Year | | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| A Utilization Data | Patients — Infusion Patients | 1,028 | 958 | 1,288 |
| | Patient Months — Infusion Pt Months | 1,921 | 1,869 | 2,554 |
| | Nursing Visits — Home Health RN Visits | 0 | 0 | 0 |
| B Revenue from Services to Patients | | | | |
| 1 Inpatient Services | | | | |
| 2 Outpatient Services | | $4,957,333 | $6,154,111 | $8,259,575 |
| 3 Emergency Services | | | | |
| 4 Other Operating Revenue | | | | |
| Gross Operating Revenue | | $4,957,333 | $6,154,111 | $8,259,575 |
| C Deductions from Gross Operating Revenue | | | | |
| 1 Contractual Adjustments | | | | |
| 2 Provsion for Charity Care | | $236,063 | $283,053 | $393,313 |
| 3 Provisions for Bad Debt | | $226,346 | $64,789 | $191,877 |
| Total Deductions | | $462,409 | $228,264 | $201,437 |
| NET OPERATING REVENUE | | $4,494,923 | $5,925,847 | $8,058,139 |
| D Operating Expenses | | | | |
| 1 Salaries and Wages | | $1,003,170 | $1,042,416 | $1,364,299 |
| Benefits | | $194,250 | $171,176 | $236,163 |
| 2 Physician Salaries and Wages | | $0 | $0 | $0 |
| 3 Supplies | | $13,839 | $24,936 | $43,985 |
| 4 Taxes | | $1,000 | $1,000 | $1,000 |
| 5 Depreciation | | $24,753 | $19,109 | $35,955 |
| 6 Rent | | $66,589 | $72,648 | $135,016 |
| 7 Interest, Other than Capital | | $0 | $0 | $0 |
| 8 Management Fees: | | | | |
| a. Fees to Affiliates | | $0 | $0 | $0 |
| b. Fees to Non-Affiliates | | $0 | $0 | $0 |
| 9 Other Expenses - Specify on Separate Page | | $2,085,929 | $2,642,612 | $4,014,586 |
| Total Operating Expenses | | $3,392,530 | $4,167,897 | $5,930,402 |
| E Other Revenue (Expenses - Net (Specify) | | | | |
| NET OPERATING INCOME (LOSS) | | $1,102,393 | $1,757,951 | $2,127,736 |
| F Capital Expenditures | | | | |
| 1 Retirement of Principal | | | | |
| 2 Interest | | | | |
| Total Capital Expenditures | | $0 | $0 | $0 |
| NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES | | $1,102,393 | $1,757,951 | $2,127,736 |

60R

SUPPLEMENTAL

HISTORICAL DATA CHART - OTHER EXPENSES

| OTHER EXPENSE CATEGORIES | | | | |
|---|---|---|---|---|
| 1 | Drugs/Materials | $1,876,923 | $2,508,131 | $3,687,703 |
| 2 | Shipping/Delivery | $119,064 | $105,468 | $192,756 |
| 3 | Travel/Lodging | $21,556 | $128,793 | $121,010 |
| | Operational Costs: Utilities, Telephone, Professional Fees, and | | | |
| 4 | Other Adminstrative Costs | $68,387 | $100,220 | $113,116 |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| | Total Other Expenses | $2,085,929 | $2,842,612 | $4,114,585 |

SUPPLEMENTAL

## PROJECTED DATA CHART -- EXISTING NASHVILLE OPERATIONS

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

2012 MAY 31 PM 4: 15

| Year | | 2012 BUDGET BEFORE PROJECT 2012 | 2013 | 2014 |
|---|---|---|---|---|
| A Utilization Data | Patients — Infusion Patients | 1,347 | 1,435 | 1,528 |
| | Patient Months — Infusion Pt Months | 2,668 | 2,841 | 3,026 |
| | Patients — Home Health Patients | 0 | 0 | 0 |
| | Nursing Visits — Home Health RN Visits | 0 | 0 | 0 |
| B Revenue from Services to Patients | | | | |
| 1 Inpatient Services | | | | |
| 2 Outpatient Services | | $9,003,373 | $9,903,710 | $10,894,081 |
| 3 Emergency Services | | | | |
| 4 Other Operating Revenue | | | | |
| Gross Operating Revenue | | $9,003,373 | $9,903,710 | $10,894,081 |
| C Deductions from Gross Operating Revenue | | | | |
| 1 Contractual Adjustments | | | | |
| 2 Provsion for Charity Care | | $428,732 | $471,605 | $518,766 |
| 3 Provisions for Bad Debt | | $257,239 | $282,963 | $311,259 |
| Total Deductions | | $685,971 | $754,568 | $830,025 |
| NET OPERATING REVENUE | | $8,317,402 | $9,149,142 | $10,064,056 |
| D Operating Expenses | | | | |
| 1 Salaries and Wages | | $1,525,468 | $1,601,742 | $1,681,829 |
| Benefits | | $244,501 | $256,726 | $269,562 |
| 2 Physician Salaries and Wages | | $0 | $0 | $0 |
| 3 Supplies | | $50,025 | $52,526 | $55,152 |
| 4 Taxes | | $1,050 | $1,103 | $1,158 |
| 5 Depreciation | | $55,784 | $58,573 | $61,601 |
| 6 Rent | | $147,407 | $154,777 | $162,516 |
| 7 Interest, Other than Capital | | $0 | $0 | $0 |
| 8 Management Fees: | | | | |
| a. Fees to Affiliates | | $0 | $0 | $0 |
| b. Fees to Non-Affiliates | | $0 | $0 | $0 |
| P Other Expenses Specify in chart | | $4,516,318 | $4,807,186 | $5,112,597 |
| Total Operating Expenses | | $6,540,552 | $6,932,631 | $7,344,814 |
| E Other Revenue (Expenses - Net (Specify) | | | | |
| NET OPERATING INCOME (LOSS) | | $1,776,850 | $2,216,511 | $2,719,742 |
| F Capital Expenditures | | | | |
| 1 Retirement of Principal | | | | |
| 2 Interest | | | | |
| Total Capital Expenditures | | $0 | $0 | $0 |
| NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES | | $1,776,850 | $2,216,511 | $2,719,742 |

PROJECTED DATA CHART - OTHER EXPENSES

| OTHER EXPENSE CATEGORIES | | | | |
|---|---|---|---|---|
| 1 | Drugs/Materials | $4,037,281 | $4,239,145 | $4,451,102 |
| 2 | Shipping/Delivery | $214,553 | $225,280 | $236,544 |
| 3 | Travel/Lodging | $134,116 | $140,822 | $147,863 |
| 4 | Operational Costs: Utilities, Telephone, Professional Fees, and Other Adminstrative Costs | $130,368 | $201,938 | $277,087 |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| | Total Other Expenses | $4,516,318 | $4,807,186 | $5,112,597 |

SUPPLEMENTAL

## PROJECTED DATA CHART -- NEW BUSINESS LINE - HOME HEALTH/NURSING VISITS

2012 MAY 31 PM 4:15

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

| Year | | 2013 | 2014 |
|---|---|---|---|
| A Utilization Data | Home Health Patients: Home Health Patients | 247 | 263 |
| | Nursing Visits: Home Health RN Visits | 1,192 | 1,252 |
| B Revenue from Services to Patients | | | |
| 1 Inpatient Services | | | |
| 2 Outpatient Services | | $212,436 | $234,211 |
| 3 Emergency Services | | | |
| 4 Other Operating Revenue | | | |
| Gross Operating Revenue | | $212,436 | $234,211 |
| C Deductions from Gross Operating Revenue | | | |
| 1 Contractual Adjustments | | $10,116 | $11,153 |
| 2 Provision for Charity Care | | $10,116 | $11,153 |
| 3 Provisions for Bad Debt | | $6,070 | $6,692 |
| Total Deductions | | $26,302 | $28,997 |
| NET OPERATING REVENUE | | $186,134 | $205,213 |
| D Operating Expenses | | | |
| 1 Salaries and Wages | | $118,864 | $126,910 |
| Benefits | | $17,680 | $18,122 |
| 2 Physician Salaries and Wages | | $0 | $0 |
| 3 Supplies (Mileage) | | $30,676 | $32,105 |
| 4 Taxes | | $26 | $27 |
| 5 Depreciation | | $0 | $0 |
| 6 Rent | | $0 | $0 |
| 7 Interest, Other than Capital | | $0 | $0 |
| 8 Management Fees: | | | |
| a. Fees to Affiliates | | $0 | $0 |
| b. Fees to Non-Affiliates | | $0 | $0 |
| 9 Other Expenses - Specify on separate page | | $0 | $0 |
| Total Operating Expenses | | $167,146 | $177,164 |
| E Other Revenue (Expenses - Net (Specify) | | $0 | $0 |
| NET OPERATING INCOME (LOSS) | | $18,989 | $28,050 |
| F Capital Expenditures | | | |
| 1 Retirement of Principal | | $0 | $0 |
| 2 Interest | | $0 | $0 |
| Total Capital Expenditures | | $0 | $0 |
| NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES | | $18,989 | $28,050 |

61R

SUPPLEMENTAL

PROJECTED DATA CHART - OTHER EXPENSES

| OTHER EXPENSE CATEGORIES | 2013 | 2014 |
|---|---|---|
| 1 | $0 | $0 |
| 2 | $0 | $0 |
| 3 | $0 | $0 |
| 4 | $0 | $0 |
| 5 | $0 | $0 |
| 6 | $0 | $0 |
| 7 | $0 | $0 |
| Total Other Expenses | $0 | $0 |

SUPPLEMENTAL

## PROJECTED DATA CHART -- CONSOLIDATED NASHVILLE OPERATIONS

2012 MAY 31 PM 4: 15

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

| Year | | | 2013 | 2014 |
|---|---|---|---|---|
| A Utilization Data | Patients | Infusion Patients | 1,435 | 1,528 |
| | Patient Months | Infusion Pt Months | 2,841 | 3,026 |
| | Patients | Home Health Patients (subset) | 247 | 263 |
| | Nursing Visits | Home Health RN Visits | 1,192 | 1,252 |
| B Revenue from Services to Patients | | | | |
| 1 Inpatient Services | | | | |
| 2 Outpatient Services | | | $10,116,146 | $11,128,292 |
| 3 Emergency Services | | | | |
| 4 Other Operating Revenue | | | | |
| Gross Operating Revenue | | | $10,116,146 | $11,128,292 |
| C Deductions from Gross Operating Revenue | | | | |
| 1 Contractual Adjustments | | | $10,116 | $11,153 |
| 2 Provsion for Charity Care | | | $481,721 | $529,919 |
| 3 Provisions for Bad Debt | | | $289,033 | $317,951 |
| Total Deductions | | | $780,870 | $859,023 |
| NET OPERATING REVENUE | | | $9,335,276 | $10,269,270 |
| D Operating Expenses | | | | |
| 1 Salaries and Wages | | | $1,720,606 | $1,808,738 |
| Benefits | | | $274,406 | $287,684 |
| 2 Physician Salaries and Wages | | | $0 | $0 |
| 3 Supplies and Mileage | | | $83,102 | $87,257 |
| 4 Taxes | | | $1,128 | $1,185 |
| 5 Depreciation | | | $58,573 | $61,501 |
| 6 Rent | | | $154,777 | $162,516 |
| 7 Interest, Other than Capital | | | $0 | $0 |
| 8 Management Fees: | | | | |
| a. Fees to Affiliates | | | $0 | $0 |
| b. Fees to Non-Affiliates | | | $0 | $0 |
| 9 Other Expenses | | | $4,807,186 | $5,112,597 |
| Total Operating Expenses | | | $7,099,777 | $7,620,478 |
| E Other Revenue (Expenses - Net (Specify) | | | $0 | $0 |
| NET OPERATING INCOME (LOSS) | | | $2,235,500 | $2,747,792 |
| F Capital Expenditures | | | | |
| 1 Retirement of Principal | | | $0 | $0 |
| 2 Interest | | | $0 | $0 |
| Total Capital Expenditures | | | $0 | $0 |
| NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES | | | $2,235,500 | $2,747,792 |

**Projected Data Chart, Underlying Assumptions**

The underlying assumptions for the Projected Data Chart on the preceding page are summarized in the following paragraphs.

- Utilization: Line A is utilization information based on the analysis presented herein.

- Gross Revenues: Line B 2 is forecasted outpatient revenues as discussed in responses to the Economic Feasibility questions herein; these charges are based on Coram's self pay charge structure it has established nationally for home health skilled nursing visits in 2012 and inflated by five percent to represent 2013 dollars.

- Contractual Adjustments: Line C 1 represents deductions from Gross Revenues based on the anticipated contractual rates for services with third party payors and private parties; because gross charges are established herein based on Coram's self pay charge structure inflated to 2013, contractual adjustments reflect 4.8 percent of gross charges, not including charity care and bad debt.

- Provisions for Charity Care: Line C 2 represents anticipated charity care which equates to five percent of net patient revenues (Gross Revenues less Contractual Adjustments).

- Provisions for Bad Debt: Line C 3 represents anticipated bad debt which equates to three percent of net patient revenues (Gross Revenues less Contractual Adjustments).

- Operating Expense: Line D 1 represents salaries per the staffing schedule provided in response to Section C, Orderly Development of Health Care, Question 3. This is strictly registered nurse personnel for the new program as incremental staff. It is expected that there will be one full time employee and the balance of the nurse requirements will be provided by Coram's pool nurses on an hourly basis. Line D 2 represents the estimated benefits for the full time registered nurse at 25 percent of the respective salary. The pool/per diem nurses do not receive benefits. Line D 3 is the supply line item. This represents mileage reimbursement assuming an average mileage reimbursement of 40 miles per visit at 52.5 cents reimbursement per mile. Regarding taxes, the Applicant's financial performance is rolled up into the company financials. Because the company overall has carry forward losses, it pays no federal taxes or excise taxes at this time. Regarding franchise taxes, those are included for the branch overall in the existing business chart. As a result of operating the home health agency in the existing pharmacy, the Applicant does not anticipate any material taxes payable yet proportionately has added taxes consistent with what it currently pays for the existing operation.

- Net Operating Income: Both years reflect a positive net operating income which demonstrates this project is financially feasible.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

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

The following table provides the average gross charge derived from the Applicant's self pay charge structure it uses nationally for home health skilled nursing visits in 2012, inflated five percent to represent 2013 dollars, average deduction and net revenue per visit for each of the two forecasted years of operation. Also included is number of visits and resulting average net revenue per visit:

| Projected Data Chart | Year One | Year Two |
|---|---|---|
| Gross Charges | $212,436 | $234,211 |
| Deductions | $10,116 | $11,153 |
| Net Revenue | $202,320 | $223,058 |
| | | |
| Visits | 1,192 | 1,252 |
| | | |
| Average Net Revenue / Visit | $170 | $178 |

The above table does not consider the budgeted charity care and bad debt, accordingly these additional revenue deductions are identified in the following table along with the resulting impact on the average net revenue per visit:

| Projected Data Chart | Year One | Year Two |
|---|---|---|
| Net Revenue | $202,320 | $223,058 |
| Charity | ($10,116) | ($11,153) |
| Bad Debt | ($6,070) | ($6,692) |
| Net After Additional Deductions | $186,134 | $205,213 |
| | | |
| Visits | 1,192 | 1,252 |
| | | |
| Average Net Revenue / Visit | $156 | $164 |

These average net revenue amounts per visit represent a blend of the average type patient with up to two hours per visit and the specialty patients who have visits lasting up to six hours.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

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.***

Since this is a new service for the Applicant, there are no existing or current charges for skilled nursing visits. The proposed charges for skilled nursing visits are based on Coram's experience in other jurisdictions in which it provides home health services, and in particular its self pay charge structure. The average charge per visit is $178 in year one and $187 in year two. Given the expected duration of the nursing visits by Coram, and three times the requirement for the specialty infusion type patients, this is reasonable. Accordingly, the average charge per visit for an antibiotic or TPN type patient is $94.50; the average charge for the specialty IVIG and alpha 1 patient is $283.50 per visit

Net revenue (before charity care and bad debt) per visit for the typical antibiotic or TPN type patient is estimated to be $90 per visit. The specialty type patient which requires three times the initiative is estimated at $270 per visit. These amounts are inflated between years one and two for inflationary purposes.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

***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).***

The proposed average charge per home health visit based on the Applicant's self pay grid structure inflated to year one (2013) is $94.50 for up to a two hour visit. For longer visits, inflated to 2013, there is a $47.25 charge for each additional hour. This results in the typical infusion patient at $94.50 per visit and three times that amount, or $283.50, for the specialty infusion patient whose treatment lasts approximately six hours.

To contrast these charges to home health agencies in the service area, it is more reasonable to contrast the typical rate, excluding the specialty rate based on the fact that Medicare certified home health agencies do not generally provide the specialty infusion nursing. Within the 2011 Joint Annual Report Summary is reported charge per visit by home health agencies by discipline. Of the 67 agencies reporting from within the defined service area for 2011, only 10 reported an average charge for a skilled nursing visit. These charges ranged between $74 and $173 per visit. Adjusting the range from 2011 dollars to 2013 dollars would result in a 2013 dollar range of $77 to $184 charge per visit. Comparing this charge to the typical charge per visit identified above, the Applicant's charges are within the range of reasonableness and in fact at the lower end.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

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

Forecasted visits for years one and two for the Coram home health agency demonstrate that the proposed program is financial viable. Because the existing infrastructure of the pharmacy, its physical space, its management team and its support staff are all in place, the incremental costs associated with the home health agency directly relate to the nurse staff to provide the skilled visits with respect to their compensation and benefits and travel reimbursement.

All infusion products and necessary equipment are provided through the licensed pharmacy in conjunction with the prescribed infusion therapies.

Therefore, this proposed home health agency is very cost effective, with the nurse staff being added as volumes increase.

As is evidenced on the Projected Data Chart, the home health program demonstrates positive net operating income and therefore demonstrates its viability.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

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

Forecasted utilization in year one results in positive net operating income; forecasted utilization in year two results in greater positive net operating income. Given the fact that all of the incremental costs associated with the home health operation are variable relative to the number of skilled nursing visits, and the average cost per visit is less than the net revenue realized per visit, the Applicant can assure the financial viability of this proposal.

With respect to sufficient cash flow until financial viability is achieved, given the cost variability of this business, there will be sufficient cash flow to cover operating costs. Notwithstanding this fact, a letter from the Applicant's ultimate parent included in Attachment, Section C, Economic Feasibility, Item 2 indicates that the ultimate parent will not only fund the initial project costs, it will provide for any necessary working capital and operating deficits, if any, until financial viability is achieved.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

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.***

The Coram Nashville Branch licensed pharmacy participates in both Medicare and TennCare and also serves medically indigent patients. The home health agency proposed by this CON application will not become Medicare/Medicaid certified. Because it is a limited service home health agency, and not providing the full range of home health services as prescribed by the Conditions of Participation, it is not eligible for certification.

Its patients will be private pay, covered by a third party provider and medically indigent. Per the Projected Data Chart, approximately five percent of the patients are expected to be charity care.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

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.***

Coram Alternate Site Services, Inc. is a wholly owned indirect subsidiary of Apria Healthcare Group Inc. Currently Coram Alternate Site Services, Inc. is not separately audited as it operates as a division of its ultimate parent, Apria Healthcare Group Inc. The ultimate parent's annual report as filed with the Securities and Exchange Commission which includes audited financial statements for the company is provided as Attachment, Section A, Item 4.2.

The audited financial statements as presented beginning on page 59 of the Attachment indicates, the ultimate parent has $29 million in cash and cash equivalents and $337 million on accounts receivable. Its current assets total $452 million; current liabilities total $311 million. This results in a current ratio of approximately 1.5 which is favorable.

With this project being a low cost project ($63,000) and the net operating income provided by the Nashville Branch's licensed pharmacy (without the project), the Applicant clearly has the financial capability to implement and operate the proposed home health agency. Additionally, the Applicant has provided a Funding Letter assuring this fact by Robert Holcombe, the ultimate parent's Executive Vice President, General Counsel and Secretary. This is included in Attachment, Section C, Economic Feasibility, Item 2.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

***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.***

The benefits intended by this proposal are varied for the patient/family, the physician and hospital referral source and the home health industry.

Patients/families will have more timely discharges from the hospital and be able to receive first dose protocols, teaching/training in self administration and readily accessible infusion in their own home. There is no less costly or more effective alternative for the patient and family.

With respect to the hospital and physician referral sources, as documented in this CON application, the lack of availability of home health agencies to provide first dose protocol, meet the needs of low intervention patients (not homebound), be available to start a patient on the evening, night or weekend therapy regimen or provide extended IVIG nursing visits is well documented. The result is the patient remains in a hospital longer than necessary resulting in an increased cost to the healthcare system. Accordingly, approval of Coram to provide this limited home health service will clearly result in a less costly and more effective alternative with respect to the hospital and other referral sources.

With respect to licensed home health agencies throughout Middle Tennessee, unfortunately in today's Medicare home health agency environment, there is not a range of certified infusion nurses available at the existing home health agencies. This is a very small skilled niche primarily providing services to non-Medicare patients. Accordingly, the service proposed herein is atypical to the average home health agency and generally not available. A detailed discussion of home health agencies patients versus the patient to be seen by the Coram home health service is presented by the Applicant in response to questions within Section C, Need, Home Health Services.

The alternative to this proposal is maintaining status quo. This was rejected by the Applicant. Maintaining status quo in Middle Tennessee means continued longer stays in hospitals; more costly hospital stays; further hardships on patients and their families; inability to enhance quality of infusion therapy services in Middle Tennessee; operating in a more costly healthcare environment – despite the industry's focus on enhancing quality and decreasing costs; and rejecting a true improvement in healthcare delivery at a lesser cost.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### ECONOMIC FEASIBILITY

***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.***

The project proposed herein is for a limited service home health agency. It does not involve any new construction. In fact, it is using its existing infrastructure that houses a licensed pharmacy and ambulatory infusion suite to establish the home health agency. Therefore the physical plant exists, is fully built out, and will require no incremental costs by the Applicant to achieve licensure of the home health service.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### 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.***

The Applicant is an existing licensed pharmacy and operates an ambulatory infusion suite. It currently has in place contractual agreements with managed care organizations throughout Middle Tennessee. These include but are not limited to the following: Aetna, Blue Cross Blue Shield of Tennessee, Blue Advantage, BlueCare, Carecentrix, Corizon, First Medical Management, HealthSprings of Tennessee, Humana, Medicare, TriCare, United Healthcare, Veterans Administration and Vanderbilt University. The Applicant is also in current negotiations with Amerigroup and upon CON approval will initiate discussions with the other TennCare providers in the area.

Aside from its payor relationships, the Applicant has significant referral relationships with the existing hospital and provider community throughout the 39-county defined service area. The provider relationships include but are not limited to the following: Affiliated Neurologists, Baptist Hospital Nashville, Centennial Medical Center, Cookeville Regional Medical Center, Cumberland Medical Center, Deberry Special Needs, Erlanger Medical Center, Hendersonville Medical Center, Home Health Care of Middle Tennessee, Memorial Health Care System, Middle Tennessee Medical Center, Parkridge Medical Center, Skyline Medical Center, Southern Hills Medical Center, NHC, Saint Thomas Hospital, Stonecrest Medical Center, Summit Medical Center, Sumner Regional Medical Center, Tennessee Oncology, University Medical Center, VA Medical Center, Vanderbilt University Medical Center, and Williamson Medical Center. Collectively, these referral sources represent between 80 and 90 percent of the Applicant's patient referrals.

The Applicant will extend the above payor relationships and provider relationships to also include nursing services for infusion patients. As evidenced by the letters of support obtained by the Applicant for this CON application, it is clear Coram has the necessary existing resources to assure its future viability.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.***

This proposal will not negatively impact existing home health providers as the services proposed herein will be very restricted and complement the home health services provided by agencies throughout Middle Tennessee. Additionally, with Coram's intent to continue to train nurses at other home health agencies in the area of infusion, it is possible the quality of care in the overall home health community will increase.

Coram's restricted license will have quite a positive effect on the existing institutional providers. As noted in Section C, Question 1, Coram has a referral relationship for its infusion products with hospitals such as Baptist Hospital Nashville, Centennial Medical Center, Cookeville Regional Medical Center, Cumberland Medical Center, Erlanger Medical Center, Hendersonville Medical Center, Memorial Health Care System, Middle Tennessee Medical Center, Parkridge Medical Center, Skyline Medical Center, Southern Hills Medical Center, Saint Thomas Hospital, Stonecrest Medical Center, Summit Medical Center, Sumner Regional Medical Center, University Medical Center, VA Medical Center, Vanderbilt University Medical Center, Williamson Medical Center, among others. With the ability to have Coram's certified infusion nurses available for first dose protocol and training in a patient's home, patients will be discharged on a more timely basis from these and other area hospitals. The ultimate effect will be a decrease in patient care costs across the continuum of the healthcare system.

Other benefits Coram believes will accrue to the community at large with its ability to provide infusion nursing services include but are not limited to the following:

- Less emergency room use
- Better disease control
- Fewer unscheduled physician office visits
- Fewer total medications
- Fewer hospitalizations
- Better self and preventative care skills by the patient and family
- Better drug compliance
- Increased patient satisfaction
- Fewer adverse drug reactions
- Seamless delivery of care by infusion therapy provider
- Certified infusion nurses able to provide hands on care in the patient's home
- Skilled, experience infusion nurse able to teach the patient in self administration, compliance and safety

Overall, these benefits will enhance the quality of care available for infusion therapy patients in a cost effective and accessible manner.

As reflected in the letters of support included in Attachment, Section C, Home Health Services, Item 5, hospitals and home agencies alike confirm the Applicant's position that approving Coram to have a restricted home health license will be a community benefit, for providers, patients and families.

In summary, the Applicant will have no negative effect on the utilization of existing home health providers, will have a positive effect through more timely discharge and a cost savings for hospital referral sources and will have a positive effect on the home health community through enhanced quality care delivery in the patient's home.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.***

The Applicant is an existing licensed pharmacy and operates an ambulatory infusion suite. Through this CON application, it will be adding nursing visits as a limited service home health agency. Currently, the Applicant employees 23.2 full time equivalents (FTEs) to provide its pharmacy and infusion services. Given its forecasted growth in those business segments, it expects to increase to 24.2 FTEs during the next two years (without home health). Because the entire management structure, admissions personnel, clerical support and clinical liaisons are already in place, with the addition of the limited home health agency and the addition of skilled nursing visits, the Applicant will only need to add additional registered nurses to provide such services.

The following table provides the number of full time equivalents employed by the Applicant, the current average salary per year for the existing operations, and forecasted FTEs for the two projection years as shown in the Projected Data Chart for the Existing Business included within the Attachments.

Additionally, the table identifies the incremental FTEs to provide the skilled nursing visits upon establishment of the limited home health service agency as the subject of this CON application.

| *Projected Data Chart – Forecasted Staffing and Salaries* | | | | |
|---|---|---|---|---|
| | *Current FTEs* | | *Forecasted FTEs by Year* | |
| *Position* | *2012* | *Current Salary* | *Year One, 2013* | *Year Two, 2014* |
| **Existing Operations** | | | | |
| Administration | 1.00 | $106,000 | 1.00 | 1.00 |
| Clinical Liaison | 2.00 | $70,000 | 2.00 | 2.00 |
| Territory Manager | 2.00 | $70,000 | 2.00 | 2.00 |
| Pharmacist | 3.40 | $108,000 | 3.40 | 3.40 |
| Pharmacy Technician | 4.00 | $34,000 | 4.00 | 4.00 |
| Dietician | 1.00 | $62,000 | 1.00 | 1.00 |
| Admissions | 2.00 | $34,500 | 2.50 | 3.00 |
| Registered Nurses | 2.00 | $70,000 | 2.00 | 2.00 |
| Customer Support | 2.00 | $31,500 | 2.00 | 2.00 |
| Warehouse Worker | 2.80 | $35,000 | 2.80 | 2.80 |
| Clerical | 1.00 | $27,000 | 1.00 | 1.00 |
| | 23.20 | | 23.70 | 24.20 |

| *Projected Data Chart – Forecasted Staffing and Salaries* | | | | |
|---|---|---|---|---|
| | *Current FTEs* | | *Forecasted FTEs by Year* | |
| *Position* | *2012* | *Current Salary* | *Year One, 2013* | *Year Two, 2014* |
| **Proposed Operations – Limited Home Health – Skilled Nursing** | | | | |
| Registered Nurses | 0.00 | (*) | 1.68 | 1.75 |
| | | | | |
| **Combined Total FTEs** | | | | |
| Total | 23.20 | -- | 25.38 | 25.95 |

(*) The planned salary is $70,720 in year one, 2013 dollars.

Average salaries by position are based on actual salaries of the Applicant since it is an existing licensed operation. These salaries are reasonably competitive as the Applicant has been able to successfully recruit and retain its employees as a longstanding Middle Tennessee employer. Average salaries for future periods were adjusted for inflationary purposes in the projected data chart. In addition to salaries, all full time employees have a benefit package. This package includes sick, holiday, vacation and insurance benefits and averages approximately 25 percent of salaries. Pool employees are not eligible for benefits.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.***

Coram Alternate Site Services, Inc. is an existing licensed pharmacy and operates an ambulatory infusion suite in Middle Tennessee. As noted in Section C, Question 3 above, it is fully staffed to provide its current and future pharmacy and ambulatory infusion services in accordance with its budget. With respect to the addition of nursing visits, Coram will add registered nurses to provide the services. Based on the number of visits anticipated, the average duration of a visit and travel time, Coram will recruit 1.68 full time equivalent (FTE) nurses in year one and 1.75 in year two. It is confident with its existing licenses and relationships in the community that it will successfully recruit the nurses it requires to provide the nursing visits in accordance with its projections.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.***

Coram Alternate Site Services, Inc. is an existing licensed pharmacy and operates an ambulatory infusion suite in Middle Tennessee (and elsewhere). It has received, reviewed, understands and intends on complying with all applicable licensure requirements of the Department of Health as it relates to medical and clinical staff. It also intends on complying with all applicable Medicare and Medicaid/Tenncare requirements regarding medical and clinical staff.

The Applicant has appropriate credentialing standards, quality assurance policies and programs, utilization review policies and programs, record keeping protocols and staff education requirements in place that will be expanded as applicable to the home health agency services.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.).***

Coram Alternate Site Services is an existing licensed pharmacy which recognizes the importance of training and education, both for students as well as healthcare professionals not familiar with Coram's unique specialty of infusion. Accordingly, Coram has the following educational and training relationships in place:

- David Lipscomb University: Pharmacists
- University of Tennessee: Pharmacists
- CareAll Home Health Agency: Train nurses in infusion services
- Physician Offices In-services on: Starting an IV; specialty drugs; infusion equipment (pump and set up); infusion of specialty drugs
- Hospital Case Managers and Dietician In-Services on: Types of infusion which are safe to administer at home; sending home on TPN; infusion equipment

It is also the Applicant's intention to add pharmacy technician training for vocational schools such as Tennessee Tech within the next year.

With the approval of this CON application for limited home health services, it is Coram's intent to expand the above relationships to additionally include the following:

- Belmont University: Pharmacists
- Contract with various nursing schools such as David Lipscomb, Belmont and Vanderbilt University to provide nurses with experiential training on infusion service

Clearly the Applicant will continue its current commitment to the training of both students and area healthcare professionals in the specialty niche in which Coram operates.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.***

   Coram Alternate Site Services has reviewed and understands the licensure requirements of the Department of Health applicable for the proposed limited service home health agency. Additionally, the Applicant is fully cognizant of the requirements for a home health agency as promulgated by the Centers for Medicare and Medicaid Services.

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

   | | |
   |---|---|
   | Licensure: | Tennessee Department of Health, Board of Licensing in accordance with Chapter 1200-08-26 Standards for Home Health Agencies |
   | Accreditation: | The Joint Commission |

   **(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.***

   The Applicant is currently licensed by the State of Tennessee as a Pharmacy. It is also accredited by The Joint Commission. It is enrolled in both Medicare and Medicaid (TennCare) to provide services to these population groups.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.***

From time to time Coram is subject to ordinary course surveys, reviews and re-certifications by governmental agencies and, accordingly, Coram has incurred non-material deficiencies, violations and/or fines. No such surveys, reviews and re-certifications have led to any loss or limitations of licensure by Coram or have had or are expected to have a material impact on Coram's operations or financial standing or have had or expected to have material impact on Coram's operations or financial standing. To the best of our knowledge, the Nashville, Tennessee Branch has not incurred any such deficiencies, violations and/or fines.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.***

The Applicant has never received any final civil or criminal judgments for fraud or theft. Furthermore, its principals and officers have never received any final civil or criminal judgments for fraud or theft against. Lastly, to the best of our knowledge, any person or entity with more than 5% ownership interest in the Applicant has never received any final civil or criminal judgments for fraud or theft.

## *SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED:*

### CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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.***

Coram Alternate Site Services, Inc. confirms that if approved, it will timely provide the Tennessee Health Services and Development Agency, Department of Health and/or any designated reviewing agency information concerning the number of patients treated, number and type of procedures performed and other data as required. It will submit its Joint Annual Report on a timely basis which also includes statistical and financial information for the home health operation as well as patient migration information utilized by the State. Furthermore, to the extent reporting requirements are altered or adjusted in future periods, Coram agrees to comply with any newly adopted reporting requirements.

## *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.***

A copy of the notice of intent with the mast and dateline intact is provided on the following page as required.

the southwest corner of Dennis Radcliff (RB 2249/470), being at the southern middle of Lot 22, being on the north right-of-way of Glendale Lane, and being 20.20 feet from the approximate centerline intersection of Andrea Street; thence with the north right-of-way of Glendale Lane, North 82 degrees 16 minutes 20 seconds West 75.13 feet to the beginning; per survey dated December 12, 2011, by Richard D. Graves, TRLS #1628, 1768 New Highway 52, Westmoreland, TN 37186.
Street Address: 202 Glendale Lane, Portland, Tennessee 37148
Parcel Number: 020P-B-036.00
Current Owner(s) of Property: Sandie Calvert and wife, Katherine Calvert
Other interested parties: Corey Eugene Calvert c/o Joseph B. Freedle, Attorney and Discover Bank c/o Michelle S. Moghadom, Attorney, Zwicker & Associates
The street address of the above described property is believed to be 202 Glendale Lane, Portland, Tennessee 37148, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
If applicable, the notice requirements of T.C.A. 35-5-117 have been met.
Notice of this Substitute Trustee's Sale has been timely given to the State of

Continued from last column

Continued from last column

Record in Plat Book 9, Page 50 and 51, Register's Office of Sumner County, Tennessee, to which reference is hereby made for a more complete description of said Lot.
Street Address: 1015 Craig Street, Gallatin, Tennessee 37066
Parcel Number: 126O-A-001.00
Current Owner(s) of Property: Donald H. Hartmann and wife, Julia C. Hartmann, as tenants by the entirety
Other interested parties: Wells Fargo Bank, N.A., successor by merger to Wells Fargo Financial Bank c/o Stone, Higgs & Drexler, Attorneys
The street address of the above described property is believed to be 1015 Craig Street, Gallatin, Tennessee 37066, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
If applicable, the notice requirements of T.C.A. 35-5-117 have been met.
All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.
The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above.

Continued to next column

Continued from last column

September 20, 2006 at Record Book 2369, Page 357; conducted by Shapiro & Kirsch, LLP, Substitute Trustee, all of record in the Sumner County Register's Office.
Owner of Debt: JPMorgan Chase Bank, National Association
The following real estate located in Sumner County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:
Described property located in the 15th Civil District of Sumner County, Tennessee, to wit:
Beginning at a point in the southerly margin of Mockingbird Hill Road, common corner to Lot 17; thence south 6 degrees 40 minutes west 1056 feet to a point; thence north 84 degrees 00 minutes west 184 feet to a point; thence north 5 degrees 15 minutes east 1105 feet to a point in the southerly margin of Mockingbird Hill Road, common corner to Lot 19; thence said southerly margin of Mockingbird Hill Road south 63 degrees 20 minutes east 81 feet to a point; thence continuing with the said margin of Mockingbird Hill Road, south 75 degrees 30 minutes east 139.5 feet to the point of beginning.
Street Address: 168 Mockingbird Hill (Per Deed of Trust), 168 Mockingbird Hill Road (Per Assessor), Hendersonville, Tennessee 37075
Parcel Number: 095-048.01
Current Owner(s) of Property: Jason Murrell and wife,

Continued to next column

Continued to next column

Continued from last column

0101550249

**NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED**

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. §§ 68-11-3601 et seq. and the Rules of the Health Services & Development Agency, that Coram Alternate Site Services, Inc. d/b/a Coram Specialty Infusion Services an Apria Healthcare Company, with an ownership type of for profit corporation to be self-managed, intends to file an application for a Certificate of Need for the establishment of a limited service home health agency only to provide and administer home infusion products and related infusion nursing services ancillary to its pharmacy services, by way of example and not limitation, line maintenance, phlebotomy services, infusion equipment repair and replacement, and dressing changes on central lines and external access ports within the following Tennessee counties: Bedford, Bledsoe, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Franklin, Giles, Grundy, Hamilton, Hickman, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marion, Marshall, Maury, Montgomery, Monroe, Overton, Putnam, Rhea, Robertson, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, and Wilson, from its current licensed home infusion pharmacy located at 2970 Sidco Drive, Nashville, Davidson County, Tennessee 37207 with an estimated project cost to not exceed $63,000.
The anticipated filing date of the application is May 14, 2012.
The contact person for this project is Jeffrey J. Miller, Attorney who may be reached at Harwell Howard Hyne Gabbert & Manner PC, 333 Commerce Street, Ste. 1500, Nashville, TN 37201, 615/256-0500.
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 & Development Agency**
**Andrew Jackson Building**
**500 Deaderick Street, Suite 850**
**Nashville, Tennessee 37243**

The published letter of intent must contain the following statement pursuant to T.C.A. § 68-11-3607(C)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services & Development Agency no later than fifteen (15) days before the regularly scheduled Health Services & 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 Development Agency at or prior to the consideration of the application by the Agency.

Continued from last column

three similar multi-year assignments. (30%)
3) **Capability of the firm to perform the service desired within an acceptable time frame.** List key project personnel's professional background, experience and workload. Identify those individuals to be assigned to the project, who at the time of submission, resides at the location to perform the work. Show permanent office location of all other key personnel and show history of successful on time and on budget project performance. (20%)
4) **Firm's familiarity with and proximity to the geographic location of the projects.** Indicate office location where work will be performed. (20%)
5) **Capability to furnish qualified construction inspectors for resident inspection.** (15%)
6) **Evaluation of firm's EEO Policy and past performance meeting professional services DBE goals.** (5%)

Following submittal, the Statement of Qualifications will be reviewed and evaluated. The three highest-scoring firms may be invited to make an in-person oral presentation or be available for telephone interviews to the selection committee. The City of Lebanon will select the firm that it feels is most qualified to provide the required services. Subsequently, a contract will be negotiated for the first grant project anticipated.

The City of Lebanon reserves the right to waive any informality in the submitted state of Qualifications, to reject any and all Statements of Qualifications or re-advertise for additional Statements of Qualifications.

City of Lebanon in accordance with Title VI of the Civil Rights Act of 1964, 78 Stat. 252, 41 U.S.C. 2000d to 2000d-4 and Title 49, code of Federal Regulations, Department of Transportation, subtitle A, Office of the Secretary, Part 21, Non-discrimination of Federally-assisted programs of the Department of Transportation issued pursuant to such Act, hereby notifies all proposers that it will affirmatively insure that in any contract entered into pursuant to this advertisement, Disadvantaged Business Enterprises (DBEs) will be afforded full opportunity to submit proposals in response to this invitation and will not be discriminated against on the grounds of race, creed, color, sex, national origin, or handicap in consideration for an award.

All respondents are responsible for costs associated with the preparation of materials in response to this RFQ. The City of Lebanon assumes no responsibility for such costs.

City of Lebanon
Engineering Department
200 N. Castle Heights Ave, Suite 300
Lebanon, TN 37087

ence Room 5, East Tower, 401 Church Street, Nashville, TN 37243. Comments will be accepted until June 14, 2012. EPA will determine by June 4, 2012, whether there is sufficient interest to warrant a public hearing. Contact Nancy H. Marsh to determine if a hearing is warranted.
**ADDRESSES:** Submit your comments, identified by Docket ID No. **EPA-HQ-OW-2011-0520**, by one of the following methods:
www.regulations.gov: Follow the on-line instructions for submitting comments.
Email: marsh.nancy@epa.gov.
Fax: (404) 562-9439.
Mail: State of Tennessee; Underground Injection Control (UIC) Program Primacy, **Environmental Protection Agency, Mailcode: 2822T, 1200 Pennsylvania Ave., NW., Washington, DC 20460.** Hand Delivery: Water Docket, EPA Docket Center (EPA/DC) EPA West, Room 3334, 1301 Constitution Ave., NW, Washington, DC. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.
**Docket:** All documents in the docket are listed in the www.regulations.gov index. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in www.regulations.gov or in hard copy at the following locations:
U.S. Environmental Protection Agency, Region 4, Library, 9th Floor, 61 Forsyth Street, SW, Atlanta, Georgia 30303. The Library is open from 9:00 a.m. - 4:00 p.m. Monday through Friday, excluding legal holidays. The telephone number for the Library is (404) 562-8190.
Tennessee Department of Environment and Conservation, 6th Floor, 401Church St., Nashville, TN 32743, The Library is open from 9:00 a.m. - 4:00 p.m. Monday through Friday, excluding legal holidays. The telephone number for the Library is (615) 532-0191.
State of Tennessee; Underground Injection Control (UIC) Program Primacy Docket, EPA/DC, EPA West, Room 3334, 1301 Constitution Ave., NW, Washington, DC. The Public Reading Room is open from 8:30 a.m. - 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566-1744, and the telephone number for the OW Docket is (202) 566-2426.
**FOR FURTHER INFORMATION CONTACT:** Nancy H. Marsh, Safe Drinking Water Branch, U.S. Environmental Protection Agency, Region 4, 61 Forsyth St., SW, Atlanta, GA 30303; telephone number: 404-562-9450. Fax number: 404-562-9439; email address: marsh.nancy@epa.gov. Comments should also be sent to this address.


**HARDING**
2 bdrm, 1.5 ba, W&D hookups, central H/A, clean, $575/mo neg + dep. Call 615-361-3975

**MADISON**
2 BDRM 1.5 BA CONDO Central H/A. No Pets. $650 mo. $300 dep., 615-868-8270

**MADISON** Briley Pkwy ground floor, 2 Bdrm condo, very nice. Appliances, water, central h/a, w/d hookups, pool, absolutely no pets. Good credit, $650 mo. 615-500-4886.

**MADISON**
**X-tra Large 1Bdrms**
**$525!!**
**Neelys Bend Condo**
**331-3055**

**PERCY PRIEST LAKE AREA**
Smith Springs Villa #96, beautiful Condo w/2 bdrms, 2 walk in closets, 2 BA, gar, hookups, hdwds, 1500 sq ft, like new, indoor pets welcome, $950 mo. Avail now! Cathy 615-794-0705 for appt.

**Duplexes**

**BELLEVUE**
**195 Hicks Rd**
2 bdrm, carpet, hookups. Possible 2 extra rms & BA. $750 mo. & up Pets ok. 615-662-1199,615-944-6504

**CRIEVE HALL**
**5137 Whitaker. Super Nice 2 Bdrm, BA, lg Den, lg Kit., DR. Fridge, stove & hookups. Central h/a. Ceiling fans. Gar, w/Opener. $895 mo. No pets. 615-831-9033**

**DONELSON DUPLEX**
Elm Hill/Bell Rd area
Apt for lease. 3 bedroom, 1.5 bath, carpet. No pets. $875/month + 1 month deposit. Call 615-300-2849
★★★★★

**EAST**
Great 2bdrm w/new paint & carpet, central h/a, stove, fridge, hookups. $615 w/1 yr. lease, 615-838-6252; 615-790-1874


107

86

2821759
HARWELL HOWARD HYNE GABBE
CON
APRIA HEALTHCARE

2012 MAY 14 PM 1: 50

# STATE OF TENNESSEE
# HAMILTON COUNTY

Before me personally appeared Linda Johnson who being duly sworn, that she is the Legal Sales Representative of the "CHATTANOOGA TIMES FREE PRESS" and that the Legal Ad of which the attached is a true copy, has been published in the above said Newspaper on the following dates, to-wit:

May 10, 2012

And that there is due or has been paid the "CHATTANOOGA TIMES FREE PRESS" for publication of such notice the sum of $383.32 Dollars. (Includes $10.00 Affidavit Charge).

Linda Johnson

Sworn to and subscribed before me, this 10 day of May 2012.

D. CORIE SOTO
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF HAMILTON

My Commission Expires 2/18/2014

Chattanooga Times Free Press

## *DEVELOPMENT SCHEDULE*

2012 MAY 14 PM 1:50

***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.***

It is the Applicant's intent to expeditiously proceed with the implementation of Coram Alternate Site Services, Inc.'s limited home health services as soon as certificate of need approval is obtained. Based on the project completion forecast as presented on the following page, the home health agency is expected to be licensed in approximately 7 months from the CON application submission, or approximately three months from the CON hearing, beginning operations on or before January 1, 2013.

## PROJECT COMPLETION FORECAST

2012 MAY 14 PM 1:50

Enter the Agency projected Initial Decision date, as published in TCA 68-11-1609( c): 22-Aug-12

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

| Phase | Days Required | Anticipated Date (Month/Year) |
|---|---|---|
| 1 Architectural and engineering contract signed | | |
| 2 Construction documents approved by the TN Dept of Health | | |
| 3 Construction contract signed | | |
| 4 Building permit secured | | |
| 5 Site preparation completed | | |
| 6 Building construction commenced | | |
| 7 Construction 40% complete | | |
| 8 Construction 80% complete | | |
| 9 Construction 100% complete (approved for occupancy) | | |
| 10 * Issuance of license | 120 | December-12 |
| 11 * Initiation of service | 10 | January-13 |
| 12 Final Architectural Certification of Payment | | |
| 13 Final Project Report Form (HF0055) | | |

* 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 actual issue date.

## AFFIDAVIT

2012 MAY 14 PM 1:50

STATE OF COLORADO

COUNTY OF DENVER

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

Michael E. Dell, V.P., General Counsel & Sec.
SIGNATURE/TITLE

Sworn to and subscribed before me this 4th day of May (Month), 2012 (Year) a Notary Public in and for the County/State of DENVER

PATRICIA V. IVANCICH NOTARY PUBLIC STATE OF COLORADO MY COMMISSION EXPIRES 6-12-2015

NOTARY PUBLIC

My commission expires June 12 (Month/Day), 2015 (Year)

# ATTACHMENT, SECTION A, ITEM 4.1

## CORAM ALTERNATE SITE SERVICES, INC.

## APPLICANT DESCRIPTION AND ORGANIZATIONAL CHART

## *CORAM ALTERNATE SITE SERVICES, INC.*

The Applicant is Coram Alternate Site Services, Inc. which is the existing licensed pharmacy and ambulatory infusion center located at 2970 Sidco Drive, Nashville, Tennessee 37204 (the "Nashville Branch"). During the past three years, the Nashville Branch has had patients residing in most counties within the State of Tennessee given the regional hospital draw of Nashville's trauma centers. Primarily, however, the Nashville Branch serves 39 counties that are situated in the central parts of Tennessee. These counties comprise more than 84 percent of the Nashville Branch's patient population and represent the area for which Coram is seeking CON approval of limited home health services.

The Applicant's Nashville Branch operates under the leadership of Grace Chambliss, RN. Ms. Chambliss earned her RN degree approximately 30 years ago. During her first 12 years in practice she worked in hospital settings, including the intensive care unit, and in home settings. Since 1994, Ms. Chambliss has focused her care on the home infusion business working for two major providers prior to joining Coram. With the other providers, her scope of responsibility progressively increased during the 15 year tenure starting as a clinical coordinator responsible for management of the home infusion patient, progressing to intake coordinator, then nurse manager and ultimately general manager, first for PharmaThera then for Walgreens Infusion Therapy. Approximately three years ago, Ms. Chambliss joined Coram where she has full responsibility for the management and operation of the Nashville Branch pharmacy and ambulatory infusion program. Ms. Chambliss will be the administrator for the licensed home health services. She satisfies the home health administrator qualifications as required by Tennessee Department of Health, Chapter 1200-08-26.

Ms. Chambliss reports to John Davis, PharmD, MBA, FASCP who is Vice President of Operations for Coram Alternate Site Services, Inc. overseeing the Nashville Branch, the Knoxville Branch, and the Memphis Branch in Tennessee. He is also responsible for Coram's operations in Georgia, Florida, Mississippi and Alabama. Dr. Davis completed his initial pharmacy degree in 1978 from Auburn University. After a short period of retail practice, he obtained experience in hospital pharmacy practice, where he led teams that accomplished decentralized dispensing, emergency response protocols, nutritional and pain support services, as well as outpatient infusion and patient medication management services. During a 4 year period of private practice and educational leave, he worked as a consultant with various national and regional providers, along with individual physicians and research entities. Upon completion of his MBA, he re-entered the corporate world, with a regional position with Home Nutritional Services. He then accepted a role with the Daughters of Charity to develop a comprehensive home care program for member hospitals nationwide. His next role, working with a regional provider and venture capital group, afforded

Dr. Davis the opportunity to move into a senior management clinical operations role, and the completion of his doctoral studies. Accepting a Regional Director position with Apria Healthcare in 2005 led to his current role with Coram. Dr. Davis also serves ACHC as an Accreditation Surveyor for Infusion, Specialty, and HME practices.

The Applicant is a wholly owned subsidiary of Coram Specialty Infusion Services, Inc., which owns 100 percent of the Applicant. The leadership of this entity includes the following seasoned professionals:

- Daniel E. Greenleaf, President and Chief Executive Officer: Mr. Greenleaf has over 19 years of relevant experience in senior leadership positions in the healthcare industry. He has served as President of Apria Healthcare's Home Infusion Therapy Division since April 2008 and additionally served as Chief Operating Officer of Apria Healthcare between December 2010 and April 2012. Prior to joining Apria, Mr. Greenleaf served as President and Chief Executive Officer for VioQuest Pharmaceuticals Inc., a New Jersey-based biopharmaceutical company. Additionally, he was the President of U.S. Operations for Celltech Biopharmaceuticals, was also the Senior Vice President of Operations for Nabi Pharmaceuticals, and held a variety of increasingly senior roles with Schering-Plough Corporation. Mr. Greenleaf has been a member of the international leadership group, Young Presidents Organization (YPO), since 2004. He is an advisory board member for the University of Miami's Health Sector Management and Policy Board, and also serves as a board member of the National Home Infusion Association (NHIA). He is a former board member of BioNJ. Mr. Greenleaf is a graduate of Denison University with a Bachelor of Arts (BA) degree in Economics. He also obtained a Masters of Business Administration (MBA) degree in Health Administration from the University of Miami. He was a captain and navigator in the United States Air Force and served in Operation Desert Storm.

- Rob Allen, Executive Vice President of Operations: Mr. Allen served previously as Coram's Chief Financial Officer and has extensive experience in the healthcare and financial worlds. Mr. Allen comes to Coram after serving as CFO for Titan Health Corporation, a venture-funded specialty focused surgery center company based in Sacramento, Calif. Prior to working for Titan, he was CFO for American Medical Response, Inc. a $1.2 billion medical transportation and physician practice management company based in Aurora, Colo. While at AMR, he oversaw the integration of two $600 million operating companies, centralizing all accounting, AP and payroll functions and supporting 22,000 employees in 240 locations.

- Harriet Albery, Executive Vice President: Ms. Albery is the Executive Vice President, Sales for Apria Healthcare and Coram Specialty Infusion Services. A seasoned sales professional with over 16 years of experience in the homecare industry, Ms. Albery was promoted to the Executive Vice President, Sales, role for Apra and Coram after having led Coram's Infusion Division's sales efforts since March of 2009 as Senior Vice President, Sales. Ms. Albery previously worked with Coram and returned to the company in September 2008, after spending over five years with Walgreens-OptionCare where she held the position of Vice President, Sales and Marketing. Prior to that, she was Vice President, Sales; Area Vice President, Managed Care; and the Director, Sales Operations. Before OptionCare, Ms. Albery spent over five years at Coram as a Financial Analyst and later served as the Vice President, Contracts and Pricing. Ms. Albery earned a dual bachelor's degree in English and Political Science from the University of Colorado, and an MBA in Finance and Marketing from Tulane University.

- Marge Brown, Senior Vice President, Quality and Compliance, Corporate Compliance Officer: Ms. Brown is responsible for the oversight and monitoring of Coram's compliance activities. Before joining Coram, Ms. Brown served as Vice President of Quality and Corporate Compliance for NeighborCare, Inc. Throughout her career, she has served in numerous roles, including Director of Corporate Quality, Director of Quality Systems Renal Division and Director of Quality Systems for Baxter Healthcare Corporation; Director of Quality and Regulatory Compliance for MedPartners/Caremark; and Quality Assurance Manager for Caremark Healthcare Services. She also served as an Investigator for the United States Food and Drug Administration.

- Keith Crawford, Senior Vice President, Medical Marketing, Manufacturing Affairs and Clinical Trials: Mr. Crawford joined Coram in June 2008 and brings with him over 15 years experience in the biopharmaceutical industry where he gained expertise in drug research and development, regulatory affairs, intellectual property prosecution, government affairs, and drug launch and commercialization. Prior to joining Coram, Mr. Crawford founded 360Pharma, a boutique management consulting firm established to provide disciplined leadership, strategic planning and to guide several crucial areas of operations to assist start-up and growth-phase pharmaceutical, biotech and medical device companies. 360Pharma helped these companies maximize the commercial value of their development-stage and in-line products while building or improving their clinical, regulatory and marketing functions. Before 360Pharma, Mr. Crawford was a founder of Proventiv Therapeutics, a specialty pharmaceutical company focused on drug discovery, re-profiling and development. While at Proventiv Therapeutics, Mr. Crawford helped advance three clinical candidates and two novel antibody therapies

directed to treat secondary hyperparathyroidism, metabolic bone disease and hyperphosphatemia associated with chronic kidney disease. Proventiv Therapeutics was acquired by Cytochroma Inc., a Canadian specialty clinical-stage pharmaceutical company where Mr. Crawford continued to serve as the Senior Vice President of Medical Marketing and Strategic Drug Development. Mr. Crawford also served as the Senior Director of Medical Marketing and Medical Affairs for Bone Care International, a specialty pharmaceutical company that focused on the discovery, development and commercialization of drug products to treat co-morbidities associated with chronic kidney disease and cancers of the prostate, breast and colon. Bone Care was acquired by Genzyme Corporation, one of the world's leading biotechnology companies. Mr. Crawford has a bachelor's degree in Marketing Management from Western Governors University in Salt Lake City, Utah.

- Michael Dell, Vice President, Associate General Counsel and Assistant Secretary: Mr. Dell serves as the Vice President, Associate General Counsel and Assistant Secretary for Coram. In this position, he is the primary counsel for Apria Healthcare's Specialty Infusion Division. Prior to his position with Coram, Mr. Dell worked as an Associate in the Health Care and Business Organizations departments of Reinhart, Boerner, Van Deuren, a Milwaukee, Wis. based law firm. Mr. Dell earned his B.A. degree from the University of Colorado at Boulder. He graduated with a J.D. degree from the Vanderbilt University School of Law, Nashville, Tenn. Prior to attending law school, Mr. Dell worked in Washington, D.C. on the legislative staff of former United States Sen. Timothy E. Wirth and in the press office of former Colorado Gov. Roy R. Romer. Mr. Dell is a member of the Denver, the Colorado and the Wisconsin Bar Associations, the American Health Lawyers Association and the Association of Corporate Counsel.

Coram Specialty Infusion Services' ultimate parent is Apria Healthcare Group Inc. Due to the fact that Apria Healthcare Group Inc. has public debt, it files quarterly and annual reports with the Securities and Exchange Commission (SEC). Its most recent annual report (10-K) as of December 31, 2011 is attached hereto as Item 4.2.

As the ultimate parent, Apria Healthcare Group Inc. is governed by its executive officers and board of directors, as follows:

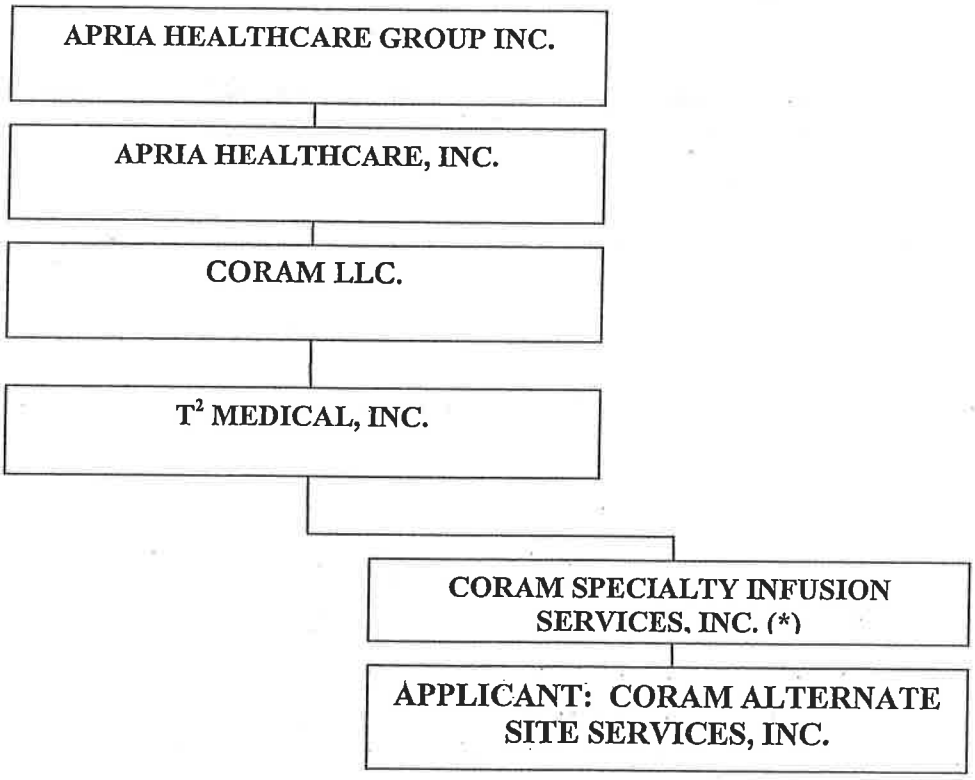
- Norman C. Payson, MD, Chairman of the Board of Directors and Chief Executive Officer
- Chris A. Karkenny, Executive Vice President and Chief Financial Officer
- Robert S. Holcombe, Executive Vice President, General Counsel & Secretary
- Harriet B. Albery, Executive Vice President, Sales (both Apria and Coram)

- Neil P. Simkins, Director
- Michael Dal Bello, Director
- Patrick J. Bourke, III, Director
- Mike S. Zafirovksi, Director

All directors and executive officers as a group in aggregate own approximately three percent of Apria Healthcare Group Inc. The majority of Apria Healthcare Group Inc., in excess of 90 percent, is owned by Blackstone Funds, an investment group through various entities as described on pages 122 and 123 of the attached 10-K.

The organizational chart reflecting the above relationships is provided on the following page.

CORAM CORPORATE STRUCTURE




*(*) Coram Specialty Infusion Services, Inc. hold 100 percent ownership of Coram Alternate Site Services, Inc. issued shares.*

# ATTACHMENT, SECTION A, ITEM 4.2

## CORAM ALTERNATE SITE SERVICES, INC.

## APRIA HEALTHCARE GROUP INC.
## ANNUAL REPORT, DECEMBER 31, 2011

# ATTACHMENT, SECTION B, PROJECT DESCRIPTION, ITEM I

## CORAM ALTERNATE SITE SERVICES, INC.

## EXISTING LICENSES AND THE JOINT COMMISSION ACCREDITATION

80008098
36913

# State of Tennessee

TENNESSEE BOARD OF PHARMACY
PHARMACY
CORAM ALTERNATE SITE SERVICES, INC.
DBA CORAM SPECIALTY INFUSION SERVICES
2970 SIDCO DRIVE
NASHVILLE TN 37204-3715

*This is to certify that all requirements of the State of Tennessee have been met.*

ID NUMBER: 0000003928
EXPIRATION DATE: 03/31/2014

CONTROLLED SUBSTANCE REGISTRATION

IN-1313
DEPARTMENT OF
HEALTH

DCF171

| DEA REGISTRATION NUMBER | THIS REGISTRATION EXPIRES | FEE PAID |
|---|---|---|
| BA8527573 | 08-31-2014 | $551 |

| SCHEDULES | BUSINESS ACTIVITY | DATE ISSUED |
|---|---|---|
| 2,2N,3<br>3N,4,5 | CHAIN PHARMACY | 08-09-2011 |

APRIA HEALTHCARE, INC.,
CORAM SPECIALTY INFUSION SERVICES, AN APRIA HEALTHCARE CO
2970 SIDCO DR
NASHVILLE, TN 37204 3715

**CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE**
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C, 20537

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacturer, distribute, dispense, import or export a controlled substance.

**THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IS NOT VALID AFTER THE EXPIRATION DATE.**

---

**CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE**
**UNITED STATES DEPARTMENT OF JUSTICE**
**DRUG ENFORCEMENT ADMINISTRATION**
WASHINGTON, D.C, 20537

| DEA REGISTRATION NUMBER | THIS REGISTRATION EXPIRES | FEE PAID |
|---|---|---|
| BA8527573 | 08-31-2014 | $551 |

| SCHEDULES | BUSINESS ACTIVITY | DATE ISSUED |
|---|---|---|
| 2,2N,3<br>3N,4,5 | CHAIN PHARMACY | 08-09-2011 |

APRIA HEALTHCARE, INC.,
CORAM SPECIALTY INFUSION SERVICES, AN APRIA HEALTHCARE CO
2970 SIDCO DR
NASHVILLE, TN 37204 3715

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

Form DEA-223 (05/04)

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

# COMMONWEALTH OF KENTUCKY

KENTUCKY BOARD OF PHARMACY
State Office Bldg. Annex Third Floor Suite 300
125 Holmes Street
Frankfort, Kentucky 40601

LICENSE / PERMIT: Out-of-State

EFFECTIVE DATE: 08/07/2008

NUMBER: TN1307

EXPIRATION DATE: 06/30/2012

Issued to: PIC: Richard Swoboda

APRIA HEALTHCARE, INC. Coram Specialty Infusion
Services, an Apria Healthcare Company
2970 SIDCO DRIVE
NASHVILLE, TN 37204-1715

ISSUED PURSUANT TO KRS CHAPTER 315

MUST BE CONSPICUOUSLY DISPLAYED

KENTUCKY BOARD OF PHARMACY
PHARMACIST ID

LICENSE NUMBER:

Not Applicable

(Not valid unless signed)

Pursuant to KRS 315. Expires:

ATTN: LICENSURE & CERTIFICATION 555
STREET, STE 1500
DENVER, CO 80202-

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

*CERTIFICATE OF WAIVER*

LABORATORY NAME AND ADDRESS
APRIA HEALTHCARE, INC D/B/A CORAM SPEC
INFUSION SERVICES, AN APRIA HEALTHCARE
2970 SIDCO DR
NASHVILLE, TN 37204

CLIA ID NUMBER
44D2030782

EFFECTIVE DATE
10/05/2011

LABORATORY DIRECTOR
LINDA PRUITT

EXPIRATION DATE
10/04/2013

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.
This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

773 - Certs1_110511

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.HHS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

44D2030782
APRIA HEALTHCARE, INC D/B/A CORAM SPEC
INFUSION SERVICES, AN APRIA HEALTHCARE
555 17TH ST, STE 1500
DENVER, CO 80202

STATE AGENCY ADDRESS AND PHONE NUMBER:

TENNESSEE HEALTH CARE FACILITIES

227 FRENCH LANDING SUITE 501
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243
(615)741-7023

Apria Healthcare, Inc
Lake Forest, CA

# Apria Healthcare, Inc.
# Coram Speciality Infusion Services, an Apria Healthcare Company
# Nashville TN

has been Accredited by

## The Joint Commission

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

Home Care Accreditation Program

June 30, 2010

Accreditation is customarily valid for up to 39 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

**Organization ID #: 439173**
Print/Reprint Date: 3/3/2011

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

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

**This reproduction of the original accreditation certificate has been issued for use in regulatory/payor agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.**

The Joint Commission

July 6, 2011

Ruth A. Ellison
Vice President Clinical Regulatory Compliance
Apria Healthcare, Inc
26220 Enterprise Court
Lake Forest, California 92630

HCO ID: #439173

Dear Ms. Ellison:

The Joint Commission had administratively extended Accreditation, effective June 23, 2011, to the following location:
Apria Healthcare of NY State, Inc., 50 Rose Pl, New Hyde Park, NY 11040-5312
The following services are being provided: Home Medical Equipment and Clinical Respiratory Services.
The following products are being provided: DM02, DM03, DM05, DM06, DM07, DM08, DM09, DM10, DM11, DM12, DM15, DM17, DM18, DM19, DM20, DM21, DM22, DM23, M01, M02, M03, M04, M05, M06, M06A, M07, M07A, M08, M09, M10, PD06, PD08, PD09, PE01, R01, R03, R04, R06, R07, R08, R09, R10, R12, S01, S02.

The Joint Commission has updated its records to reflect that the following location has moved to:
Apria Healthcare, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2970 Sidco Drive, Nashville, TN 37204-3715

The Joint Commission has updated our records to reflect the following corrected address:
Apria Healthcare, Inc., 612 Beatty Road, Ste D, Monroeville, PA 15146-1595

The following locations have closed and have been removed from our records:
Apria Healthcare, Inc., 1805 Taylor Ave, Louisville, KY 40213
Apria Healthcare, Inc., 10 Lane Rd, Raymond, NH 03077

If I can be of further assistance I can be reached at (630) 792-5732.

Sincerely,

Kenneth M. Gauss

Kenneth M. Gauss
Senior Account Executive, Team 3
Accreditation and Certification Operations

cc: Correspondence File

# ATTACHMENT, SECTION B, PROJECT DESCRIPTION, ITEM II (A)

## CORAM ALTERNATE SITE SERVICES, INC.

## SQUARE FOOTAGE AND COST CHART

## SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

| A. Unit / Department | Existing Location | Existing SF | Temporary Location | Proposed Final Location | Proposed Final Square Footage | | | Proposed Final Cost/SF | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Renovated | New | Total | Renovated | New | Total |
| Lobby | Rm 100 | 185 | | | 0 | 0 | 185 | | | $ - |
| AIS with restroom | Rm 110 / 111 | 326 | | | 0 | 0 | 326 | | | $ - |
| Conference | Rm 101 | 312 | | | 0 | 0 | 312 | | | $ - |
| Break Area | Rm 112 | 288 | | | 0 | 0 | 288 | | | $ - |
| Clean Room | Rem 115 | 307 | | | 0 | 0 | 307 | | | $ - |
| Ante Room | Rm 116 | 44 | | | 0 | 0 | 44 | | | $ - |
| Prep Room | Rm 117 | 282 | | | 0 | 0 | 282 | | | $ - |
| Drug Storage | Rm 118/119 | 276 | | | 0 | 0 | 276 | | | $ - |
| Open Office | Rm 105 | 1,105 | | | 0 | 0 | 1,105 | | | $ - |
| Office 1 | Rm 103 | 121 | | | 0 | 0 | 121 | | | $ - |
| Office 2 | Rm 102 | 121 | | | 0 | 0 | 121 | | | $ - |
| Nurse Office | Rm 109 | 132 | | | 0 | 0 | 132 | | | $ - |
| RX Office | Rm 106 | 125 | | | 0 | 0 | 125 | | | $ - |
| Warehouse | Rm 120 | 1,605 | | | 0 | 0 | 1,605 | | | $ - |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Restrooms | Rm 113/114 | 265 | | | 0 | 0 | 265 | | | $ - |
| Copy room | Rm 104 | 105 | | | 0 | 0 | 105 | | | $ - |
| Vestibule | Rm 122 | 78 | | | 0 | 0 | 78 | | | $ - |
| MDF and Files | Rm 106/107 | 202 | | | 0 | 0 | 202 | | | $ - |
| | | | | | | | | | | |
| B. Unit/Depart. GSF Sub-Total | | 5,879 | | | 0 | 0 | 5,879 | | | $ - |
| C. Mechanical/Electrical GSF | | | | | | | | | | |
| D. Circulation/Structure GSF | | 921 | | | 0 | 0 | 921 | | | $ - |
| E. Total GSF | | 6,800 | | | 0 | 0 | 6,800 | | | $ - |

# ATTACHMENT, SECTION B, PROJECT DESCRIPTION, ITEM III (A),1

## CORAM ALTERNATE SITE SERVICES, INC.

## SITE PLAN AND VICINITY PLAN

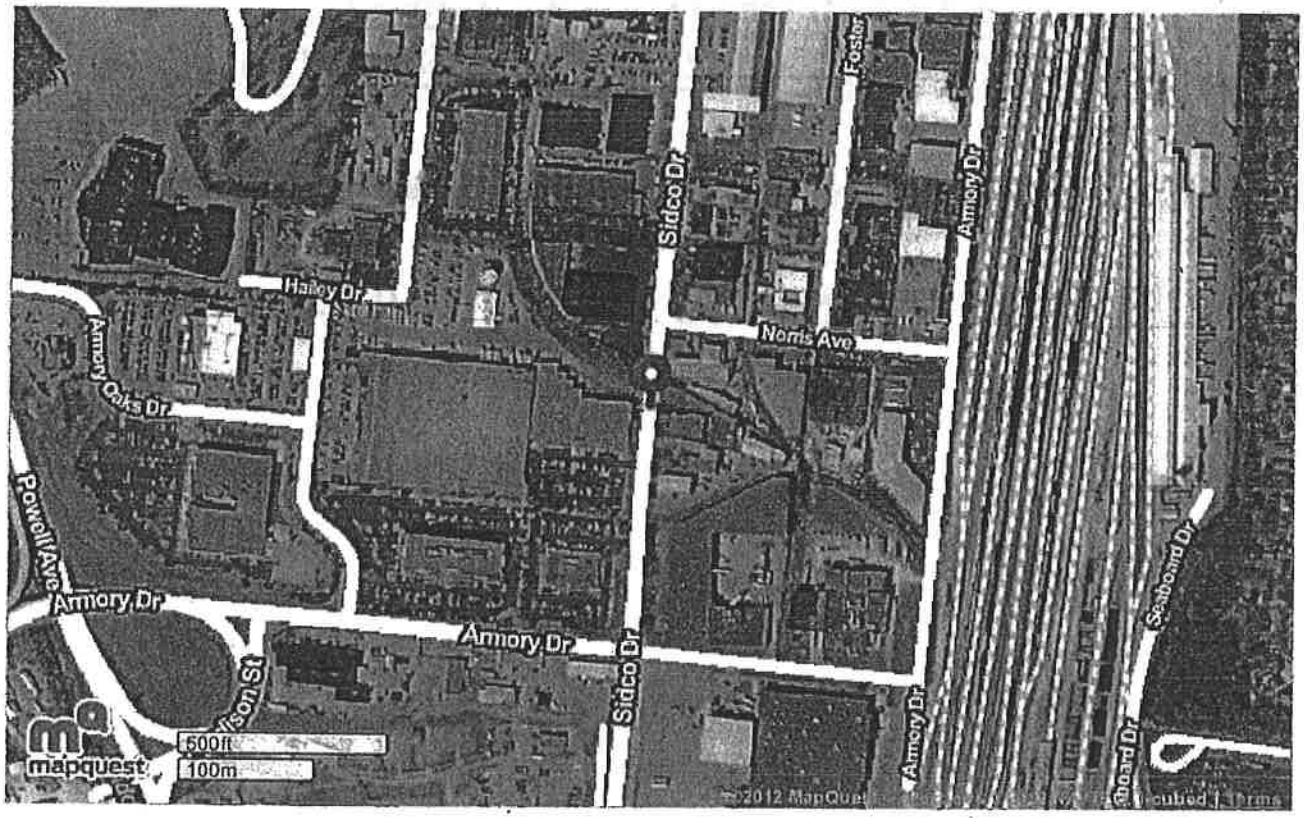
Notes

Location of Coram Alternate Site Services, Inc.

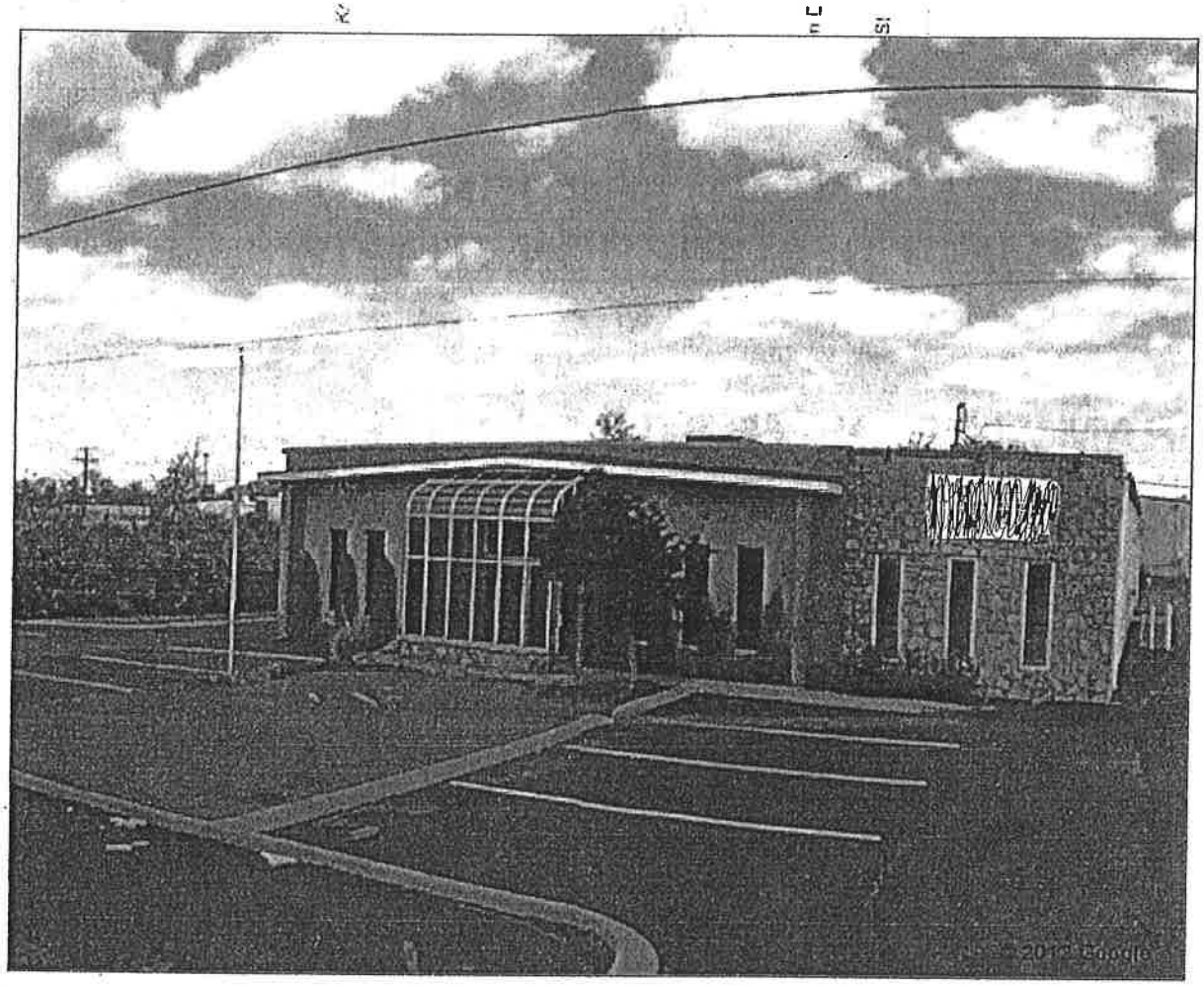
Map of:

**2970 Sidco Dr**

Nashville, TN 37204-3715



Coram Alternate Site Services, Inc.
2970 Sidco Drive
Nashville, Tennessee 37204

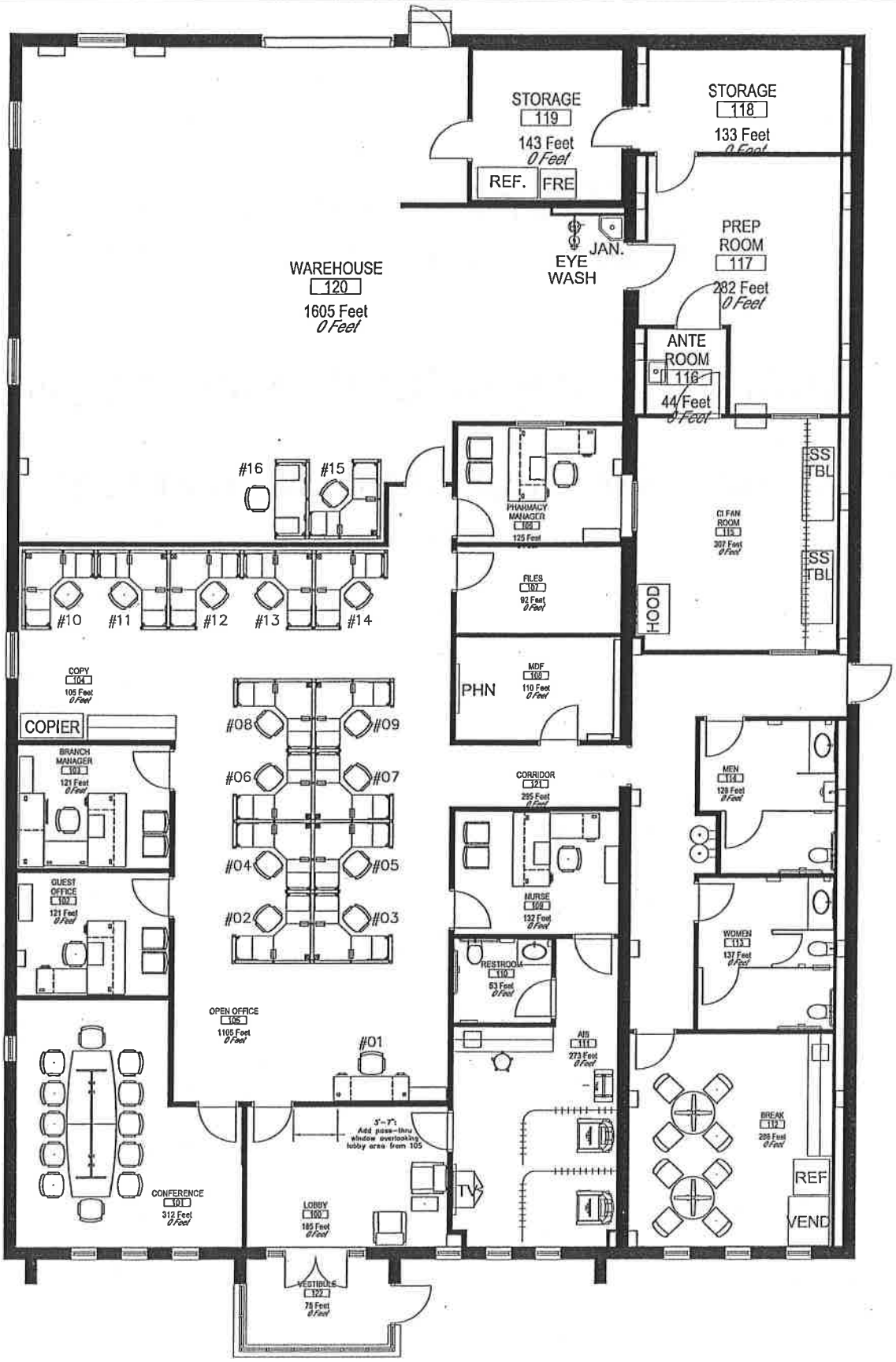


# ATTACHMENT, SECTION B, PROJECT DESCRIPTION, ITEM IV

## CORAM ALTERNATE SITE SERVICES, INC.

## FLOOR PLAN

a_nfp01-1022100-RAL.dwg




business interiors by STAPLES
www.businessinteriorsbystaples.com

2777 Stemmons Frwy
Suite 199
Dallas, TX 75207

Coram Specialty Infusion Services
Nashville, TN: Furniture Layout

| | | | |
|---|---|---|---|
| PROJECT #: 000000 | SALES REP: J Morlimer | INITIAL DATE: 05/31/201 | |
| SCALE: Not to scale | DESIGNER: J Morlimer | REVISION DATE: 10/18/201 | |
| FILE NAME: a_nfp01-1022100-RAL.dwg | | | |

The information, ideas and depictions incorporated in this drawing or design document ("Design") are the sole and exclusive property of Business Interiors by STAPLES, which owns all rights, title and interest in this Design, including without limitation, the copyrights and trademarks associated with this Design. The information, ideas and depictions are confidential and proprietary to Business Interiors by STAPLES. Any use of this Design, including reproduction, distribution, or incorporation in bid solicitations or quotes without the written consent of Business Interiors by STAPLES is expressly prohibited. This Design is not to be used for construction purposes. Contractors, subcontractors and other third parties are not permitted to rely solely on the representations, data or measurements contained in this Design, and each must verify all dimensions and conditions on site before proceeding with fabrication or installation work depicted in this Design. The Design and all data it contains is not to be used for fabrication or installation until countersigned by the Business Interiors by STAPLES designated designer or project controller.

WE CANNOT ACCEPT CHANGES, RETURNS OR CANCELLATIONS AFTER YOUR ORDER IS PROCESSED OR IS IN PRODUCTION. ADDITIONAL CHANGES MAY BE APPLIED ON A FORFEIT OF DEPOSIT IN CERTAIN CIRCUMSTANCES. YOUR SIGNATURE APPROVES DESIGN AND SPECIFICATIONS.

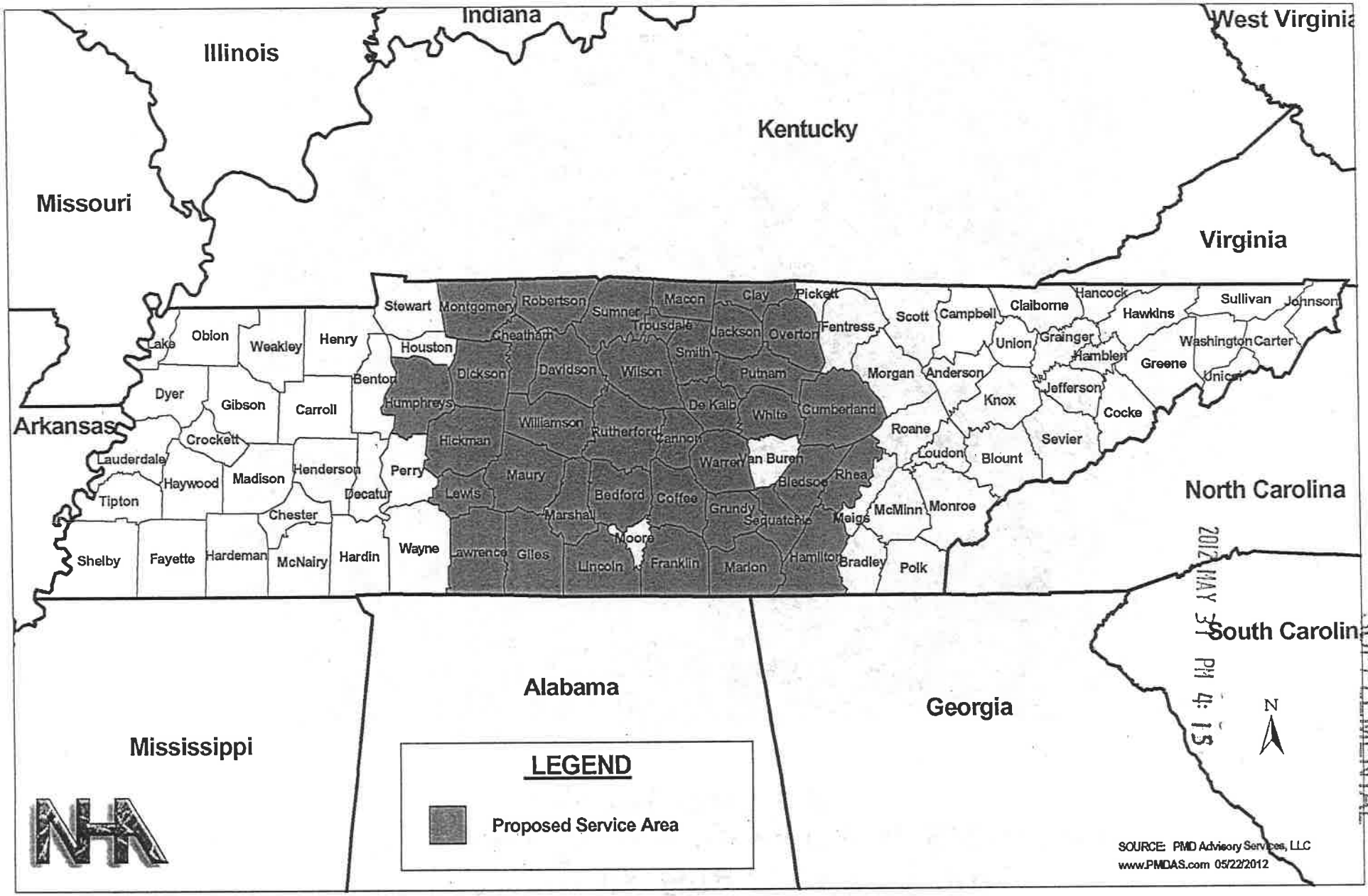
SIGNATURE:

# ATTACHMENT, SECTION B, PROJECT DESCRIPTION, ITEM V

## CORAM ALTERNATE SITE SERVICES, INC.

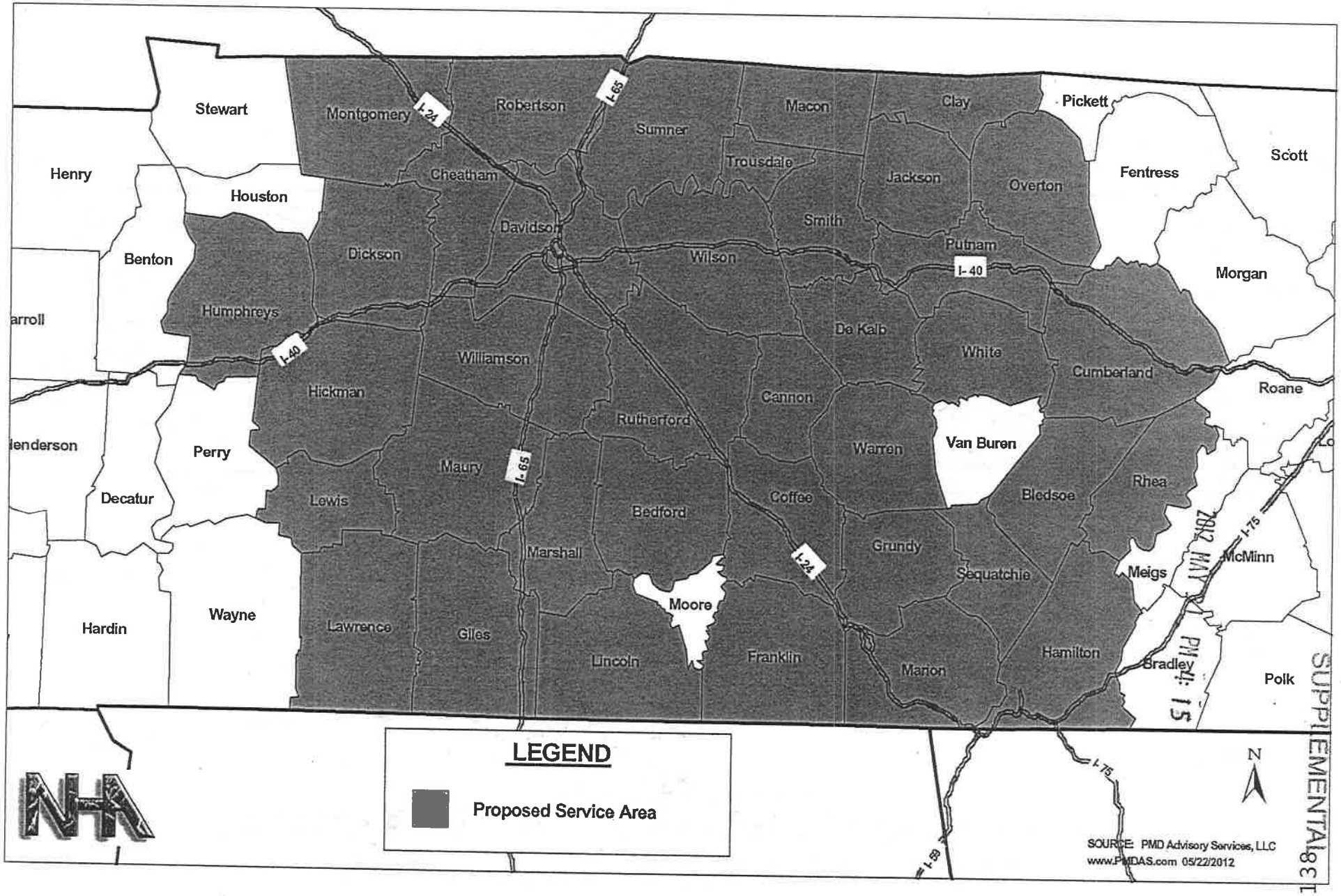
## STATE OF TENNESSEE MAP WITH SERVICE AREA

# Coram Alternate Site Services, Inc.
## Proposed Restricted Service Home Health Service Area
### State of Tennessee




2012 MAY 31 PM 4: 15
SUPPLEMENTAL

# Coram Alternate Site Services, Inc.
## Proposed Restricted Service Home Health Service Area
### Middle Tennessee Area




2012 MAY 21 PM 4:15

SUPPLEMENTAL

138

# ATTACHMENT, SECTION C, HOME HEALTH SERVICES, ITEM 1

## CORAM ALTERNATE SITE SERVICES, INC.

## STATE OF TENNESSEE
## HOME HEALTH NEED BY COUNTY

## Joint Annual Report of Home Health Agencies - 2010 Final
## Comparison of Population Based Need Projection vs. Actual Utilization (2016 vs. 2010)

| Service Area | Agencies Licensed to Serve | Agencies Report Serving | Total Patients Served | Estimated 2010 Pop. | Use Rate | Projected 2016 Pop. | Projected Capacity | Projected Need (.015 x 2016 Pop.) | Need or (Surplus) for 2016 |
|---|---|---|---|---|---|---|---|---|---|
| Tennessee | 1,588 | 1,397 | 168,130 | 6,264,654 | 0.0268 | 6,575,165 | 176,463 | 98,627 | (77,836) |
| Anderson | 20 | 19 | 2,810 | 74,167 | 0.0379 | 75,016 | 2,842 | 1,125 | (1,717) |
| Bedford | 21 | 19 | 1,032 | 46,576 | 0.0222 | 51,282 | 1,136 | 769 | (367) |
| Benton | 14 | 13 | 646 | 16,657 | 0.0388 | 16,922 | 656 | 254 | (402) |
| Bledsoe | 11 | 8 | 449 | 13,425 | 0.0334 | 13,886 | 464 | 208 | (256) |
| Blount | 19 | 18 | 2,678 | 123,692 | 0.0217 | 131,158 | 2,840 | 1,967 | (872) |
| Bradley | 14 | 13 | 2,545 | 97,379 | 0.0261 | 102,597 | 2,681 | 1,539 | (1,142) |
| Campbell | 19 | 18 | 1,674 | 41,583 | 0.0403 | 42,486 | 1,710 | 637 | (1,073) |
| Cannon | 21 | 16 | 457 | 14,025 | 0.0326 | 14,805 | 482 | 222 | (260) |
| Carroll | 14 | 12 | 1,063 | 29,631 | 0.0359 | 30,345 | 1,089 | 455 | (633) |
| Carter | 12 | 12 | 1,812 | 59,708 | 0.0303 | 60,564 | 1,838 | 908 | (930) |
| Cheatham | 23 | 22 | 744 | 41,241 | 0.0180 | 44,357 | 800 | 665 | (135) |
| Chester | 15 | 15 | 491 | 16,645 | 0.0295 | 17,438 | 514 | 262 | (253) |
| Claiborne | 17 | 15 | 1,906 | 32,209 | 0.0592 | 33,257 | 1,968 | 499 | (1,469) |
| Clay | 9 | 5 | 233 | 8,184 | 0.0285 | 8,301 | 236 | 125 | (112) |
| Cocke | 15 | 14 | 1,323 | 36,331 | 0.0364 | 37,681 | 1,372 | 565 | (807) |
| Coffee | 19 | 16 | 1,761 | 53,726 | 0.0328 | 56,774 | 1,861 | 852 | (1,009) |
| Crockett | 12 | 10 | 494 | 14,944 | 0.0331 | 15,788 | 522 | 237 | (285) |
| Cumberland | 15 | 13 | 1,776 | 54,840 | 0.0324 | 57,735 | 1,870 | 866 | (1,004) |
| Davidson | 32 | 31 | 13,847 | 595,833 | 0.0232 | 618,202 | 14,367 | 9,273 | (5,094) |
| Decatur | 14 | 11 | 681 | 11,516 | 0.0591 | 11,526 | 682 | 173 | (509) |
| DeKalb | 24 | 18 | 908 | 19,080 | 0.0476 | 20,024 | 953 | 300 | (653) |
| Dickson | 20 | 17 | 1,381 | 48,742 | 0.0283 | 51,903 | 1,471 | 779 | (692) |
| Dyer | 16 | 14 | 1,518 | 38,716 | 0.0392 | 39,857 | 1,563 | 598 | (965) |
| Fayette | 20 | 18 | 765 | 38,247 | 0.0200 | 41,453 | 829 | 622 | (207) |
| Fentress | 11 | 9 | 1,131 | 17,965 | 0.0630 | 18,577 | 1,170 | 279 | (891) |
| Franklin | 17 | 14 | 1,498 | 42,550 | 0.0352 | 44,351 | 1,561 | 665 | (896) |
| Gibson | 17 | 16 | 1,864 | 48,956 | 0.0381 | 49,750 | 1,894 | 746 | (1,148) |
| Giles | 11 | 10 | 937 | 29,855 | 0.0314 | 30,638 | 962 | 460 | (502) |
| Grainger | 19 | 18 | 638 | 23,382 | 0.0273 | 24,501 | 669 | 368 | (301) |
| Greene | 17 | 14 | 1,965 | 67,443 | 0.0291 | 69,363 | 2,021 | 1,040 | (980) |
| Grundy | 18 | 16 | 600 | 14,805 | 0.0405 | 15,212 | 616 | 228 | (388) |
| Hamblen | 19 | 17 | 2,406 | 62,835 | 0.0383 | 65,113 | 2,493 | 977 | (1,517) |
| Hamilton | 15 | 17 | 8,391 | 316,977 | 0.0265 | 322,740 | 8,544 | 4,841 | (3,702) |
| Hancock | 15 | 10 | 584 | 6,802 | 0.0859 | 6,865 | 589 | 103 | (486) |
| Hardeman | 16 | 14 | 856 | 29,491 | 0.0290 | 31,139 | 904 | 467 | (437) |
| Hardin | 13 | 12 | 940 | 26,741 | 0.0352 | 27,465 | 965 | 412 | (553) |
| Hawkins | 20 | 17 | 1,952 | 58,811 | 0.0332 | 61,494 | 2,041 | 922 | (1,119) |
| Haywood | 16 | 14 | 688 | 19,662 | 0.0350 | 19,985 | 699 | 300 | (400) |
| Henderson | 15 | 14 | 1,050 | 27,584 | 0.0381 | 28,795 | 1,096 | 432 | (664) |
| Henry | 11 | 10 | 1,110 | 32,394 | 0.0343 | 33,284 | 1,140 | 499 | (641) |
| Hickman | 19 | 14 | 594 | 25,379 | 0.0234 | 27,616 | 646 | 414 | (232) |
| Houston | 12 | 10 | 206 | 8,207 | 0.0251 | 8,344 | 209 | 125 | (84) |
| Humphreys | 16 | 13 | 580 | 18,876 | 0.0307 | 19,515 | 600 | 293 | (307) |
| Jackson | 13 | 11 | 334 | 11,277 | 0.0296 | 11,730 | 347 | 176 | (171) |
| Jefferson | 17 | 16 | 1,619 | 52,244 | 0.0310 | 56,061 | 1,737 | 841 | (896) |
| Johnson | 7 | 7 | 892 | 18,567 | 0.0480 | 19,172 | 921 | 288 | (633) |
| Knox | 23 | 21 | 9,514 | 423,945 | 0.0224 | 440,468 | 9,885 | 6,607 | (3,278) |
| Lake | 7 | 6 | 273 | 7,423 | 0.0368 | 7,366 | 271 | 110 | (160) |



Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics

February 2012

## Joint Annual Report of Home Health Agencies - 2010 Final
## Comparison of Population Based Need Projection vs. Actual Utilization (2016 vs. 2010)

| Service Area | Agencies Licensed to Serve | Agencies Report Serving | Total Patients Served | Estimated 2010 Pop. | Use Rate | Projected 2016 Pop. | Projected Capacity | Projected Need (.015 x 2016 Pop.) | Need or (Surplus) for 2016 |
|---|---|---|---|---|---|---|---|---|---|
| Lauderdale | 14 | 13 | 980 | 27,888 | 0.0351 | 29,412 | 1,034 | 441 | (592) |
| Lawrence | 14 | 11 | 1,489 | 42,163 | 0.0353 | 43,918 | 1,551 | 659 | (892) |
| Lewis | 11 | 9 | 472 | 12,044 | 0.0392 | 12,599 | 494 | 189 | (305) |
| Lincoln | 14 | 14 | 924 | 33,709 | 0.0274 | 34,940 | 958 | 524 | (434) |
| Loudon | 22 | 20 | 1,638 | 46,504 | 0.0352 | 48,896 | 1,722 | 733 | (989) |
| McMinn | 18 | 16 | 1,676 | 53,914 | 0.0311 | 56,435 | 1,754 | 847 | (908) |
| McNairy | 16 | 15 | 1,040 | 26,161 | 0.0398 | 26,803 | 1,066 | 402 | (663) |
| Macon | 19 | 14 | 703 | 22,746 | 0.0309 | 24,183 | 747 | 363 | (385) |
| Madison | 16 | 17 | 2,780 | 99,334 | 0.0280 | 104,160 | 2,915 | 1,562 | (1,353) |
| Marion | 14 | 15 | 980 | 28,332 | 0.0346 | 28,787 | 996 | 432 | (564) |
| Marshall | 17 | 13 | 770 | 30,332 | 0.0254 | 32,304 | 820 | 485 | (336) |
| Maury | 21 | 18 | 2,502 | 82,338 | 0.0304 | 88,120 | 2,678 | 1,322 | (1,356) |
| Meigs | 19 | 15 | 285 | 12,219 | 0.0233 | 12,897 | 301 | 193 | (107) |
| Monroe | 20 | 18 | 1,384 | 46,499 | 0.0298 | 49,780 | 1,482 | 747 | (735) |
| Montgomery | 21 | 18 | 2,259 | 155,391 | 0.0145 | 167,554 | 2,436 | 2,513 | 77 |
| Moore | 11 | 9 | 95 | 6,285 | 0.0151 | 6,593 | 100 | 99 | (1) |
| Morgan | 20 | 16 | 578 | 20,675 | 0.0280 | 21,373 | 598 | 321 | (277) |
| Obion | 11 | 10 | 1,168 | 32,626 | 0.0358 | 33,111 | 1,185 | 497 | (689) |
| Overton | 13 | 11 | 719 | 21,208 | 0.0339 | 21,747 | 737 | 326 | (411) |
| Perry | 9 | 8 | 280 | 7,776 | 0.0360 | 7,923 | 285 | 119 | (166) |
| Pickett | 8 | 6 | 222 | 5,001 | 0.0444 | 5,203 | 231 | 78 | (153) |
| Polk | 13 | 12 | 536 | 16,177 | 0.0331 | 16,492 | 546 | 247 | (299) |
| Putnam | 18 | 15 | 2,189 | 71,140 | 0.0308 | 75,364 | 2,319 | 1,130 | (1,189) |
| Rhea | 15 | 12 | 858 | 31,357 | 0.0274 | 32,809 | 898 | 492 | (406) |
| Roane | 23 | 20 | 2,047 | 54,276 | 0.0377 | 55,572 | 2,096 | 834 | (1,262) |
| Robertson | 26 | 25 | 1,565 | 66,529 | 0.0235 | 72,906 | 1,715 | 1,094 | (621) |
| Rutherford | 30 | 28 | 5,096 | 248,172 | 0.0205 | 274,920 | 5,645 | 4,124 | (1,521) |
| Scott | 17 | 14 | 1,052 | 22,854 | 0.0460 | 24,086 | 1,109 | 361 | (747) |
| Sequatchie | 12 | 10 | 375 | 13,727 | 0.0273 | 14,701 | 402 | 221 | (181) |
| Sevier | 15 | 16 | 2,222 | 86,655 | 0.0256 | 93,612 | 2,400 | 1,404 | (996) |
| Shelby | 26 | 26 | 18,253 | 938,186 | 0.0195 | 976,726 | 19,003 | 14,651 | (4,352) |
| Smith | 18 | 13 | 612 | 19,702 | 0.0311 | 20,984 | 652 | 315 | (337) |
| Stewart | 12 | 13 | 312 | 13,831 | 0.0226 | 14,854 | 335 | 223 | (112) |
| Sullivan | 14 | 12 | 5,775 | 154,096 | 0.0375 | 154,872 | 5,804 | 2,323 | (3,481) |
| Sumner | 24 | 23 | 3,731 | 158,385 | 0.0236 | 170,883 | 4,025 | 2,563 | (1,462) |
| Tipton | 20 | 17 | 1,282 | 61,300 | 0.0209 | 66,587 | 1,393 | 999 | (394) |
| Trousdale | 18 | 12 | 281 | 8,154 | 0.0345 | 8,611 | 297 | 129 | (168) |
| Unicoi | 12 | 11 | 660 | 17,851 | 0.0370 | 17,973 | 665 | 270 | (395) |
| Union | 17 | 15 | 502 | 20,336 | 0.0247 | 21,970 | 542 | 330 | (213) |
| Van Buren | 14 | 11 | 152 | 5,513 | 0.0276 | 5,560 | 153 | 83 | (70) |
| Warren | 21 | 15 | 1,972 | 41,541 | 0.0475 | 43,792 | 2,079 | 657 | (1,422) |
| Washington | 15 | 13 | 4,008 | 117,899 | 0.0340 | 122,518 | 4,165 | 1,838 | (2,327) |
| Wayne | 11 | 8 | 570 | 17,250 | 0.0330 | 17,801 | 588 | 267 | (321) |
| Weakley | 16 | 15 | 1,115 | 33,799 | 0.0330 | 34,247 | 1,130 | 514 | (616) |
| White | 16 | 13 | 985 | 25,189 | 0.0391 | 26,236 | 1,026 | 394 | (632) |
| Williamson | 26 | 26 | 2,588 | 177,123 | 0.0146 | 200,247 | 2,926 | 3,004 | 78 |
| Wilson | 31 | 29 | 2,832 | 111,199 | 0.0255 | 121,203 | 3,087 | 1,818 | (1,269) |
| Service Area | 714 | 613 | 69,519 | 2,762,157 | 0.0252 | 2,932,472 | 73,503 | 43,987 | (29,516) |

Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics

# ATTACHMENT, SECTION C, HOME HEALTH SERVICES, ITEM 3.1

## CORAM ALTERNATE SITE SERVICES, INC.

## SERVICE AREA MAP: MIDDLE TENNESSEE WITH SERVICE AREA

# ATTACHMENT, SECTION C, HOME HEALTH SERVICES, ITEM 5

## CORAM ALTERNATE SITE SERVICES, INC.

## LETTERS OF SUPPORT CONSTITUENTS

HOME HEALTH CARE
OF MIDDLE TENNESSEE

*Your home.*
*Our heart.*

April 19, 2012

To Whom It May Concern:

We understand that Coram is seeking a restricted home health agency CON to provide nursing services. We support this effort as it does not compete with our available services and will enhance patient services in the region.

Some of the patients who would benefit from home infusion services do not meet the requirement of Medicare/Medicaid home bound status. We would want Coram's home health agency to care for these types of patients and train these patients in self administration.

We ask that you consider Coram's request. Should you have any questions please feel free to call me at the numbers listed below.

Sincerely,

Veronica L Spann, RN

Veronica L. Spann, RN
Director of Patient Care
Home Health Care of Middle Tennessee
(615) 361-4859 or (615) 584-0061

(Private Duty) 410 New Salem Highway, Suite 100, Murfreesboro, TN 37129, Phone: 615.217.2065, Fax: 615.217.1346
Two International Plaza Drive, Suite 901, Nashville, TN 37217, Phone: 615.361.4859, Fax: 615.361.5187
2325 South Park Drive, Murfreesboro, TN 37128, Phone: 615.867.4007, Fax: 615.867.4979
1412 Trotwood Avenue, Suite 19, Columbia, TN 38401, Phone: 931.381.1603, Fax: 931.490.5873
8 Mathis Drive, Dickson, TN 37055, Phone: 615.446.3113, Fax: 615.446.6225
1019 Bradley Drive, Suite B3 , Springfield, TN 37172, Phone: 615.384.3311, Fax: 615.384.3301

CUMBERLAND MEDICAL CENTER
421 South Main Street, Crossville TN, 38555 Ph: (931) 484-9511

4/12/11

To Whom It May Concern,

I would like to express my support for the CON for infusion service nursing in the home.

It is common for patients to be ready for discharge from the hospital, but the discharges become delayed as patients are required to stay in the hospital an extra day because there is no home health agency that is available to administer the patient's first dose of medication in the home (this is usually when an evening dose is required).

Most home health agencies have policies that prevent them from starting a first dose of a medication in the home. This requires an increase in patients' length of stay in order to give the first dose before discharge. Additionally, we may need to discharge a patient home on the weekend, but are unable to locate a home health agency that is capable of admitting and caring for the patient until Monday morning, thus incurring extra costs and length of stay for the patient.

If infusion company nurses were able to assist with administering the first dose in patients' homes, this would help alleviate discharge delays that often create financial and other hardships for our patients.

Sincerely,

Sharon Parker

Sharon Parker, RN
Assistant Director Case Management
Cumberland Medical Center

TRI STAR MEDICAL GROUP
Indian Lake Neurology

353 New Shackle Island Rd. #249C
Hendersonville, TN 37075
Phone: 615-826-0442
Fax: 615-826-0447

To whom it may concern:

I am writing in support of Coram Healthcare to obtain a limited Certificate of Need for infusion in Tennessee. As a practicing physician, it is often difficult to find the necessary agencies to provide specialty infusion to my patients in a timely manner. Many of my patients require drugs such as IVIG that require long infusion times and need special training to administer.

Because of the lack of nursing agencies to provide this specialty infusion, many patients are forced to be hospitalized when home initiation would save time and money.

Nursing agencies increasingly shy away from these types of patients for low reimbursement. This service is needed to ensure that patients are receiving adequate, accessible care.

By granting this Certificate of Need to Coram Healthcare you would make patient care in the home more accessible and affordable, reducing overall costs to the health care system.

Sincerely,

Helion W. Cruz, M.D.
*Neurology*

Vanderbilt

To whom it may concern:

As a Case Manager for a large hospital system, I experience delays in discharge of patients to home on a daily basis due to lack of home nursing. This delay costs our hospital thousands of dollars each day which could be avoided.

I am writing in support of Coram Healthcare to receive a Certificate of Need for nursing in the state of Tennessee. If granted, Coram would be able to help facilitate early discharge of hospital patients to the home.

We are a large hospital system and see patients from all over the state of Tennessee. Finding sufficient nursing services for many of these patients is often difficult and sometimes non-existent. Many factors affect the ability of nursing agencies to accept patients such as insurance coverage, numbers of patients and availability of registered nurses.

By allowing Coram Healthcare the ability to provide nursing many of these delays would be avoided thereby, saving the hospital and patients money. These costs can run from $1500.00 per day and up.

Please grant the requested Certificate of Need to Coram Healthcare.

Best Regards,

Linda Busch, RN
Orthopedic case manager
Vanderbilt Univ. Medical Center

Hematology and Stem Cell Transplant Program 2665 The Vanderbilt Clinic Nashville, TN 37232-5505
p 615.936.1803 www.mc.vanderbilt.edu

# AFFILIATED NEUROLOGISTS, PLC

James P. Anderson, M.D.
Susan R. Bracey, APN, FNP-C

314 Bluebird Drive
Goodlettsville, TN 37072
615-851-5757 (Central Office)
615-851-4607 (Fax)

Clarksville, TN 931/221-0563
Nashville, TN 615/327-8730
Hendersonville, TN 615/824-6664

To whom it may concern:

I am writing in support of Coram Specialty Infusion to receive a certificate of need for home nursing. I am a practicing Neurologist with multiple offices in the middle Tennessee area. I treat patients that have limited access to facilities and conditions that restrict mobility.

I cannot find a home health agency that will support patients with first dosing. As a result, patients are delayed in receiving care. This delay directly affects health care costs.

Coram Specialty Infusion is an expert in blood product administration. I fully support and welcome the expertise they can bring to Middle Tennessee.

Thank you,

James Anderson, MD 5/3/12

# AFFILIATED NEUROLOGISTS, PLC

James P. Anderson, M.D.
Susan R. Bracey, APN, FNP-C

314 Bluebird Drive
Goodlettsville, TN 37072
615-851-5757 (Central Office)
615-851-4607 (Fax)

Clarksville, TN 931/221-0563
Nashville, TN 615/327-8730
Hendersonville, TN 615/824-6664

To whom it may concern:

I am writing in support of Coram Healthcare to obtain a limited Certificate of Need for infusion in Tennessee. As a practicing physician, it is often difficult to find the necessary agencies to provide specialty infusion to my patients in a timely manner. Many of my patients require drugs such as IVIG that require long infusion times and need special training to administer.

Because of the lack of nursing agencies to provide this specialty infusion, many patients are forced to be hospitalized when home initiation would save time and money.

Nursing agencies increasingly shy away from these types of patients for low reimbursement. This service is needed to ensure that patients are receiving adequate, accessible care.

By granting this Certificate of Need to Coram Healthcare you would make patient care in the home more accessible and affordable, reducing overall costs to the health care system.

Sincerely,

Susan Bracey

# ATTACHMENT, SECTION C, ECONOMIC FEASIBILITY, ITEM 2

## CORAM ALTERNATE SITE SERVICES, INC.

## FUNDING LETTER

APRIA HEALTHCARE®

26220 Enterprise Court
Lake Forest, California 92630
Tel (949) 639-2000

May 3, 2011

Ms. Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
500 Deaderick Street
Nashville, Tennessee 37243

**RE: Certificate of Need Application by Coram Alternate Site Services, Inc.**
**Establishment of a Limited Service Home Health Agency in Middle Tennessee**

Dear Ms. Hill:

Coram Alternate Site Services, Inc. is filing the Certificate of Need (CON) application described above to become approved in 40 counties throughout Middle Tennessee. Coram Alternate Site Services, Inc. is a wholly owned subsidiary of Coram Specialty Infusion Services, Inc., which owns 100 percent of the Applicant's issued shares. The ultimate parent is Apria Healthcare Group Inc. As the ultimate parent, I hereby make the following funding commitment to Coram Alternate Site Services, Inc. for the purpose of establishing, licensing and operating the proposed limited service home health agency in Middle Tennessee.

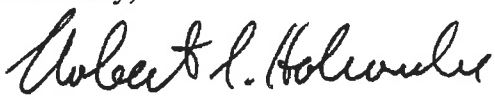
The project costs identified on the Project Cost Chart in the CON application are $63,000. Apria Healthcare Group Inc. will fund these costs from its existing current assets (cash on hand). As the audit of Apria indicates, we have in excess of $29 million cash and cash equivalents on hand as of December 31, 2011.

In addition to the commitment for the above noted project costs, Apria Healthcare Group Inc. is also committed to providing the necessary working capital for this proposed home health agency as well as funding any operating deficits and other pre-opening costs. Apria Healthcare Group Inc. has sufficient resources to fully fund these expenditures in addition to its other ongoing obligations. This is evidenced by Apria's balance sheet which is included as an attachment within the CON application.

Please accept this letter as confirmation of Apria Healthcare Group Inc. commitment to fund the proposed project including the total project costs, any necessary working capital, and any operating deficits incurred in the start up through its ongoing operation. We are fully committed to the funding of this project and look forward to the successful implementation of this program.

Thank you for your consideration.

Sincerely,



Robert Holcombe
Executive Vice President, General Counsel & Secretary

cc: Michael E. Dell, VP, General Counsel & Secretary, Coram Alternate Site Services, Inc.

# ATTACHMENT, SECTION C, ECONOMIC FEASIBILITY, ITEM 4

## CORAM ALTERNATE SITE SERVICES, INC.

## FORECASTED UTILIZATION AND FINANCIAL PERFORMANCE – EXISTING LICENSED PHARMACY

## PROJECTED DATA CHART -- EXISTING NASHVILLE OPERATIONS

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

| Year | | | 2012 BUDGET BEFORE PROJECT 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| A Utilization Data | Patients | Infusion Patients | 1,347 | 1,435 | 1,528 |
| | Patient Months | Infusion Pt Months | 2,668 | 2,841 | 3,026 |
| | Patients | Home Health Patients | 0 | 0 | 0 |
| | Nursing Visits | Home Health RN Visits | 0 | 0 | 0 |
| B Revenue from Services to Patients | | | | | |
| 1 Inpatient Services | | | | | |
| 2 Outpatient Services | | | $9,003,373 | $9,903,710 | $10,894,081 |
| 3 Emergency Services | | | | | |
| 4 Other Operating Revenue | | | | | |
| Gross Operating Revenue | | | $9,003,373 | $9,903,710 | $10,894,081 |
| C Deductions from Gross Operating Revenue | | | | | |
| 1 Contractual Adjustments | | | | | |
| 2 Provsion for Charity Care | | | $428,732 | $471,605 | $518,766 |
| 3 Provisions for Bad Debt | | | $257,239 | $282,963 | $311,259 |
| Total Deductions | | | $685,971 | $754,568 | $830,025 |
| NET OPERATING REVENUE | | | $8,317,402 | $9,149,142 | $10,064,056 |
| D Operating Expenses | | | | | |
| 1 Salaries and Wages | | | $1,525,468 | $1,601,742 | $1,681,829 |
| Benefits | | | $244,501 | $256,726 | $269,562 |
| 2 Physician Salaries and Wages | | | $0 | $0 | $0 |
| 3 Supplies | | | $50,025 | $52,526 | $55,152 |
| 4 Taxes | | | $0 | $0 | $0 |
| 5 Depreciation | | | $55,784 | $58,573 | $61,501 |
| 6 Rent | | | $147,407 | $154,777 | $162,516 |
| 7 Interest, Other than Capital | | | $0 | $0 | $0 |
| 8 Other Expenses | | Drugs/Materials | $4,037,281 | $4,239,145 | $4,451,102 |
| | | Shipping/Delivery | $214,553 | $225,280 | $236,544 |
| | | Travel/Lodging | $134,116 | $140,822 | $147,863 |
| | | Other | $130,368 | $201,938 | $277,087 |
| Total Operating Expenses | | | $6,539,502 | $6,931,528 | $7,343,157 |
| E Other Revenue (Expenses - Net (Specify) | | | | | |
| NET OPERATING INCOME (LOSS) | | | $1,777,900 | $2,217,614 | $2,720,899 |
| F Capital Expenditures | | | | | |
| 1 Retirement of Principal | | | | | |
| 2 Interest | | | | | |
| Total Capital Expenditures | | | $0 | $0 | $0 |
| NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES | | | $1,777,900 | $2,217,614 | $2,720,899 |

## PROJECTED DATA CHART -- CONSOLIDATED NASHVILLE OPERATIONS

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

| Year | | | 2013 | 2014 |
|---|---|---|---|---|
| A Utilization Data | Patients | Infusion Patients | 1,435 | 1,528 |
| | Patient Months | Infusion Pt Months | 2,841 | 3,026 |
| | Patients | Home Health Patients (subset) | 247 | 263 |
| | Nursing Visits | Home Health RN Visits | 1,192 | 1,252 |
| B Revenue from Services to Patients | | | | |
| 1 Inpatient Services | | | | |
| 2 Outpatient Services | | | $10,116,146 | $11,128,292 |
| 3 Emergency Services | | | | |
| 4 Other Operating Revenue | | | | |
| Gross Operating Revenue | | | $10,116,146 | $11,128,292 |
| C Deductions from Gross Operating Revenue | | | | |
| 1 Contractual Adjustments | | | $10,116 | $11,153 |
| 2 Provsion for Charity Care | | | $481,721 | $529,919 |
| 3 Provisions for Bad Debt | | | $289,033 | $317,951 |
| Total Deductions | | | $780,870 | $859,023 |
| NET OPERATING REVENUE | | | $9,335,276 | $10,269,270 |
| D Operating Expenses | | | | |
| 1 Salaries and Wages | | | $1,720,606 | $1,808,738 |
| Benefits | | | $274,406 | $287,684 |
| 2 Physician Salaries and Wages | | | $0 | $0 |
| 3 Supplies and Mileage | | | $83,102 | $87,257 |
| 4 Taxes | | | $0 | $0 |
| 5 Depreciation | | | $58,573 | $61,501 |
| 6 Rent | | | $154,777 | $162,516 |
| 7 Interest, Other than Capital | | | $0 | $0 |
| 8 Other Expenses | | Drugs/Materials | $4,239,145 | $4,451,102 |
| | | Shipping/Delivery | $225,280 | $236,544 |
| | | Travel/Lodging | $140,822 | $147,863 |
| | | Other | $201,938 | $277,087 |
| Total Operating Expenses | | | $7,098,648 | $7,520,293 |
| E Other Revenue (Expenses - Net (Specify) | | | $0 | $0 |
| NET OPERATING INCOME (LOSS) | | | $2,236,628 | $2,748,976 |
| F Capital Expenditures | | | | |
| 1 Retirement of Principal | | | $0 | $0 |
| 2 Interest | | | $0 | $0 |
| Total Capital Expenditures | | | $0 | $0 |
| NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES | | | $2,236,628 | $2,748,976 |

# Copy
# Supplemental #1

## Coram Alternate Site Services

# CN1205 -020

SUPPLEMENTAL

**AFFIDAVIT**

2012 MAY 31 PM 4: 14

STATE OF COLORADO )
)
COUNTY OF DENVER )

NAME OF APPLICANT: **CORAM ALTERNATE SITE SERVICES, INC.**

I, Michael E. Dell, after being duly sworn, state under oath that I am the lawful agent of applicant named in this Certificate of Need application, that I have reviewed all of the supplemental information submitted herewith, and that to the best of my knowledge, it is true, accurate and complete.

Michael E. Dell
Vice President, General Counsel & Secretary

Sworn to and subscribed before me, a Notary Public, this the 30th day of May, 2012, witness my hand at office in the County of Denver, State of Colorado.

PATRICIA V. IVANCICH NOTARY PUBLIC STATE OF COLORADO MY COMMISSION EXPIRES 6-12-2015

Patricia V. Ivancich, NOTARY PUBLIC, STATE OF COLORADO
My commission expires June 12, 2015.

SUPPLEMENTAL

1. **Bureau of TennCare Letter on HSDA web site.**

A). Please review the Bureau of TennCare's Letter posted on the HSDA's website and describe what it has on the preparation of the home health business plan and this CON application. Please modify any utilization numbers and Projected Data Chart information, if applicable.

**RESPONSE: The applicant is aware of and reviewed the TennCare letter regarding private duty nursing providers needing to be certified as a Medicare HHA in order to participate in TennCare as well as the limited TennCare HHA benefit. As noted in the application, the applicant is seeking a home health agency CON limited to administering its infusion therapies and skilled nursing services related to the same. It will not be seeking to participate in Medicare or TennCare for reimbursement of its nursing services.**

B). Has the applicant had discussions with the TennCare MCOs which serve the applicant's proposed service area (i.e., AmeriChoice, BlueCare, TennCare Select, and others) to see if there is interest in contracting with another home health agency? If so, please identify and provide letter of interest.

**RESPONSE: Because the applicant is not intending to be a participating provider for infusion nursing services it has not had any discussion with TennCare MCOs regarding becoming a contracting provider.**

2. **Filing of the Application.**

**RESPONSE: The applicant has revised the relevant charts and calculations relevant to the removal of Moore County from the scope of the proposed service area, which are attached hereto as substitutes for those filed with the application.**

3. **Section B, Project Description, Item I**

A) Please provide a description of the duties, functions and tasks which the applicant intends to perform as part of these "home health nursing services".

**RESPONSE: As part of its administration of home infusion therapies the applicant intends to (a) take and record vital signs of the patients; (b) draw blood and other fluids for labs; (c) treat any issues associated with the access site or port; (d) change dressings associated with access points; (e) administer the therapy or blood products; (f) line maintenance; (g) phlebotomy services, and (h) infusion equipment repair and replacement.**

B) Should a patient served by Coram Alternative Site Services require home health services for conditions other than those related to the medication infusion products, how does the applicant intend to respond to these needs? Will these services be provided directly or will the applicant seek to refer the patient out to another licensed home health agency to provide the care not related specifically to the infusion service?

**RESPONSE: For patients in need of home health services other than those associated with the applicant's delivery and administration of home infusion products, the applicant will make reasonable efforts to communicate that need with the patient's treating physician who can order such services through another licensed home health agency. The applicant will not**

**provide the service when another full service HHA stands ready willing and able to serve the patient. In other words, "If they can do it all, we will give it to them."**

C) Please define IVIG and Alpha 1 Therapies, First Dose Administration, Low Intervention Patients, Three Dose Schedule Patients, Rural and Pediatric patients and discuss what special needs and care the caregiver will require to provide for quality patient care

**RESPONSE: IVIG, intravenous immunoglobulin, is given as a plasma protein replacement therapy for immune deficient patients who have decreased or abolished antibody production capabilities. Alpha-1 antitrypsin infusion therapy is given to treat the genetic disorder alpha 1-antitrypsin deficiency that causes defective production of the alpha 1-antitrypsin (A1AT) leading to decreased A1AT in the blood and lungs. First Dose Administration is the first time a prescribed infusion therapy is provided to the patient.**

**A Low Intervention Patient is a patient who is not homebound and do not require significant nursing intervention; rather, they comprise a group of patients who are taught to self-administer thereby limiting the number of home skilled nursing visits.**

**Three Dose Schedule Patients are infusion therapy patients whose therapy is administered three times throughout the day (i.e., 8 am, 2 pm and 10 pm). Rural Patients are infusion therapy patients who reside well outside the major cities in Middle Tennessee such as Clarksville, Nashville, Cookeville, Murfreesboro, and Chattanooga, where major medical centers and infusion providers are prevalent. Pediatric Patients are children who require infusion therapy products and services.**

**The applicant's nursing staff are specially trained in the art and skill of providing infusion therapies, most are certified, have over 1,600 hours of clinical infusion therapy experience, and have developed training and skills necessary to identify, collaborate and treat infusion therapy related effects, as well as communicate to patients on proper care of catheter sites, sterile treatment and monitoring of equipment and supplies.**

D) Which Home Health Agencies have been providing these home infusion services in the past? In other words, has the applicant worked in a coordinative fashion with various HHAs in the past? Why haven't these arrangements worked and how will the creation of another agency improve coordination and quality of care?

**RESPONSE: Provided the patient qualifies for home health services (e.g., home bound), and after the first dose, and provided that the therapy is not of repeat or long duration, incumbent home care agencies such as CareAll and Middle Tennessee Home Health have on occasion provided care to the applicant's patients. These arrangements do not work because: (a) many of these patients are not truly home bound so they do not qualify for reimbursement, and thus the HHAs do not want these patients; (b) because many of these therapies are of a long duration (3+ hours) it is not economically advantageous for a full service agency to tie up an RN for that length of time; and (c) because none of the full service agencies will do first dosage patients, nor will any infuse blood or blood products in the home.**

E) The applicant is proposing a significantly wide and topographically diverse service area. Discuss how does the applicant intends to service this large geographical area from a single location in Nashville? What is the applicant's operational delivery model? Please include in the discussion the infusion product delivery methods and the infusion nurse deployment methodology.

**RESPONSE: As discussed in the application, the applicant will install one (1) full time infusion nurse centrally located in Nashville, and will add per diem, or per visit, infusion nurses throughout the service area as needed to respond expeditiously to requests for service. Operationally, on occasion if the patient is local, the infusion nurse will take the infusion product from the compounding pharmacy to the patient's home for administration. More often, the infusion product will be compounded at the applicant's Sidco Drive facility and taken by secure courier to the patient's home where it is met by the infusion nurse for administration.**

F) Please discuss how the applicant intends to develop, manage, supervise and maintain patients' plans of care.

**RESPONSE: The applicant's encounter with a patient begins upon the patient's attending physician ordering an infusion product or service and a referral is made to the applicant (either by the physician or discharge planners at area medical centers). The applicant verifies insurance, the physician order, and the patient's demographic information and transmits that data to the pharmacy which compound's the patient's drug therapy. Three groups within the applicant then coordinate the patient's care: the pharmacy with respect to the drug mix, the courier service for secure and timely delivery, and nursing for education and administration. The applicant has implemented an electronic medical record system that securely communicates with the home office regarding nursing encounter notes for services rendered in the home and summaries of care are shared with the patient's physician.**

G) How does the applicant intend to implement the proposed home health agency's quality of care plan?

**RESPONSE: The applicant employs a director of nursing services who will be the supervisor for all the nursing functions associated with the applicant who will be available at all time during operating hours and shall participate in all activities relevant to the professional home health services provided, including the development of qualifications and assignment of personnel. In addition, the agency shall have a committee, consisting of the nursing director, the agency's executive director and the regional president who shall review at least annually past and present HHA services to determine the appropriateness and effectiveness of the care provided.**

## 4. Section B, Project Description, Item IIC

The applicant indicates "as a licensed pharmacy providing infusion therapy products to patients in their homes, Coram is intimately familiar with patients throughout the region, and the hardships encountered by hospitals, physicians and patients/families in effecting a timely discharge from a hospital when hospitalization is no longer required, but the

patient and family have not initiated their first infusion dose nor are they knowledgeable about the process, infusion equipment, and the specific regimen which must be followed".

A) Please provide some anecdotal examples.

**RESPONSE: The applicant experiences situations as described below on a near daily basis:**

**76 yr old male diagnosed with IDDM foot ulcer at risk of amputation, had orders from the physician to change the antibiotic from Vancomycin to Daptomycin. Pt had to be admitted to the ER for his first dose, because a Home Health Agency could not be identified to give a first dose in the home.**

**43 yr old female diagnosed with CIDP needing monthly infusions of IVIG had to drive 4 hours to the nearest clinic every month because no Home Health Agency could be identified that would give the lengthy infusion in the home**

**23 yr old female diagnosed with exacerbation of MS symptoms had to drive to the nearest clinic over 2 hours away, 5 days/week to get her solumedrol infusions because no Home Health Agency could be identified who would do her infusions because she did not meet homebound criteria**

**54 yr old female diagnosed with PID had to travel approx. 3 hours into the nearest AIS (ambulatory infusion suite) for teaching and first infusion of SQ hizentra because no Home Health Agency could be identified that had the expertise or knowledge of giving SQ hizentra or willing to give first dose in the home**

**32 yr old male patient diagnosed with infected hardware, post ortho surgery ordered to have 6-8 weeks of IV antibiotics. After 3 weeks, due to wound not healing, MD ordered antibiotic changed from Vancomycin to continuous infusion Nafcillin—patient had to drive over 4 hours to the nearest hospital and be admitted to the outpatient clinic, waiting approx. 3 hours to be seen—in order to get his first dose of Nafcillin because no Home Health Agency could be identified that would give a first dose in the home**

**24 yr old female diagnosed with hyperemesis needing to be started at home on SQ zofran ASAP! Patient had no mode of transportation, was very sick, mildly dehydrated and overall feeling miserable, had to take a taxi to the ER because no Home Health Agency could be identified to give the first dose of SQ zofran to a pregnant woman in the home**

**7 yr old male diagnosed with CIDP needed 5 days of IVIG infusions every month. Patient had to be admitted to the hospital each month for 5 days in order to get his infusions because no Home Health Agency could be identified that would give a lengthy infusion of this blood product for 5 days each month**

**6mo old female infant on TPN/lipids and omegavan had to remain in the hospital (discharge delayed) an extra 30 days because no Home Health Agency could be identified in their area with expertise to give these**

**complicated therapies to an infant. Ultimately the parents were taught and the infant was sent home without any HHA support.**

B) How will the applicant meet the needs of home infusion better than the existing process? Better coordination of administration, better trained nurses?

**RESPONSE: As noted in the application, this patient population's needs are not being met by the incumbent HHA providers, primarily because of reimbursement issues. They cannot get reimbursed for patient's that are not home bound, they cannot get adequately reimbursed for an infusion therapy that lasts several hours, and they only get reimbursed for one visit, even though for three (3) therapy regimens require 3 visits in the same day. Furthermore, the existing agencies will not treat patients on their first dose, and will not administer blood or blood products in the home. By granting the applicant's limited service HHA these patients can remain in their home, thereby avoiding the time and inconvenience of traveling to an outpatient hospital clinic, as well as avoiding exposure of their immune suppressed bodies to nosocomial infections. Finally, the care rendered by the applicant's certified infusion nurses is vastly superior to that of the RN untrained in spotting infusion complications, educating patients on sterile site and site maintenance.**

C) From the applicant's experience, please provide an estimate of the additional hospital days which could be eliminated by initiation of this new service?

**RESPONSE: The applicant has commissioned studies of the impact of infusion nursing in other markets and found that on average 80% of referrals are made on the expected last day of the patient's stay, and with home infusion nursing availability the applicant is able to discharge 50-70% of these patients that day, and the remainder the next. The applicant's payer partners value this opportunity to avoid another overnight stay in the hospital.**

D) From the applicant's experience, please provide an estimate of the additional health care delivery cost savings which could be realized by initiation of this new service.

**RESPONSE: The applicant only tracks actual encounters with patients and does not track cases where it could not meet a patient's need in the home due to the factors set forth in the application (i.e., not home bound, long duration infusions, first dose infusions, 3 dose infusions, blood products) which are non-encounters. As noted above, the applicant's studies show that with the infusion nursing component available the applicant is able to reduce hospital stays by at least one day in 50-70% of cases. Additionally, the letter of support from Vanderbilt Medical Center, which also has its own home health agency, indicates that for each day saved in the hospital, it will experience a corresponding $1,500/day savings in costs.**

## 5. Section B, Project Description, Item III (Plot Plan)

As required in the application for all projects, the Plot Plan must provide **the size of the site (in acres), location of the structure on the site, the location of the proposed project (*location of the HHA*), and the names of streets, roads, highways that cross or border the site**. Please provide a Plot Plan with all the required information.

**RESPONSE: As reported by the Davidson County GIS, the acreage for the applicant's location at 2970 Sidco Drive is 1.1 acres. The map provided as attached Tab A shows the information requested above.**

6. **Section B, Project Description, Item IV (Floor Plan)**

A) Please indicate on the floor plan drawing for the facility **location of the HHA and indicate the square footage which will be required to support the home health agency operations**. Note according to Rules of the Tennessee Department of Health, Board of Licensing, the HHA must provide separated space for maintenance of the HHA's records, including personnel, business and patient records.

**RESPONSE: The revised floor plan attached hereto as Tab B shows within the applicant's existing infusion pharmacy location where the HHA will be housed and its approximate footprint of approximately 200 square feet as indicated by the yellow highlight. One office for the permanent infusion nurse stationed in Nashville, two cubes for scheduling, support and administration, and a 5x5 area of the fileroom for separate secure storage of the HHA business and medical records.**

7. **Section B, Project Description, Item V (Home Health Agency)**

The applicant indicates it is licensed for a limited service home health agency whereby its license will be restricted to provide only infusion nursing and "related skilled services." Please define "related skilled services."

**RESPONSE: The applicant intends to provide the following skilled services in conjunction with its home infusion therapy product: (a) take and record vital signs of the patients; (b) draw blood and other fluids for labs; (c) treat any issues associated with the access site or port; (d) change dressings associated with access points; (e) administer the therapy or blood products; (f) line maintenance; (g) phlebotomy services, and (h) infusion equipment repair and replacement.**

8. **Section C, Need, Item 1.**

Please discuss how the proposed project will relate to the 5 Principals for Achieving Better Health found in the State Health Plan."

**RESPONSE:**

1. **Improve the Health of Tennessee. As noted, health in Tennessee will be improved through this project because current immune compromised individuals will not be required to leave their home and expose themselves to advantageous pathogens in order to receive their life-saving therapies.**
2. **Reasonable Access to Care for Every Citizen. By making these services more widely available in the home, access to even some of the most remote citizens is improved because they will no longer be required to travel to a major medical center for outpatient infusion therapy.**

SUPPLEMENTAL

3. **Health care resource development that encourages competitive markets, economic efficiencies and continued development of the state's health care system. The proposed project makes these improvements in health care at minimal cost and disruption by narrowly focusing on a particular patient population whose needs are not being fully served, or who are being served but at great expense when in home care would be much safer and less costly.**
4. **Confidence in the quality of health care is continually monitored and standards are adhered to by providers. The applicant's nursing director will review a sufficient sample of patient charts for each caregiver in order to identify and eliminate poor quality of care, and to accentuate and reward outstanding quality of care and outcomes.**
5. **State support for development, recruitment and retention of a sufficient and quality health care workforce. The applicant intends to maintain one full time registered infusion nurse in Nashville and employ certified infusion nurses on a per diem or per visit basis thereby supporting a highly skilled and specialized nursing workforce throughout Tennessee.**

9. **Section C, Need, Item 1.a. (Project Specific Criteria-Home Health Services) (1.-4.)**

Your response to the item 1 is noted. In you're the response, the applicant notes the "need for this special service was developed by the applicant based on its existing infusions therapy patient profiles including age, county of residence, infusion service requirement, payor, referral source and identified hardship experiences by patients, families and their referral sources (hospitals, physicians and others) to obtain infusion nursing service in the home on a timely basis."

A)

B) Please define "timely basis"

**RESPONSE: Depending on the urgency, day of week, and hour of the day, the applicant makes commercially reasonable efforts to see patients within 2-3 hours of physician order.**

C) Over the past two-three years, please complete the following chart.

| | 2009 | 2010 | 2011 | 2012 YTD |
|---|---|---|---|---|
| Total home infusion patients | 1,028 | 958 | 1,288 | |
| | 1,213 | 1,117 | 1,545 | |
| Number of home patients whose infusion has been delayed | n/a | n/a | n/a | n/a |
| Number of days of delay in initiation home infusion services | n/a | n/a | n/a | n/a |
| Number of additional days in the hospital due to delays in initiation home infusion services | n/a | n/a | n/a | n/a |

**RESPONSE: The applicant cannot complete the bottom 3 rows of the chart because it does keep records or track interactions with patients that do not result in an encounter. As noted above, the applicant has commissioned studies in other markets to gauge the effectiveness of having a home infusion**

**nursing component to its services and on average is able to reduce hospitalizations by one day in 50-70% of its hospital discharges by having nursing available.**

D) Please define and differentiate "Unduplicated Patients" and "Duplicated Patients/ Unduplicated Therapies"

**RESPONSE: "Unduplicated Patients" reflects the number of unique patients seen by the applicant in the past year regardless of the number of different therapies ordered or administered.**

**Duplicated Patients/Unduplicated Therapies reflects the number of unique therapies administered to all patients in the past year, which may arise when one patient receives more than one infusion therapy.**

E) A review of the Department of Health Division for Licensing Health Care Facilities indicates there are eighty-eight (88) home health agencies licensed to serve the applicant's proposed service area. A listing of the 88 HHA's is attached. This expanded listing will likely affect your calculations of gross need, the inventory of agencies which are currently serving the proposed service area, and the net need for additional agencies at this time and in the near-term future (CY 2016).

**RESPONSE: The applicant has revised the various charts and relevant pages in the application where the service area and revised agencies are applicable and attaches those to this supplement as collective Tab C.**

F) ***Guidelines for Growth* Methodology**: Because the scope of the project includes the creation of an HHA, the applicant must include all existing licensed HHAs authorized to serve the Shelby County service area in order to apply the need formula correctly. This can be done using the following table (*please note that utilization is requested for three JAR reporting periods.*

**Existing Licensed HHAS & Their Utilization serving the 38 County Declared Service Area**

| Agency (license #) | County of Parent Office | Total Counties Authorized in License (# of Counties in service area) | 2009 JAR Total Patients Served | 2010 JAR Total Patients Served | 2011 JAR Total Patients Served |
|---|---|---|---|---|---|
| 02024 | Bedford | 6 | 322 | 284 | 282 |
| 03025 | Benton | 3 | 320 | 305 | 305 |
| 06043 | Bradley | 1 | 9 | 11 | 5 |
| 06063 | Bradley | 8 | 2462 | 2381 | 2384 |
| 09065 | Carroll | 0 | 2 | 0 | 0 |
| 14024 | Clay | 7 | 389 | 303 | 347 |
| 16024 | Coffee | 8 | 842 | 714 | 696 |
| 16034 | Coffee | 12 | 878 | 1035 | 972 |
| 18054 | Cumberland | 1 | 417 | 545 | 536 |

SUPPLEMENTAL

2012 OCT 31 PM 4:14

| Agency (license #) | County of Parent Office | Total Counties Authorized in License (# of Counties in service area) | 2009 JAR Total Patients Served | 2010 JAR Total Patients Served | 2011 JAR Total Patients Served |
|---|---|---|---|---|---|
| 19654 | Davidson | 10 | 596 | 342 | 139 |
| 19674 | Davidson | 11 | 3035 | 2858 | 2798 |
| 19024 | Davidson | 5 | 1121 | 1406 | 1500 |
| 19684 | Davidson | 1 | 631 | 701 | 752 |
| 19664 | Davidson | 6 | 731 | 788 | 905 |
| 19494 | Davidson | 28 | 636 | 385 | 114 |
| 19614 | Davidson | 14 | 772 | 769 | 1040 |
| 19714 | Davidson | 1 | 0 | 9 | 10 |
| 19084 | Davidson | 10 | 1629 | 1345 | 1239 |
| 19544 | Davidson | 33 | 1866 | 1892 | 1942 |
| 19584 | Davidson | 14 | 3457 | 4017 | 4246 |
| 19504 | Davidson | 2 | 72 | 0 | 73 |
| 19364 | Davidson | 11 | 357 | 386 | 644 |
| 19704 | Davidson | 9 | 77 | 154 | 138 |
| 19374 | Davidson | 1 | 91 | 113 | 118 |
| 19324 | Davidson | 12 | 2928 | 4728 | 5428 |
| 19394 | Davidson | 7 | 1173 | 1155 | 1179 |
| 19314 | Davidson | 7 | 885 | 1049 | 1180 |
| 19694 | Davidson | 20 | 2860 | 3406 | 3087 |
| 20045 | Decatur | 4 | 201 | 157 | 157 |
| 20055 | Decatur | 4 | 324 | 302 | 299 |
| 21024 | DeKalb | 7 | 406 | 1282 | 1406 |
| 25044 | Fentress | 5 | 1438 | 1437 | 1189 |
| 25034 | Fentress | 3 | 68 | 175 | 455 |
| 26054 | Franklin | 10 | 1234 | 1180 | 1081 |
| 26024 | Franklin | 16 | 1007 | 1215 | 1380 |
| 27085 | Gibson | 1 | 19 | 15 | 63 |
| 32132 | Hamblen | 0 | 0 | 0 | 0 |
| 33423 | Hamilton | 3 | 36 | 6 | 10 |
| 33103 | Hamilton | 6 | 1444 | 1367 | 1583 |
| 33213 | Hamilton | 5 | 1379 | 1405 | 1492 |
| 33383 | Hamilton | 4 | 16 | 17 | 20 |
| 33093 | Hamilton | 6 | 315 | 425 | 450 |
| 33083 | Hamilton | 6 | 1021 | 1173 | 1324 |
| 33133 | Hamilton | 3 | 132 | 223 | 206 |
| 33363 | Hamilton | 6 | 297 | 365 | 652 |
| 33303 | Hamilton | 4 | 427 | 390 | 298 |

| Agency (license #) | County of Parent Office | Total Counties Authorized in License (# of Counties in service area) | 2009 JAR Total Patients Served | 2010 JAR Total Patients Served | 2011 JAR Total Patients Served |
|---|---|---|---|---|---|
| 33433 | Hamilton | 4 | 61 | 82 | 50 |
| 33253 | Hamilton | 6 | 3044 | 3215 | 3198 |
| 33033 | Hamilton | 3 | 206 | 199 | 194 |
| 36025 | Hardin | 1 | 75 | 87 | 96 |
| 39035 | Henderson | 0 | 0 | 0 | 0 |
| 40075 | Henry | 1 | 0 | 0 | 1 |
| 41034 | Hickman | 6 | 142 | 148 | 144 |
| 47202 | Knox | 0 | 0 | 0 | 0 |
| 47062 | Knox | 2 | 10 | 9 | 14 |
| 47182 | Knox | 0 | 37 | 0 | 0 |
| 52024 | Lincoln | 9 | 563 | 588 | 698 |
| 52044 | Lincoln | 3 | 375 | 259 | 356 |
| 60074 | Maury | 7 | 353 | 338 | 269 |
| 60044 | Maury | 7 | 1056 | 1022 | 1184 |
| 60024 | Maury | 14 | 1998 | 1946 | 2152 |
| 60084 | Maury | 4 | 840 | 877 | 748 |
| 54043 | McMinn | 2 | 82 | 184 | 33 |
| 62052 | Monroe | 2 | 0 | 0 | 159 |
| 63034 | Montgomery | 4 | 800 | 800 | 966 |
| 63044 | Montgomery | 3 | 411 | 0 | 176 |
| 67024 | Overton | 6 | 844 | 865 | 865 |
| 71014 | Putnam | 9 | 594 | 596 | 553 |
| 71084 | Putnam | 6 | 268 | 262 | 230 |
| 74064 | Robertson | 5 | 335 | 325 | 289 |
| 74054 | Robertson | 5 | 664 | 830 | 867 |
| 75054 | Rutherford | 3 | 673 | 647 | 591 |
| 75064 | Rutherford | 13 | 905 | 1527 | 1677 |
| 75024 | Rutherford | 18 | 2654 | 2501 | 2700 |
| 79106 | Shelby | 1 | 13 | 0 | 1 |
| 80064 | Smith | 7 | 344 | 316 | 312 |
| 83114 | Sumner | 6 | 1300 | 1097 | 978 |
| 89074 | Warren | 5 | 525 | 508 | 503 |
| 89084 | Warren | 9 | 938 | 1042 | 983 |
| 89064 | Warren | 9 | 693 | 496 | 638 |
| 92025 | Weakley | 1 | 157 | 145 | 148 |
| 94074 | Williamson | 13 | 938 | 1340 | 1221 |
| 94094 | Williamson | 1 | 70 | 62 | 63 |

| Agency (license #) | County of Parent Office | Total Counties Authorized in License (# of Counties in service area) | 2009 JAR Total Patients Served | 2010 JAR Total Patients Served | 2011 JAR Total Patients Served |
|---|---|---|---|---|---|
| 94084 | Williamson | 15 | 33 | 0 | 81 |
| 95084 | Wilson | 11 | 2007 | 1931 | 1705 |
| 95064 | Wilson | 20 | 1736 | 1650 | 1441 |
| 95034 | Wilson | 18 | 932 | 1076 | 1237 |
| 95074 | Wilson | 10 | 31 | 128 | 217 |

** show the # of all counties for each HHA. The # of counties in the applicant's primary service area (PSA) should be shown separately in the bracket*

The next step regarding the need formula for home health services (Items 1-4) is to collate the data and show your work using the chart that follows:

**Home Health Need Formula in the Applicant's 38-county additional Service Area**

| **County (A)** | **# Authorized Agencies* (B)** | **2011 Pop** (C)** | **Patients served (2011) (D)** | **Use Rate (Patient /1000 pop.) (E)** | **2016 Pop (F)** | **Projected Capacity (G)** | **Projected Need (H)** | **Additional Need (Surplus) for 2015 (G-H)** |
|---|---|---|---|---|---|---|---|---|
| | | | | (Column D Divided by Column C) | | Column E Times Column F | Column F Times 0.015 | Column G Minus Column H |
| Bedford | 24* | | | | | | | |
| Bledsoe | 17 | | | | | | | |
| Cannon | 24 | | | | | | | |
| Cheatham | 30 | | | | | | | |
| Clay | 10 | | | | | | | |
| Coffee | 23 | | | | | | | |
| Cumberland | 19 | | | | | | | |
| Davidson | 36 | | | | | | | |
| DeKalb | 28 | | | | | | | |
| Dickson | 28 | | | | | | | |
| Franklin | 18 | | | | | | | |
| Giles | 13 | | | | | | | |
| Grundy | 25 | | | | | | | |
| Hamilton | 20 | | | | | | | |
| Hickman | 24 | | | | | | | |
| Humphreys | 19 | | | | | | | |
| Jackson | 14 | | | | | | | |
| Lawrence | 15 | | | | | | | |
| Lewis | 15 | | | | | | | |
| Lincoln | 15 | | | | | | | |
| Macon | 22 | | | | | | | |
| Marion | 18 | | | | | | | |
| Marshall | 23 | | | | | | | |
| Maury | 25 | | | | | | | |
| Montgomery | 24 | | | | | | | |
| Overton | 13 | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Putnam | 19 | | | | | | | |
| Rhea | 22 | | | | | | | |
| Robertson | 30 | | | | | | | |
| Rutherford | 37 | | | | | | | |
| Sequatchie | 19 | | | | | | | |
| Smith | 24 | | | | | | | |
| Sumner | 31 | | | | | | | |
| Trousdale | 23 | | | | | | | |
| Warren | 26 | | | | | | | |
| White | 20 | | | | | | | |
| Williamson | 35 | | | | | | | |
| Wilson | 35 | | | | | | | |
| Total | 88 | | | | | | | |

*** Note the numbers we have included here are "corrected" numbers of licensed agencies for each county.**

**** The official population source used by HSDA is the TN Dept. of Health, Division of Health Statistics' Population Projections, 2010-2020**

**RESPONSE: Please see the attached HHA Need formula attached hereto as Tab D.**

C) Based on the data initially submitted in the application, the applicant has submitted information which shows a sizeable surplus of home health services to the projected need for CY 2016 in the each of the 38 counties and the service area as a whole. Please discuss why the applicant feels there is a need for an additional home health service agency at this time.

**RESPONSE: As discussed in the application, existing home health agencies are reluctant and refuse to treat many of these patients in their homes for a variety of reasons, mostly because the patients are not truly "home bound" they do not qualify for home care reimbursement, in other cases, the nature of the therapy, such as IVIG, or Three Dose Therapies, which are either frequent throughout the day or require a several hour administration and observation, is not economically viable for existing HHAs to tie up a nurse for such low reimbursements, and, finally, no existing HHA will even consider administering First Dose Therapies and will only treat established infusion therapy patients.**

D) The applicant indicates the "need for its home health skill nursing infusion services should be measured by the special circumstances demonstrated by the Applicant, not the traditional or general observations included in the Guidelines [for Growth]". The applicant projects it will serve 263 patients per year. Please provide your methodology, showing assumptions, rationale and calculations, through which the applicant determines the need and its volume projections.

**RESPONSE: It is estimated that 100 percent of the specialty patients will require the service each month. The reason for such high utilization is these patient infusions last up to 6 hours per treatment. As such, the more traditional home health agency providing intermittent services is not generally staffed for nor compensated for under Medicare guidelines such long nursing visits. Ongoing, Coram has significant challenges to find nursing services for these patients resulting in these patients remaining in the hospital for an unnecessary prolonged period, having the patient**

**travel to his/her physician office for Coram to meet the patient in that setting or having the patient travel to another licensed location – all creating hardship on the patient and family.**

**For the balance of Coram's therapy patients, it is estimated that 10 percent of those patients will require infusion nursing provided by Coram's home health agency. Similarly, this patient estimate is based on the Applicant's assessment of its patient case load and the challenges it regularly faces in admitting a patient to the pharmacy service that can not obtain at home support to initiate the infusion therapy. Depending on the therapy, each patient will receive between two and four visits per month.**

**Extrapolating the above utilization assumptions and applying them to the estimated monthly census of infusion therapy patients results in a computed approximate 17 percent of Coram's pharmacy patients requiring skilled nursing services be provided by Coram. In the following table are the total number of home health patients and visits for each of the first two forecast years:**

| *Factor* | *CY 2013* | *CY 2014* |
|---|---|---|
| Number of Home Health Patients | 247 | 263 |
| | | |
| ***Skilled Home Health Visits by Infusion Therapy Type*** | | |
| Antibiotic Therapy | 667 | 701 |
| Total Parenteral Nutrition Therapy | 77 | 81 |
| Pain Management | 14 | 15 |
| Cardiac Treatment | 22 | 23 |
| IVIG | 132 | 139 |
| Alpha 1 | 108 | 113 |
| Viva | 65 | 68 |
| Antiemetic | 18 | 19 |
| Other | 89 | 93 |
| Total Annual Skilled Nursing Visits | 1,192 | 1,252 |

## 10. Section C. Need, Item 1 (Specific Criteria: Home Health Services, Item 5 – Documentation of Referral Sources)

The applicant provided responses to the following standards but did not provide the required documentation. Please provide the documentation requested in the following standards:

A. *The applicant shall provide letters of intent from physicians and other referral sources pertaining to patient referral.*
B. *The applicant shall provide information indicating the types of cases physicians would refer to the proposed home health agency and the projected number of cases by service category to be provided in the initial year of operation.*

The letters from the various physicians and potential referral sources indicate support, but do not indicate the "*projected number of cases by service category.*" Please provide the *projected number of cases by service category by referral source.*

**RESPONSE: The applicant analyzed the last 3-years of data regarding referral sources for infusion therapy services which reveals:**

| Referral Source | % of Referrals | Projected Cases |
|---|---|---|
| Hospitals | 80% | 210 |
| Physicians & Clinics | 14% | 37 |
| Other HHAs | 3% | 8 |
| Other Coram Affiliates | 2% | 5 |
| All Other | 1% | 3 |
| Total | 100% | 263 |

**There is only 1 service category for the applicant's limited home health agency CON request: administration of infusion therapy products and nursing care related to those services.**

C. *The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.*

The applicant has provided letters from physicians and other potential referral sources, however, there are no letters of support from patients experiencing difficulty, delay or inability to obtain the applicant's proposed services. Please provide letters from patients.

**RESPONSE: The applicant is reticent of soliciting its patients to advocate on its behalf, not the least of which it may violate the therapeutic boundary between caregiver and patient, and, while patients have express interest in attending the Agency hearing on this CON and expressing their support, the applicant does not desire for them to disclose their medical conditions and difficulties in a document that will become a public record.**

**11. Section C. Need, Item 1 (Specific Criteria: Home Health Services, Item 5 – Documentation of Referral Sources)**

A) Has the applicant held discussions with existing home health providers regarding this delay in service issue? Further documentation of these discussions including additional letters of support will be helpful.

**RESPONSE: The applicant has discussions of this nature daily with existing home health agencies, however, the applicant does not maintain documentation or data on interactions that do not ultimately result in an encounter with a patient.**

B) Has the applicant held discussions with existing hospital providers regarding this delay in discharge issue? Further documentation of these discussions including additional letters of support will be helpful.

**RESPONSE: The applicant does have discussions with hospital discharge planners regarding obtaining home infusion services for their patients, but unless the applicant actually provides that service it does not maintain records of such interactions. Indeed, the letter from Vanderbilt Medical Center, with its own home health agency, is indicative of its support and the need for these services.**

**12. Section C. Need, Item 1 (Specific Criteria: Home Health Services)- Item 6a and 6b**

Your response is noted. Although the applicant does not intend to charge for this service, the questions request the "average cost per visit" and the "average cost per patient based on the projected number of visits per patient" be listed. Please provide a response to the information which the question is requesting.

**RESPONSE: The Applicant will charge for its skilled nursing services. It is the only service it will provide as 100 percent of its visits will be skilled nursing. It will not provide any other type of home health services.**

**The average cost per skilled nursing visit for the Applicant is forecasted to be $140 in 2013 dollars. This is computed based on taking projected data chart total costs and dividing by the number of visits. It is based upon a mix of patients as described previously with some portion of the visits lasting up to six hours, or three times as long as the typical visit duration.**

**The Applicant's average skilled nursing cost per patient in 2013 dollars is $677. This is computed based on taking projected data chart total costs and dividing by the number of patients in each year.**

**13. Section C, Need, Item 3**

A) Your response is noted. The application question asked the applicant to identify and justify the reasonableness of the proposed service area. Please provide the number of patients by patient county of residence for the most recent year available at Coram Infusion

| County | No. of Coram Infusion patients in county | % of total patients |
|---|---|---|
| County #1 | | |
| County #2 | | |
| Etc. | | |
| Total | | 100% |

**RESPONSE: Please see the attached chart as Tab E.**

B) Please revise the map showing the proposed service area without Moore County.

**RESPONSE: Please see the attached revised map as Tab F.**

**14. Section C, Need, Item 4.**

Please complete the following chart.

| Demographic Data | 38 County Service area | State of TN Total |
|---|---|---|
| Total 2012 Population | 2,808,944 | 6,311,234 |
| Total Population- | 2,925,879 | 6,575,165 |
| Total 2016 Population % Change | 116,935 | 263,931 |
| Under 65 Pop. – 2012 | 2,444,747 | 5,432,738 |

| | | |
|---|---|---|
| **Under 65 Pop. – 2016** | **2,512,528** | **5,588,091** |
| **Under 65 Population Change** | **67,781** | **155,353** |
| **Under 65 Population % Change** | **87.0%** | **86.1%** |
| **Under 65 Population % of Total Population** | **85.9%** | **85.0%** |
| **Median Household Income** | **$45,409** | **$41,997** |
| **TennCare Enrollees** | **481,323** | **1,211,113** |
| **TennCare Enrollees as % of Total Population** | **17.1%** | **19.2%** |
| **Persons Below Poverty Level** | **414,819** | **1,041,354** |
| **% of Total Population below Poverty Level** | **14.8%** | **16.5%** |

*Sources: Population from Tennessee Department of Health, Tennessee Counties and the State; TennCare Enrollees from TennCare latest published data (November 2011); Median Household Income from Claritas, Inc.; and, Percent Poverty Level from U.S. Government and applied to Tennessee projections of population*

**15. Section C. Economic Feasibility Item 1 (Project Cost Chart)**

Your response is noted. However, there will likely be costs incurred in the development and licensure of the home health agency. Since the applicant had already provided this service and allocated space and equipment for the provision of these nursing services, one would speculate that there will be minimal cash outlay in continuing this service if the Certificate of Need is granted. However, there are lease costs for the space, equipment costs and other expenses associated with conducting the home health agency service such separate personnel records, business records, patient charts, patient care plans. If the applicant intends to utilize electronic medium for these items, there will still be hardwire and software costs and the cost of implementing these systems. Please identify these costs on the Project Cost Chart and submit a revised Project Cost Chart.

**RESPONSE: All support staff have equipment in place and no additional costs are anticipated to be incurred. At most, nurses will be provided some type of tablet computer or handheld device for recording and transmitting data from each patient visit in close to real time. The applicant anticipates incurring between $500 and $1,000 per device for an estimated 4-5 persons (1 FTE and the remaining pool nurses). Additionally, as noted in the application the applicant will be accessing mostly unutilized space in its leased current infusion compounding pharmacy and thus there are no incremental lease costs associated with adding this service.**

**16. Section C. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)**

A) The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised information Historical and Projected Data Charts provided at the end of this requests for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

**RESPONSE: The revised Historical and Projected Data Charts are attached as part of collective Tab C. The applicant confirms that there are no management fees, as described above, incurred by the applicant, whether to an affiliate or otherwise.**

B) Please discuss why there are no taxes listed on both the Historical and Projected Data Charts.

**RESPONSE: The applicant incurs no taxes at the branch level as they are all consolidated and reported up to the parent. With respect to Tennessee franchise taxes, the applicant has incurred $5,546, $3,295 and $2,971 in Tennessee F&E taxes in 2008, 2009 and 2010 respectively across all 3 branches (Memphis, Nashville and Knoxville). The applicant's derived approximately $1,000 in TN F&E taxes for the Nashville branch is updated in the Historical and Projected Data Charts. The applicant's TN excise tax is income based, but is $0 for each reported year due to carry forward losses from prior tax years.**

C) Also the please revise your underlying assumptions description for the projected Data Chart. Mileage is noted on Line D.3, not D.4.

**17. Section C. Economic Feasibility Item 4 (Average Gross Charge)**

Your response is noted. Why has the applicant chosen to show a two-step calculation of the requested information? Normally applicants include Contractual Adjustments, Charity and Bad Debt together in Deductions form Gross Revenue to derive Net Revenue.
Please provide an Average Gross Charge/ Visit.
Please provide an Average Gross Charge/ Patient Episode, Deduction from Revenue/ Patient Episode and a Net Revenue/ Patient Episode.

**RESPONSE: Please see the below requested chart:**

| Projected Data Chart | Year One | Year Two |
|---|---|---|
| Gross Charges | $212,436 | $234,211 |
| Deductions | ($10,116) | ($11,153) |
| Charity | ($10,116) | ($11,153) |
| Bad Debt | ($6,070) | ($6,692) |
| Net Revenue | $186,134 | $205,213 |
| | | |
| Patients | 247 | 263 |
| Visits | 1,192 | 1,252 |
| | | |
| Average Gross Charge/Visit | $178 | $187 |
| Average Gross Charge/Patient | $861 | $891 |
| Deductions/Patient | $107 | $110 |
| Average Net Revenue / Patient | $754 | $781 |
| Average Net Revenue / Visit | $156 | $164 |

SUPPLEMENTAL

**18. Section C. Economic Feasibility Item 6.B.**

Your Response is noted. Rather than providing ranges of charges per nursing visit for the 10 reporting agencies, please report each agency's skilled nursing charge. 2012 MAY 31 PM 4: 15

**RESPONSE: Following are the ten agencies by name and charge per skilled visit as reported in their 2011 Joint Annual Report.**

| *Agency Name* | *2011 Charge Per Skilled Visit* |
|---|---|
| **Continuous Care Services, LLC** | **$173** |
| **Elk Valley Health Services, Inc.** | **$79** |
| **Maxim Healthcare Services, Inc. (Davidson)** | **$85** |
| **SunCrest Home Health (Davidson)** | **$74** |
| **Vanderbilt Community and Home Services** | **$140** |
| **SunCrest Home Health (DeKalb)** | **$115** |
| **Maxim Healthcare Services (Hamilton)** | **$90** |
| **Hickman Community Home Care, Inc.** | **$164** |
| **SunCrest Home Health of Nashville, Inc.** | **$74** |
| **Home Health Care Services, LLC** | **$73** |

**19. Section C, Economic Feasibility, Item 9**

What is the current payor mix for Coram? Please complete the following chart.

| Payor | 2010 Gross Revenues | % of Total Revenues | 2011 Gross Revenues | % of Total Revenues | | 2013 HHA Gross Revenues | % of Total HHA Revenues |
|---|---|---|---|---|---|---|---|
| Medicare | 1,846,233 | 30% | 2,477,872 | 30% | | -0- | 0% |
| Medicaid/TennCare | 246,164 | 4% | 330,383 | 4% | | -0- | 0% |
| Commercial Insurance | 3,692,466 | 60% | 4,955,745 | 60% | | 185,283 | 87% |
| Self-Pay | 61,541 | 1% | 82,595 | 1% | | 17,037 | 8% |
| Charity | 307,705 | 5% | 412,978 | 5% | | 10,116 | 5% |
| Total | $6,154,111 | | $8,259,575 | | | $212,436 | 100% |

Since approximately 30% of the patients will be Medicare eligible, how will these patients have their infusion administration services paid for?

**RESPONSE: For patients that are home bound and Medicare eligible for HHA reimbursement, the applicant will continue its historical and current practice of trying to obtain full-service HHA coverage; for patients who do not qualify for Medicare reimbursement, or whose therapies existing HHAs decline to administer, the applicant will service these patient's needs through its newly implemented limited scope HHA that is the subject of the application.**

**20. Section C, Economic Feasibility, Item 10**

Please provide the Financial Statements (Balance Sheet and Income Statement) for Coram Alternative Site Services, Inc. for the latest annual accounting period.

**RESPONSE: Please see the attached unaudited balance sheet and income statement for the applicant at Tab G. Please note that these financial statements are consolidated for all three Tennessee branches.**

**21. Section C, Contribution to Orderly Development, Item 3**

Please clarify the number of additional of "pool/per diem" nurses which the applicant is proposing from year one to year two The applicant will be adding 1.68 FTE pool nurses in year one. Will the applicant be adding 0.07 FTE's or 1.75 FTE in the second year? What will be the total complement of pool RN's added by the second year.

**RESPONSE: As noted in the projected utilization, the vast majority of the applicant's anticipated patient need will come from Davidson County and its immediate environs, with others less intense utilization coming from counties grouped roughly north, east and south of Davidson County. The applicant therefore intends to meet this need by employing 1 full time infusion nurse operating out of Davidson County. The applicant calculates that it will need approximately ¾ of another full time infusion nurse (or approximately 1,360 – 1,500 hours annually) which it will obtain from pools of qualified infusion nurses in these geographic areas. The applicant anticipates the total complement of nurses to be the one full time nurse based out of Davidson County, and 3-4 rotating pool nurses (compensated either on a per diem or per visit basis) from the regions north, east and south of Davidson County. The total number of RN FTEs in Year2 will be 1.75 FTEs, an increase of 0.07 from Year1, as there are projected to be only 16 additional patients in Year2 (263) compared to Year1 (247).**

**22. Section C, Contribution to Orderly Development, Item 4**

The applicant envisions that a pool of Certified Infusion Registered Nurses (CIRN) will be recruited from around the proposed 38 county service area. The applicant plans to have enough pool CIRNs so that the average roundtrip to the patients' homes will be approximately 40 miles. Please describe further the geographic placement of these hopefully recruited CIRNs.

**RESPONSE: Geographic placement will be determinant on the number of patients in the area and their needs. The applicant believes one full time CIRN located in Nashville, with a pool of between 8-15 per diem/per visit CIRNs located near larger population centers throughout the service area (e.g., Clarksville to the north, Tullahoma/Winchester to the southwest, Chattanooga to the southeast, and Cookeville to the east) will be sufficient to cover the anticipated patient population to be served by this limited HHA.**

**23. Section C, Contribution to Orderly Development, Item 7b**

A copy of the TN Pharmacy license which Coram currently holds along with the most recent annual survey/inspection by the Department of Health is noted. Please discuss what measures the applicant has taken to prevent these citations, if any, from occurring again.

**RESPONSE: No measures other than those in the ordinary course of business and consistent with the applicant's policies and procedures were taken in response to the latest licensing survey because that survey noted no deficiencies.**

The applicant indicates it is also accredited by the Joint Commission. Please provide the results of The Joint Commission survey as well.

**RESPONSE: The applicant is accredited organizationally by the Joint Commission, which may or may not result in a survey of the applicant's Sidco Drive location. A copy of the applicant's latest Joint Commission approval is attached as Tab H. The Nashville location was not separately surveyed.**

PLEASE COMMENT HERE!

SUPPLEMENTAL

Active Layer: Ownership Parcels

Search

Locator

Layers

Legend (Key)

Measure

Select

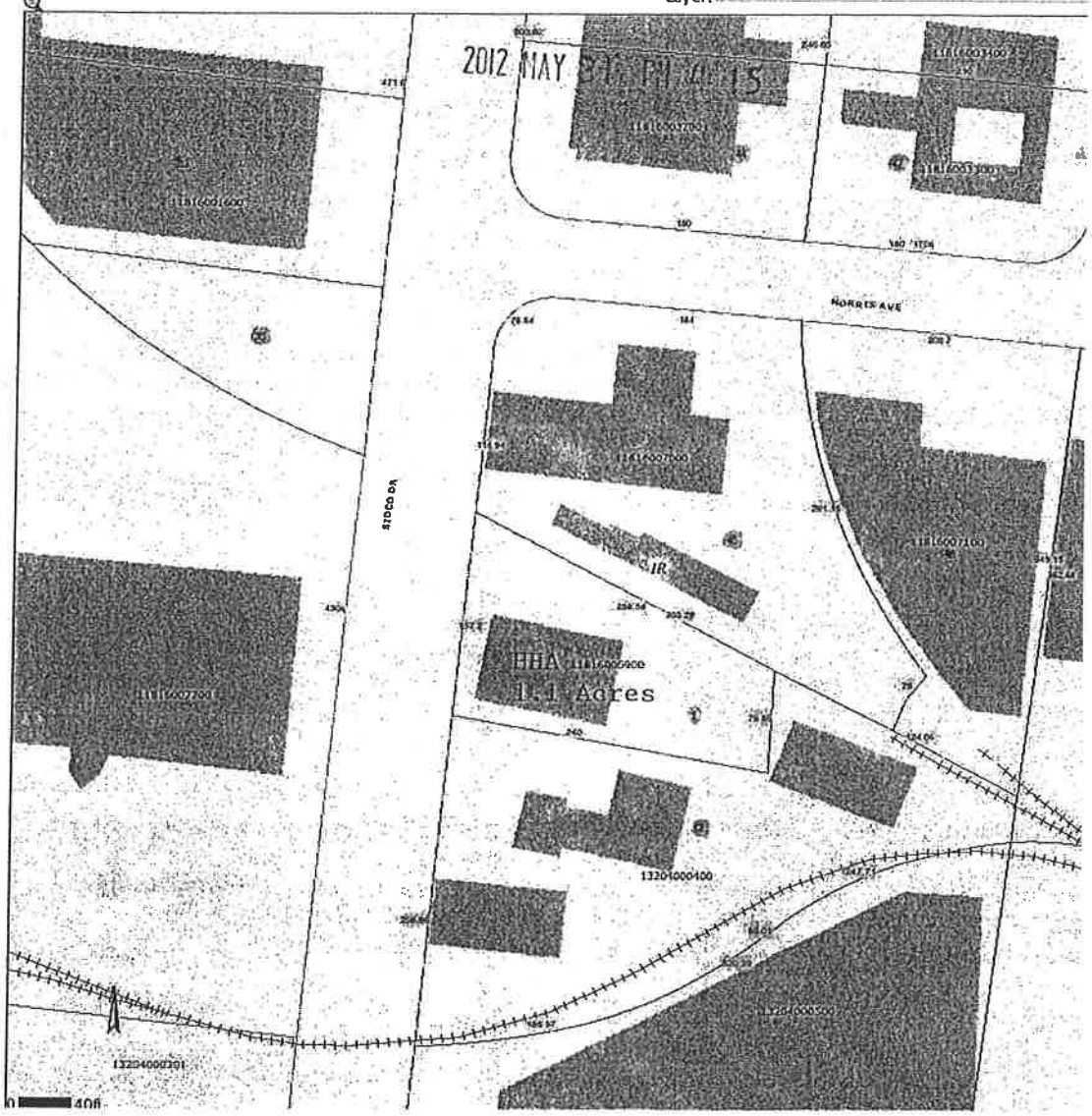
Selected Set

Results

Print

Help

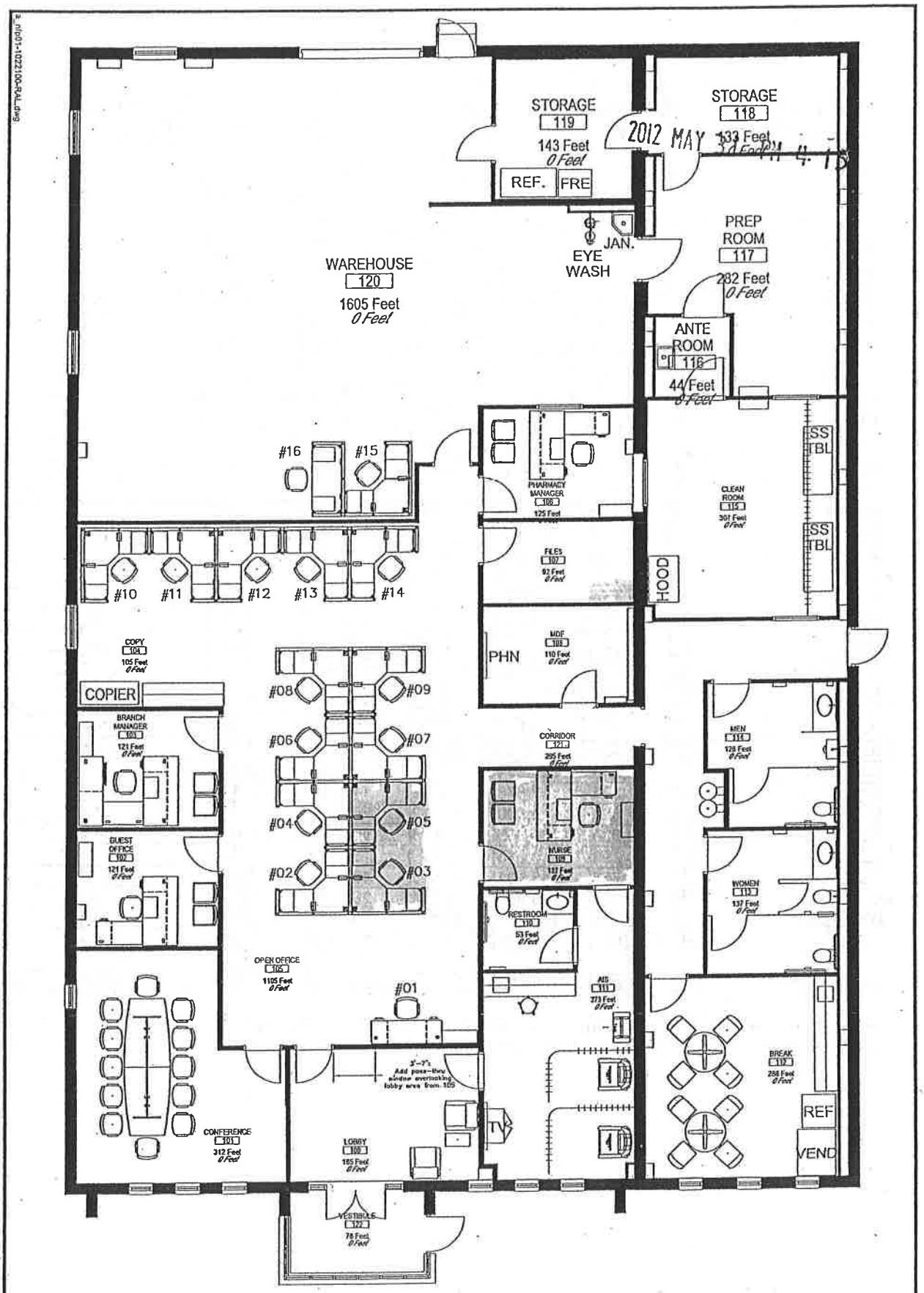
Go






naps.nashville.gov/propertykiva/site/main.htm

SUPPLEMENTAL




business interiors by STAPLES
www.businessinteriorsbystaples.com

2777 Stemmons Fwy
Suite 199
Dallas, TX 75207

Coram Specialty Infusion Services
Nashville, TN: Furniture Layout

| | | | |
|---|---|---|---|
| PROJECT #: 000000 | SALES REP: J Mortimer | INITIAL DATE: 05/31/2011 |
| SCALE: Not to scale | DESIGNER: J Mortimer | REVISION DATE: 10/18/2011 |
| FILE NAME: a_nfp01-1022100-RAL.dwg | | |

The information, ideas and depictions incorporated in this drawing or design document ("Design") are the sole and exclusive property of Business Interiors by STAPLES, which owns all rights, title and interest in this Design, including without limitation, the copyrights and trademarks associated with this Design. The information, ideas and depictions are confidential and proprietary to Business Interiors by STAPLES. Any use of this Design, including reproduction, distribution, or incorporation in bid submissions or quotes without the written consent of Business Interiors by STAPLES is expressly prohibited. This Design is not to be used for construction purposes. Contractors, subcontractors and other third parties are not permitted to rely solely on the representations, data or measurements contained in this Design, and each must verify all dimensions and conditions on site before proceeding with fabrication or installation work depicted in this Design. The Design and all data it contains is not to be used for fabrication or installation until countersigned by the Business Interiors by STAPLES designated designer or project controller.

WE CANNOT ACCEPT CHANGES, RETURNS OR CANCELLATIONS AFTER YOUR ORDER IS PROCESSED OR IS IN PRODUCTION. ADDITIONAL CHARGES MAY BE APPLIED OR A FORFEIT OF DEPOSIT IN CERTAIN CIRCUMSTANCES. YOUR SIGNATURE APPROVES DESIGN AND SPECIFICATIONS.

SIGNATURE:

| Service Area | Agencies Licensed to Serve | Patients Served, 2011 | Estimated 2011 Pop. | Use Rate | Projected 2016 Pop. | Projected Capacity | Projected Need (.015 x 2016 Pop.) | Need or (Surplus) for 2016 |
|---|---|---|---|---|---|---|---|---|
| Bedford | 24 | 1,053 | 47,312 | 0.0223 | 51,282 | 1,141 | 769 | (372) |
| Bledsoe | 17 | 458 | 13,487 | 0.0340 | 13,886 | 472 | 208 | (263) |
| Cannon | 24 | 425 | 14,143 | 0.0301 | 14,805 | 445 | 222 | (223) |
| Cheatham | 30 | 779 | 41,700 | 0.0187 | 44,357 | 829 | 665 | (163) |
| Clay | 10 | 269 | 8,186 | 0.0329 | 8,301 | 273 | 125 | (148) |
| Coffee | 23 | 1,942 | 54,205 | 0.0358 | 56,774 | 2,034 | 852 | (1,182) |
| Cumberland | 19 | 1,794 | 55,300 | 0.0324 | 57,735 | 1,873 | 866 | (1,007) |
| Davidson | 36 | 13,728 | 598,895 | 0.0229 | 618,202 | 14,171 | 9,273 | (4,898) |
| DeKalb | 28 | 669 | 19,211 | 0.0348 | 20,024 | 697 | 300 | (397) |
| Dickson | 28 | 1,463 | 49,238 | 0.0297 | 51,903 | 1,542 | 779 | (764) |
| Franklin | 18 | 1,506 | 42,820 | 0.0352 | 44,351 | 1,560 | 665 | (895) |
| Giles | 13 | 987 | 29,955 | 0.0329 | 30,638 | 1,010 | 460 | (550) |
| Grundy | 25 | 604 | 14,859 | 0.0406 | 15,212 | 618 | 228 | (390) |
| Hamilton | 20 | 8,938 | 317,758 | 0.0281 | 322,740 | 9,078 | 4,841 | (4,237) |
| Hickman | 24 | 686 | 25,740 | 0.0267 | 27,616 | 736 | 414 | (322) |
| Humphreys | 19 | 655 | 18,961 | 0.0345 | 19,515 | 674 | 293 | (381) |
| Jackson | 14 | 343 | 11,350 | 0.0302 | 11,730 | 354 | 176 | (179) |
| Lawrence | 15 | 1,555 | 42,423 | 0.0367 | 43,918 | 1,610 | 659 | (951) |
| Lewis | 15 | 467 | 12,120 | 0.0385 | 12,599 | 485 | 189 | (296) |
| Lincoln | 15 | 1,100 | 33,895 | 0.0325 | 34,940 | 1,134 | 524 | (610) |
| Macon | 22 | 733 | 22,974 | 0.0319 | 24,183 | 772 | 363 | (409) |
| Marion | 18 | 1,029 | 28,383 | 0.0363 | 28,787 | 1,044 | 432 | (612) |
| Marshall | 23 | 771 | 30,637 | 0.0252 | 32,304 | 813 | 485 | (328) |
| Maury | 25 | 2,523 | 83,218 | 0.0303 | 88,120 | 2,672 | 1,322 | (1,350) |
| Montgomery | 24 | 2,970 | 157,247 | 0.0189 | 167,554 | 3,165 | 2,513 | (651) |
| Overton | 13 | 750 | 21,282 | 0.0352 | 21,747 | 766 | 326 | (440) |
| Putnam | 19 | 2,329 | 71,810 | 0.0324 | 75,364 | 2,444 | 1,130 | (1,314) |
| Rhea | 22 | 894 | 31,576 | 0.0283 | 32,809 | 929 | 492 | (437) |
| Robertson | 30 | 1,632 | 67,533 | 0.0242 | 72,906 | 1,762 | 1,094 | (668) |
| Rutherford | 37 | 5,240 | 252,394 | 0.0208 | 274,920 | 5,708 | 4,124 | (1,584) |
| Sequatchie | 19 | 391 | 13,878 | 0.0282 | 14,701 | 414 | 221 | (194) |
| Smith | 24 | 621 | 19,900 | 0.0312 | 20,984 | 655 | 315 | (340) |
| Sumner | 31 | 3,820 | 160,366 | 0.0238 | 170,883 | 4,071 | 2,563 | (1,507) |
| Trousdale | 23 | 296 | 8,215 | 0.0360 | 8,611 | 310 | 129 | (181) |
| Warren | 26 | 1,755 | 41,901 | 0.0419 | 43,792 | 1,834 | 657 | (1,177) |
| White | 20 | 974 | 25,347 | 0.0384 | 26,236 | 1,008 | 394 | (615) |
| Williamson | 35 | 2,655 | 180,620 | 0.0147 | 200,247 | 2,944 | 3,004 | 60 |
| Wilson | 35 | 3,058 | 112,787 | 0.0271 | 121,203 | 3,286 | 1,818 | (1,468) |
| Service Area | 88 | 71,862 | 2,781,626 | 0.0258 | 2,925,879 | 75,331 | 43,888 | (31,443) |

*Sources: Population Projections, Tennessee Counties and State, 2010 - 2020; and, Joint Annual Report Summary, Report #6 - Patients Served by County of Residence*

**#11 SECTION c, Need, Item 3**
**CORAM - UNDUPLICATED THERAPIES**
**PER PATIENT COUNTY**

SUPPLEMENTAL

| County | 2011 Count of Unduplicated Therapies by County | Subtotal Count | 2011 Percent of Unduplicated Therapies by County | Subtotal Percent |
|---|---|---|---|---|
| **Defined Service Area** | | | | |
| BEDFORD | 11 | | 0.7% | |
| BLEDSOE | 2 | | 0.1% | |
| CANNON | 7 | | 0.5% | |
| CHEATHAM | 11 | | 0.7% | |
| CLAY | 2 | | 0.1% | |
| COFFEE | 26 | | 1.7% | |
| CUMBERLAND | 33 | | 2.1% | |
| DAVIDSON | 446 | | 28.9% | |
| DEKALB | 9 | | 0.6% | |
| DICKSON | 19 | | 1.2% | |
| FRANKLIN | 17 | | 1.1% | |
| GILES | 13 | | 0.8% | |
| GRUNDY | 8 | | 0.5% | |
| HAMILTON | 93 | | 6.0% | |
| HICKMAN | 7 | | 0.5% | |
| HUMPHREYS | 11 | | 0.7% | |
| JACKSON | 2 | | 0.1% | |
| LAWRENCE | 11 | | 0.7% | |
| LEWIS | 2 | | 0.1% | |
| LINCOLN | 13 | | 0.8% | |
| MACON | 5 | | 0.3% | |
| MARION | 8 | | 0.5% | |
| MARSHALL | 17 | | 1.1% | |
| MAURY | 34 | | 2.2% | |
| MONTGOMERY | 44 | | 2.8% | |
| OVERTON | 15 | | 1.0% | |
| PUTNAM | 40 | | 2.6% | |
| RHEA | 7 | | 0.5% | |
| ROBERTSON | 21 | | 1.4% | |
| RUTHERFORD | 70 | | 4.5% | |
| SEQUATCHIE | 4 | | 0.3% | |
| SMITH | 5 | | 0.3% | |
| SUMNER | 93 | | 6.0% | |
| TROUSDALE | 3 | | 0.2% | |
| WARREN | 40 | | 2.6% | |
| WHITE | 16 | | 1.0% | |
| WILLIAMSON | 105 | | 6.8% | |
| WILSON | 54 | | 3.5% | |
| | | 1324 | | 85.7% |

Coram, Inc
2011 Actuals
Base and AIS

SUPPLEMENTAL

2012 MAY 31 PM 4:15

| Nashville Market | FY_2011 | TM% |
|---|---|---|
| **Net Revenue** | | |
| TPN | 1,295,108 | 85.3% |
| Antibiotic | 3,417,809 | 56.2% |
| Cardiovascular | 338,443 | 90.9% |
| Pain Management | 54,511 | 46.9% |
| **Core Branch** | **5,105,871** | **65.8%** |
| IVIG | 643,507 | 24.3% |
| Vivaglobin | 999,385 | 34.9% |
| Aralast | 432,133 | 19.1% |
| Zemaira | 176,620 | 17.3% |
| Remicade | 95 | 100.0% |
| Hyperemesis/Zofran | 19,491 | 79.0% |
| Biotherapy | 4,218 | 21.8% |
| **Specialty Branch** | **2,275,449** | **27.9%** |
| Cather Care | 2,034 | 57.3% |
| Chemotherapy | 8,407 | 76.8% |
| Hydration | 133,901 | 90.0% |
| Other Therapy | 33,421 | 48.9% |
| **Non-Core Therapy** | **481,760** | **101.3%** |
| All Other | 3,182 | 100.0% |
| **Net Revenue** | **7,866,262** | **57.0%** |
| | | |
| **Therapy Margin** | **4,484,643** | |
| **Therapy Margin %** | **57.0%** | |
| | | |
| Materials not incl D-S | 306,084 | |
| **Total Other Materials** | **306,084** | |
| **% of Net Revenue** | **3.9%** | |
| | | |
| **Gross Product Margin** | **4,178,559** | |
| **Gross Product Margin %** | **53.1%** | |
| | | |
| **Nursing** | | |
| Total Labor | 212,717 | |
| General Expenses | 6,848 | |
| **Total Nursing Combined** | **219,565** | |
| **% of Net Revenue** | **2.8%** | |
| | | |
| **Pharmacy** | | |
| Total Labor | 531,120 | |
| General Expenses | 3,743 | |
| **Total Pharmacy Combined** | **534,863** | |
| **% of Net Revenue** | **6.8%** | |
| | | |
| **Warehouse** | | |
| Total Labor | 55,974 | |
| General Expenses | 4,524 | |
| **Total Warehouse** | **60,498** | |
| **% of Net Revenue** | **0.8%** | |
| | | |
| **Delivery** | | |
| Total Labor | 0 | |
| General Expenses | 187,527 | |
| **Total Delivery** | **187,527** | |
| **% of Net Revenue** | **2.4%** | |

Coram, Inc
2011 Actuals
Base and AIS
Nashville Market

SUPPLEMENTAL

| | FY_2011 |
|---|---|
| **Branch Administration** | |
| Total Labor | 156,992 |
| General Expenses | 181,558 |
| **Total Branch Administration** | **338,550** |
| % of Net Revenue | 4.3% |
| **Facilities Branch** | |
| Total Labor | 0 |
| General Expenses | 97,263 |
| **Total Facilities Branch** | **97,263** |
| % of Net Revenue | 1.2% |
| **Clinical Total** | |
| Total Labor | 956,803 |
| General Expenses | 481,462 |
| **Total Clinical** | **1,438,266** |
| % of Net Revenue | 18.3% |
| **Admissions** | |
| Total Labor | 175,554 |
| General Expenses | 1,299 |
| **Total Admissions** | **176,853** |
| % of Net Revenue | 2.2% |
| **Branch Contribution Margin** | **2,563,441** |
| % of Net Revenue | 32.6% |
| **PFS** | |
| Total Labor | 16 |
| General Expenses | 15 |
| **Total PFS** | **31** |
| % of Net Revenue | 0.0% |
| **Selling** | |
| Total Labor | 468,089 |
| General Expenses | 121,746 |
| **Total Selling** | **589,834** |
| % of Net Revenue | 7.5% |

**Coram, Inc**
**2011 Actuals**
**Base and AIS**
**Nashville Market**

SUPPLEMENTAL

| | FY_2011 |
|---|---|
| **All Departments OpEx** | |
| Wages Expense | 1,306,222 |
| Benefits Expense | 236,163 |
| Contract Labor | 58,077 |
| **Total Labor** | **1,600,462** |
| **% of Net Revenue** | **20.3%** |
| | |
| Marketing | 10,481 |
| Rent and Cam | 135,015 |
| Utilities Total | 61,288 |
| Cleaning and Other Services | 2,505 |
| Shipping and Delivery | 192,756 |
| Office Expenses | 43,385 |
| Equipment Expenses | 10,915 |
| Employee Expenses | 240 |
| Travel and Entertainment | 121,010 |
| Professional Fees and Licenses | 4,376 |
| Real, Personal and Sales Tax | 21,905 |
| Insurance | (35) |
| Other General Expenses | 1,441 |
| **General Expenses** | **605,282** |
| **% of Net Revenue** | **7.7%** |
| | |
| **Total All Depts OpEx** | **2,205,744** |
| **% of Net Revenue** | **28.0%** |
| | |
| **Bad Debt** | **(191,877)** |
| **% of Net Revenue** | **-2.4%** |
| | |
| **EBITDA** | **2,164,691** |
| **% of Net Revenue** | **27.5%** |
| | |
| Depreciation - Amortization | 35,955 |
| | |
| **Net Income (Fully Loaded)** | **2,128,736** |
| **% of Net Revenue** | **27.1%** |

SUPPLEMENTAL

2012 MAY 31 PM 4: 15

May 30, 2012

Ruth Ann Ellison
Vice President Clinical Regulatory Compliance
Apria Healthcare, Inc
26220 Enterprise Court
Lake Forest, California 92630

HCO ID: #439173

Dear Ms. Ellison:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual noted below:

- Comprehensive Accreditation Manual for Home Care

This accreditation cycle is effective beginning June 30, 2010. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Services provided by your organization: Home Health, Ambulatory Infusion, Pharmacy Dispensing, and/or Clinical Consultant Pharmacist Services.
Sites accredited:

Coram Healthcare Corporation of Alabama, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 300 Riverhills Business Park, Suite 390, Birmingham, AL 35242
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 1519 S Bowman Rd, Ste C, Little Rock, AR 72211
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 4310 East Cotton Center Blvd, Suite 110, Phoenix, AZ 85040
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 6375 East Tanque Verde Road, Suite 50, Tucson, AZ 85715
Kern Home Health Resources, dba Coram Healthcare, 3101 Sillect Avenue, Suite 109, Bakersfield, CA 93308
Coram Healthcare Corporation of Southern California, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 5571 Ekwill Street, Suite A- B, Goleta, CA 93111
Coram Healthcare Corporation of Northern California, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 3160 Corporate Place, Hayward, CA 94545
Coram Healthcare Corporation of Southern California, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2710 Media Center Drive, Building #6, Suite 150, Los Angeles, CA 90065
Coram Healthcare Corporation of Southern California, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 4355 East Lowell Street, Suite C, Ontario, CA 91761

Coram Healthcare Corporation of Northern California, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 9332 Tech Center Drive, Suite 100, Sacramento, CA 95826
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 12310 World Trade Drive, Suite 100, San Diego, CA 92128
Coram Healthcare Corporation of Northern California, dba Coram Specialty Infusion Services, an Apria Healthcare Company 1635 Divisadero, Suite 135 San Francisco, CA 94115
Coram Healthcare Corporation of Southern California, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 3002 Dow Avenue, Suite 104, Tustin, CA 92780
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 12450 East Arapahoe Road, Suite A1, Centennial, CO 80112
Coram Clinical Trials, Inc., 555 17th Street, Suite 1500, Denver, CO 80202
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2 Barnes Industrial Park Road South, Suite A, Wallingford, CT 06492
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 9143 Philips Highway, Suite 300, Jacksonville, FL 32256
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 555 Winderley Place, Suite 300, Maitland, FL 32751
Coram Healthcare Corporation of Southern Florida, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 11948-50 Miramar Parkway, Miramar, FL 33025
Coram Healthcare Corporation of Florida, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 8508 Benjamin Road, Suite C Tampa, FL 33634
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 3416 Jenks Avenue, Suite A, Panama City, FL 32405
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 3439 North 12th Avenue, Suite A & B, Pensacola, FL 32503
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2140 Newmarket Parkway, Suite 106, Marietta, GA 30067
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 3513 Vine Court, Davenport, IA 52806
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 11660 West Executive Drive, Boise, ID 83713
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2022 Glenn Park Drive, Champaign, IL 61821
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 1471 Business Center Drive, Suite 500, Mount Prospect, IL 60056
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 11711 North College Avenue, Suite 125, Carmel, IN 46032-5601
Coram Healthcare Corporation of Indiana, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 1290 Arrowhead Court, Suite A, Crown Point, IN 46307
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 431 Fernhill Avenue, Fort Wayne, IN 46805
Apria Healthcare, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 11711 North College Avenue, Suite 125, Indianapolis, IN 46237
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 8013 Flint Street, Lenexa, KS 66214
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 8201 East 34th Street Circle North, Ste 905, Wichita, KS 67226
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 115 James Drive West, Suite 100, St. Rose, LA 70087
Coram Healthcare Corporation of Massachusetts, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 575 University Avenue, Suite 2, Norwood, MA 02062
Coram Healthcare Corporation of Greater D.C., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 7150 Columbia Gateway Drive, Suite E, Columbia, MD 21046
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 14 Yarmouth Junction, Suite #1, Yarmouth, ME 04096

The Joint Commission

Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 4334 Brockton Drive SE, Suite D, Kentwood, MI 49512
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 4915 Contec Drive, Lansing, MI 48910
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 28550 Cabot Drive, Suite 200, Novi, MI 48377
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2345 Waters Drive, Mendota Heights, MN 55120
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services an Apria Healthcare Company, 2901 Frontage Road South, 10 Highway East, Suite 7, Moorhead, MN 56560
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2900 Falling Leaf Drive, Suite 101, Columbia, MO 65201
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 8248 Lackland Road, Suite 101, St Louis, MO 63114
Coram Healthcare Corporation of Mississippi, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2929 Layfair Drive, Suite 100, Flowood, MS 39232
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 30 Garfield Street, Suite B, Asheville, NC 28803
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 9401-J Southern Pine Blvd., Charlotte, NC 28273
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 507 Airport Blvd., Suite 100, Morrisville, NC 27560
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2324-36 South 156th Circle, Omaha, NE 68130
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 11 H Commerce Way, Totowa, NJ 07512
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 7400 Washington Street NE, Albuquerque, NM 87109
Coram Healthcare Corporation of Nevada, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 1951 Ramrod Avenue, Suite 110, Henderson, NV 89014
Coram Healthcare Corporation of Nevada, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 101 North Pecos Road, Suite 106, Las Vegas, NV 89101
Coram Healthcare Corporation of Nevada, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 6490 South McCarran Blvd., Suite 29, Reno, NV 89509
Coram Healthcare Corporation of Greater New York, 1361 Lincoln Avenue, Suite 9, Holbrook NY 11741
Coram Healthcare Corporation of Greater New York, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 12 Jupiter Lane, Albany, NY 12205
Coram Healthcare Corporation of Greater New York, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 375 North French Road, Suite 108, Amherst, NY 14228
Coram Healthcare Corporation of Greater New York, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 625 Sawkill Road, Kingston, NY 12401
Coram Healthcare Corporation of Greater New York, 45 South Service Road, Plainview, NY 11803
Coram Healthcare Corporation of Greater New York, 97 -77 Queens Blvd., Suite 1100, Rego Park, NY 11374
Coram Healthcare Corporation of Greater New York, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2949 Erie Blvd. East, Suite 103, Syracuse, NY 13224
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 4060 Business Park Drive, Suite 101, Columbus, OH 43204-5023
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 4305 Mulhauser Road, Suite 1, Fairfield, OH 45014
Coram Alternate Site Services, Inc., dba Toledo IV Care, 4060 Technology Drive, Maumee, OH 43537
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 6565 Davis Industrial Parkway, Suite AA, Solon, OH 44139
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 235 North MacArthur Boulevard, Suite 100, Oklahoma City, OK 73127

SUPPLEMENTAL

Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 7358 S.W. Durham Road, Portland, OR 97224
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 220 Executive Drive, Suite 500, Cranberry Township, PA 16066
CoramRX, LLC, 4 Spring Mill Drive, Malvern (Base), PA 19355
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 6 Spring Mill Drive, Malvern, PA 19355
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 155 N Donnerville Rd, Ste 1, Mountville, PA 17554
Coram Healthcare Corporation of Massachusetts, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 1240 Pawtucket Avenue, East Providence, RI 02916
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 5955 Core Ave, Suite 512, North Charleston, SC 29406
Coram Healthcare/Carolina Home Therapeutics, 720 Gracern Road, Suite 123, Columbia, SC 29210
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 1828 Midpark Rd, Ste D, Knoxville, TN 37921
Coram Alternate Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 1680 Century Center Parkway, Suite 12, Memphis, TN 38134
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2970 Sidco Drive, Nashville, TN 37204
Coram Alternate Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 1905-A Kramer Lane, Suite 500, Austin, TX 78758
Coram Healthcare Corporation of North Texas, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 10105 Technology Blvd. West, Suite 102, Dallas, TX 75220
Coram Alternate Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 7365 Remcon Circle, Suite A-102, El Paso, TX 79912
Coram Alternate Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 10611 South Sam Houston Parkway West, Ste 200, Houston, TX 77071
Apria Healthcare, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 9400 Kirby Drive, Houston, TX 77054
Coram Alternate Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 10118 Huebner Road, San Antonio, TX 78240
Coram Healthcare Corporation of Utah, dba Coram Specialty Infusion Services, an Apria Healthcare Company, 120 West Vine Street, Suite 140, Murray, UT 84107
Coram Healthcare Corporation of Greater D.C., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 4115 Pleasant Valley Road, Suite 200, Chantilly, VA 20151
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 14935 NE 87th Street, Suite 101, Redmond, WA 98052
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 720 Olive Way, Suite 815, Seattle, WA 98101-1836
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, East 520 North Foothills Drive, Suite 400, Spokane, WA 99207
Coram Alternate Site Services, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 5345 South Moorland Road, Suite 101, New Berlin, WI 53151

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision. Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

SUPPLEMENTAL

If I can be of further assistance I can be reached at (630) 792-5732.

Sincerely,

Kenneth M. Gauss

Kenneth M. Gauss
Senior Account Executive, Team 3
Accreditation and Certification Operations

cc: Correspondence File

SUPPLEMENTAL

2012 MAY 31 PM 4: 15

Apria Healthcare, Inc
Lake Forest, CA

# Apria Healthcare, Inc.
# Coram Speciality Infusion Services, an Apria Healthcare Company
# Nashville TN

has been Accredited by

## The Joint Commission

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

Home Care Accreditation Program

June 30, 2010

Accreditation is customarily valid for up to 39 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

**Organization ID #:** 439173
Print/Reprint Date: 3/3/2011

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

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

**This reproduction of the original accreditation certificate has been issued for use in regulatory/payor agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.**

SUPPLEMENTAL

July 6, 2011

Ruth A. Ellison
Vice President Clinical Regulatory Compliance
Apria Healthcare, Inc
26220 Enterprise Court
Lake Forest, California 92630

HCO ID: #439173

Dear Ms. Ellison:

The Joint Commission had administratively extended Accreditation, effective June 23, 2011, to the following location:
Apria Healthcare of NY State, Inc., 50 Rose Pl, New Hyde Park, NY 11040-5312
The following services are being provided: Home Medical Equipment and Clinical Respiratory Services.
The following products are being provided: DM02, DM03, DM05, DM06, DM07, DM08, DM09, DM10, DM11, DM12, DM15, DM17, DM18, DM19, DM20, DM21, DM22, DM23, M01, M02, M03, M04, M05, M06, M06A, M07, M07A, M08, M09, M10, PD06, PD08, PD09, PE01, R01, R03, R04, R06, R07, R08, R09, R10, R12, S01, S02.

The Joint Commission has updated its records to reflect that the following location has moved to:
Apria Healthcare, Inc., dba Coram Specialty Infusion Services, an Apria Healthcare Company, 2970 Sidco Drive, Nashville, TN 37204-3715

The Joint Commission has updated our records to reflect the following corrected address:
Apria Healthcare, Inc., 612 Beatty Road, Ste D, Monroeville, PA 15146-1595

The following locations have closed and have been removed from our records:
Apria Healthcare, Inc., 1805 Taylor Ave, Louisville, KY 40213
Apria Healthcare, Inc., 10 Lane Rd, Raymond, NH 03077

If I can be of further assistance I can be reached at (630) 792-5732.

Sincerely,

Kenneth M. Gauss

Kenneth M. Gauss
Senior Account Executive, Team 3
Accreditation and Certification Operations

cc: Correspondence File

# Copy
# Supplemental #2

## Coram Specialty Infusion Services

# CN1205 -020

h3gm
HARWELL HOWARD HYNE GABBERT & MANNER, P.C.
333 commerce street, suite 1500
nashville, tennessee 37201
*phone:* 615.256.0500 *fax:* 615.251.1059
h3gm.com

SUPPLEMENTAL- # 2
June 15, 2012
3:28 pm

2012 JUN 15 PM 3 27

June 15, 2012

**VIA HAND DELIVERY**
Philip M. Wells, FACHE
State of Tennessee
Health Services & Development Agency
500 Deaderick Street, Ste. 850
Nashville, TN 37243

**Re:** Certificate of Need Application CN1205-020
Applicant's Response to Second Request for Supplemental Information

Dear Phil:

We are in receipt of the Agency's Second Request for Supplemental Information. Please accept this as the Applicant's response to the same. Mr. Dell's Affidavit is attached hereto as Exhibit A.

1. **SECTION B, PROJECT DESCRIPTION, ITEM I**

   D) **Which Home Health Agencies have been providing these home infusion services in the past? In other words, has the applicant worked in a coordinative fashion with various HHAs in the past? Why haven't these arrangements worked and how will the creation of another agency improve coordination and quality of care?**

   1) How has Coram distributed and initiated infusion services in the past without the cooperation and assistance of home health agencies?

**RESPONSE: If an inpatient prescribed infusion therapy services is unable to obtain incumbent HHA assistance that individual would remain in the hospital until they received their first infusion and training sufficient that they could be discharged home in order to self-infuse thereafter. Subsequently, the Applicant would send the compounded infusion product from the Nashville pharmacy via secure medical courier. However, if the infusion therapy is inappropriate to administer in the home without nursing supervision, such as blood products or IVIG, the patient must travel to an outpatient clinic, such as an oncology clinic, physician practice, hospital or ambulatory infusion suite (which the Applicant has established in its Nashville location) in order to obtain their medication. In addition, patients without nursing assistance who self-infuse in the home are ill equipped to handle even the most minor of complications, such as a blocked line, and must instead travel to the nearest hospital emergency room, sometimes by private transportation, but also by**

2012 JUN 15 PM 3 27

**ambulance, in order to alleviate the problem. Similarly, patients who require a line change must also go to a hospital for such a procedure. All of these situations, and their attendant expenses, would be substantially eliminated by the Applicant implementing its limited scope HHA.**

2) In order to substantiate the lack of interest by other home health agencies who have been unable to provide the service needs of Coram Alternative Site Services patients, the Agency members appreciate receiving letters of support which identify other agencies' inability to service Coram's patients' needs and their support for your proposed services. Please provide those as they become available before the Agency meeting.

**RESPONSE: The Applicant has provided a letter of support from Home Health Care of Middle Tennessee at collective page 105 of the Application. The Applicant is actively seeking additional letters of support from other area home health agencies, however, the Applicant does not believe any home health agency is going to admit that it is unable to perform any particular licensed home health agency service. Additionally, the Applicant was unable to find anywhere in the enabling statute, promulgated regulations of the HSDA, or the Guidelines for Growth any criteria that requires an applicant for any CON produce documentation that incumbent providers lack interest in the services proposed to be provided by a CON applicant. The Applicant will supplement the record up to the hearing date upon receipt of additional letters of support from any of the incumbent home health agencies.**

**2. SECTION B, PROJECT DESCRIPTION, ITEM IIC**

**The applicant indicates "as a licensed pharmacy providing infusion therapy products to patients in their homes, Coram is intimately familiar with patients throughout the region, and the hardships encountered by hospitals, physicians and patients/families in effecting a timely discharge from a hospital when hospitalization is no longer required, but the patient and family have not initiated their first infusion dose nor are they knowledgeable about the process, infusion equipment, and the specific regimen which must be followed".**

**A) Please provide some anecdotal examples.**

Your response is noted. However, several of your examples communicate extraordinary drive times to the nearest clinics (ex: 2 hours) and nearest hospitals (ex: 4 hours). There is no clinic or hospital in Tennessee which are four hour drive times from patients. Does the applicant mean nearest clinic or hospital capable of providing the specific infusion service needed by the patient? Please clarify your response.

2012 JUN 15 PM 3 27

**RESPONSE: Patients are required to drive what appear to be extraordinary distances to obtain infusion treatment because the facility that they go to is the only one qualified to routinely perform this service. Many of the local community hospitals and critical access hospitals have not worked with central lines, Hickman's lines or Port-a-caths. Also, many times the physician instructs the patient that if there is a problem they need to come back to the hospital where the physician has privileges. In these cases, if the patient goes to the local hospital, and it knows how to infuse via a central line, the patient is charged an ER visit and can be waiting hours to be seen. Some patients have expressed that they are not comfortable getting this service in the local ER and choose to drive the distance.**

C) **From the applicant's experience, please provide an estimate of the additional hospital days which could be eliminated by initiation of this new service?**

Your response is noted. The applicant states "the applicant's payer partners value this opportunity to avoid another overnight stay in the hospital." In order to substantiate the support by Coram Alternative Site Service's payer partners, the Agency members appreciate receiving letters of support from these third party payers. Please provide those as they become available before the Agency meeting.

**RESPONSE: The Applicant is actively seeking letters of support from its commercial payers and will contemporaneously supplement the record with the same right up to the hearing date.**

3. **SECTION C. NEED, ITEM 1 (SPECIFIC CRITERIA: HOME HEALTH SERVICES, ITEM 5 – DOCUMENTATION OF REFERRAL SOURCES)**

C. ***The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.***

The Agency is not interested in the intimate patient history or medical details. What we are interested in is the patient testimony that a necessary medical service in their treatment was delayed or was not obtainable, and they support the service that the applicant is proposing. In order to substantiate the support by Coram Alternative Site Service's patients, the Agency members appreciate receiving letters of support from patients and/or their families.

**RESPONSE: The Applicant has provided numerous letters from providers explaining that they have difficulty in obtaining infusion services in the home. Those letters from Cumberland Medical Center, Indian Lake Neurology, Vanderbilt Medical Center, and Affiliated Neurologists can be found at collective page 106 of the Application. The Applicant is actively seeking letters of support**

SUPPLEMENTAL- # 2
June 15, 2012
3:28 0m

2012 JUN 15 PM 3 27

**from patients and will contemporaneously supplement the record with the same up to the date of the hearing.**

4. **Section C. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)**

In the Historical Data Chart, there are no contractual adjustments. The applicant indicates it does not intend to contract with Medicare or TennCare. Please discuss why there are contractual adjustments anticipated in the Projected Data Chart.

**RESPONSE: The Historical Data Chart is for the pre-existing infusion pharmacy business only. All pharmacy revenues are booked at the contractual rates with the third party payers, rather than at an arbitrary list price with a contractual adjustment to the amount to contract. Accordingly, there are no contractual allowances shown in the Historical Data ~~Chart for the~~ existing infusion pharmacy business, nor in any future budgets for the existing infusion pharmacy business.**

**The projected data chart on page 61 of the application ONLY considers the projected infusion therapy home health agency volume. The gross charges are listed at an average of $178.22 per visit based on mix of short and long duration visits; average reimbursement is expected to be $169.73. Accordingly the $8.59 differential in this calculation is reflected as a contractual allowance from third party payers. This is for those payers other than Medicare or TennCare since the applicant will not be participating or making claims to either of those payers for infusion home health services.**

**We also note that at collective page 107 of the application, the Applicant included Projected Data Charts for the infusion pharmacy by itself and Projected Data Charts that consolidate the projections for the infusion pharmacy business line together with the projections for the infusion home health services line which shows contractual allowances for home health services but none for pharmaceutical, which, as noted above, is consistent with the Applicant's historical experience.**

Very truly yours,

HARWELL HOWARD HYNE
GABBERT & MANNER, P.C.

Jeff Miller /cgb

Jeffrey J. Miller

JJM/cgb
cc: Michael Dell, Esq. (via email)

**SUPPLEMENTAL- # 2**
**June 15, 2012**
**3:28 0m**

**AFFIDAVIT**

2012 JUN 15 PM 3 28

STATE OF COLORADO )
)
COUNTY OF DENVER )

NAME OF APPLICANT: **CORAM ALTERNATE SITE SERVICES, INC.**

I, Michael E. Dell, after being duly sworn, state under oath that I am the lawful agent of applicant named in this *Certificate of Need Application CN1205-020, Applicant's Response to Second Request for Supplemental Information*, that I have reviewed all of the supplemental information submitted herewith, and that to the best of my knowledge, it is true, accurate and complete.

Michael E. Dell
Vice President, General Counsel & Secretary

Sworn to and subscribed before me, a Notary Public, this the 14th day of June, 2012, witness my hand at office in the County of Denver, State of Colorado.

PATRICIA V. IVANCICH NOTARY PUBLIC STATE OF COLORADO MY COMMISSION EXPIRES 6-12-2015

Patricia V. Ivancich, NOTARY PUBLIC, STATE OF COLORADO
My commission expires June 12, 2015.

waller

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

2012 SEP 10 AM 10 00

September 7, 2012

**VIA EMAIL**
**ORIGINAL BY HAND DELIVERY**

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
500 Deaderick Street
Suite 850
Nashville, Tennessee

RE Coram Alternate Site Services, dba
Coram Specialty Infusion Services, Inc.
CN1205-020

Dear Melanie:

This is to provide official notice that SunCrest Healthcare, Inc. wishes to oppose the application of Coram Specialty Infusion Services, Inc. an Apria Healthcare Company CN1205-020 for the establishment of a limited home health agency to provide and administer home infusion productions and relation infusion nursing services.

If you have any questions, please give me a call at 850-8722.

Very truly yours,

Kim Harvey Looney

KHL:
Enclosure
cc: John W. Dant III (SunCrest Healthcare, Inc.)

9107977.1

NHC
NATIONAL HEALTHCARE CORPORATION

2012 SEP 10 AM 9 39

September 7, 2012

Ms. Melanie Hill, Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: Coram Alternate Site Services, Inc., CN1205-020 **OPPOSITION LETTER**

Dear Ms. Hill:

We are aware of the intent of Coram Alternate Site Services, Inc., (Coram) to establish a "limited" Home Health Care organization and to provide services to Bedford, Bledsoe, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Franklin, Giles, Grundy, Hamilton, Hickman, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marion, Marshall, Maury, Montgomery, Overton, Putnam, Rhea, Robertson, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Warren, White, Williamson, and Wilson County. We are concerned that approval of this application would set a bad precedent to further segment the health care delivery system at a time when the country is moving toward a more integrated health care model. Specifically, in the absence of any specific need criteria regarding a single service home care provider, how will the HSDA determine if and when there are adequate services available? For example, if this CON were to be approved in the 38 county area, would there be further need for similar specialty agencies? Who would determine this need? Is it really the best practice to have each applicant come up with their own need methodology? In addition, past approval of "limited" home care CON's have come back over time to the HSDA to become fully licensed home care agencies that then compete with us on a daily basis. It is because of these concerns that we continue to look toward the health planning efforts in the State and the Guidelines for Growth, to help and direct the CON process before the HSDA. **Because the home health care need formula applied in the State of Tennessee does not show a need for the aforementioned application, approval of said application would not only duplicate existing services, but also adversely impact the existing home health care delivery system. Therefore, I am writing this letter in opposition to the referenced project pursuant to T.C.A., Section 68-11-1609(g)(1).**

Ms. Hill, as an existing provider in the target market, I have firsthand knowledge that market area home health care needs are being met by our agency and other licensed agencies as well. The Coram proposed project is not consistent with the State's need formula which shows excess capacity of (31,443) in the Coram service area, as projected to four years into the future to 2016 by the Department of Health, Division of Health Statistics. Consequently, Coram is not orderly and will adversely impact other existing providers if approved. Lastly, we question the projects financial feasibility. We contend that the project fails to meet any of the three criteria and standards required for CON approval.

The addition of another agency will not only duplicate and drive up the cost for services already provided, but it will also adversely deplete the existing nursing pool of trained nursing professionals. A redistribution of patients to an agency that is not needed further dilutes the patient pool, the staffing pool and consequently does not promote the orderly development of health care.

As to the issue of need, based on the current home health care need formula, as applied by the TN Department of Health, there exists a surplus of (31,443) patients served in the applicant's 38 county

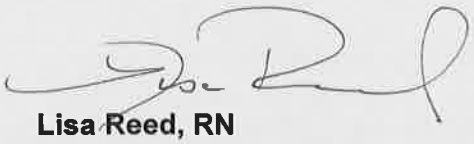
City Center • 100 East Vine Street • Murfreesboro, Tennessee 37130 (615) 890-2020

service area. Please note that the 38 county service area is projected to be served from one office located in Nashville, Davidson County. (Need projections are based on the Joint Annual Reports for 2011 and population projections for the year 2016).

In summary, I am opposed to this CON and ask that it not be approved. If you need any additional information please do not hesitate to call me.

Sincerely,

**NHC/OP, L.P. d/b/a NHC HomeCare, Athens, NHC HomeCare, Columbia, NHC HomeCare, Chattanooga, NHC HomeCare, Murfreesboro, & NHC HomeCare, Springfield**



**Lisa Reed, RN**
Vice President/HomeCare

Cc: Mr. Jeffery J. Miller, Attorney
Harwell, Howard, Hayne Gabbert & Manner, P.C.
333 Commerce St., Suite 1500
Nashville, TN 37201

Via: Regular Mail

VANDERBILT UNIVERSITY MEDICAL CENTER

*C. Wright Pinson, M.B.A., M.D.*
*Deputy Vice Chancellor for Health Affairs*
*Chief Executive Officer of the Hospitals and Clinics*
*President, Vanderbilt Health Services*
*Senior Associate Dean for Clinical Affairs*

September 13, 2012

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Ms. Hill,

It has come to my attention that the Coram Certificate of Need application (#CN1205-020) for the establishment of home health based specialty infusion services includes an assertion that Vanderbilt University Medical Center is in support of the application. I am writing to clarify that Vanderbilt University Medical Center does not support the Coram application.

The letter submitted with the Coram application was not reviewed by my office per our normal process. The letter has the appearance of being from Ms. Linda Burch, a discharge planner in the Department of Orthopaedics, although Ms. Burch denies knowingly signing anything in connection with this CON and the letterhead is not from her department. Regardless, before the Coram application is heard, we ask that the agency members be made aware that, contrary to the assertions made by the applicant, Vanderbilt University Medical Center does not support the application.

Thank you for your assistance in this matter.

Sincerely,

C. Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs
CEO of the Vanderbilt Health System

1161 21st Avenue South
D-3300 Medical Center North
Nashville, TN 37232-2104

tel 615.343.9324
fax 615.343.2330
wright.pinson@vanderbilt.edu

cc: Ronald Hill

Dan H. Elrod, Esq.
Butler, Snow, O'Mara, Stevens & Cannada, PLLC
1200 One Nashville Place
150 Fourth Avenue North
Nashville, TN 37219

Jeffrey J. Miller
Harwell Howard Hyne Gabbert & Manner
333 Commerce Street
Suite 1500
Nashville, Tennessee 37201

VANDERBILT UNIVERSITY MEDICAL CENTER

*C. Wright Pinson, M.B.A., M.D.*
*Deputy Vice Chancellor for Health Affairs*
*Chief Executive Officer of the Hospitals and Clinics*
*President, Vanderbilt Health Services*
*Senior Associate Dean for Clinical Affairs*

September 13, 2012

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Ms. Hill,

It has come to my attention that the Coram Certificate of Need application (#CN1205-020) for the establishment of home health based specialty infusion services includes an assertion that Vanderbilt University Medical Center is in support of the application. I am writing to clarify that Vanderbilt University Medical Center does not support the Coram application.

The letter submitted with the Coram application was not reviewed by my office per our normal process. The letter has the appearance of being from Ms. Linda Burch, a discharge planner in the Department of Orthopaedics, although Ms. Burch denies knowingly signing anything in connection with this CON and the letterhead is not from her department. Regardless, before the Coram application is heard, we ask that the agency members be made aware that, contrary to the assertions made by the applicant, Vanderbilt University Medical Center does not support the application.

Thank you for your assistance in this matter.

Sincerely,

C. Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs
CEO of the Vanderbilt Health System

1161 21st Avenue South
D-3300 Medical Center North
Nashville, TN 37232-2104

tel 615.343.9324
fax 615.343.2330
wright.pinson@vanderbilt.edu

cc: Ronald Hill

Dan H. Elrod, Esq.
Butler, Snow, O'Mara, Stevens & Cannada, PLLC
1200 One Nashville Place
150 Fourth Avenue North
Nashville, TN 37219

Jeffrey J. Miller
Harwell Howard Hyne Gabbert & Manner
333 Commerce Street
Suite 1500
Nashville, Tennessee 37201

**CERTIFICATE OF NEED**
**REVIEWED BY THE DEPARTMENT OF HEALTH**
**DIVISION OF HEALTH STATISTICS**
615-741-1954

**DATE:** August 31, 2012

**APPLICANT:** Coram Alternate Site Services, Inc.
D/b/a Coram Specialty Infusion Services, Inc.
2970 Sidco Drive
Nashville, Tennessee 37207

**CONTACT PERSON:** Jeffery J. Miller, Esquire
Harwell Howard Hayne Gabbert & Manner, P.C.
333 Commerce Street, Suite 1500
Nashville, Tennessee 37201

**COST:** $63,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

**SUMMARY:**

The applicant, Coram Alternative Site Services, inc. d/b/a Coram Specialty Infusion Services, Inc. (CSIS), located in Nashville (Davidson County), Tennessee, seeks Certificate of Need (CON) approval for the establishment of a limited home health agency only to provide and administer home infusion products and related infusion nursing services ancillary to its pharmacy services, by way of example and not limitation, line maintenance, phlebotomy services, infusion equipment repair and replacement, and dressing changes on central lines and external access ports from its current licensed home infusion pharmacy located at 2970 Sidco Drive in Nashville. Operationally, the applicant will operate the home health service as part of its existing Nashville branch operations. Adding the nursing service to its existing product line will enhance the operation while providing its patients with a service that is historically difficult to obtain resulting in prolonged hospital stays. The financial projections which are a part of this application demonstrate that the service is restricted in scope, is financially feasible, and generates a positive net income from operations.

The existing 6,800 square feet of space houses its licensed pharmacy services and includes the pharmacy, distribution warehouse, ambulatory infusion suite, and administrative offices and support space. The addition of the restricted home health services will be under the existing leadership and operate from the existing leased space. Accordingly, there is no construction, renovation, or modification required to implement this proposed project. The square footage chart for the currently leased space is included as Attachment Section B. Project Description, Item II (A).

The applicant is a Delaware Corporation which is a wholly owned subsidiary of Coram Specialty Infusion Services, Inc. The entities parent is Apria Healthcare Group, Inc. A description of the applicant and its organizational chart is included in Attachment, Section A, Item 4.1.

The total estimated project cost is $63,000 and will be funded through cash reserves as attested to in a letter from the Executive Vice President, General Counsel, and Secretary for the ultimate parent company in Attachment C, Economic Feasibility, Item 2.

## GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

**NEED:**
The applicant service area consists of 38 counties in Middle Tennessee.

The following chart illustrates the total population projections for 2012 and 2016.

**Service Area Total Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase or (Decrease) |
|---|---|---|---|
| Bedford | 48,083 | 51,282 | 6.7% |
| Bledsoe | 13,565 | 13,886 | 2.4% |
| Cannon | 14,269 | 14,805 | 3.8% |
| Cheatham | 42,222 | 44,357 | 5.1% |
| Clay | 8,201 | 8,301 | 1.2% |
| Coffee | 54,707 | 56,774 | 3.8% |
| Cumberland | 55,798 | 57,735 | 3.5% |
| Davidson | 602,257 | 618,202 | 2.6% |
| DeKalb | 19,366 | 20,024 | 3.4% |
| Dickson | 49,744 | 51,903 | 4.3% |
| Franklin | 43,112 | 44,351 | 2.9% |
| Giles | 30,076 | 30,638 | 1.9% |
| Grundy | 14,925 | 15,212 | 1.9% |
| Hamilton | 318,632 | 322,740 | 1.3% |
| Hickman | 26,100 | 27,616 | 5.8% |
| Humphreys | 19,067 | 19,515 | 2.3% |
| Jackson | 11,419 | 11,730 | 2.7% |
| Lawrence | 42,709 | 43,918 | 2.8% |
| Lewis | 12,208 | 12,599 | 3.2% |
| Lincoln | 34,084 | 34,940 | 2.5% |
| Macon | 23,208 | 24,183 | 4.2% |
| Marion | 28,455 | 28,787 | 1.2% |
| Marshall | 30,958 | 32,304 | 4.3% |
| Maury | 84,148 | 88,120 | 4.7% |
| Montgomery | 159,209 | 167,554 | 5.2% |
| Overton | 21,377 | 21,747 | 1.7% |
| Putnam | 72,489 | 75,364 | 4.0% |
| Rhea | 31,803 | 32,809 | 3.2% |
| Robertson | 68,589 | 72,906 | 6.3% |
| Rutherford | 256,765 | 274,920 | 7.1% |
| Sequatchie | 14,042 | 14,701 | 4.7% |
| Smith | 20,104 | 20,984 | 4.4% |
| Sumner | 162,422 | 170,883 | 5.2% |
| Trousdale | 8,287 | 8,611 | 3.9% |
| Warren | 42,263 | 43,792 | 3.6% |
| White | 25,521 | 26,236 | 2.8% |
| Williamson | 184,323 | 200,247 | 8.6% |
| Wilson | 114,437 | 121,203 | 5.9% |
| **Total** | **2,808,944** | **2,925,879** | **4.2%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision*, Tennessee Department of Health, Division of Health Statistics

The following chart illustrates the service are need and utilization for the applicant's proposed service area.

**Service Area Need and Utilization for 2011**

| Service Area | Agencies Licensed to Serve | Total Patients Served | Estimated 2011 Pop. | Projected 2016 Pop. | Projected Capacity | Projected Need (.015 x 2016 Pop.) | Need or(Surplus) for 2016 |
|---|---|---|---|---|---|---|---|
| Bedford | 23 | 1,053 | 47,312 | 51,282 | 1,141 | 769 | (372) |
| Bledsoe | 12 | 458 | 13,487 | 13,886 | 472 | 208 | (263) |
| Cannon | 20 | 425 | 14,143 | 14,805 | 445 | 222 | (223) |
| Cheatham | 26 | 779 | 41,700 | 44,357 | 829 | 665 | (163) |
| Clay | 9 | 269 | 8,186 | 8,301 | 273 | 125 | (148) |
| Coffee | 20 | 1,942 | 54,205 | 56,774 | 2,034 | 852 | (1,182) |
| Cumberland | 15 | 1,794 | 55,300 | 57,735 | 1,873 | 866 | (1,007) |
| Davidson | 31 | 13,728 | 598,895 | 618,202 | 14,171 | 9,273 | (4,898) |
| DeKalb | 23 | 669 | 19,211 | 20,024 | 697 | 300 | (397) |
| Dickson | 26 | 1,463 | 49,238 | 51,903 | 1,542 | 779 | (764) |
| Franklin | 17 | 1,506 | 42,820 | 44,351 | 1,560 | 665 | (895) |
| Giles | 12 | 987 | 29,955 | 30,638 | 1,010 | 460 | (550) |
| Grundy | 22 | 604 | 14,859 | 15,212 | 618 | 228 | (390) |
| Hamilton | 17 | 8,938 | 317,758 | 322,740 | 9,078 | 4,841 | (4,237) |
| Hickman | 20 | 686 | 25,740 | 27,616 | 736 | 414 | (322) |
| Humphreys | 18 | 655 | 18,961 | 19,515 | 674 | 293 | (381) |
| Jackson | 12 | 343 | 11,350 | 11,730 | 354 | 176 | (179) |
| Lawrence | 14 | 1,555 | 42,423 | 43,918 | 1,610 | 659 | (951) |
| Lewis | 13 | 467 | 12,120 | 12,599 | 485 | 189 | (296) |
| Lincoln | 14 | 1,100 | 33,895 | 34,940 | 1,134 | 524 | (610) |
| Macon | 20 | 733 | 22,974 | 24,183 | 772 | 363 | (409) |
| Marion | 17 | 1,029 | 28,383 | 28,787 | 1,044 | 432 | (612) |
| Marshall | 20 | 771 | 30,637 | 32,304 | 813 | 485 | (328) |
| Maury | 24 | 2,523 | 83,218 | 88,120 | 2,672 | 1,322 | (1,350) |
| Montgomery | 20 | 2,970 | 157,247 | 167,554 | 3,165 | 2,513 | (651) |
| Overton | 13 | 750 | 21,282 | 21,747 | 766 | 326 | (440) |
| Putnam | 17 | 2,329 | 71,810 | 75,364 | 2,444 | 1,130 | (1,314) |
| Rhea | 17 | 894 | 31,576 | 32,809 | 929 | 492 | (437) |
| Robertson | 26 | 1,632 | 67,533 | 72,906 | 1,762 | 1,094 | (668) |
| Rutherford | 33 | 5,240 | 252,394 | 274,920 | 5,708 | 4,124 | (1,584) |
| Sequatchie | 15 | 391 | 13,878 | 14,701 | 414 | 221 | (194) |
| Smith | 20 | 621 | 19,900 | 20,984 | 655 | 315 | (340) |
| Sumner | 27 | 3,820 | 160,366 | 170,883 | 4,071 | 2,563 | (1,507) |
| Trousdale | 17 | 296 | 8,215 | 8,611 | 310 | 129 | (181) |
| Warren | 22 | 1,755 | 41,901 | 43,792 | 1,834 | 657 | (1,177) |
| White | 16 | 974 | 25,347 | 26,236 | 1,008 | 394 | (615) |
| Williamson | 31 | 2,655 | 180,620 | 200,247 | 2,944 | 3,004 | 60 |
| Wilson | 30 | 3,058 | 112,787 | 121,203 | 3,286 | 1,818 | (1,468) |
| | **88** | **71,862** | **2,781,626** | **2,925,879** | **75,331** | **43,888** | **(31,443)** |

Source: *Joint Annual Report of Home Health Agencies* 2011, Tennessee Department of Health, Division of Health Statistics

The applicant is seeking to establish a limited service home health agency, specifically to provide and administer home infusion products and related infusion nursing services. These services will be provided by a registered nurse who is appropriately credentialed and is certified with a CRNI designation (certified registered nurse infusion). Additionally, the applicant intends to provide the

following skilled nursing services in conjunction with its home infusion therapy product; a) take and record vital signs; b) draw blood and other fluids for labs; c) treat any issues associated with the access site or port; d) change dressings associated with access points; e) administer the therapy or blood products; f) line maintenance; g) phlebotomy services; and h) infusion equipment and repair. These services and credentials are a unique service and not typical of the average Medicare certified home health agency available to Middle Tennesseans. The administrator of the home health agency will be the existing manager of the Nashville Branch and will be seamlessly added to the existing infrastructure of the Nashville Branch.

The applicant's nursing staff are specially trained in the art and skill of providing infusion therapies, most are certified, have over 1,600 hours of clinical infusion therapy experience, and have developed training and skills necessary to identify, collaborate, and treat therapy related effects, as well as communicate to patients on the proper care of catheter sites, sterile treatment, and monitoring of equipment and supplies.

According to the applicant, the types of patients will be restricted to infusion therapy patients. Types of infusion products to be administered include: antibiotics; total parenteral nutrition (TPN); hydration; cardiac products (such as inotropic therapies); intravenous immunoglobulin (IVIG) and other similar specialty drugs; pain management; antiemetic: and steroids. The types of patients served by Coram who have demonstrated needs for infusion nursing services from home which are otherwise unavailable from other home health agencies include the following:

- Specialty patients requiring IVIG and Alpha 1 therapies (IVIG is a plasma protein replacement for immune deficient patients who have decreased or abolished antibody production capabilities and Alpha 1 infusion therapy is given to treat the genetic disorder alpha 1 antitrypsin leading to decreased A1AT in the blood and lungs);

- First dose administration (First dose administration is the first time a prescribed infusion therapy is provided to the patient);

- Low intervention patients (a patient who is not homebound and does not require significant nursing intervention; rather they comprise a group of patients who are taught to self administer thereby limiting the number of home skilled nursing visits;

- Three dose schedule patients and rural and pediatric patients (three dose patients are infusion patients whose therapy is administered three times throughout the day)

- Rural and Pediatric patients (rural patients are infusion therapy patients who reside well outside the major cities, and pediatric patients are children who require infusion therapy products and services).

According to the applicant, infusion nursing is highly specialized in protocol, equipment management, patient/family education training and time commitment. These aspects of home care delivery are not typical with the average Medicare certified home health agency patient profile and delivery, or with their available nursing staff. Average Medicare certified home health agencies patient profile including documentation in the Joint Annual Report Summary has the following characteristics:

- Homebound;

- Average visit duration is one to two hours;

- Equipment usually is not involved;

- 80% of the visits are Medicare patients; and

- 71% are 65 years of age or older with nearly 50% being 75 or older

Of total visits statewide,

- 38% are physical, occupational, and speech therapy;
- 18% are home health aide and homemaker services;
- 1% are medical social services; and
- Just 42% are skilled nursing.

Infusion nursing patients, and those proposed to be served by Coram limited service home health agency, differ from the average Medicare certified home health agency patient. Notable differences are:

- The predominant age of the patient is under the age of 65;
- Private insurance is the dominant payor;
- Specialty patient infusion visits last up to six hours (one time per month for lengthy infusions of immunoglobin);
- Antibiotic therapy and TPN patients can have up to three doses (infusions) per day at eight hour intervals;
- Nurses require specialized understanding of and protocol for infusion equipment;
- The goal of infusion nursing is to train the patient to self administer with limited follow up as needed by the nurse;
- The patient may not be homebound, but may not have reasonable geographic or financial access to reach an ambulatory infusion center, hospital, or other venue for infusion; Infusion therapy in the home is more cost effective to the system than accessing the product and service in an institution.

The needs of this high specific patient population with unique infusion therapy requirements is not being met in the most appropriate, accessible, and available means. With Coram's approval for a limited service home health agency license, these access problems can be ameliorated.

The applicant states the uniqueness of its patient population drives the need for Coram to be licensed as a home health agency. Approval of Coram's restricted home health license will enable a specific subset of the population to receive a higher standard of care in a lower cost environment, thereby contributing to the orderly development of health care while meeting a distinct patient and community need.

The applicant reports they have defined an unmet community need to provide home health services limited to infusion nursing and related services. The need for this service results from a lack of available or accessible home infusion nursing capabilities throughout Middle Tennessee. As a licensed pharmacy providing infusion therapy to patients in their homes, Coram is intimately familiar with the patients throughout the region and the hardships encountered by hospitals, physicians, and patients/families in effecting a timely discharge from the hospital when hospitalization is no longer required, but the patient and family have not initiated their first infusion dose nor are they knowledgeable about the process, the infusion equipment, and the specific regimen which must be followed (the applicant provides anecdotal example of these claims in Supplemental 1). Furthermore, as the pharmacy providing the infusion product to the patient, Coram's staff regularly meets with the patients and understands their skilled nursing needs, but is unable to assist in that regard as it does not have a home health license.

In response to questions concerning what home heath agencies have been providing infusion

services in the past and if the applicant had worked in a collaborative fashion with agencies asked by HSDA staff in Supplemental 1, the applicant stated that provided the patient qualifies for home health services (e.g., home bound), and after the first dose, and provided that the therapy is not of repeat or long duration, incumbent home care agencies such as CareAll and Middle Tennessee Home Health have on occasion provided care to the applicant's patients. The applicant reported these arrangements do not work because: a) many of these patients are not truly home bound so they do not qualify for reimbursement, and thus home health agencies do not want these patients; b) because many of there therapies are of long duration (3+ hours) it is not economically advantageous for a full service agency to tie up an RN for that length of time; and c) because none of the full service agencies will do first dosage patients, nor will any infuse blood or blood products in the home.

The applicant states in Supplemental 1 they will install one FTE infusion nurse centrally located in Nashville, and will add per diem or per visit infusion nurses throughout the service area as needed to respond expeditiously to requests for service. Operationally on occasion if the patient is local, the infusion nurse will take the infusion product from the compounding pharmacy to the patient's home for administration. More often, the infusion product will be compounded at the applicant's Sidco Drive facility and taken by secure courier to the patient's home where it is met by the infusion nurse for administration.

The applicant's encounter with a patient begins upon the patient's attending physician ordering an infusion or service and a referral is made to the applicant (either by the physician or discharge planners at area medical centers). The applicant verifies insurance, the physician order, and the patient's demographic information and transmits that data to the pharmacy which compounds the patient's drug therapy. Three groups within the applicant's organization then coordinate the patient's care: the pharmacy with respect to the drug mix, the courier service for secure and timely delivery, and nursing the education and administration. The applicant has implemented an electronic medical record system that securely communicates with the home office and summaries of care are shared with the patient's physician.

The applicant employs a director of nursing services who will be the supervisor for all the nursing functions associated with the applicant who will be available at all time during operating hour and shall participate in all activities relevant to the professional home health services provided, including the development of qualifications and assignment of personnel. In addition, the agency shall have a committee consisting of the nursing director, the agency's executive director, and the regional president who shall review at least annually past and present home health services to determine the appropriateness and effectiveness of the care provided.

According to the applicant, they are better able to meet this populations needs. This patient population's needs are not being met by incumbent home health providers, primarily because of reimbursement issues. They cannot get reimbursed for patients that are not home bound, they cannot get adequately reimbursed for infusion therapy that lasts several hours, and they only get reimbursed for one visit, even though three therapy regimens require three visits in the same day. Furthermore, the existing agencies will not treat patients on the first dose, and will not administer blood or blood products in the home. By granting the applicant's limited home health agency CON, these patients can remain in their home, thereby avoiding the time and inconvenience of traveling to an outpatient hospital clinic, as well as avoiding exposure of their immune suppressed bodies to nosocomial infections. Finally, care rendered by the applicant's certified infusion nurses is vastly superior to that of the RN untrained in spotting infusion complications, educating patients on the sterile site, and site maintenance.

The applicant states they have commissioned studies of the impact of infusion nursing in other markets and found that, on average, 80% of referrals are made on the expected last day of the patient's hospital stay, and with home infusion nurses availability the applicant is able to discharge 50-70% of these patients that day, and the remainder the next. The applicant states the payer partners' value this opportunity to avoid another overnight stay in the hospital.

When questioned by HSDA staff as to their experience in the additional health care delivery cost savings realized by the initiation of this new service, the applicant states they only track actual encounters with patients and do not track cases where it could not meet a patient's need in home due to the factors set forth in the application (i.e., not home bound, long duration, first infusions, 3 dose infusions, blood product) which are non-encounters. As already noted, the applicant is able to reduce hospital stays by at least one day in 50-70% of cases. Additionally, the letter of support from Vanderbilt University Medical Center, which also has it own home health agency, indicates that for each day saved in the hospital, it will experience a corresponding $1,500 a day savings in costs.

The applicant projects 247 home health patients in year one and 263 in year two of the project.

**TENNCARE/MEDICARE ACCESS**

The applicant states the home health agency proposed by this CON will not become Medicare/Medicaid certified. Because it is a limited service home health agency, and not providing the full range of home health services as prescribed by the Conditions of Participation, it is not eligible for certification

Patients will be private pay, covered by third party provider, and medically indigent. Per the Projected Data Chart, 5% of the patients are expected to be charity care.

**TennCare Enrollees in the Service Area**

| COUNTY | TOTAL TENNCARE REC. | 2012 POPULATION | % OF POP ON TENNCARE |
|---|---|---|---|
| Bedford | 10,508 | 48,083 | 21.9% |
| Bledsoe | 2,960 | 13,565 | 21.8% |
| Cannon | 2,783 | 14,269 | 19.5% |
| Cheatham | 6,122 | 42,222 | 14.5% |
| Clay | 1,964 | 8,201 | 23.9% |
| Coffee | 10,942 | 54,707 | 20.0% |
| Cumberland | 10,299 | 55,798 | 18.5% |
| Davidson | 118,944 | 602,257 | 19.7% |
| DeKalb | 4,375 | 19,366 | 22.6% |
| Dickson | 8,895 | 49,744 | 17.9% |
| Franklin | 6,446 | 43,112 | 15.0% |
| Giles | 5,433 | 30,076 | 18.1% |
| Grundy | 4,671 | 14,925 | 31.3% |
| Hamilton | 55,409 | 318,632 | 17.4% |
| Hickman | 5,389 | 26,100 | 20.6% |
| Humphreys | 3,578 | 19,067 | 18.8% |
| Jackson | 2,558 | 11,419 | 22.4% |
| Lawrence | 8,593 | 42,709 | 20.1% |
| Lewis | 2,727 | 12,208 | 22.3% |
| Lincoln | 6,597 | 34,084 | 19.4% |
| Macon | 5,826 | 23,208 | 25.1% |
| Marion | 6,431 | 28,455 | 22.6% |
| Marshall | 5,620 | 30,958 | 18.2% |
| Maury | 15,191 | 84,148 | 18.1% |
| Montgomery | 23,758 | 159,209 | 14.9% |

| | | | |
|---|---|---|---|
| Overton | 4,599 | 21,377 | 21.5% |
| Putnam | 14,314 | 72,489 | 19.7% |
| Rhea | 7,978 | 31,803 | 25.1% |
| Robertson | 11,541 | 68,589 | 16.8% |
| Rutherford | 36,947 | 256,765 | 14.4% |
| Sequatchie | 3,578 | 14,042 | 25.5% |
| Smith | 3,907 | 20,104 | 19.4% |
| Sumner | 22,806 | 162,422 | 14.0% |
| Trousdale | 1,627 | 8,287 | 19.6% |
| Warren | 9,455 | 42,263 | 22.4% |
| White | 5,699 | 25,521 | 22.3% |
| Williamson | 8,840 | 184,323 | 4.8% |
| Wilson | 14,013 | 114,437 | 12.2% |
| **Total** | **481,295** | **2,808,944** | **17.1%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics and *Tennessee TennCare Management Information System, Recipient Enrollment,* Bureau of TennCare

**ECONOMIC FACTORS/FINANCIAL FEASIBILITY:**

In the Project Costs Chart, the total estimated project cost is $63,000, which includes $60,000 for legal, administrative, and consultant fees; and $3,000 for CON filing fees.

In the Historical Data Chart for the existing Nashville Operations located in Supplemental 1, the applicant reports 1,028, 958, and 1,288 patients in 2009, 2010, and 2011 with gross operating revenues of $4,957,333, $6,154,111, and $8,259,575 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $4,494,923, $5,925,847, and $8,058,139 each year. The applicant reports a net operating income of $1,102,393, $1,757,951, and $2,127,736 each year, respectively.

In the Projected Data Chart for the home health/nursing visits located in Supplemental 1, the applicant projects 247 home health patients and 1,192 RN visits in year one and 263 home health patients and 1,252 RN visits in year two with gross operating revenues of $212,436 and $234,211 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $186,134 and $205,213 each year. The applicant projects a net operating income in year one of $18,989 and $28,050 in year two of the project.

In Supplemental 1, the applicant's projected year one average gross charge is $178 per visit, with an average gross charge/patient episode of $861, with an average patient diction of $107, resulting in an average net revenue/patient of $754 and average net revenue/visit of $156. In year two, the applicant's projected average gross charge is $187 per visit, with an average gross charge/patient episode of $891, with an average patient diction of $110, resulting in an average net revenue/patient of $781 and average net revenue/visit of $164. The applicant provided the 2011 charges for a skilled visit for ten agencies from the 2011 Joint Annual Report of Home Health Agencies ranging from $173 per visit to $73 in Supplemental 1.

The applicant states the only alternative to this proposal is maintaining the status quo. Maintaining the status quo in Middle Tennessee means continued longer stays in hospitals; more costly hospital stays; further hardships on patients and their families; inability to enhance quality of infusion therapy services in Middle Tennessee; operating in a more costly healthcare environment despite the industry's focus on enhancing quality and decreasing costs; and rejecting a true improvement in healthcare delivery at a lesser cost.

The applicant reports the proposed project does not involve any new construction. The applicant will use its existing structure that houses a licensed pharmacy and ambulatory infusion suite to

establish the home health agency. Therefore the physical plant exists, is fully built out, and will require no incremental costs by the applicant to achieve licensure of the home health service.

**CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:**
The applicant is an existing licensed pharmacy and operates an ambulatory infusion suite. The currently have in place numerous contractual agreements throughout Middle Tennessee

Aside from payor relationships, the applicant has significant referral relationships with the existing hospital and provider community throughout the 38 county service area. The applicant provides a listing of these relationships on page 72 of the application.

The applicant states this proposal will not negatively impact existing home health providers as the services proposed will be very restricted and complement home health services provided by agencies throughout Middle Tennessee. Additionally, with Coram's intent to continue to train nurses at other home health agencies in the area of infusion, it is possible the quality of care in the overall home health community will increase.

Coram's restricted license will have a positive effect on existing institutional providers. Coram has a referral relationship for its infusion products with numerous Middle Tennessee hospitals. With the ability to have Coram's certified infusion nurses available for first dose protocol and training in a patient's home, patients will be discharged on a timelier basis from these area hospitals. The ultimate effect will be a decrease in patient costs across the continuum of the healthcare system.

According to the applicant, other benefits Coram believes will accrue to the community at large with its ability to provide infusion nursing services include but are not limited to the following:

- Less emergency room use;
- Better disease control;
- Fewer unscheduled physician office visits;
- Fewer total medications;
- Fewer hospitalizations;
- Better self and preventative care skills by the patient and family;
- Better drug compliance;
- Seamless delivery of care by infusion therapy provider;
- Certified infusion nurse able to provide hands on care in the patients home; and
- Skilled experience infusion able to teach the patient self administration, compliance and safety.

In summary, the applicant believes this project will have no negative effect on the utilization of existing home health providers, will have a positive effect through more timely discharge and a cost savings for hospital referral sources, and will have a positive effect on the home health community through enhanced quality care delivery in the patient's home.

The applicant states the majority of their patients will come from Davidson County and the immediate surrounding areas. To meet this need, the applicant intends to hire 1.0 FTE infusion RN operating out of Davidson County. The applicant calculates that they will need approximately .75 FTE infusion RN (or approximately 1.360-1,500 hours annually, which it will obtain from pools of qualified infusion nurses in these geographic areas. The applicant anticipates the total complement of nurses to be the one full-time nurse based out of Davidson County, and 3-4 rotating pool nurses (compensated either per diem or per visit) from regions north, east, and south of Davidson County or 1.68 FTE pool nurses. The total number of RNs FTEs for year 2 will be 1.75 FTEs, an increase of 0.07 FTE from year one, as there are projected to have only 16 additional patients in year two compared to year one.

Coram has educational and training relationships with David Lipscomb University, University of Tennessee, CareAll Home Health Agency, Physician Offices In-services, hospital case managers

and dietician In-services. The applicant states with approval of this CON application, Coram will expand relationships with Belmont and Vanderbilt Universities.

The applicant will seek licensure from the Tennessee Department of Health, Board for Licensing Healthcare Facilities as a home health agency and is accredited by The Joint Commission.

## SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

## HOME HEALTH SERVICES

1. The need for home health agencies/services shall be determined on a county by county basis.

   *The need for home health services was calculated based on the applicant's 38 county service area.*

2. In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county.

   The 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed service area.

   *The need was calculated using the 1.5 percent of the total population as stated in the criterion.*

3. Using recognized population sources, projections for four years into the future will be used.

***Service Area Total Population Projections for 2012 and 2016***

| County | 2012 Population | 2016 Population | % Increase or (Decrease) |
|---|---|---|---|
| Bedford | 48,083 | 51,282 | 6.7% |
| Bledsoe | 13,565 | 13,886 | 2.4% |
| Cannon | 14,269 | 14,805 | 3.8% |
| Cheatham | 42,222 | 44,357 | 5.1% |
| Clay | 8,201 | 8,301 | 1.2% |
| Coffee | 54,707 | 56,774 | 3.8% |
| Cumberland | 55,798 | 57,735 | 3.5% |
| Davidson | 602,257 | 618,202 | 2.6% |
| DeKalb | 19,366 | 20,024 | 3.4% |
| Dickson | 49,744 | 51,903 | 4.3% |
| Franklin | 43,112 | 44,351 | 2.9% |
| Giles | 30,076 | 30,638 | 1.9% |
| Grundy | 14,925 | 15,212 | 1.9% |
| Hamilton | 318,632 | 322,740 | 1.3% |
| Hickman | 26,100 | 27,616 | 5.8% |
| Humphreys | 19,067 | 19,515 | 2.3% |
| Jackson | 11,419 | 11,730 | 2.7% |
| Lawrence | 42,709 | 43,918 | 2.8% |
| Lewis | 12,208 | 12,599 | 3.2% |
| Lincoln | 34,084 | 34,940 | 2.5% |
| Macon | 23,208 | 24,183 | 4.2% |
| Marion | 28,455 | 28,787 | 1.2% |
| Marshall | 30,958 | 32,304 | 4.3% |
| Maury | 84,148 | 88,120 | 4.7% |

| | | | |
|---|---|---|---|
| Montgomery | 159,209 | 167,554 | 5.2% |
| Overton | 21,377 | 21,747 | 1.7% |
| Putnam | 72,489 | 75,364 | 4.0% |
| Rhea | 31,803 | 32,809 | 3.2% |
| Robertson | 68,589 | 72,906 | 6.3% |
| Rutherford | 256,765 | 274,920 | 7.1% |
| Sequatchie | 14,042 | 14,701 | 4.7% |
| Smith | 20,104 | 20,984 | 4.4% |
| Sumner | 162,422 | 170,883 | 5.2% |
| Trousdale | 8,287 | 8,611 | 3.9% |
| Warren | 42,263 | 43,792 | 3.6% |
| White | 25,521 | 26,236 | 2.8% |
| Williamson | 184,323 | 200,247 | 8.6% |
| Wilson | 114,437 | 121,203 | 5.9% |
| **Total** | **2,808,944** | **2,925,879** | **4.2%** |

*Source: Tennessee Population Projections 2000-2020, February 2008 Revision, Tennessee Department of Health, Division of Health Statistics*

4. The use rate of existing home health agencies in the county will be determined by examining the latest utilization rate as calculated in the Joint Annual Report of existing home health agencies in the service area.

   Based on the number of patients served by home health agencies in the service area, an estimation will be made as to how many patients could be served in the future.

   *The following chart illustrates the service area need and utilization for the applicant's proposed service area.*

**Service Area Need and Utilization for 2011**

| Service Area | Agencies Licensed to Serve | Total Patients Served | Estimated 2011 Pop. | Projected 2016 Pop. | Projected Capacity | Projected Need (.015 x 2016 Pop.) | Need or(Surplus) for 2016 |
|---|---|---|---|---|---|---|---|
| Bedford | 23 | 1,053 | 47,312 | 51,282 | 1,141 | 769 | (372) |
| Bledsoe | 12 | 458 | 13,487 | 13,886 | 472 | 208 | (263) |
| Cannon | 20 | 425 | 14,143 | 14,805 | 445 | 222 | (223) |
| Cheatham | 26 | 779 | 41,700 | 44,357 | 829 | 665 | (163) |
| Clay | 9 | 269 | 8,186 | 8,301 | 273 | 125 | (148) |
| Coffee | 20 | 1,942 | 54,205 | 56,774 | 2,034 | 852 | (1,182) |
| Cumberland | 15 | 1,794 | 55,300 | 57,735 | 1,873 | 866 | (1,007) |
| Davidson | 31 | 13,728 | 598,895 | 618,202 | 14,171 | 9,273 | (4,898) |
| DeKalb | 23 | 669 | 19,211 | 20,024 | 697 | 300 | (397) |
| Dickson | 26 | 1,463 | 49,238 | 51,903 | 1,542 | 779 | (764) |
| Franklin | 17 | 1,506 | 42,820 | 44,351 | 1,560 | 665 | (895) |
| Giles | 12 | 987 | 29,955 | 30,638 | 1,010 | 460 | (550) |
| Grundy | 22 | 604 | 14,859 | 15,212 | 618 | 228 | (390) |
| Hamilton | 17 | 8,938 | 317,758 | 322,740 | 9,078 | 4,841 | (4,237) |
| Hickman | 20 | 686 | 25,740 | 27,616 | 736 | 414 | (322) |
| Humphreys | 18 | 655 | 18,961 | 19,515 | 674 | 293 | (381) |
| Jackson | 12 | 343 | 11,350 | 11,730 | 354 | 176 | (179) |
| Lawrence | 14 | 1,555 | 42,423 | 43,918 | 1,610 | 659 | (951) |
| Lewis | 13 | 467 | 12,120 | 12,599 | 485 | 189 | (296) |
| Lincoln | 14 | 1,100 | 33,895 | 34,940 | 1,134 | 524 | (610) |
| Macon | 20 | 733 | 22,974 | 24,183 | 772 | 363 | (409) |
| Marion | 17 | 1,029 | 28,383 | 28,787 | 1,044 | 432 | (612) |
| Marshall | 20 | 771 | 30,637 | 32,304 | 813 | 485 | (328) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *Maury* | *24* | *2,523* | *83,218* | *88,120* | *2,672* | *1,322* | *(1,350)* |
| *Montgomery* | *20* | *2,970* | *157,247* | *167,554* | *3,165* | *2,513* | *(651)* |
| *Overton* | *13* | *750* | *21,282* | *21,747* | *766* | *326* | *(440)* |
| *Putnam* | *17* | *2,329* | *71,810* | *75,364* | *2,444* | *1,130* | *(1,314)* |
| *Rhea* | *17* | *894* | *31,576* | *32,809* | *929* | *492* | *(437)* |
| *Robertson* | *26* | *1,632* | *67,533* | *72,906* | *1,762* | *1,094* | *(668)* |
| *Rutherford* | *33* | *5,240* | *252,394* | *274,920* | *5,708* | *4,124* | *(1,584)* |
| *Sequatchie* | *15* | *391* | *13,878* | *14,701* | *414* | *221* | *(194)* |
| *Smith* | *20* | *621* | *19,900* | *20,984* | *655* | *315* | *(340)* |
| *Sumner* | *27* | *3,820* | *160,366* | *170,883* | *4,071* | *2,563* | *(1,507)* |
| *Trousdale* | *17* | *296* | *8,215* | *8,611* | *310* | *129* | *(181)* |
| *Warren* | *22* | *1,755* | *41,901* | *43,792* | *1,834* | *657* | *(1,177)* |
| *White* | *16* | *974* | *25,347* | *26,236* | *1,008* | *394* | *(615)* |
| *Williamson* | *31* | *2,655* | *180,620* | *200,247* | *2,944* | *3,004* | *60* |
| *Wilson* | *30* | *3,058* | *112,787* | *121,203* | *3,286* | *1,818* | *(1,468)* |
| | ***88*** | ***71,862*** | ***2,781,626*** | ***2,925,879*** | ***75,331*** | ***43,888*** | ***(31,443)*** |

*Source: Joint Annual Report of Home Health Agencies 2011, Tennessee Department of Health, Division of Health Statistics*

5. Documentation from referral sources:

   a. The applicant shall provide letters of intent from physicians and other referral sources pertaining to patient referral.

      *The applicant states in Supplemental 1 they have discussions daily regarding delays in service issues with existing home health agencies , however, the applicant does not maintain documentation or data on interactions that do not ultimately result in an encounter with a patient.*

   b. The applicant shall provide information indicating the types of cases physicians would refer to the proposed home health agency and the projected number of cases by service category to be provided in the initial year of operation.

      *In Supplemental 1, the applicant states they have discussions with hospital discharge planners regarding obtaining home infusion services for their patients, but unless the applicant actually provides that service it does not maintain records of such interactions. The applicant cites a letter from Vanderbilt Medical Center, with its own home health agency, as indicative of its support and the need for these services.*

   c. The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.

      *The applicant states in Supplemental 2, they have provided numerous letters from providers explaining difficulty in obtaining infusion services in the home. Those letters are from Cumberland Medical Center, Indian Lake Neurology, Vanderbilt Medical Center, and Affiliated Neurologists and can be found on page 106 of the application. The applicant states they are actively seeking letters of support from patients and will contemporaneously supplement the record with the same up to the date of the hearing.*

   d. The applicant shall provide information concerning whether a proposed agency would provide services different from those services offered by existing agencies.

      *In response to questions concerning what home heath agencies have been providing infusion services in the past and if the applicant had worked in a collaborative fashion with agencies asked by HSDA staff in Supplemental 1, the applicant stated that*

*provided the patient qualifies for home health services (e.g., home bound), and after the first dose, is provided that the therapy is not of repeat or long duration, incumbent home care agencies such as CareAll and Middle Tennessee Home Health have on occasion provided care to the applicant's patients. The applicant reported these arrangements do not work because: a) many of these patients are not truly home bound so they do not qualify for reimbursement, and thus home health agencies do not want these patients; b) because many of there therapies are of long duration (3+ hours) it is not economically advantageous for a full service agency to tie up an RN for that length of time; and c) because none of the full service agencies will do first dosage patients, nor will any infuse blood or blood products in the home.*

6. The proposed charges shall be reasonable in comparison with those of other similar facilities in the service area or in adjoining service areas.

   a. The average cost per visit by service category shall be listed.

   b. The average cost per patient based upon the projected number of visits per patient shall be listed.

*In Supplemental 1, the applicant states they will charge for skilled nursing services. It is the only service they will provide as 100% of their visits will be skilled nursing. They state they will not provide any other type of home health services.*

*The applicant reports the average cost per skilled nursing visit is forecasted to be $140 in 2013 dollars. This is computed based on taking projected data chart total costs and dividing by the number of visits. It is based upon a mix of patients as describe previously with some portion of the visits lasting up to six hours, or three times as long as the typical visit duration.*

*The applicant states their average skilled nursing cost per patient in 2013 dollars is $677. This is computed based on taking projected data chart total costs and dividing by the number of patients in each year.*

**HEALTH SERVICES AND DEVELOPMENT AGENCY**
**SEPTEMBER 26, 2012**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | Metro Knoxville HMA, LLC, d/b/a, North Knoxville Medical Center |
| PROJECT NUMBER: | CN1206-027 |
| ADDRESS: | 7551 Danaher Lane<br>Powell (Knox County), TN 37849 |
| LEGAL OWNER: | Metro Knoxville HMA Holdings, LLC, d/b/a, TennNova Healthcare<br>200 E. Blount Avenue, Suite 600<br>Knoxville (Knox County), TN 37920 |
| OPERATING ENTITY: | Not Applicable |
| CONTACT PERSON: | Jeffrey Potter<br>(865) 632-5605 |
| DATE FILED: | June 13, 2011 |
| PROJECT COST: | $1,309,471.00 |
| FINANCING: | Cash Reserves |
| PURPOSE FOR FILING: | Initiation of Mobile Positron Emission Tomography/ Computerized Tomography (PET/CT) Services |

DESCRIPTION:

North Knoxville Medical Center (NKMC) is seeking approval for initiation of mobile Positron Emission Tomography/Computerized Tomography (PET/CT) Services one day per week on its campus located at 7551 Dannaher Way, Powell, Tennessee 37849. NKMC is a 108 bed satellite hospital of Tennova Healthcare's-Physicians Regional Medical Center, located 900 E. Oak Hill Avenue, Knoxville, Tennessee. The proposed equipment is a mobile PET/CT unit provided by Alliance Healthcare Services, Inc., d/b/a Alliance Imaging ("Alliance"). The unit is a Siemens Biograph 6 PET/CT system manufactured in 2008. *A profile of the proposed equipment is attached at Attachment B.I. Project Description.1.* Alliance's

mobile PET/CT unit will be parked adjacent to the NKMC's Cancer Center one day per week in order to provide PET/CT services to NKMC's cancer patients. Construction will involve pouring a concrete pad (46 ft. long and 8.5 ft. wide or 391 square feet) for the mobile unit, as well as a concrete sidewalk with a canopy and sidewalls for easy access from the back of NKMC's Cancer Center to the mobile unit. Electrical upgrades sewer and water service are also required. *See Attachment B.III. for the Plot Plan and Attachment B.IV. for the Floor Plan of the proposed project.*

SPECIFIC CRITERIA AND STANDARDS REVIEW:

POSITRON EMISSION TOMOGRAPHY SERVICES

1. Applicants proposing a new stationary PET unit should project a minimum of at least 1,000 PET procedures in the first year of service, building to a minimum of 1,600 procedures per year by the second year of service and for every year thereafter. Providers proposing a mobile PET unit should project a minimum of at least 133 mobile PET procedures in the first year of service per day of operation per week, building to an annual minimum of 320 procedures per day of operation per week by the second year of service and for every year thereafter. The minimum number of procedures for a mobile PET unit should not exceed a total of 1600 procedures per year if the unit is operated more than five (5) days per week. The application for mobile and stationary units should include projections of demographic patterns, including analysis of applicable population-based health status factors and estimated utilization by patient clinical diagnoses category (ICD-9).

   For units with a combined utility, e.g., PET/CT units, only scans involving the PET function will count towards the minimum number of procedures.

   *The applicant projects it will perform 250 PET procedures in the first year of operation, 2013. The applicant's PET procedure projections in the second year of operation, 2014, will grow to 320. The applicant has included socio-demographic profiles for each of the counties in this project's declared service area as well as the latest available incidence rates for cancer in each of these counties.*

   *It appears the applicant will meet the criterion by the second year.*

2. All providers applying for a proposed new PET unit should document that the proposed location is accessible to approximately 75% of the service area's population. Applications that include non-Tennessee counties in their proposed service areas should provide evidence of the number of existing PET units that service the non-Tennessee counties and the impact on PET unit utilization in the

non-Tennessee counties, including the specific location of those units located in the non-Tennessee counties, their utilization rates, and their capacity.

*The applicant indicates the NKMC campus is located 0.2 miles off of 1-75, the primary interstate running through the service area. NKMC is eight miles north of Physicians Regional Medical Center, and is the only hospital operating on the far northern side of Knox County. Patients traveling from Campbell, Claiborne, Grainger, Scott, and Union Counties would be closer to NKMC than to other providers of PET/CT services in the region, as well as closer to NKMC than they are to Physicians Regional Medical Center, where Tennova Healthcare's fixed PET/CT is located.*

*It appears the application meets this criterion.*

3. All providers should document that alternate shared services and lower cost technology applications have been investigated and found less advantageous in terms of accessibility, availability, continuity, cost, and quality of care.

*The applicant indicates the Mobile PET/CT services allow NKMC's comprehensive Cancer Center to provide this key service to oncology patients without incurring the significant costs involved with a fixed unit. Because of Health Management Associates' national relationship with Alliance, NKMC is able to take advantage of a contract with very favorable terms related to pricing and volumes. For $75,000 of capital investment, the campus will be prepared to accept the mobile unit, which is the lowest cost alternative for providing PET/CT services. By building the covered sidewalk with sidewalls from the Cancer Center to the mobile unit, access will be very easy for patients who are used to navigating the Cancer Center. The Siemens 6 unit that will be provided by Alliance is FDA approved and is a machine that is currently in service and providing quality images.*

*It appears the application meets this criterion.*

4. Any provider proposing a new mobile PET unit should demonstrate that it offers or has established referral agreements with providers that offer as a minimum, cancer treatment services, including radiation, medical and surgical oncology services.

*The applicant identifies NKMC offers a full complement of cancer services, including prevention, detection, diagnosis, and treatment of cancer. The full complement of cancer treatment modalities is also offered at NKMC, including radiation therapy, chemotherapy*

*infusion, and surgery, and all patients are treated with a multi-disciplinary approach. PET/CT's primary application is for cancer patients. The greatest percentages of referrals to PET/CT come from Medical Oncologists and Radiation Oncologists. The applicant indicates there are currently five Medical Oncologists and two Radiation Oncologists treating patients on the NKMC campus.*

*It appears the application meets this criterion.*

5. A need likely exists for one additional stationary PET unit in a service area when the combined average utilization of existing PET service providers is at or above 80% of the total capacity of 2,000 procedures during the most recent twelve-month period reflected in the provider medical equipment report maintained by the HSDA. The total capacity per PET unit is based upon the following formula:

   Stationary Units: Eight (8) procedures/day x 250 days/year = 2,000 procedures/year

   Mobile Units: Eight (8) procedures /day x 50 days/year= 400 procedures/year

   The provider should demonstrate that its acquisition of an additional stationary or mobile PET unit in the service area has the means to perform at least 1,000 stationary PET procedures or 133 mobile PET procedures per day of operation per week in the first full one-year period of service operations, and at least 1,600 stationary PET procedures or 320 mobile PET procedures per day of operation per week for every year thereafter.

   *As reported to the HSDA Medical Equipment Registry, the service area's 6.8 Full Time Equivalent (FTE) operating PET/CT scanners in 2011 were utilized at an average of 79% of the State Health Plan's PET minimum standard (see the utilization details on page 10 of this Summary). The proposed PET/CT scanner is projected to provide 320 mobile PET procedures per day of operation per week for by the second year and every year thereafter.*

   *It appears the application does not meet the existing service area-wide utilization standard, but intends to meet the mobile unit standard in the second year of operation.*

6. The applicant should provide evidence that the PET unit is safe and effective for its proposed use.

a. The United States Food and Drug Administration (FDA) must certify the proposed PET unit for clinical use.

*A FDA approval letter included in the attachments to the application indicates the Siemens 6 PET/CT is certified for clinical use.*

*It appears the application meets this criterion.*

b. The applicant should demonstrate that the proposed PET procedures will be offered in a physical environment that conforms to applicable federal standards, manufacturer's specifications, and licensing agencies' requirements.

*The lease agreement indicates the PET/CT procedures will be offered in a physical environment in compliance with federal, state and local codes, and manufacturer's specifications was included in the attachments to the application.*

*It appears the application meets this criterion.*

c. The applicant should demonstrate how emergencies within the PET unit facility will be managed in conformity with accepted medical practice.

*The applicant states a board certified physician will be present when patients receive diagnostic services and technologists will be trained in handling of emergency situations.*

*It appears the application meets this criterion.*

d. The applicant should establish protocols that assure that all clinical PET procedures performed are medically necessary and will not unnecessarily duplicate other services.

*Protocols to assure medical appropriateness and medical necessity were included in the attachments to the application.*

*It appears the application meets this criterion.*

e. The PET unit should be under the medical direction of a licensed physician. The applicant should provide documentation that attests to the nature and scope of the duties and responsibilities of the physician medical director. Clinical supervision and interpretation services must be provided by physicians who are licensed to practice medicine in the state of Tennessee and are board certified in Nuclear Medicine or Diagnostic Radiology. Licensure

and oversight for the handling of medical isotopes and radiopharmaceuticals by the Tennessee Board of Pharmacy and/or the Tennessee Board of Medical Examiners—whichever is appropriate given the setting—is required. Those qualified physicians that provide interpretation services should have additional documented experience and training, credentialing, and/or board certification in the appropriate specialty and in the use and interpretation of PET procedures.

*The applicant indicates the PET scans will be read by the radiologists associated with Abercrombie Radiological Consultant. The credentials for the Medical Director of Radiology Services and NKMC were included in the attachments to the application.*

*It appears the application meets this criterion.*

f. All applicants should seek and document emergency transfer agreements with local area hospitals, as appropriate. An applicant's arrangements with its physician medical director must specify that said physician be an active member of the subject transfer agreement hospital medical staff.

*The applicant indicates as part of the services of NKMC, most emergencies can be managed on site, utilizing the Emergency Department physicians. Emergency transfer procedures are also included as an attachment to the application describing the process for emergency transfer to NKMC's affiliated tertiary care hospital, Physicians Regional Medical Center.*

*It appears the application meets this criterion.*

7. The applicant should provide assurances that it will submit data in a timely fashion as requested by the HSDA to maintain the HSDA Equipment Registry.

*The applicant states it will comply with all requests from the HSDA and submit in timely fashion data to the HSDA Medical Equipment Registry. It appears the applicant meets this criterion.*

8. In light of Rule 0720-4-.01 (1), which lists the factors concerning need on which an application may be evaluated, the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

*The applicant indicates several of the counties that are in this project's service area have some partial designation by the United States Health Resources and Services Administration (HRSA) as medically underserved areas. These counties include Campbell, Claiborne, Cocke, Hamblen, Scott and Union. Medically underserved areas are so designated due to shortage of primary care, dental and mental health providers.*

*It appears the application meets this criterion.*

b. Who documents that the service area population experiences a prevalence, incidence and/or mortality from cancer, heart disease, neurological impairment or other clinical conditions applicable to PET unit services that is substantially higher than the State of Tennessee average;

*The applicant indicates the cancer incidence rates in eight of the eleven service area counties are higher than the average for the state of Tennessee in both of the latest reporting periods of the Tennessee cancer Registry: 2002-2006 and 2003-2007. Additionally, the incidence rate of cancer increased in every county in the service area. The increase in most counties was between 3-6%.*

*It appears the application meets this criterion.*

c. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program and/or is a comprehensive cancer diagnosis and treatment program as designated by the Tennessee Department of Health and/or the Tennessee Comprehensive Cancer Control Coalition; or

*The applicant indicates this criterion does not apply.*

d. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program.

*The applicant indicates Tennova Healthcare and the NKMC will continue to participate in all TennCare MCOs and in Medicare.*

*It appears the application meets this criterion.*

SUMMARY:

Tennova Healthcare d/b/a North Knoxville Medical Center (NKMC) indicates PET/CT is a specialized imaging process most heavily utilized for cancer patients, although it also has applications for cardiac and neurology patients, specifically related to the diagnosis of Alzheimer's disease and dementia. NKMC has a full-service, comprehensive Cancer Center. In fact according to the applicant, the Cancer Center was the first building on the campus, and the hospital developed around the Cancer Center. The full complement of cancer treatment is offered at NKMC, including prevention, detection, diagnosis, and treatment of cancer. The full complement of cancer treatment modalities is also offered at NKMC, including radiation therapy, chemotherapy infusion, and surgery, and all patients are treated with a multidisciplinary approach. However, patients needing PET/CT scans for the diagnosis or staging of cancer must today travel to a different location to have that scan. According to the applicant, NKMC is the only comprehensive cancer center in the region without PET/CT services.

North Knoxville Medical Center (NKMC) proposes that the new PET/CT service will be offered 8:00AM to 5:00PM on Fridays when the mobile PET/CT is parked by NKMC's Cancer Center. According to the applicant, NKMC is located 0.2 miles from 1-75, at the Emory Road exit, making it easily accessible by car to residents of its 11 county service area. While the Knoxville Area Transit bus system does not service the NKMC campus, patients in need of transportation may have access through Knoxville Community Action Committee (CAC) Service vans, which provide service to those patients who qualify, and give priority to patients who need transportation for cancer treatment. The campus is also served by East Tennessee HRA Public Transit (ETHRA) for patients in the service area's rural counties.

The nearest PET/CT for most of the patients in the service area, particularly those in the more rural counties to the north of NKMC, is at Physicians Regional Medical Center, another 8 miles further south. For a map of the service area showing the Tennova hospital locations, see Attachment B.I. (Project Description) 4. For cancer patients, the additional travel time, as well as the struggle to locate a different facility and navigate a complicated hospital campus is a major challenge. By offering PET/CT at NKMC, those patients can easily access the service, just by parking near and walking into the cancer center they utilize for treatments on an ongoing basis.

North Knoxville Medical Center operates as a satellite hospital under the hospital license owned by Metro Knoxville, HMA, LLC, d/b/a Tennova Healthcare, which has a total licensed bed complement of 903 licensed beds

(including Physicians Regional Medical Center, North Knoxville Medical Center, Turkey Creek Medical Center, and Tennova Medical Center-Riverside (*which closed its inpatient services in 2009*). Metro Knoxville, HMA, LLC is owned by Healthcare Management Associates, Inc. (HMA). Headquartered in Naples, Florida, HMA provides healthcare services through 70 hospitals with over 10,500 licensed beds and 461 clinics in 15 states. Besides the North Knoxville Medical Center, Physicians Regional Medical Center and Turkey Creek Medical Center in Knox County, HMA also operates Lafollette Medical Center in LaFollette (Campbell County), Jefferson Memorial Hospital in Jefferson City (Jefferson County), Newport Hospital in Newport (Cocke County), Jamestown Regional Hospital in Jamestown (Fentress County) , Harton Regional Medical Center in Tullahoma (Coffee County), and University Medical Center Hospital in Lebanon (Wilson County) in Tennessee. *The applicant has provided an organizational chart reflecting the ownership of Tennova Healthcare and its various entities in Attachment A.4.c.*

The applicant states the service area for this project consists of the following 11 counties in Tennessee: Anderson, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Scott, Sevier, and Union, because residents of these counties account for approximately 95% of the oncology services utilization at North Knoxville. *A map of the service area is included as Attachment C.6.* Between 2012 and 2016, the total service area population is expected to grow 2.9% from 888,532 to 914,251. Residents age 65 and over are projected to rise 12.4% from 128,686 to 144,647. The proportion of the population enrolled in TennCare averages 22.4%, with Sevier County averaging 17.8% and Scott County averaging 31.3% of its population. The Average TennCare enrollment statewide is 19.2%.

The cancer incidence rate in the NKC identified service area is also increasing in the service area, according to Tennessee Department of Health statistics. The latest projections show an estimated 4.2% increase in cancer incidence in the service area per year. With the anticipated population growth of 2.9% and the cancer incidence rate growth of 4.2% per year, demand for cancer services on the campus will continue to grow. *Note to Agency members: Charts showing the project population and cancer incidence growth rates are attached on Attachment 4.*

A review of the inventory of the existing PET capabilities within the service area shows there are eight (8) providers which currently hold Certificates of Need for nine (9) PET/CT scanners. Three (3) of the providers offer PET services through mobile PET/CT units which are provided on their sites either 1 or 2 days/week. The remaining 5 providers are operating 6 fixed PET/CT machines, with the University of Tennessee's Medical Center operating two (2) PET/CT scanners.

The historical utilization of these PET/CT units is shown below:

**Historical Service Area Utilization of Linear Accelerators**

| | | | 2009 | 2010 | 2011 | '09-'11 | '11 |
|---|---|---|---|---|---|---|---|
| **County** | **Facility** | **# PET/CT(2011)** | **Procs.** | **Procs.** | **Procs.** | **% change** | **% G of G Util. Std. *** |
| Anderson | Methodist Med Ctr- Oak Ridge | Mobile 1 day/wk | 151 | 464 | 465 | +208% | 145% |
| Hamblen | Morristown -Hamblen Hosp. | Mobile 2 day/wk | 341 | 296 | 317 | -7.0% | 50% |
| Knox | East TN Diagnostic Ctr | 1 fixed | 1,435 | 1,200 | 1,173 | -18.3% | 73% |
| Knox | Physicians Regional Med Ctr | 1 fixed | 1,703 | 1,469 | 1,180 | -31.7% | 74% |
| Knox | UTMC | 2 fixed | 5,014 | 4,056 | 3,634 | -27.5% | 114% |
| Knox | Thompson Cancer Survival Ctr-Downtown | 1 fixed | 600 | 979 | 967 | +61.2% | 60% |
| Knox | Thompson Cancer Survival Ctr -West | 1 fixed | 1,850 | 1,030 | 741 | -60.0% | 46% |
| Sevier | Thompson Cancer Survival Ctr - Sevier | Mobile 1 day/wk | 2 | 58 | 161 | 795% | 50% |
| | **Total – 8 providers; 9 units** | **6.8 FTE units** | **11,096** | **9,552** | **8,638** | **-22.2%** | **79%** |

Source: HSDA Medical Equipment Registry

*Based on *State Health Plan's* minimum capacity standard of 80% of 2,000 procedures = 1,600 and 80% of 400 procedures for one day/week mobile units = 320 procedures/unit/year

As reported to the HSDA Medical Equipment Registry, the information shows the entire service area's 6.8 Full Time Equivalent (FTE) operating PET/CT scanners in 2011 were being utilized at an average of 79% of the *State Health Plan's PET* minimum standard of 1,600 procedures/PET unit/year. Only two (2) of the nine (9) units met or exceeded the *State Health Plan's PET standard* of 1,600 annual procedures annually for fixed PET units and 320 procedures per mobile PET unit: University Of Tennessee Medical Center and Methodist Medical Center, respectively. The other Tennova hospital, Physicians Regional Medical Center, was operating a 74% of *State Health Plan's* PET scanner utilization standard. The applicant indicates that most PET/CT providers in the service area experienced a reduction in volume between 2010 and 2011. The most significant driver of this reduction in volume was a shift in the PET/CT approval process by most managed care payors as well as Medicare. It became significantly more difficult to obtain approval from payors to conduct a PET/CT scan and there has been an adjustment period by most providers to the new approval criteria. Rather than relocate the current PET/CT scanner at Physicians Regional to the North Knoxville site, where the majority of cancer patients are increasingly being diagnosed and treated, the applicant feels there is sufficient utilization through new PET applications, most notably in brain and spine applications, where the Physicians Regional PET/CT unit will continue to provide services to patients requiring other medical specialties and will continue to need PET/CT services. *Note to Agency members: A more detailed justification is outlined by the applicant on page 27 of the application and page 6 of the supplemental response.* Below the applicant displays its historical and projected usage of Tennova's PET imaging modality:

**Historical and Projected Utilization of Tennova's PET Scanners**

| | | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|
| Physicians Regional | Fixed | 1,703 | 1,469 | 1,180 | 1,200 | 1,050 | 1,100 |
| North Knoxville | Mobile 1 day/wk | 0 | 0 | 0 | 0 | 250 | 320 |
| Tennova Total | 1.2 FTE PET/CT | 1,703 | 1,469 | 1,180 | 1,200 | 1,300 | 1,420 |

*Note to Agency members: The applicant's affiliated facility's (Physicians Regional medical Center) current utilization is 74% of the State Health Plan's PET minimum utilization standard and the addition of this mobile unit is projected by the applicant to reduce its utilization to 68%.*

The projected Average Gross Charge per scan is $4,750, with average deductions from revenue reducing the Average Net Revenue collected to $1,488 per case. Based on the 250 projected cases, the Net Operating Income less Capital Expenditures (NOI) projected is $19,830, an amount equal to approximately 1.7% of Gross Operating Revenue during the first year of operation. NOI is expected to increase to 8.0% of Gross Operating Revenue on 320 cases in the second year of the project, raising its Net Operating Income less Capital Expenditures to $121,382.

Alliance, which will be providing the PET/CT scanner and its upkeep, will also provide a technician to operate the unit.

The applicant holds Medicare and TennCare certification and projects (during the initial year of operation) its Medicare revenue (estimated at $724,372) will equate to 61% of the total gross revenue and the TennCare revenue (estimated at $142,500) will equate to 12%. The applicant already contracts with all three TennCare MCOs: TennCare Select, AmeriChoice and BlueCare.

A June 21, 2012 letter from the Chief Financial Officer of Tennova Healthcare states the applicant intends to finance the project from cash reserves of Tennova Healthcare, which is funded daily through Health Management Associates (HMA). The HMA's December 31, 2011 Balance sheet shows a balance of Cash and Cash Equivalents of $64,143,000.

The total estimated project cost is $1,309,471.00, of which $1,198,971 consists of the per-scan lease arrangement with no minimum usage requirements with Alliance over a four year term. The construction with contingency costs is estimated at $82,500.00. The construction cost for this project is estimated at $191.82/square foot. *The HSDA's records for hospital construction costs from 2009-2011 indicate the second quartile of hospital new construction costs ranges from $167.99 per square*

*foot to $249.32 per square foot.* The remainder of the project costs is consumed by legal, administrative and consultant fees ($25,000), and CON filing fees ($3,000).

*The applicant has submitted the required corporate documents, deed, and major medical equipment with their FDA approvals. Also submitted were HMA's annual corporate report and HMA's SEC Form 10-K filing. Financial Statements portions of the SEC filing are provided with the application packet, however, the remainder of this voluminous document will be available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.*

Should the Agency vote to approve this project, the CON would expire in three years.

**CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:**

There are no other Letters of Intent, denied or pending applications for this applicant.

Outstanding Certificates of Need

**North Knoxville Medical Center f/k/a Mercy Medical Center-North, CN1106-019A,** has an outstanding Certificate of Need that will expire on 12/1/2014. The CON was approved at the October 26, 2011 Agency meeting for acquisition of a second linear accelerator for its radiation therapy department located on Mercy Medical Center-North campus located at 7551 Dannaher Way, Powell (Knox County), Tennessee 37849. The estimated project cost is **$4,694,671.** *Project Status Update: On June 2, 2012 the applicant indicated the progress on this project was interconnected with the replacement of the Physicians Regional Medical Center (f/k/a, St. Mary's Medical Center (Oak Hill) through the relocation of the linear accelerator from the closed Tennova Riverside campus (f/k/a, Baptist Hospital of East Tennessee).The relocation project took longer than expected due to electrical issues at the Physicians Regional Medical Center (PRMC) radiation therapy department's vault. Once the Physicians Regional Medical Center's linear accelerator vault upgrade and linear accelerator is installed and operational, construction on the North Knoxville Medical Center's second linear accelerator vault will begin. PRMC is projected to start seeing patients 9/17/2012.*

**CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:**

There are no Letters of Intent or pending applications from other health care organizations in the service area for projects similar to this application.

Denied Applications

**East Tennessee Diagnostic Center, Morristown, CN0909-049A,** had an application denied at the February 24, 2010 Agency meeting for the establishment of an outpatient diagnostic center, the acquisition of an MRI and combination PET/CT unit, and the initiation of MRI and PET services at an unaddressed site at the intersection of Merchants Green Road and Veterans Highway, Morristown (Hamblen County), Tennessee 37816. The estimated project cost was for **$11,704,209.** *Reason for Denial: The applicant was not able to establish a demonstrated additional need for the services offered by the Outpatient Diagnostic Center due to these services already being offered in the community. The project was not economically feasible due to its negative impact on the local hospitals, and, therefore, the project would not contribute to the orderly development of healthcare in the community.*

Outstanding Certificates of Need

**Morristown-Hamblen Hospital, CN1009-040A,** has an outstanding Certificate of Need that is due to expire on February 1, 2014. The Certificate of Need was approved at the December 15, 2010 Agency meeting for the acquisition of a stationary (fixed) PET/CT unit to replace and upgrade existing mobile PET/CT equipment on its campus at 908 West Fourth Street, Morristown (Hamblen County), Tennessee. The estimated project cost is **$4,695,707.** *Project Status: The Annual Progress Report filed in July 2012 reported initial project schematics and equipment considerations were developed in 2010-2011: however, replacement project implementation has been postponed from the original timeline pending further consideration of new equipment/technology options and pricing; physician needs, capacity, and referral issues across subspecialties; industry trends, payer issues, and related PET/CT demand (nationally, statewide and across the service area). Due to the limited scope of this project, there is adequate time to complete project before the CON expiration date.*

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**

PMW (8/31/12)

# LETTER OF INTENT

2012 JUN -8 AM 9:52

# LETTER OF INTENT
# TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Knoxville News Sentinel (Name of Newspaper) which is a newspaper of general circulation in Knox (County), Tennessee, on or before June 8 (Month / day), 2012 (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: Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare, Hospital (Name of Applicant) (Facility Type-Existing) owned by: Tennova Healthcare with an ownership type of Limited Liability Corporation and to be managed by: Tennova Healthcare intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

the initiation of mobile Positron Emission Tomography/Computerized Tomography (PET/CT) services at Tennova Healthcare - North Knoxville Medical Center ("NKMC"), 7551 Dannaher Way, Powell, TN 37849. Mobile services are being proposed one day per week. No other services will be initiated. No inpatient beds are involved in this project. The estimated total cost of the project is $1,316,019.

The anticipated date of filing the application is: June 13, 2012

The contact person for this project is Jeffrey D. Potter (Contact Name) Senior Vice President (Title)

who may be reached at: Tennova Healthcare (Company Name) 200 E. Blount Avenue, Suite 600 (Address)

Knoxville (City) TN (State) 37920 (Zip Code) 865-632-5605 (Area Code / Phone Number)

(Signature) 6/7/12 (Date) jeff.potter@hma.com (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**
**500 Deaderick Street, Suite 850**
**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.

==========

HF0051 (Revised 05/03/04 – all forms prior to this date are obsolete)

# ORIGINAL APPLICATION

SUPPLEMENTAL

2012 JUN 22 AM 10: 20

**SECTION A:**

**APPLICANT PROFILE**

| 1. ***Name of Facility, Agency, or Institution*** | | | |
|---|---|---|---|
| Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – North Knoxville Medical Center | | | |
| Name | | | |
| 7551 Dannaher Way | | Knox | |
| Street or Route | | County | |
| Powell | TN | 37849 | |
| City | State | Zip Code | |
| 2. ***Contact Person Available for Responses to Questions*** | | | |
| Jeffrey D. Potter | Senior Vice President | | |
| Name | Title | | |
| Tennova Healthcare | jeff.potter@hma.com | | |
| Company Name | Email address | | |
| 200 E. Blount Ave., Suite 600 | Knoxville | TN | 37920 |
| Street or Route | City | State | Zip Code |
| Employee | 865-632-5605 | 865-632-5630 | |
| Association with Owner | Phone Number | Fax Number | |
| 3. ***Owner of the Facility, Agency or Institution*** | | | |
| Metro Knoxville HMA Holdings, LLC d/b/a Tennova Healthcare | 865-632-5600 | | |
| Name | Phone Number | | |
| 200 E. Blount Avenue, Suite 600 | Knox | | |
| Street or Route | County | | |
| Knoxville | TN | 37920 | |
| City | State | Zip Code | |

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

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

**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)*** | | |
|---|---|---|
| Not applicable | | |
| Name | | Phone Number |
| | | |
| Street or Route | County | |
| | | |
| City | State | 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 | X | D. | Option to Lease | |
| B. | Option to Purchase | | E. | Other (Specify) _____ | |
| C. | Lease of _____ Years | | | | |

**PUT ALL ATTACHMENTS AT THE END 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) General | 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 Health Care Service as defined in TCA §68-11-1607(4) (Specify) Mobile PET/CT | X | H. | Change of Location | |
| E. | Discontinuance of OB Services | | I. | Other (Specify)_____ | |
| F. | Acquisition of Equipment | | | | |

18

**9. Bed Complement Data**
***Please indicate current and proposed distribution and certification of facility beds.***

| | | Current Beds Licensed | *CON | Staffed Beds | Beds Proposed | TOTAL Beds at Completion |
|---|---|---|---|---|---|---|
| A. | Medical | 96 | | 60 | | 96 |
| B. | Surgical | | | | | |
| C. | Long-Term Care Hospital | | | | | |
| D. | Obstetrical | | | | | |
| E. | ICU/CCU | 12 | | 12 | | 12 |
| F. | Neonatal | | | | | |
| G. | Pediatric | | | | | |
| H. | Adult Psychiatric | | | | | |
| I. | Geriatric Psychiatric | | | | | |
| J. | Child/Adolescent Psychiatric | | | | | |
| K. | Rehabilitation | | | | | |
| 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** *CON-Beds approved but not yet in service | 108 | | 72 | | 108* |

* This is the approved licensed bed complement of beds at North Knoxville Medical Center, which is a sateliite of Tennova Healthcare - Physicians Regional Medical Center.

**10. Medicare Provider Number 44-0120**
**Certification Type Hospital**

Tennova Healthcare – North Knoxville Medical Center is a satellite of Tennova Healthcare – Physicians Regional Medical Center. It shares a Medicare provider number with Tennova Healthcare's metro Knoxville hospitals.

**11. Medicaid Provider Number 44-0120**
**Certification Type Hospital**

Tennova Healthcare – North Knoxville Medical Center is a satellite of Tennova Healthcare –

Physicians Regional Medical Center. It shares a Medicaid provider number with Tennova Healthcare's metro Knoxville hospitals.

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

Not applicable.

**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.***

The TennCare MCOs/BHOs operating in the proposed service area are:

- Blue Cross Blue Care / TennCare Select
- Americhoice

Tennova Healthcare contracts through master provider agreements with each TennCare MCO/BHO operating in the service area.

- Blue Cross BlueCare / TennCare Select utilizing ValueOptions (MCO). Tennova Healthcare – North Knoxville Medical Center is listed as a provider with ValueOptions.
- AmeriChoice TennCare utilizes United Behavioral Health (BHO). Tennova Healthcare – North Knoxville Medical Center is listed as a provider with United Behavioral Health.

There is no current intent to alter participation in these plans.

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

Tennova Healthcare is in network with all TennCare MCOs/BHOs in the area.

**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.

2. **Section A, Item 9 (Bed Complement Chart)**

**The applicant indicates North Knoxville Medical Center is a satellite of Physicians Medical Center (*on Oak Hill in downtown Knoxville*) and shares the same Medicare provider number. The Department of Health's website indicates Turkey Creek Medical Center is also a satellite of Mercy Medical Center (*on Oak Hill in downtown Knoxville*).**

**Please provide the Bed Complement Chart of the Metro Knoxville HMA, LLC d/b/a Tennova Healthcare's (license number 0000000045) 903 licensed beds.**

The bed complement chart for Metro Knoxville HMA, LLC d/b/a Tennova Healthcare is shown below.

**9. Bed Complement Data**
***Please indicate current and proposed distribution and certification of facility beds.***

| | | *Current Beds* | | *Staffed* | *Beds* | *TOTAL Beds at* |
|---|---|---|---|---|---|---|
| | | *Licensed* | **CON* | *Beds* | *Proposed* | *Completion* |
| A. | Medical (Med/Surg) | 764 | | 414 | | 764 |
| B. | Surgical | | | | | |
| C. | Long-Term Care Hospital | | | | | |
| D. | Obstetrical | | | | | |
| E. | ICU/CCU | 56 | | 56 | | 56 |
| F. | Neonatal | 15 | | 15 | | 15 |
| G. | Pediatric | | | | | |
| H. | Adult Psychiatric | 38 | | 38 | | 38 |
| I. | Geriatric Psychiatric | | | | | |
| J. | Child/Adolescent Psychiatric | | | | | |
| K. | Rehabilitation | 30 | | 30 | | 30 |
| 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**<br>*CON-Beds approved but not yet in service | 903 | | 553 | | 903 |

**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.**

Project Description

Tennova Healthcare – North Knoxville Medical Center ("NKMC"), an acute care, 108 bed hospital, is a satellite location of Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare. In metro Knoxville, Tennova Healthcare provides inpatient care on three campuses, Physicians Regional Medical Center ("Physicians Regional"), North Knoxville Medical Center and Turkey Creek Medical Center ("TCMC"). Those three campuses operate under a single hospital license and Medicare provider number. Tennova Healthcare also includes three community hospitals; Jefferson Memorial Hospital, LaFollette Medical Center, and Newport Medical Center. In total, Tennova Healthcare serves sixteen counties in East Tennessee, offering both inpatient and outpatient services. As the single entity arising out of the merger of the St. Mary's and Baptist Healthcare systems, Tennova Healthcare, formerly Mercy Health Partners, has been providing hospital services to the residents of East Tennessee for over 80 years. Tennova Healthcare is a subsidiary of Health Management Associates, Inc., a for-profit hospital management company based in Naples, Florida.

Tennova Healthcare proposes to initiate mobile Positron Emission Tomography/Computerized Tomography (PET/CT) services at North Knoxville Medical Center, one day per week. PET/CT is a specialized imaging process most heavily utilized for cancer patients, although it also has applications for cardiac and neurology patients, specifically related the diagnosis of Alzheimer's disease and dementia. NKMC has a full-service, comprehensive Cancer Center, including services for the prevention, detection, diagnosis and treatment of cancer. In fact, the Cancer Center was the first building on the campus, and the hospital developed around the Cancer Center. The full complement of cancer treatment is offered at NKMC, including radiation therapy, chemotherapy infusion, and surgery. However, patients needing PET/CT scans for the diagnosis or staging of cancer must travel to a different location to have that scan. NKMC is the only comprehensive cancer center in the region without PET/CT services.

Services and Equipment

The proposed equipment is a mobile PET/CT unit provided by Alliance Healthcare Services, Inc., d/b/a Alliance Imaging ("Alliance"). The unit is a Siemens Biograph 6 PET/CT system manufactured in 2008. A profile of the proposed equipment is attached at Attachment B.I.Project Description.1. Alliance will provide mobile services one day per week at NKMC. The mobile unit will be located adjacent to the Cancer Center. Construction will involve pouring a concrete pad for the mobile unit, as well as a sidewalk with a canopy and sidewalls for easy access to the mobile unit. Electrical upgrades are also required.

Ownership Structure

The site of service for this project is North Knoxville Medical Center ("NKMC"), which is a satellite location of Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare. NKMC is a satellite location of Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare. In metro Knoxville, Tennova Healthcare provides inpatient care on three campuses, Physicians Regional Medical Center ("Physicians Regional"), North Knoxville Medical Center and Turkey Creek Medical Center ("TCMC"). Those three campuses operate under a single hospital license and Medicare provider number.

Metro Knoxville HMA, LLC is wholly owned and operated by Health Management Associates, LLC, headquartered in Naples, Florida, as shown on the attached organizational chart, Attachment B.I.Project Description.2.

Service Area

While Tennova Healthcare's overall service area encompasses 16 counties, the service area for this project consists of the following 11 counties in Tennessee: Anderson, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Scott, Sevier, and Union, because residents of these counties account for approximately 95% of the oncology services utilization at NKMC. A map of the service area is included as Attachment B.I.Project Description.3.

Need

PET/CT imaging is a service that is primarily used for cancer patients, although it also has applications for cardiology as well as neurology. As Tennova Healthcare's primary and busiest cancer center, NKMC offers comprehensive services for the diagnosis and treatment of cancer, with the exception of PET/CT imaging. Patients who are diagnosed and/or being treated for cancer at NKMC must travel to Physicians Regional Medical Center or other providers in order to receive a PET/CT scan. In fact, NKMC is the only comprehensive cancer center in the region without PET/CT technology.

The NKMC service area is expected to grow by approximately 2.9% between 2012 and 2016, based on Tennessee Department of Health Division of Health Statistics population projections. Additionally, the cancer incidence rate is also increasing in the service area, according to Tennessee Department of Health statistics. The latest projections show an estimated 4.2% increase in cancer incidence in the service area per year. With the anticipated population growth of 2.9% and the cancer incidence rate growth of 4.2% per year, demand for cancer services on the campus will continue to grow. Charts showing the project population and cancer incidence growth rates are attached on Attachment B.I.Project Description.4.

The nearest PET/CT for most of the patients in the service area, particularly those in the more rural counties to the north of NKMC, is at Physicians Regional Medical Center, another 8 miles further south. For a map of the service area showing the Tennova hospital locations, see Attachment B.I.Project Description.4. For cancer

patients, the additional travel time, as well as the struggle to locate a different facility and navigate a complicated hospital campus is a major challenge. By offering PET/CT at NKMC, those patients can easily access the service, just by parking near and walking into the cancer center they utilize for treatments on an ongoing basis.

Project Cost

The estimated project cost is $1,309,471, including the application fee. This reflects the cost per scan projected over the four years of the contract with Alliance, as well the construction costs to pour a concrete pad, provide electrical service to the mobile unit, and construct a covered and walled sidewalk for patients. All costs of operation and maintenance are included in the per scan fee.

Funding and Financial Feasibility

No outside financing will be required to fund the project. The construction costs of the project will be funded through capital provided by Health Management Associates, Tennova Healthcare's parent company, as part of their commitment to invest a minimum of $180 million of capital in this region over five years. The project is financially feasible in the first year, as demonstrated in the Project Data Chart.

Staffing

Staffing for the mobile PET/CT services will be provided by Alliance. At a minimum, a certified PET/CT technologist will be on-site to prepare each patient and perform the scans. As volumes increase, Alliance will provide a Patient Care Coordinator to assist with patient flow and prepare patients for scanning.

**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.**

Since the PET/CT scanner is a mobile unit, the only required construction is a

concrete pad, upgrade to electrical service, sewer and water service, and safe, convenient access to the unit for patients. The concrete pad for the mobile unit will be 46' long and 8'6" wide. A concrete sidewalk will be constructed leading from the back of the Cancer Center to the mobile unit. The sidewalk will have a canopy and sidewalls. The cost for each segment of construction is detailed below:

- Concrete pad for mobile unit, sidewalk with canopy and sidewalls: $37,279.00
- Provision of electrical service to the unit: $19,599.00
- Installation of sewer and water lines for unit: $8,972.00
- Architectural fees: approximately $9,150.00
- Total construction costs: $75,000.00

Contractors' quotes are attached as Attachment B.II.A.

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.**

Not applicable.

## SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

| A. Unit / Department | Existing Location | Existing SF | Temporary Location | Proposed Final Location | Proposed Final Square Footage | | | Proposed Final Cost/ SF | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Renovated | New | Total | Renovated | New | Total |
| Mobile PET/CT | N/A | N/A | | | | 391 sf | 391 sf | | $191.82 | $191.82 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| B. Unit/Depart. GSF Sub-Total | | | | | | | | | $191.82 | $191.82 |
| | | | | | | | | | | |
| C. Mechanical/ Electrical GSF | | | | | | | | | | |
| D. Circulation /Structure GSF | | | | | | | | | | |
| E. Total GSF | | | | | | 391 | 391 | | | $191.82 |



SUPPLEMENTAL

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

PET/CT imaging is a service that is primarily used for cancer patients, although it also has applications for cardiology as well as neurology. As Tennova Healthcare's primary and busiest cancer center, NKMC offers comprehensive services for the diagnosis and treatment of cancer, with the exception of PET/CT imaging. Patients who are diagnosed and/or being treated for cancer at NKMC must travel to Physicians Regional Medical Center or other providers in order to receive a PET scan. In fact, NKMC is the only comprehensive cancer center in the region without PET/CT technology.

The NKMC service area is expected to grow by approximately 2..9% between 2012 and 2016, based on Tennessee Department of Health Division of Health Statistics population projections. Additionally, the cancer incidence rate is also increasing in the service area, according to Tennessee Department of Health statistics. The latest projections show an estimated 4.2% increase in cancer incidence in the service area per year. With the anticipated population growth of 2.9% and the cancer incidence rate growth of 4.2% per year, demand for cancer services on the campus will continue to grow.

The nearest PET/CT for most of the patients in the service area, particularly those in the more rural counties to the north of NKMC, is at Physicians Regional Medical Center, another 8 miles further south. For cancer patients, the additional travel time, as well as the struggle to locate a different facility and navigate a complicated hospital campus is a major challenge. By offering PET/CT at NKMC, those patients can easily access the service, just by parking

near and walking into the cancer center they utilize for treatments on an ongoing basis.

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

Not applicable.

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.**
2. **For mobile major medical equipment:**
   a. **List all sites that will be served;**

      North Knoxville Medical Center – 7551 Dannaher Way, Powell, TN 37849

   b. **Provide current and/or proposed schedule of operations;**

      The proposed schedule of operations is to operate one day each week, from 8:00 a.m. – 5:00 p.m.

   c. **Provide the lease or contract cost**

      The cost of the contract is $945.00 per scan, with no minimum volume requirements.

      See contract, attached as Attachment B.II.E.2.c.

   d. **Provide the fair market value of the equipment; and**

      The estimated fair market value for the mobile equipment is $275,000. For a letter confirming the fair market value of the equipment, see Attachment B.II.E.2.d.

   e. **List the owner for the equipment.**

      The owner for the equipment is Alliance Healthcare, Inc., d/b/a Alliance Imaging.

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.**

   The equipment will be leased on a per scan basis from Alliance. Tennova will have no ownership interest. A copy of the leasing and service contract between Health Management Associates that functions as a master contract for all Health Management hospitals is attached as Attachment B.II.E.2.c.

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

A copy of the plot plan of the site is attached as Attachment B.III.(A).

(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.**

NKMC is located 0.2 miles from I-75, at the Emory Road exit, making it easily accessible by car to residents of its 11 county service area. While the Knoxville Area Transit bus system does not service the NKMC campus, patients in need of transportation may have access through Knoxville Community Action Committee (CAC) Service vans, which provide service to those patients who qualify, and give priority to patients who need transportation for cancer treatment. The campus is also served by East Tennessee HRA Public Transit (ETHRA) for patients in the service area's rural counties.

**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: ***<u>DO NOT SUBMIT BLUEPRINTS</u>***. Simple line drawings should be submitted and need not be drawn to scale.

A floor plan of the mobile unit is attached, as Attachment B.IV.

**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**

## 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.**

**See below, for a response to each criterion and standard in the Guidelines for Growth for Positron Emission Tomography Services, as outlined in the 2009 State Health Plan.**

**GUIDELINES FOR GROWTH:**

**POSITRON EMISSON TOMOGRAPHY SERVICES**
**Standards and Criteria**

**1. Applicants proposing a new stationary PET unit should project a minimum of at least 1,000 PET procedures in the first year of service, building to a minimum of 1,600 procedures per year by the second year of service and for every year thereafter. Providers proposing a mobile PET unit should project a minimum of at least 133 mobile PET procedures in the first year of service per day of operation per week, building to an annual minimum of 320 procedures per day of operation per week by the second year of service and for every year thereafter. The minimum number**

**of procedures for a mobile PET unit should not exceed a total of 1600 procedures per year if the unit is operated more than five (5) days per week. The application for mobile and stationary units should include projections of demographic patterns, including analysis of applicable population-based health status factors and estimated utilization by patient clinical diagnoses category (ICD-9).**

**For units with a combined utility, e.g., PET/CT units, only scans involving the PET function will count towards the minimum number of procedures.**

The applicant proposes one day of mobile PET/CT service per week. In order to meet the guidelines for growth, a minimum of 133 scans per day of service is required in the first year, building to an annual minimum of 320 scans per year by the second year of service. Given the number of patients currently traveling down the I-75 corridor in the northern portion of the service area and based on discussions with the Medical Oncology practice on campus referring patients for PET/CT scans, there is a projection of 250 scans in the first year, growing to 320 by the second year of service.

This application estimates the following utilization by CPT code:

| CPT Code | Description | % of Total Utilization |
|---|---|---|
| 12004 | PET&CT SKULL/THIGH | 93.0% |
| 12005 | PET&CT WHOLE BODY | 4.0% |
| 97007 | BRAIN IMAGE PET META | 1.0% |
| 95814 | BRAIN DEMENTIA EVAL | 1.0% |
| 97052 | PET INIT CARD VIABLE F/P RING | 0.5% |
| 97033 | PET MYOCARD IMG MULTI | 0.5% |

Demographic Patterns for PET/CT

Based on a comparison of PET/CT utilization in Tennessee versus the nation, PET/CT is not being overutilized in Tennessee. PET/CT utilization rates per 1,000 population are shown below:

National average: 5.9 per 1,000
Tennessee average: 5.3 per 1,000

This project's service area has a current population of 882,350. If NKMC had 100 percent of the PET/CT volume in the area, based on the Tennessee average, it would perform 4,675 PET/CT scans per year. NKMC's overall market share is 6.6%. When that market share is applied to the expected 4,675 PET/CT scans per year, it indicates that NKMC should perform approximately 309 PET/CT scans per year. This application projects slightly exceeding that number by year 2 of the project, with continued growth due to population growth and cancer incidence rates, as well as the understanding that NKMC's market share in outpatient cancer services is higher than its inpatient market share.

**2. All providers applying for a proposed new PET unit should document that the proposed location is accessible to approximately 75% of the service area's population. Applications that include non-Tennessee counties in their proposed service areas should provide evidence of the**

**number of existing PET units that service the non-Tennessee counties and the impact on PET unit utilization in the non-Tennessee counties, including the specific location of those units located in the non-Tennessee counties, their utilization rates, and their capacity.**

The NKMC campus is located 0.2 miles off of I-75, the primary interstate running through the service area. NKMC is eight miles north of Physicians Regional Medical Center, and is the only hospital operating on the far northern side of Knox County. Patients traveling from Campbell, Claiborne, Grainger, Scott, and Union Counties are closer to NKMC than to other providers of PET/CT services in the region, and certainly closer to NKMC than they are to Physicians Regional Medical Center.

**3. All providers should document that alternate shared services and lower cost technology applications have been investigated and found less advantageous in terms of accessibility, availability, continuity, cost, and quality of care.**

Mobile PET/CT services allow NKMC, a comprehensive Cancer Center, to provide this key service to oncology patients without incurring the significant costs involved with a fixed unit. Because of Health Management's national relationship with Alliance, NKMC is able to take advantage of a contract with very favorable terms related to pricing and volumes. For $75,000 of capital investment, the campus will be prepared to accept the mobile unit. Mobile services are clearly the lowest cost alternative for providing PET/CT services. By building the covered sidewalk with sidewalls from the Cancer Center to the mobile unit, access will be very easy for patients who are used to navigating the Cancer Center. The Siemens 6 unit that will be provided by Alliance is FDA approved and is a machine that is currently in service and providing quality images.

**4. Any provider proposing a new mobile PET unit should demonstrate that it offers or has established referral agreements with providers that offer as a minimum, cancer treatment services, including radiation, medical and surgical oncology services.**

PET/CT's primary application is for cancer patients. The greatest percentage of referrals to PET/CT come from Medical Oncologists and Radiation Oncologists. There are currently five Medical Oncologists and two Radiation Oncologists treating patients on the NKMC campus.

**5. A need likely exists for one additional stationary PET unit in a service area when the combined average utilization of existing PET service providers is at or above 80% of the total capacity of 2,000 procedures during the most recent twelve month period reflected in the provider medical equipment report maintained by the HSDA. The total capacity per PET unit is based upon the following formula:**

Stationary Units: Eight (8) procedures/day x 250 days/year = 2,000 procedures/year

Mobile Units: Eight (8) procedures /day x 50 days/year= 400 procedures/year

The provider should demonstrate that its acquisition of an additional stationary or mobile PET unit in the service area has the means to perform at least 1,000 stationary PET procedures or 133 mobile PET procedures per day of operation per week in the first full one-year period of service operations, and at least 1,600 stationary PET procedures or 320 mobile PET procedures per day of operation per week for every year thereafter.

Most cancer patients who are undergoing treatment at NKMC's Cancer Center and require PET/CT scans are being sent to Physicians Regional Medical Center for those scans. For patients from Cocke, Hamblen, Jefferson, Sevier, and portions of Knox County, Physicians Regional Medical Center is a convenient location and does not necessarily create hardship for the patient to travel there for the scan. However, for patients residing in northern Knox County, Campbell, Claiborne, Grainger, Scott, and Union Counties, as well as eastern portions of Anderson County, NKMC is closer and easier to find. With a dedicated entrance just off the main parking lot, NKMC's Cancer Center is easy to access.

Analysis of the patient origin of those patients being referred from NKMC Oncology offices for PET/CT scans, approximately 25% of the patients currently receiving scans at Physicians Regional Medical Center would benefit from the reduced travel and ease of access to NKMC. Over the past three years, Physicians Regional Medical Center has averaged 1,450 PET scans annually. Approximately 20%, or an average of 290 of those scans, have been cardiac scans. Another 5%, or an average of 73 of those scans, have been neurological brain scans. The remaining 1,087 scans are cancer scans. With approximately 20-25% of the patients coming from a portion of the service area that is closest to NKMC, this application projects volumes of 250 scans in the first year, growing to 320 in year 2, and growing approximately 6% per year thereafter, based on population and cancer incidence growth rates.

Because the base volume in the new mobile unit is projected to primarily shift from PRMC, an analysis of remaining volumes at Physicians Regional Medical Center is warranted to ensure continued viability of that unit. Continued utilization of the Physicians Regional Medical Center fixed unit is warranted for the following reasons:

- Of the 1,180 PET/CT scans performed at Physicians Regional in 2011, 862 were for patients in NKMC's primary service area. Of that 862 patients, 566 of them live closer to Physicians Regional than NKMC, making it more likely that those patients would choose to utilize Physicians Regional.
- 236 of the 1,180 PET/CT scans performed at Physicians Regional in 2011 were cardiac studies. With 15 cardiologists providing services on the Physicians Regional campus, it is critical that PET/CT technology remain on the campus to service those patients.
- For the past several years, Physicians Regional has had a reduced Neurology program, primarily utilizing locum tenens for coverage.

Beginning in July, 2012, Physicians Regional will have a full time Neurologist not only providing hospital coverage but also an outpatient clinic, and recruiting efforts continue to add to this service line. With its applications for neurology, particularly in the diagnosis of Alzheimer's disease and dementia, it will be critical to maintain PET/CT services on the campus. PET/CT volumes for neurology are expected to increase as this program grows.

**6. The applicant should provide evidence that the PET unit is safe and effective for its proposed use.**

**a. The United States Food and Drug Administration (FDA) must certify the proposed PET unit for clinical use.**

The FDA has certified the Siemens 6 PET/CT unit for clinical use. A copy of the FDA certification is attached, as Attachment C.1.6.a.

**b. The applicant should demonstrate that the proposed PET procedures will be offered in a physical environment that conforms to applicable federal standards, manufacturer's specifications, and licensing agencies' requirements.**

The PET/CT procedures will be offered in a physical environment that conforms to applicable federal standards, manufacturers' specifications, and licensing agencies' requirements.

**c. The applicant should demonstrate how emergencies within the PET unit facility will be managed in conformity with accepted medical practice. The applicant should establish protocols that assure that all clinical PET procedures performed are medically necessary and will not unnecessarily duplicate other services.**

Emergency Procedures are detailed in Attachment C.1.6.c.

**d. The PET unit should be under the medical direction of a licensed physician. The applicant should provide documentation that attests to the nature and scope of the duties and responsibilities of the physician medical director. Clinical supervision and interpretation services must be provided by physicians who are licensed to practice medicine in the state of Tennessee and are board certified in Nuclear Medicine or Diagnostic Radiology. Licensure and oversight for the handling of medical isotopes and radiopharmaceuticals by the Tennessee Board of Pharmacy and/or the Tennessee Board of Medical Examiners—whichever is appropriate given the setting—is required. Those qualified physicians that provide interpretation services should have additional documented experience and training, credentialing, and/or board certification in the appropriate specialty and in the use and interpretation of PET procedures.**

The PET/CT unit will be under the medical direction of Abercrombie

Radiological Consultants, PLLC, ("Abercrombie"), which provides all radiology services for NKMC. All physicians providing services to NKMC as part of Abercrombie are fully licensed to practice medicine in the state of Tennessee and are board certified in either Nuclear Medicine or Diagnostic Radiology. In addition, all Abercrombie physicians providing services for patients at NKMC must maintain full hospital privileges. Dr. John Simmons is the Medical Director for Radiology Services at NKMC. Dr. Simmons' CV is attached as Attachment C.1.6.d.

**e. All applicants should seek and document emergency transfer agreements with local area hospitals, as appropriate. An applicant's arrangements with its physician medical director must specify that said physician be an active member of the subject transfer agreement hospital medical staff.**

As part of the services of NKMC, most emergencies can be managed on-site, utilizing the Emergency Department physician personnel, or other on-call physicians as necessary. If deemed necessary, emergency transfer procedures are in place, ensuring quick transfer to Physicians Regional Medical Center, Tennova Healthcare's tertiary hospital. Emergency transfer procedures are attached as Attachment C.1.6.e.

**7. The applicant should provide assurances that it will submit data in a timely fashion as requested by the HSDA to maintain the HSDA Equipment Registry.**

If approved, the applicant will submit data in a timely fashion as requested by the HSDA to maintain the HSDA Equipment Registry.

**8. In light of Rule 0720-4-.01 (1), which lists the factors concerning need on which an application may be evaluated, the HSDA may decide to give special consideration to an applicant:**

**a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;**

Several of the counties that are part of this project's service area have some designation as medically underserved areas, as designated by the United States Health Resources and Services Administration. The following counties have at least a partial designation as medically underserved:

- Campbell County
- Claiborne County
- Cocke County
- Hamblen County
- Scott County
- Union County

**b. Who documents that the service area population**

**experiences a prevalence, incidence and/or mortality from cancer, heart disease, neurological impairment or other clinical conditions applicable to PET unit services that is substantially higher than the State of Tennessee average;**

The cancer incidence rate in eight of the eleven service area counties higher than the average for the state of Tennessee. This holds true for the last two reporting periods of the Tennessee Cancer registry, 2002-2006 and 2003-2007. In addition, the incidence rate increased in every county in the service area. The increase in most counties was between 3 and 6 percent. See table below.

**Service Area Cancer Rates (all cancers, male & female)**
Age adjusted rates per 100,000 population

| | 2002 - 2006 | 2003 - 2007 | Change | % Change |
|---|---|---|---|---|
| Jefferson | 526.0 | 539.3 | 13.3 | 3% |
| Grainger | 510.4 | 512.9 | 2.5 | 0% |
| Claiborne | 495.0 | 508.1 | 13.1 | 3% |
| Campbell | 481.2 | 503.4 | 22.2 | 5% |
| Sevier | 476.8 | 502.1 | 25.3 | 5% |
| Knox | 455.5 | 474.4 | 18.9 | 4% |
| Anderson | 441.6 | 467.3 | 25.7 | 6% |
| Cocke | 442.3 | 458.1 | 15.8 | 4% |
| **State of TN** | **440.7** | **457.2** | **16.5** | **4%** |
| Scott | 429.3 | 450.3 | 21.0 | 5% |
| Hamblen | 416.5 | 446.2 | 29.7 | 7% |
| Union | 397.5 | 420.6 | 23.1 | 6% |

Source: Tennessee Cancer Registry Annual Reports

c. **Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program and/or is a comprehensive cancer diagnosis and treatment program as designated by the Tennessee Department of Health and/or the Tennessee Comprehensive Cancer Control Coalition; or**

NKMC is not a designated "safety net hospital" or "children's hospital."

d. **Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program.**

Tennova Healthcare and NKMC participate in all TennCare

MCO programs and Medicare.

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

Not applicable.

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

As part of Tennova Healthcare's overall development plans for its metropolitan Knoxville hospitals, a key focus area for the NKMC campus has been the growth of the campus as a comprehensive, full-service Cancer Center, including services for the prevention, detection, diagnosis, and treatment of cncer. The full complement of cancer treatment is offered at NKMC, including radiation therapy, chemotherapy infusion, and surgery, and all patients are treated with a multi-disciplinary approach. While the majority of patients utilizing NKMC's cancer services are treated as outpatients, as a full-service, acute care hospital, NKMC is equipped to provide the highest quality care to cancer patients requiring care in the inpatient setting.

The quality of the Cancer Center at NKMC that has been developed is such that the entire program has been accredited by the American College of Surgeons Commission on Cancer. The breast cancer program at NKMC was the second program in the state of Tennessee to receive accreditation by the American College of Surgeons National Accreditation Program for Breast Centers.

Just as it is for all six Tennova hospitals, the long range development plan for NKMC is to serve the citizens of the current service area, continuously improving the quality of care the patients receive while ensuring that services and capabilities are added to enhance access and convenience for patients. In particular, it is important that services continue to be expanded that allow NKMC to effectively serve a growing population, living in rural counties, where the cancer incidence rates continue to rise.

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. <u>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.).</u>**

The service area of the project is an eleven (11) county region of East Tennessee with Knoxville and Knox County at its center. This group is counties where NKMC draws approximately 95% of its oncology patients.

A map of the service area is attached as Attachment C.3.

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

Between 2011 and 2015, the total service area population is expected to grow from 882,350 to 909,072. This is an increase of 3%. See table below.

**Total Population by County 2012-2016**

| | | | | Growth | |
|---|---|---|---|---|---|
| **County** | **2012** | **2016** | | **2012-2016** | |
| Anderson | 74,373 | 75,016 | | 643 | 0.9% |
| Campbell | 41,882 | 42,486 | | 604 | 1.4% |
| Claiborne | 32,519 | 33,257 | | 738 | 2.3% |
| Cocke | 36,767 | 37,681 | | 914 | 2.5% |
| Grainger | 23,739 | 24,501 | | 762 | 3.2% |
| Hamblen | 63,551 | 65,113 | | 1,562 | 2.5% |
| Jefferson | 53,483 | 56,061 | | 2,578 | 4.8% |
| Knox | 429,161 | 440,468 | | 11,307 | 2.6% |
| Scott | 23,253 | 24,086 | | 833 | 3.6% |
| Sevier | 88,941 | 93,612 | | 4,671 | 5.3% |
| Union | 20,863 | 21,970 | | 1,107 | 5.3% |
| Total | 888,532 | 914,251 | | 25,719 | 2.9% |

Source: Division of Health Statistics, Tennessee Department of Health

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.**

A closer look at the population's makeup reveals that growth in the senior population (age 65+) continues to outpace growth of other age groups in both the service area and the state as a whole. For both areas, the senior population is expected to grow at a rate of 18%. The increase in the number of people in the 65+ group exceeds the increase in all other age groups. Growth in the 18-41 age group is stagnant (0%), and moderate in the 0-17 and the 45-64 age groups (4-5 percent). From 2000 to 2015, the median age of the service area population is expected to increase from 38 to 41. This compares to 37 and 40 for the state as a whole. See tables below.

Percent Change in Population by Age Group 2010-2015

| | 0-17 | 18-44 | 45-64 | 65+ | All Ages |
|---|---|---|---|---|---|
| Project Service Area | 5% | 0% | 5% | 18% | 5% |
| State of Tennessee | 4% | 0% | 5% | 18% | 4% |

Source: Thomson Reuters – The Market Planner Plus

Median Age (in years) of Population 2000 to 2015

| | 2000 | 2010 | 2015 |
|---|---|---|---|
| Project Service Area | 37 | 39 | 41 |
| State of Tennessee | 37 | 39 | 40 |

Source: Thomson Reuters – The Market Planner Plus

There is a low degree of ethnic diversity in the service area, with close to 90% of the population classified as White Non-Hispanic. This compares to 77% statewide. The largest minority group is classified as Black Non-Hispanic (5% of the total population) and the fastest growing minority group is classified as Hispanic (31% projected growth between 2010 and 2015). See table below.

Service Area Race-Ethnicity Make-up

| Race-Ethnicity | 2010 | 2015 | Change | % Change | | 2010 % of Total | 2015 % of Total |
|---|---|---|---|---|---|---|---|
| White Non-Hispanic | 797,536 | 827,971 | 30,435 | 4% | | 89% | 88% |
| Black Non-Hispanic | 47,919 | 51,595 | 3,676 | 8% | | 5% | 5% |
| Hispanic | 25,736 | 33,689 | 7,953 | 31% | | 3% | 4% |
| Multiracial Non-Hispanic | 11,375 | 13,468 | 2,093 | 18% | | 1% | 1% |
| Asian Non-Hispanic | 9,961 | 11,711 | 1,750 | 18% | | 1% | 1% |
| Native American Non-Hispanic | 2,702 | 3,047 | 345 | 13% | | 0% | 0% |
| Other Non-Hispanic | 713 | 698 | -15 | -2% | | 0% | 0% |
| Pacific Islander Non-Hispanic | 306 | 389 | 83 | 27% | | 0% | 0% |
| Grand Total | 896,248 | 942,568 | 46,320 | 5% | | 100% | 100% |

Source: Thomson Reuters – The Market Planner Plus

Economically, the service area is similar to the state as a whole. The Median Household Income is slightly lower for the service area than for the state. The percentage of service area residents living in poverty is very close to that for the state. The unemployment rate is slightly better for the service area than for the state, even with the recent recession. See tables below.

Median Household Income 2000 to 2015

| | 2000 | 2010 | 2015 |
|---|---|---|---|
| Project Service Area | $30,155 | $35,964 | $38,249 |
| State of Tennessee | $32,113 | $38,698 | $40,886 |

| | 2000 | 2010 | 2015 |
|---|---|---|---|
| Service Area Median HH Income as a percent of TN Median HH Income | 93.9% | 92.9% | 93.6% |

Source: Thomson Reuters – The Market Planner Plus

Persons living below the Poverty Threshold, 2007

| | Persons Below Poverty Threshold | Percent Below Poverty Threshold |
|---|---|---|
| Project Service Area | 135,118 | 15.6% |
| State of Tennessee | 972,447 | 15.8% |
| United States | 39,189,620 | 13.0% |

Source: Fedstats.gov

Unemployment Rate, April 2011 (11 County)

| | Unemployed Civilians | Percent Unemployment |
|---|---|---|
| Project Service Area | 42,710 | 9.4 |
| State of Tennessee | 298,700 | 9.6 |
| United States | 13,237,000 | 8.7 |

Source: TN Dept of Labor & Workforce Development

Currently, it is estimated that approximately half of the service area population is covered by Commercial insurance, with the remaining half split fairly evenly between Medicare, TennCare, and no insurance. Based on successful implementation of the recently enacted Affordable Care Act, the projections for 2015 suggest a drop in the numbers of uninsured by more than half, with the differences absorbed by Medicaid/TennCare, Medicare, and Commercial payers. See table below.

Insurance Coverage Estimates 2010 and 2015

| | Service Area | | | State of Tennessee | |
|---|---|---|---|---|---|
| | 2010 | 2015 | | 2010 | 2015 |
| Medicare | 18% | 20% | | 16% | 18% |
| TennCare | 17% | 21% | | 17% | 20% |
| Commercial | 47% | 52% | | 51% | 55% |
| Uninsured | 19% | 8% | | 16% | 7% |
| TOTAL | 100% | 100% | | 100% | 100% |

Source: Thomson Reuters – The Market Planner Plus

Insurance Coverage Estimates 2010 and 2015
Post-Reform

| | Service Area | | | State of Tennessee | |
|---|---|---|---|---|---|
| | 2010 | 2015 | | 2010 | 2015 |
| Medicaid | 17% | 21% | | 17% | 20% |
| Medicare | 14% | 15% | | 12% | 14% |
| Medicare Dual Eligible | 4% | 4% | | 4% | 4% |
| Private - Direct | 6% | 5% | | 6% | 5% |
| Private – ESI | 41% | 43% | | 45% | 46% |
| Private - Exchange | 0% | 4% | | 0% | 4% |
| Uninsured | 19% | 8% | | 16% | 7% |
| TOTAL | 100% | 100% | | 100% | 100% |

Source: Thomson Reuters – The Market Planner Plus

The cancer incidence rate in eight of the eleven service area counties is higher than the average for the state of Tennessee. This holds true for the last two reporting periods of the Tennessee Cancer registry, 2002-2006 and 2003-2007. In the most recent report, the largest difference was in Jefferson County, where

the incidence was 18% higher than the state average. In addition, the incidence rate increased in every county in the service area. The increase in most counties was between 3 and 6 percent. See table below.

**Service Area Cancer Rates (all cancers, male & female)**
Age adjusted rates per 100,000 population

| | 2002 - 2006 | 2003 - 2007 | Change | % Change |
|---|---|---|---|---|
| Jefferson | 526.0 | 539.3 | 13.3 | 3% |
| Grainger | 510.4 | 512.9 | 2.5 | 0% |
| Claiborne | 495.0 | 508.1 | 13.1 | 3% |
| Campbell | 481.2 | 503.4 | 22.2 | 5% |
| Sevier | 476.8 | 502.1 | 25.3 | 5% |
| Knox | 455.5 | 474.4 | 18.9 | 4% |
| Anderson | 441.6 | 467.3 | 25.7 | 6% |
| Cocke | 442.3 | 458.1 | 15.8 | 4% |
| **State of TN** | **440.7** | **457.2** | **16.5** | **4%** |
| Scott | 429.3 | 450.3 | 21.0 | 5% |
| Hamblen | 416.5 | 446.2 | 29.7 | 7% |
| Union | 397.5 | 420.6 | 23.1 | 6% |

Source: Tennessee Cancer Registry Annual Reports

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.**

In NKMC's 11 county service area, there are currently eight sites of service offering PET/CT. Between those eight sites, there are six fixed units and three mobile units. Three years of utilization data are shown below:

| Provider | Fixed/ Mobile | # of units or day per week | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Methodist Med Ctr - Oak Ridge | Mobile | 1 | 151 | 464 | 465 |
| Morristown-Hamblen Hospital | Mobile | 2 | 341 | 296 | 317 |
| East Tennessee Diagnostic Center | Fixed | 1 | 1435 | 1200 | 1173 |
| Physicians Regional Medical Center | Fixed | 1 | 1703 | 1469 | 1180 |
| Thompson Cancer Survival Center | Fixed | 1 | 600 | 979 | 967 |
| Thompson Cancer Survival Center - West | Fixed | 1 | 1850 | 1030 | 741 |
| University of Tennessee Medical Center | Fixed | 2 | 5014 | 4056 | 3634 |
| Thompson Cancer Survival Center - Sevier | Mobile | 1 | 2 | 58 | 161 |

The only approved but unimplemented CON for PET/CT services is held by Morristown-Hamblen Hospital, which currently has a mobile unit, but was approved in December, 2010 for a fixed unit. The most recently implemented site of service is

Thompson Cancer Survival Center – Sevier, which initiated service after opening its new hospital in 2009.

Most PET/CT providers in the service area experienced a reduction in volume between 2010 and 2011. The most significant driver of this reduction in volume was a shift in the PET/CT approval process by most managed care payors as well as Medicare. It became significantly more difficult to obtain approval from payors to conduct a PET/CT scan, and there has been an adjustment period by most providers to the new approval criteria. However, new clinical applications for PET/CT, most notably in the areas of brain and spinal scans, are nearing approval and will help to offset the volume impact of the more stringent approval guidelines.

Despite the tightening criteria for approval of PET/CT scans by payors, cancer incidence rates and population continue to grow in the area being served by NKMC. For the benefit of those cancer patients in rural counties served by NKMC, and to round out the services of the robust Cancer Center on the campus, it is necessary to add PET/CT services to the campus. NKMC is the only comprehensive cancer center in the region without PET/CT capabilities.

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.**

As a new service at NKMC, there is no historical utilization data available, other than the number of patients being treated at NKMC who are being referred to Physicians Regional Medical Center for PET/CT scans. No scans are anticipated to be shifted from current providers to NKMC, other than from Physicians Regional Medical Center. The PET/CT scans performed in 2011 at Physicians Regional Medical Center on patients originating from counties in NKMC's service area break down as follows:

SUPPLEMENTAL

2012 JUN 22 AM 10: 21

| County | PRMC Scans in 2011 - NKMC Service Area | | PRMC Scans in 2011 - Northern Rural Counties | PRMC Scans in 2011 - North Knox County Zip Codes |
|---|---|---|---|---|
| Anderson | 32 | | | |
| Campbell | 37 | | 37 | |
| Claiborne | 47 | | 47 | |
| Cocke | 26 | | | |
| Grainger | 30 | | 30 | |
| Hamblen | 24 | | | |
| Jefferson | 66 | | | |
| Knox | 501 | | | 112 |
| Scott | 17 | | 17 | |
| Sevier | 29 | | | |
| Union | 53 | | 53 | |
| | | | | |
| Subtotal | 862 | | **184** | **112** |
| *PRMC Scans from outside NKMC service area* | *318* | | | |
| *Total PRMC Scans - 2011* | *1180* | | | |

All other scans performed at Physicians Regional Medical Center in 2011 were for patients living outside of NKMC's service area. If the only volume expected for the NKMC PET/CT were volume originating from the rural counties to the north of the hospital, simply because NKMC will be the closest and most easily accessible PET/CT, 184 scans could be projected. In addition, a percentage of the Knox County volumes must be considered, since patients living on the northern side of I-640 in Knox County could most conveniently travel to NKMC.

Patients originating from the northern zip codes of Knox County who utilized Physicians Regional Medical Center's PET/CT in 2011 total 112, and come from the following zip codes: 37849, 37912, 37938, 37918, and 37928, which can be seen on the map of Knox County zip codes, Attachment C.Need.6. Adding the 112 from the most accessible portions of Knox County to the 184 patients travelling from rural counties to the north of NKMC brings the first year estimate to 296. Given historical patterns and the time required to fully establish a new service, this application projects that 85% of those patients would be served at NKMC, bringing the first year estimate to 250 scans. In year two, based on population growth, cancer incidence growth, as well as greater awareness of the PET/CT services being offered at NKMC, 320 scans have been projected. In the next two subsequent years, growth is expected to be approximately 6% per year, given population and cancer incidence projected growth rates.

There is a strong base of Medical Oncologists and Radiation Oncologists on the NKMC campus to support one day per week of mobile PET/CT services. Tennessee Cancer Specialists, an independent Medical Oncology practice, has an office inside NKMC's Cancer Center, where five physicians practice. Premier Radiation Oncology

has two Radiation Oncologists working at NKMC.

## ECONOMIC FEASIBILITY

I. **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 CON filing fee was calculated to be $2,954, requiring that the minimum fee of $3,000 be paid in accordance with the instructions.

- **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 per-scan lease arrangement has no minimum requirements. Based on projected volumes for the PET/CT over the four year lease term, total payments to Alliance will be $1,198,971. This cost not only includes equipment but also includes staffing, transportation, set-up, maintenance, systems, and supplies.

- **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.**

  All maintenance costs, taxes, and installation charges are included in the "moveable equipment" calculation. Construction costs for the pad, walled and roofed sidewalk, and water and electrical service are included under "construction costs" in the project cost chart.

- **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.**

  Contractors' quotes are attached as Attachment C.Economic Feasibility.I.

## PROJECT COSTS CHART

| | | | |
|---|---|---|---|
| A. | Construction and equipment acquired by purchase: | | |
| | 1. | Architectural and Engineering Fees | |
| | 2. | Legal, Administrative (Excluding CON Filing Fee), Consultant Fees | $25,000 |
| | 3. | Acquisition of Site | $0 |
| | 4. | Preparation of Site | $0 |
| | 5. | Construction Costs | $75,000 |
| | 6. | Contingency Fund | $7,500 |
| | 7. | Fixed Equipment (Not included in Construction Contract) | |
| | 8. | Moveable Equipment (List all equipment over $50,000) | $1,198,971 |
| | 9. | Other (Specify) _____ | |

| | | | |
|---|---|---|---|
| B. | Acquisition by gift, donation, or lease: | | |
| | 1. | Facility (inclusive of building and land) | |
| | 2. | Building only | |
| | 3. | Land only | |
| | 4. | Equipment (Specify) _____ | |
| | 5. | Other (Specify) _____ | |

| | | | |
|---|---|---|---|
| C. | Financing Costs and Fees: | | |
| | 1. | Interim Financing | |
| | 2. | Underwriting Costs | |
| | 3. | Reserve for One Year's Debt Service | |
| | 4. | Other (Specify) _____ | |

| | | |
|---|---|---|
| D. | Estimated Project Cost (A+B+C) | $1,306,471 |

| | | |
|---|---|---|
| E. | CON Filing Fee | $3,000 |

| | | |
|---|---|---|
| F. | Total Estimated Project Cost (D+E) | $1,309,471 |

| | | |
|---|---|---|
| | TOTAL | $1,309,471 |

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;charges.
   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--Appropriate documentation from Chief Financial Officer.
   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.**

   With the limited scope of construction for this project, it is not comparable on a square footage basis to other, more construction-oriented projects. The most recent mobile PET application in which pad construction was required had construction costs of $55,000 in 2008 (Methodist Medical Center).

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).**

   A completed Historical Data Chart and Projected Data Chart follow.

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

   Average gross charge per scan: $4,750
   Average deduction from operating revenue: $3,262
   Average net charge: $1,488

46

SUPPLEMENTAL

## 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 January.

2012 JUN 22 AM 10:19

| | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|
| A. Utilization Data (Specify unit of measure) | 3,321 | 3,321 | 3,026 |
| B. Revenue from Services to Patients | | | |
| 1. Inpatient Services | $55,385,792 | $67,882,942 | $69,714,103 |
| 2. Outpatient Services | 152,666,490 | 187,292,222 | 182,050,451 |
| 3. Emergency Services | | | |
| 4. Other Operating Revenue (Specify) See page 3 | 872,309 | 761,417 | 1,657,910 |
| **Gross Operating Revenue** | **$208,924,591** | **$255,936,581** | **$253,422,464** |
| C. Deductions from Gross Operating Revenue | | | |
| 1. Contractual Adjustments | $140,085,298 | $181,879,958 | $181,536,021 |
| 2. Provision for Charity Care | 8,861,552 | 8,614,562 | 4,970,948 |
| 3. Provisions for Bad Debt | 5,559,486 | 5,339,160 | 7,906,915 |
| **Total Deductions** | **$154,506,336** | **$195,833,680** | **$194,413,884** |
| **NET OPERATING REVENUE** | **$54,418,255** | **$60,102,901** | **$59,008,580** |
| D. Operating Expenses | | | |
| 1. Salaries and Wages | $17,416,752 | $19,169,289 | $18,559,892 |
| 2. Physician's Salaries and Wages | 857,544 | 1,003,243 | 0 |
| 3. Supplies | 12,624,155 | 14,667,838 | 9,330,723 |
| 4. Taxes | 0 | 0 | 363,872 |
| 5. Depreciation | 6,386,480 | 6,275,129 | 5,372,410 |
| 6. Rent | 1,078,205 | 935,792 | 906,437 |
| 7. Interest, other than Capital | 4,645,335 | 4,334,225 | 3,352,014 |
| 8. Management Fees: | | | |
| a. Fees to Affiliates | 0 | 0 | 8,737,825 |
| b. Fees to Non-Affiliates | 0 | 0 | 0 |
| 9. Other Expenses – Specify on separate page 14 | 4,108,619 | 4,722,603 | 6,436,233 |
| **Total Operating Expenses** | **$47,117,090** | **$51,108,119** | **$53,059,409** |
| E. Other Revenue (Expenses) – Net (Specify)_____ | $0 | $0 | $0 |
| **NET OPERATING INCOME (LOSS)** | **$7,301,165** | **$7,709,803** | **$5,949,171** |
| F. Capital Expenditures | | | |
| 1. Retirement of Principal | $7,103,952 | $7,709,803 | $489,008 |
| 2. Interest | 0 | 0 | 0 |
| **Total Capital Expenditures** | **$7,103,952** | **$7,709,803** | **$489,008** |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | **$197,213** | **$1,284,979** | **$5,460,163** |

## PROJECTED DATA CHART

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

| | | Year 2013 | Year 2014 |
|---|---|---|---|
| A. | Utilization Data (PET/CT Scans) | 250 | 320 |
| B. | Revenue from Services to Patients | | |
| | 1. Inpatient Services | $0 | $0 |
| | 2. Outpatient Services | 1,187,500 | 1,520,000 |
| | 3. Emergency Services | 0 | 0 |
| | 4. Other Operating Revenue (Specify)_____ | 0 | 0 |
| | **Gross Operating Revenue** | **$1,187,500** | **$1,520,000** |
| C. | Deductions from Gross Operating Revenue | | |
| | 1. Contractual Adjustments | $815,500 | $1,043,840 |
| | 2. Provision for Charity Care | 18,600 | 23,808 |
| | 3. Provisions for Bad Debt | 22,320 | 28,570 |
| | **Total Deductions** | **$856,420** | **$1,096,218** |
| **NET OPERATING REVENUE** | | **$331,080** | **$423,782** |
| D. | Operating Expenses | | |
| | 1. Salaries and Wages | $0 | $0 |
| | 2. Physician's Salaries and Wages | 0 | 0 |
| | 3. Supplies | 0 | 0 |
| | 4. Taxes | 0 | 0 |
| | 5. Depreciation | 0 | 0 |
| | 6. Rent | 0 | 0 |
| | 7. Interest, other than Capital | 0 | 0 |
| | 8. Management Fees: | | |
| | a. Fees to Affiliates | 0 | 0 |
| | b. Fees to Non-Affiliates | 0 | 0 |
| | 9. Other Expenses – Specify on separate page 14 | 236,250 | 302,400 |
| | **Total Operating Expenses** | **$236,250** | **$302,400** |
| E. | Other Revenue (Expenses) -- Net (Specify)_____ | $0 | $0 |
| **NET OPERATING INCOME (LOSS)** | | **$94,380** | **$121,382** |
| F. | Capital Expenditures | | |
| | 1. Retirement of Principal | $75,000 | $75,000 |
| | 2. Interest | 0 | 0 |
| | **Total Capital Expenditures** | **$75,000** | **$75,000** |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | | **$19,830** | **$121,382** |

## HISTORICAL DATA CHART-OTHER EXPENSES

| OTHER EXPENSES CATEGORIES | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|
| 1. Professional Fees | $_____ | $_____ | $956,122 |
| 2. Outside Services | _____ | _____ | 2,667,832 |
| 3. Utilities | _____ | _____ | 1,734,678 |
| 4. Insurance | _____ | _____ | 419,796 |
| 5. Misc incl. Dues, Travel, Freight, Repairs. | _____ | _____ | 657,805 |
| 6. | _____ | _____ | |
| 7. | _____ | _____ | |
| **Total Other Expenses** | **$_____** | **$_____** | **$6,436,233** |

## PROJECTED DATA CHART-OTHER EXPENSES

| OTHER EXPENSES CATEGORIES | Year 2013 | Year 2014 |
|---|---|---|
| 1. Per Scan fee to Alliance Imaging | $236,250 | $302,400 |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |
| 6. | _____ | _____ |
| 7. | _____ | _____ |
| **Total Other Expenses** | **$236,250** | **$236,250** |

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.**

| CPT Code | Description | Charge |
|---|---|---|
| 12004 | PET&CT SKULL/THIGH | $4,721 |
| 12005 | PET&CT WHOLE BODY | $4,541 |
| 97007 | BRAIN IMAGE PET METABOLIC EVAL | $4,941 |
| 95814 | PET BRAIN DEMENTIA EVAL | $4,941 |
| 97052 | PET INITCARD VIABLE F/P RING | $4,941 |
| 97033 | PET MYOCARD IMG MULT REST/STR | $4,412 |

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).**

The average proposed gross charge for this project is $4,750, which is in keeping with Tennova's current charges for PET/CT scans at Physicians Regional Medical Center The proposed average gross charge for this project includes both the technical component for PET/CT scans and the required pharmaceuticals.

In reviewing the most recent previous PET/CT applications to the HSDA, average projected gross charges were reported to be:

- Morristown-Hamblen Hospital - $4,500 (2009)
- Cleveland Radiology - $4,160 (2008)
- Thompson Cancer Survival Center - $4,900 (2008)
- Methodist Medical Center - $4,944 (2008)

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

Because the contract for mobile services with Alliance has no minimum required usage, and because Alliance provides all staffing and other requirements to operate the service, other than patient registration, the projected utilization rates are sufficient to maintain cost-effectiveness.

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

The project is projected to be profitable by the end of the first year of service. For

more detail, refer to the Projected Data Chart.

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.**

   Tennova Healthcare participates in the Medicare and Tenncare programs and contracts with each of the TennCare MCOs in the service area. As part of the Purchase Agreement between Health Management Associates and Mercy Health Partners in 2011, Tennova Healthcare adopted the same charity care policies that were in place when the system was owned by Catholic Health Partners. Based on historical data, Tennova expects 61% of its net revenue from Medicare and 12% of its net revenue from TennCare. Charity Care has been planned at 5% of net revenue.

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.**

    Audited financial statements for Health Management Associates are attached. Tennova Healthcare is not audited separately or reported on as a separate entity, but rather is reflected as a component of the Health Management Associates' audit report which is attached as Attachment C.Economic Feasibility-10. Tennova Healthcare's acquisition is referenced on page two (2) of the attachment.

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.**

       Given the quality of NKMC's cancer program and the number of patients it serves, particularly patients who live in rural, underserved communities, PET/CT services are a necessary addition to the campus. All alternatives considered were either significantly more costly, such as a fixed unit, or potentially added unneeded capacity, such as mobile service with additional days. By requesting one day per week of mobile service, as well as providing the service under a very favorable contract negotiated by Health Management, the option presented is the lowest cost and most orderly

alternative.

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.**

The only new construction involved in this project is to prepare a location for the mobile unit. The basic requirements for the mobile unit are a concrete pad, electrical and water service, and a safe walkway for patients. Other alternatives that were rejected would require purchasing a fixed unit with much more extensive construction.

## 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.**

Tennova Healthcare has contractual and working relationships with the following providers:

| | |
|---|---|
| Asbury Acres HealthCare | Athens Community Hospital |
| Baptist Convalescent Center | Baptist Health Care Center |
| Brakebill Nursing Home | Blount Memorial Hospital |
| East Tennessee Children's Hospital | Briarcliff Health Care Center |
| Claiborne County Nursing Home | Claiborne County Hospital |
| Hillcrest Medical Nursing Institute | Farragut Healthcare |
| Holston Health and Rehabilitation Center | Hillhaven Health Care |
| Knoxville Convalescent Center | Jellico Community Hospital |
| Maynardville Community Medical Center | LifeCare Center |
| Northhaven Health Care Center | Morgan County Center for Health Care |
| Regency Health Care Center | Peninsula Hospital |
| Rockwood Health Care Center | Ridgeview Terrace of LifeCare |
| Serene Manor Medical Center | Shannondale Nursing Home |
| Parkwest Surgery Center | UT Medical Center – Knoxville |
| Vanderbilt University | Rural/Metro Ambulance Services |
| TN Division of Rehabilitation Services | Laughlin Memorial Hospital |
| Knoxville Surgery Center | Takoma Adventist Hospital |
| Lafollette Medical Center | NHC, Fort Sanders of Knoxville |

| | |
|---|---|
| Tennessee Nursing Services, Inc. | Physicians Surgery Center |
| Wellington Place of Kingston | Select Specialty Hospital - North Knoxville, Inc. |

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.**

The project will have a positive impact on the healthcare system, by improving access to a key service for patients of NKMC's Cancer Center, as well as improving access to PET/CT for patients from the more rural counties in the service area. The proposed mobile arrangement allows Tennova to enhance services in a cost effective, low risk way.

The project should have no impact on the utilization rates of other providers in the service area of the project, with the exception of NKMC's sister hospital, Physicians Regional Medical Center. With the addition of outpatient neurology services and the strength of Physicians Regional's cardiology program, volumes are anticipated to continue to grow, which will backfill for the loss of some oncology PET/CT volumes to NKMC.

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.**

Staffing for the PET/CT will be provided by Alliance. Alliance will provide the following staff for PET/CT:

| | |
|---|---|
| PET/CT Technologist | 1.0 FTE |
| Patient Care Coordinator | 1.0 FTE (dependent on volumes) |

Wage rates as compared to the prevailing wage as published by the Tennessee Department of Labor & Workforce Development are listed below:

| | Alliance Rate | Prevailing Wage |
|---|---|---|
| PET/CT Technologist | $29-$32/hour | $28.59-$31.38/hour |
| Patient Care Coordinator | $12-$15/hour | $12.73-$14.37/hour |

Job descriptions for the PET/CT Technologist and Patient Care Coordinator are attached as Attachment C.Orderly Development.3.

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.**

Because the proposed schedule is for one day of service per week, Alliance will provide staffing from its existing workforce, without the need to hire additional staff.

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.***

The applicant has reviewed and understands all licensing certification required by the State of Tennessee for medical/clinical staff.

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.).**

Tennova Healthcare has education affiliations with the following schools and organizations:

AT Still University (Arizona School of Health Sciences)
Carson Newman College
Creighton University
East Tennessee State University
Grace Academy
Independence University
Iowa College Acquisition Co (Kaplan University)
Lincoln Memorial University
Pellissippi State Community College
Roane State Community College
South College
Tennessee Technical College at Jacksboro
Tennessee Technical College of Knoxville
Tennessee Technical College of Oneida
Union Co Schools
University of New England
University of Miami
University of North Carolina at Chapel Hill
University of Tennessee, Knoxville
University of Tennessee, Memphis
Vanderbilt University
Walden University
Walters State University
Wesleyan College Fort Sanders Nursing Dept.

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.**

   Tennova Healthcare 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, as well as the Medicare requirements.

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

   Licensure: Tennessee Department of Health, Board for Licensing Health Care Facilities

   Accreditation: Joint Commission

   (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.**

   Tennova Healthcare – North Knoxville Medical Center is in good standing with all licensing, certifying and accrediting agencies. A copy of the hospital license is attached as Attachment C.Orderly Development.7.c.

   (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.**

   Tennova Healthcare is in good standing with all licensing agencies. A copy of the most recent survey inspection is attached as Attachment C.Orderly Development.7.d.

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.**

   There are none.

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**

There are none.

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.**

    If the proposal is approved, 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 requested.

## 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.**

The Publisher's Affidavit is attached.

## 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.**

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

SUPPLEMENTAI

# PROJECT COMPLETION FORECAST CHART

2012 JUN 22 AM 10: 21

Enter the Agency projected Initial Decision date, as published in T.C.A. § September, 2012.

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.

| **Phase** | **DAYS REQUIRED** | **Anticipated Date (MONTH/YEAR)** |
|---|---|---|
| 1. Architectural and engineering contract signed | Not required | |
| 2. Construction documents approved by the Tennessee Department of Health | 60 | 12/2012 |
| 3. Construction contract signed | 60 | 12/2012 |
| 4. Building permit secured | 90 | 1/2013 |
| 5. Site preparation completed | 120 | 3/2013 |
| 6. Building construction commenced | | |
| 7. Construction 40% complete | | |
| 8. Construction 80% complete | | |
| 9. Construction 100% complete (approved for occupancy | 150 | 3/2013 |
| 10. *Issuance of license | | |
| 11. *Initiation of service | 180 | 4/2013 |
| 12. Final Architectural Certification of Payment | 180 | 4/2013 |
| 13. Final Project Report Form (HF0055) | 210 | 5/2013 |

*** 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.**

58

**To:** TENNOVA HEALTH CARE

**(Advertising)** PUBLICNOTICETHISISTOPROVI **(Ref No.** 2012 993237) AM 10: 16

**PUBLIC NOTICE**

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: Metro Knoxville HMA LLC, d/b/a Tennova Healthcare, Hospital owned by: Tennova Healthcare with an ownership type of Limited Liability Corporation and to be managed by: Tennova Healthcare intends to file an application for a Certificate of Need for the initiation of mobile Positron Emission Tomography Computerized Tomography (PET/CT) services at Tennova Healthcare – North Knoxville Medical Center ("NKMC"), 755 Dannaher Way, Powell, TN 37849. Mobile services are being proposed one day per week. No other services will be initiated. No inpatient beds are involved in this project. The estimated total cost of the project is $1,316,019.

The anticipated date of filing the application is: June 13, 2012.

The contact person for this project is Jeffrey D. Potter, Senior Vice President, who may be reached at: Tennova Healthcare 200 E. Blount Avenue, Suite 600, Knoxville TN 37920, (865) 632-5605.

Upon written request by interested parties a local Fact-Finding public hearing shall be conducted. Written requests for hearings should be sent to:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
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.

# PUBLISHER'S AFFIDAVIT

State of Tennessee }
s.s
County of Knox }

Before me, the undersigned, a Notary Public in and for said county, this day personally ca first duly sworn, according to law, says that he/she is a duly authorized representative of *News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of :

(The Above-Referenced)

of which the annexed is a copy, was published in said paper on the following date(s):

June 8, 2012

and that the statement of account herewith is correct to the best of his/her knowledge, information, and belief.

Kathy Oakes

Subscribed and sworn to before me this 8th day of June 20 12

Rebecca D Spann
Notary Public

My commission expires November 20 14

REBECCA D. SPANN
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY

**AFFIDAVIT**

2012 JUN 13 AM 10: 18

STATE OF Tennessee

COUNTY OF Knox

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

SIGNATURE/TITLE

Sworn to and subscribed before me this 12th day of June, 2012 a Notary

Public in and for the County/State of Knox, Tennessee.

Susan E. England
NOTARY PUBLIC

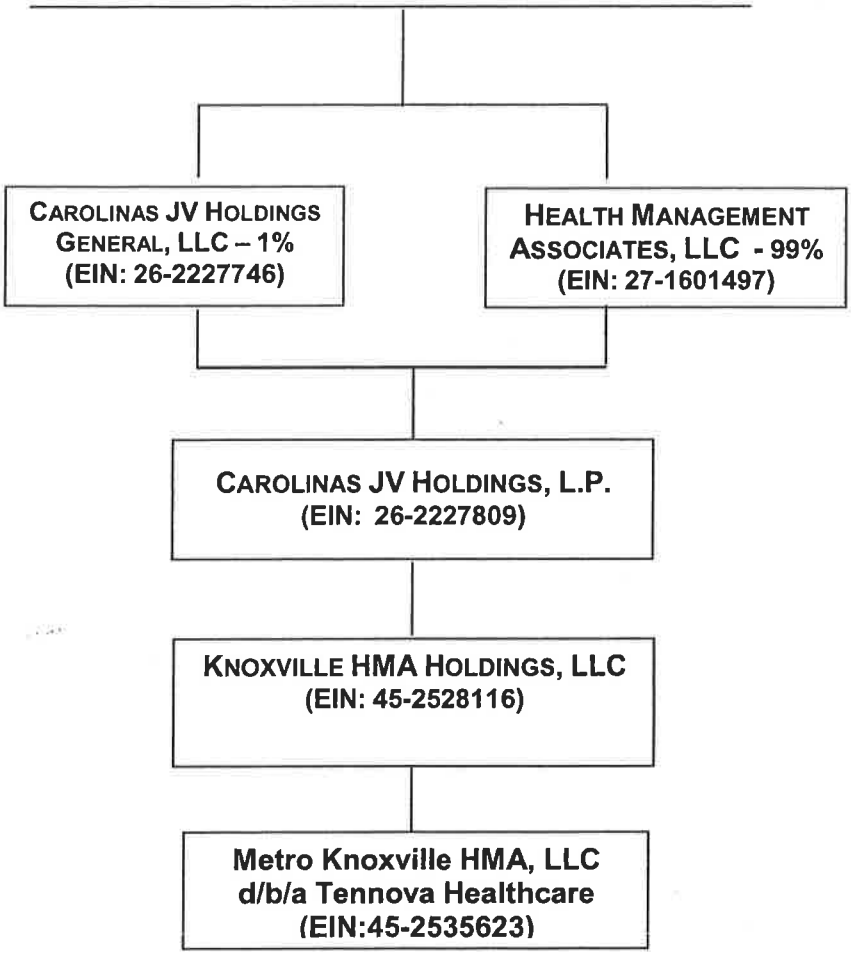
My commission expires , July 7, 2015.
(Month/Day) (Year)

SUSAN E. ENGLAND
STATE TENNESSEE NOTARY PUBLIC
KNOX COUNTY

## Attachment A.4.c

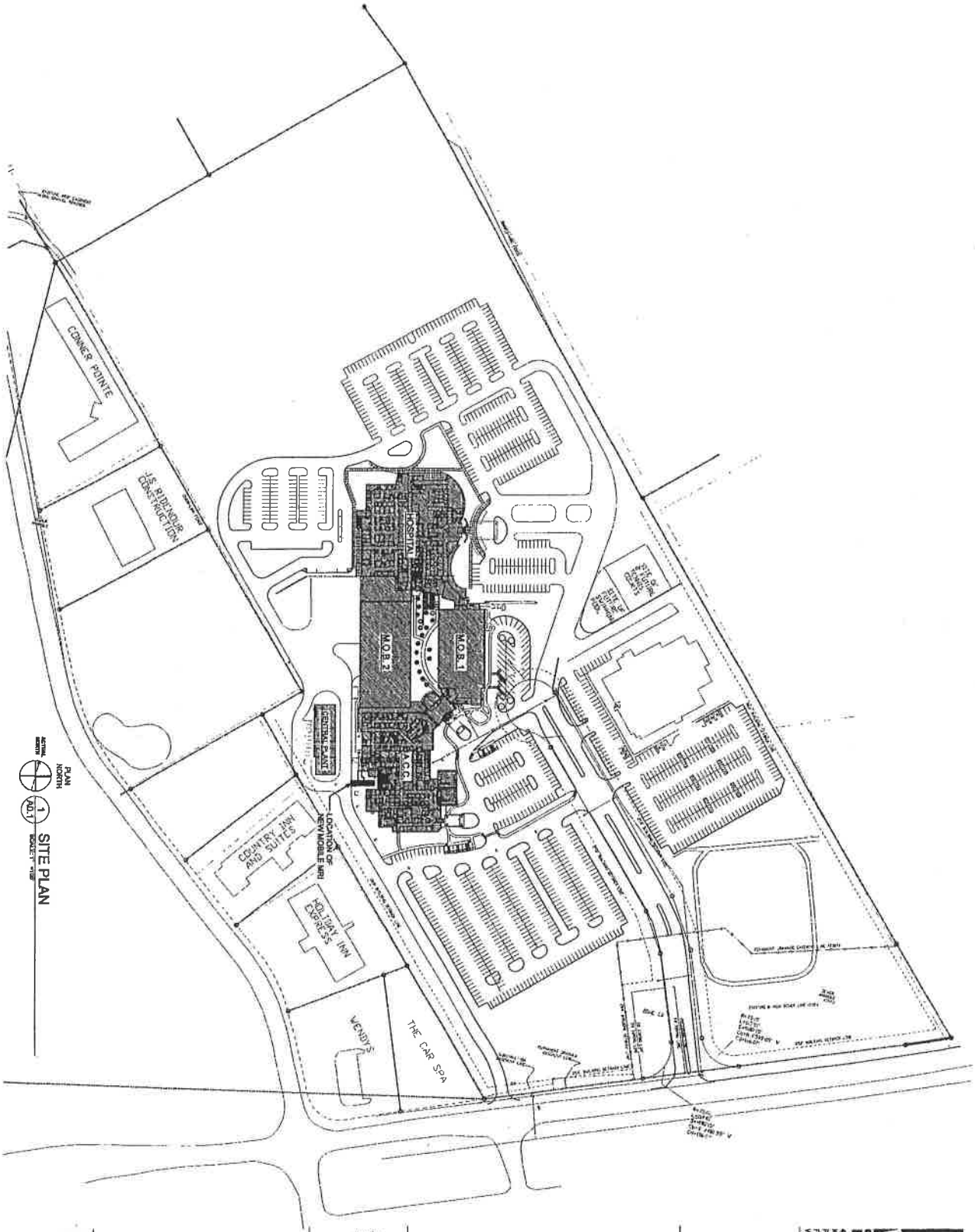
## METRO KNOXVILLE HMA, LLC

**DIRECT AND INDIRECT OWNERSHIP**



**Attachment B.III.(A)**

2012 JUN 13 AM 10: 17




A0.1

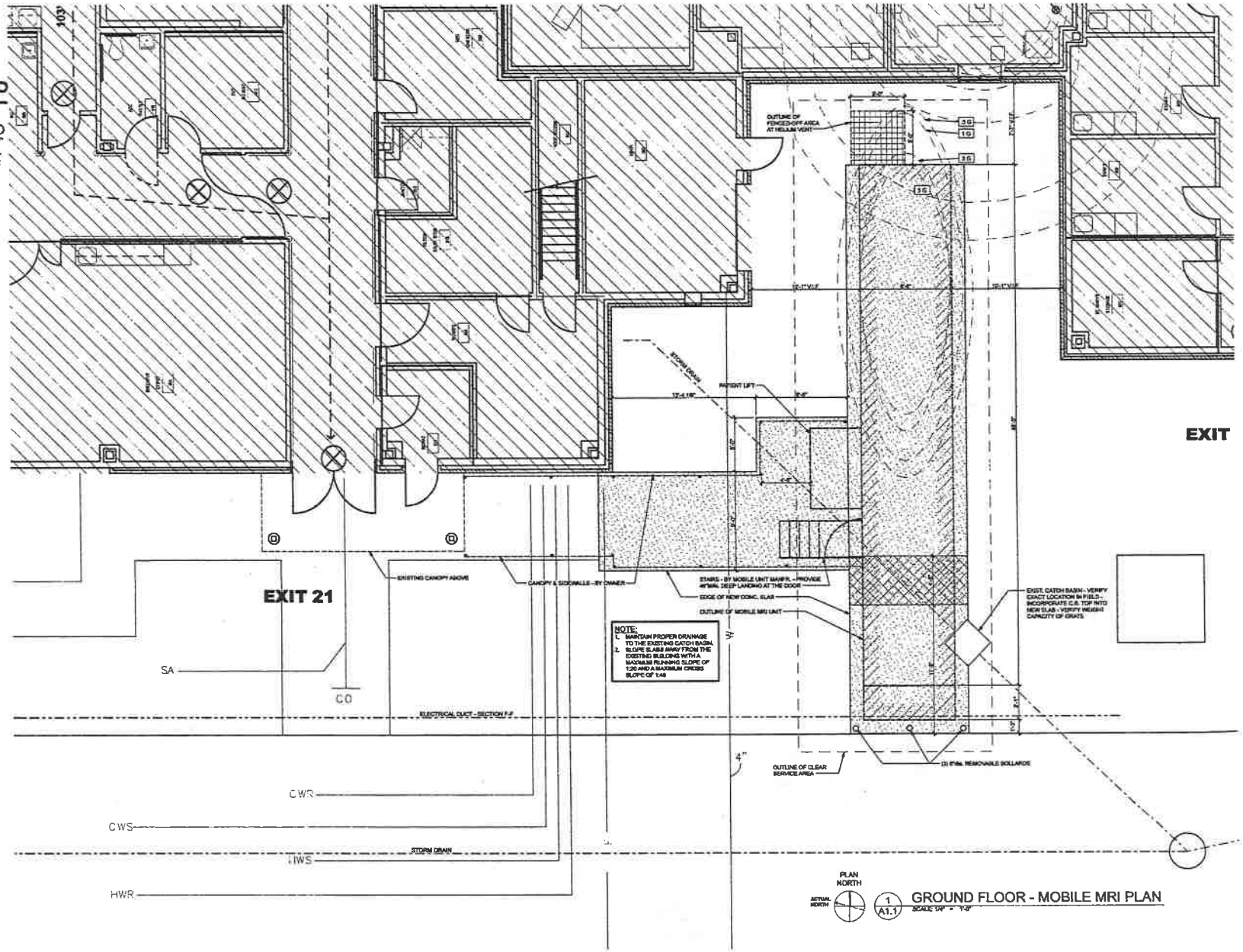
DATE: 9 JUNE 2011
PROJECT NO.: 11059
PROJECT MGR.: WRL

SITE PLAN

A NEW MOBILE MRI AT:
**MERCY MEDICAL CENTER, NORTH**
MERCY HEALTH PARTNERS
POWELL, TENNESSEE

GEORGE ARMOUR EWART
404 Bearden Park Circle
Knoxville, TN 37919
Phone 865.602.7771
Fax 865.602.7742
Web: www.georgeewart.com

2012 JUN 13 AM 10:16



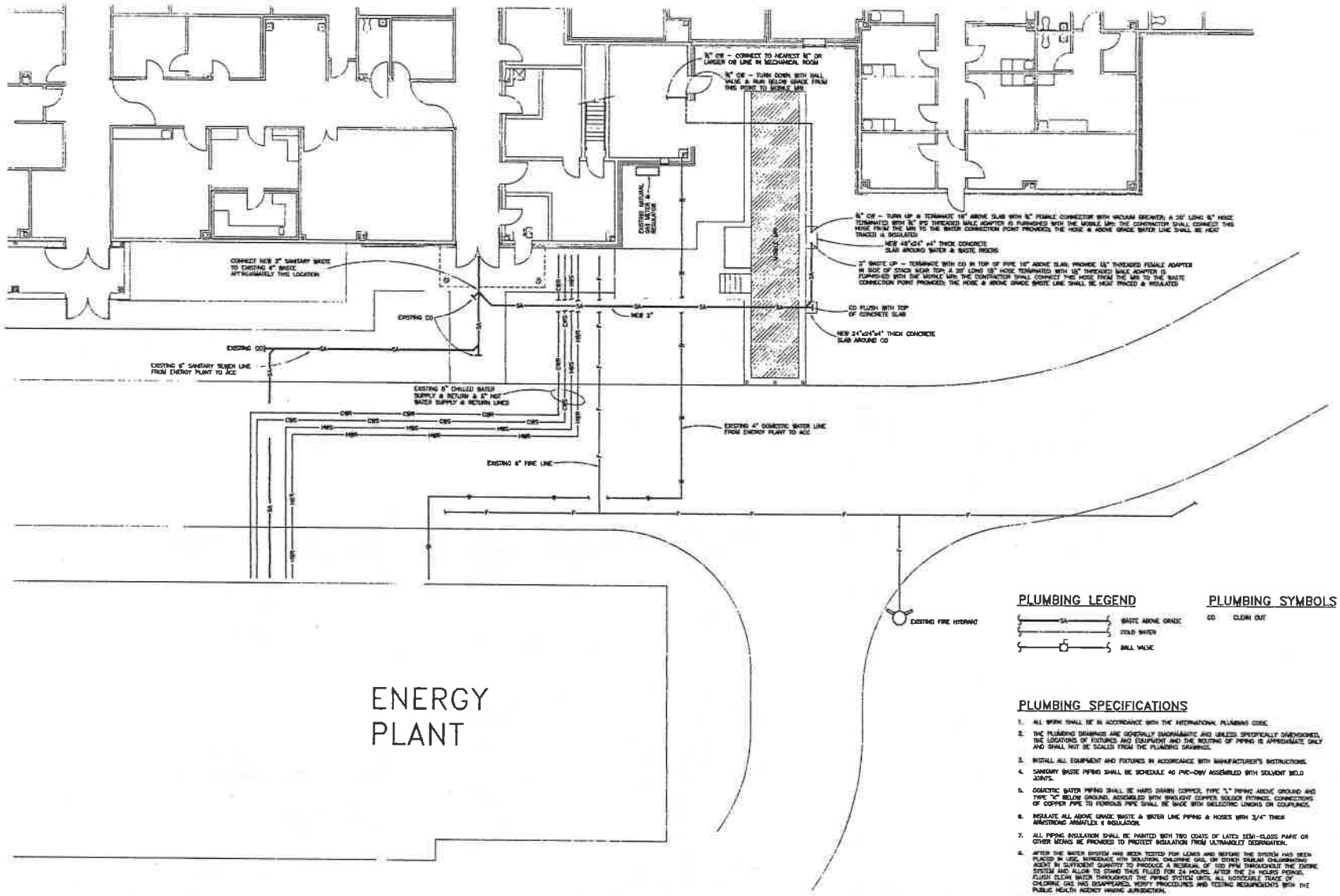

GEORGE ARMOUR EWART
ARCHITECT
404 Bearden Park Circle
Knoxville, TN 37919
Phone 865.802.7771
Fax 865.802.7742
Web: www.georgeewart.com

A NEW MOBILE MRI AT:
**MERCY MEDICAL CENTER, NORTH**
MERCY HEALTH PARTNERS
POWELL, TENNESSEE

PARTIAL GROUND FLOOR PLAN

DATE: 9 JUNE 2011
PROJECT NO.: 11059
PROJECT MGR.: WRL

**A1.1**




SITE PLAN – WASTE & WATER
1/8"=1'-0"

## PLUMBING LEGEND

- WASTE ABOVE GRADE
- COLD WATER
- BALL VALVE

## PLUMBING SYMBOLS

CO CLEAN OUT

## PLUMBING SPECIFICATIONS

1. ALL WORK SHALL BE IN ACCORDANCE WITH THE INTERNATIONAL PLUMBING CODE.
2. THE PLUMBING DRAWINGS ARE GENERALLY DIAGRAMMATIC AND UNLESS SPECIFICALLY DIMENSIONED, THE LOCATIONS OF FIXTURES AND EQUIPMENT AND THE ROUTING OF PIPING IS APPROXIMATE ONLY AND SHALL NOT BE SCALED FROM THE PLUMBING DRAWINGS.
3. INSTALL ALL EQUIPMENT AND FIXTURES IN ACCORDANCE WITH MANUFACTURER'S INSTRUCTIONS.
4. SANITARY WASTE PIPING SHALL BE SCHEDULE 40 PVC-DWV ASSEMBLED WITH SOLVENT WELD JOINTS.
5. DOMESTIC WATER PIPING SHALL BE HARD DRAWN COPPER, TYPE "L" PIPING ABOVE GROUND AND TYPE "K" BELOW GROUND, ASSEMBLED WITH WROUGHT COPPER SOLDER FITTINGS. CONNECTIONS OF COPPER PIPE TO FERROUS PIPE SHALL BE MADE WITH DIELECTRIC UNIONS OR COUPLINGS.
6. INSULATE ALL ABOVE GRADE WASTE & WATER LINE PIPING & HOSES WITH 3/4" THICK ARMSTRONG ARMAFLEX II INSULATION.
7. ALL PIPING INSULATION SHALL BE PAINTED WITH TWO COATS OF LATEX SEMI-GLOSS PAINT OR OTHER MEANS BE PROVIDED TO PROTECT INSULATION FROM ULTRAVIOLET DEGRADATION.
8. AFTER THE WATER SYSTEM HAS BEEN TESTED FOR LEAKS AND BEFORE THE SYSTEM HAS BEEN PLACED IN USE, INTRODUCE HTH SOLUTION, CHLORINE GAS, OR OTHER SIMILAR CHLORINATING AGENT IN SUFFICIENT QUANTITY TO PRODUCE A RESIDUAL OF 100 PPM THROUGHOUT THE ENTIRE SYSTEM AND ALLOW TO STAND THUS FILLED FOR 24 HOURS. AFTER THE 24 HOURS PERIOD, FLUSH CLEAN WATER THROUGHOUT THE PIPING SYSTEM UNTIL ALL NOTICEABLE TRACE OF CHLORINE GAS HAS DISAPPEARED. VERIFY PROCEDURES AND TESTING REQUIREMENTS WITH THE PUBLIC HEALTH AGENCY HAVING JURISDICTION.
9. THE WORK SHALL BE GUARANTEED AGAINST ALL DEFECTIVE MATERIALS & WORKMANSHIP FOR A PERIOD OF ONE YEAR AFTER ACCEPTANCE. THE CONTRACTOR SHALL MAKE ALL NECESSARY CORRECTIONS WITHOUT COST TO THE OWNER.


GEORGE ARMOUR EWART
464 Knowles Park Circle
Knoxville, TN 37919
865-602-7771
Fax 865-601-7742
www.georgearmour.com


MOBILE MRI FOR
MERCY MEDICAL CENTER, NORTH
POWELL, TENNESSEE

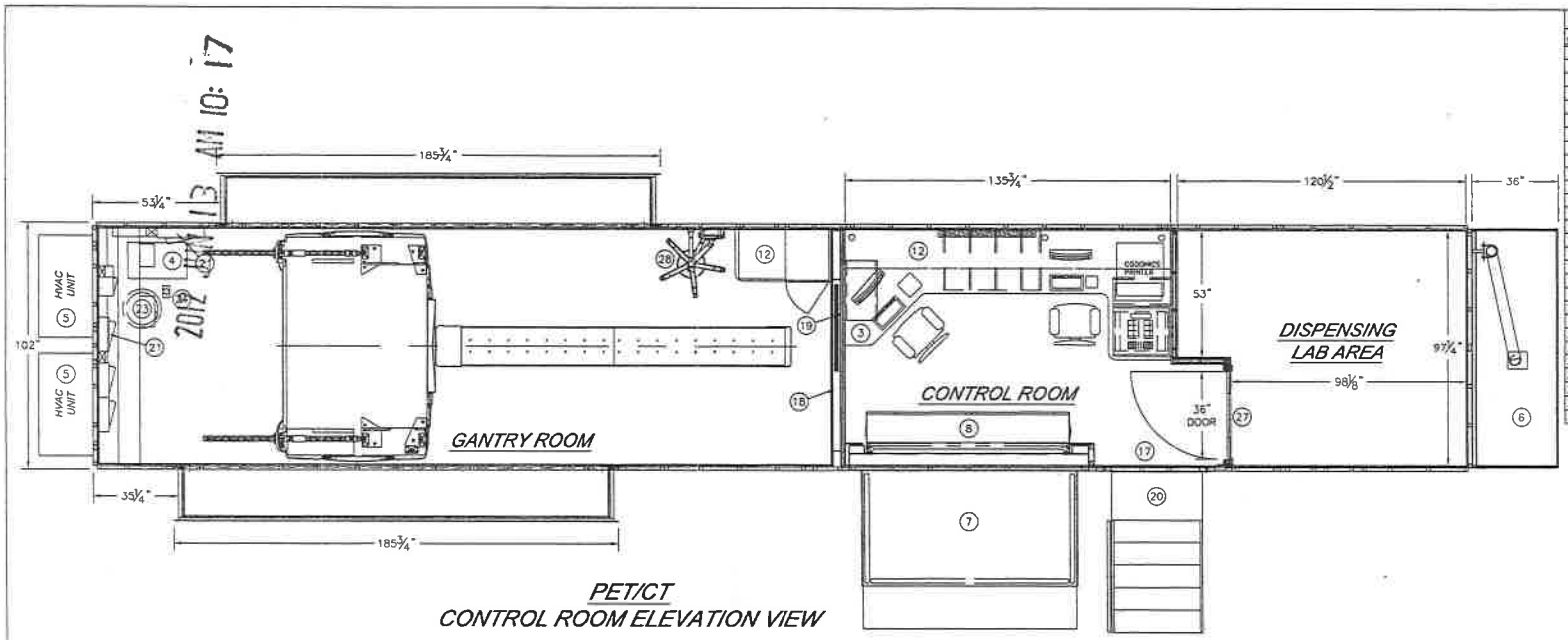
SITE PLAN - WASTE & WATER

DATE: 10 JUN 2011
EWART PROJECT: 11000

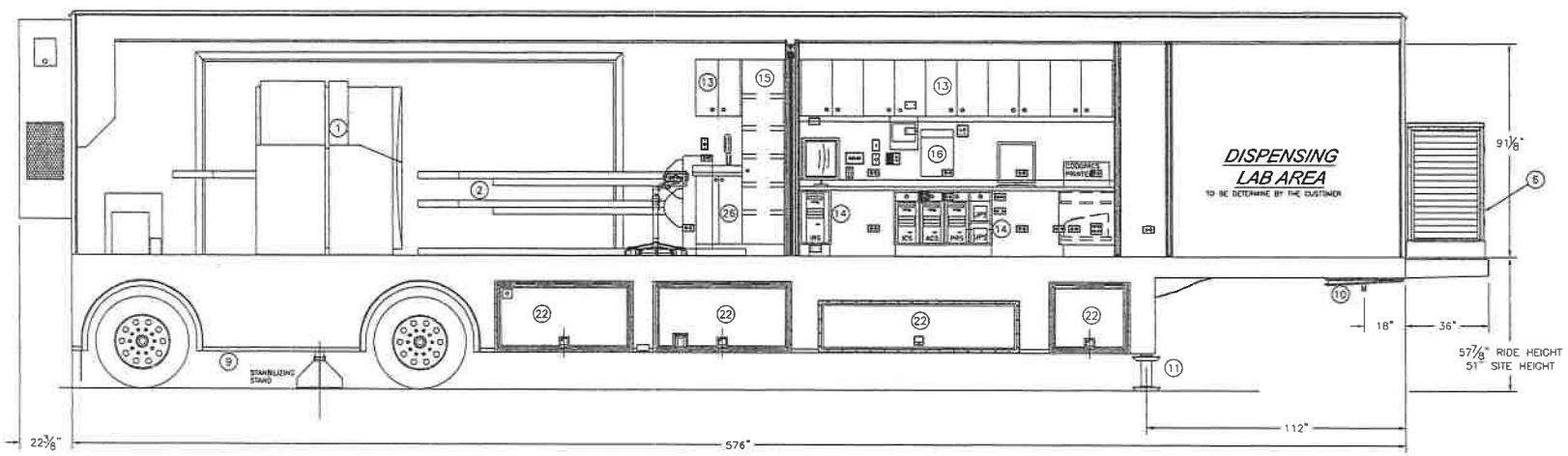
ALBERT F.G. BEDINGER CONSULTING ENGINEERS, P.C.
ESTABLISHED 1946
ONE CLYDE STREET - KNOXVILLE TENNESSEE 37921
TELEPHONE - FACSIMILE - www.BEDINGERGROUP.com

P1.1

# Attachment B.IV




PET/CT
CONTROL ROOM ELEVATION VIEW




PET/CT
ELEVATION VIEW

MATERIAL LIST

| IT. NO. | QTY. | DESCRIPTION |
|---|---|---|
| 1 | 1 | PET/CT SCANNER |
| 2 | 1 | PATIENT TABLE |
| 3 | 1 | OPERATOR WORK STATION |
| 4 | 1 | SYSTEM CHILLER |
| 5 | 2 | 48,000 BTU AIR CONDITIONER |
| 6 | 1 | 100KW DIESEL GENERATOR |
| 7 | 1 | PATIENT LIFT-89" WIDE ALUMINUM PLATFORM |
| 8 | 1 | ROLL-UP DOOR, 7' X 6'-6" |
| 9 | 1 | AIR RIDE SUSPENSION, 34,000 LB CAP. |
| 10 | 1 | AIR RIDE UPPER COUPLER (KING PIN) |
| 11 | 2 | HYDRAULIC LEVELING LEGS, 31,000 LB. CAP. |
| 12 | 3 | WORK COUNTER |
| 13 | 5 | OVERHEAD STORAGE CABINET |
| 14 | 2 | CPU CABINET |
| 15 | 1 | STORAGE CABINET |
| 16 | 1 | VIEWER |
| 17 | 1 | 40" X 82" ENTRY DOOR |
| 18 | 1 | 34" X 80" LEADED DOOR w/ 18" X 36" LEADED WINDOW |
| 19 | 1 | 18" X 36" LEADED WINDOW |
| 20 | 1 | ENTRY DOOR STAIRS & HANDRAIL |
| 21 | 2 | ELECTRICAL SERVICE PANELS (1-480V / 1-208V) |
| 22 | 9 | LOWER COMPARTMENT DOORS (4-PS / 5-OS) |
| 23 | 2 | LARGE SOURCE HOLDERS |
| 24 | 1 | SMALL SOURCE |
| 25 | | |
| 26 | 1 | UNDER COUNTER STORAGE CABINET |
| 27 | 1 | 36" X 84" LEADED DOOR W/ 18" X 36" LEADED WINDOW |
| 28 | 1 | MEDRAD INJECTOR-(CUSTOMER SUPPLIED OPTION) |

| DESCRIPTION | DATE | REV |
|---|---|---|
| | | |

REVISIONS

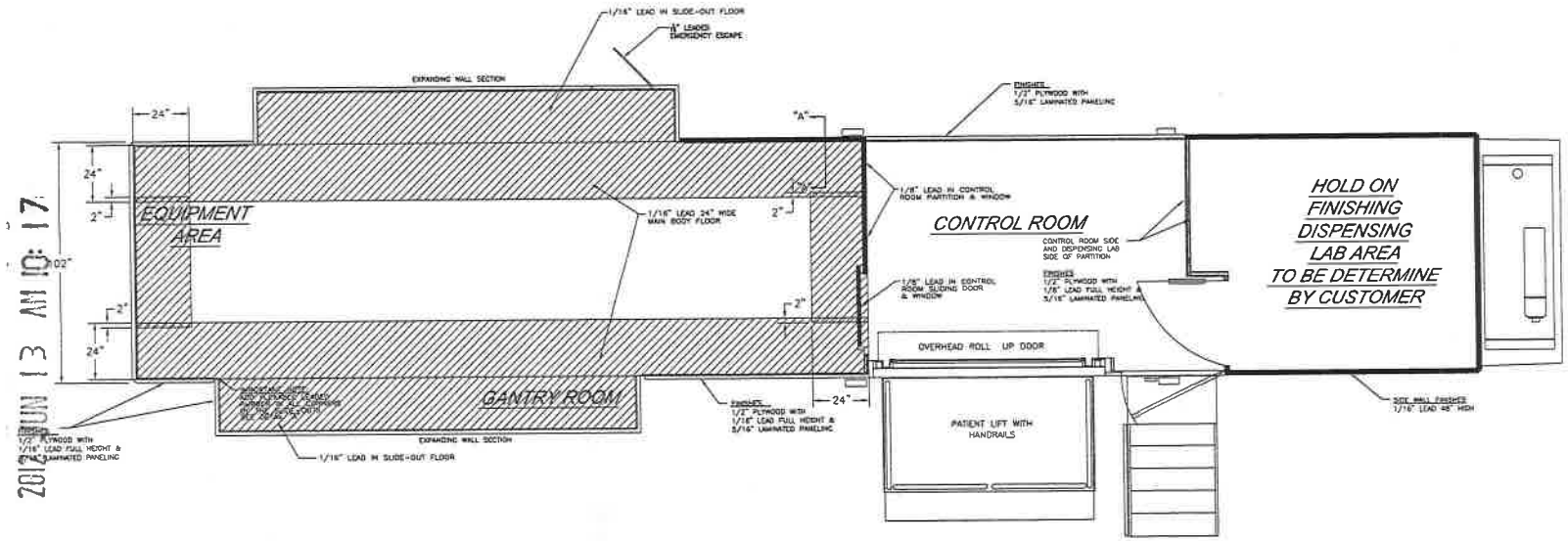
THIS DRAWING IS PROPRIETARY AND THE PROPERTY OF AK ASSOCIATES, L.L.C. IT SHALL NOT BE DUPLICATED, REPRODUCED, OR SUBMITTED TO OTHERS FOR EXAMINATION. IT IS CONSIDERED ON LOAN AND SHALL BE RETURNED TO AK ASSOCIATES, L.L.C. UPON REQUEST.

TITLE: GENERAL LAYOUT
CPS PET/CT MOBILE
8'-6" X 13'-6" X 48'-0" TRAILER

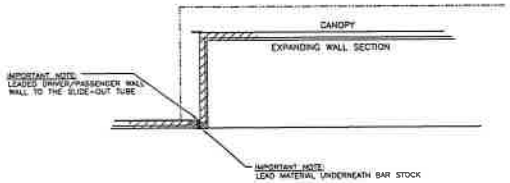
DATE: 06AUG03 | SCALE: 1/2" = 1'-0"
DRAWN BY: [illegible]
APPROVED BY:
DRAWING NUMBER: 10235-A01 | REV 09

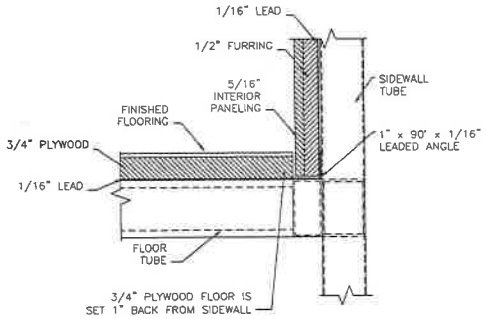
AK SPECIALTY VEHICLES
16745 S. LATHROP AVENUE
HARVEY, IL 60426
Phone: (708) 596-5066
Fax: (708) 596-2480

JOB#




PLAN VIEW




SECTION "A-A"
SCALE: 1:2

| DESCRIPTION | DATE | REV |
|---|---|---|
| ADDED LEAD FROM 12" TO 24" IN SCAN ROOM-WL | 19AUG03 | 04 |

REVISIONS

THIS DRAWING IS PROPRIETARY AND THE PROPERTY OF AK SPECIALTY VEHICLES IT SHALL NOT BE DUPLICATED, REPRODUCED, OR SUBMITTED TO OTHERS FOR EXAMINATION. IT IS CONSIDERED ON LOAN AND SHALL BE RETURNED TO AK SPECIALTY VEHICLES UPON REQUEST.

| SHEET NUMBER | REFERENCE DRAWING | TITLE: PLAN VIEW LEAD REQUIMENTS CPS PET FLEX & PET/CT MOBILES 8'-6" x 13'-6" x 48'- 0" TRAILER | DATE: 29JAN03 | SCALE: 1/2" = 1'-0" |
|---|---|---|---|---|
| JOB# | | AK SPECIALTY VEHICLES 10745 S. LATHROP AVENUE HARVEY, IL 60426 Phone: (708) 596-5066 Fax: (708) 596-2480 | DRAWN BY: SNM | CHECKED BY: |
| | | | DRAWING NUMBER: 10235-A18 | REV 04 |

2013 JUN 13 AM 10:17

**Attachment C.Need.1.6.a**

# Attachment 4

## Growth Charts – Population and Cancer Incidence

### Total Population by County 2012-2016

| County | 2012 | 2016 | | Growth 2012-2016 | |
|---|---|---|---|---|---|
| Anderson | 74,373 | 75,016 | | 643 | 0.9% |
| Campbell | 41,882 | 42,486 | | 604 | 1.4% |
| Claiborne | 32,519 | 33,257 | | 738 | 2.3% |
| Cocke | 36,767 | 37,681 | | 914 | 2.5% |
| Grainger | 23,739 | 24,501 | | 762 | 3.2% |
| Hamblen | 63,551 | 65,113 | | 1,562 | 2.5% |
| Jefferson | 53,483 | 56,061 | | 2,578 | 4.8% |
| Knox | 429,161 | 440,468 | | 11,307 | 2.6% |
| Scott | 23,253 | 24,086 | | 833 | 3.6% |
| Sevier | 88,941 | 93,612 | | 4,671 | 5.3% |
| Union | 20,863 | 21,970 | | 1,107 | 5.3% |
| Total | 888,532 | 914,251 | | 25,719 | 2.9% |

Source: Division of Health Statistics, Tennessee Department of Health

### Service Area Cancer Rates (all cancers, male & female)

Age adjusted rates per 100,000 population

| | 2002 - 2006 | 2003 - 2007 | Change | % Change |
|---|---|---|---|---|
| Jefferson | 526.0 | 539.3 | 13.3 | 3% |
| Grainger | 510.4 | 512.9 | 2.5 | 0% |
| Claiborne | 495.0 | 508.1 | 13.1 | 3% |
| Campbell | 481.2 | 503.4 | 22.2 | 5% |
| Sevier | 476.8 | 502.1 | 25.3 | 5% |
| Knox | 455.5 | 474.4 | 18.9 | 4% |
| Anderson | 441.6 | 467.3 | 25.7 | 6% |
| Cocke | 442.3 | 458.1 | 15.8 | 4% |
| **State of TN** | **440.7** | **457.2** | **16.5** | **4%** |
| Scott | 429.3 | 450.3 | 21.0 | 5% |
| Hamblen | 416.5 | 446.2 | 29.7 | 7% |
| Union | 397.5 | 420.6 | 23.1 | 6% |

Source: Tennessee Cancer Registry Annual Reports

| Demographic Variable/Geographic Area | Anderson | Campbell | Claiborne | Cocke | Grainger | Hamblen |
|---|---|---|---|---|---|---|
| Total Population-2012 | 74,373 | 41,882 | 32,519 | 36,767 | 23,739 | 63,551 |
| Total Population-2016 | 75,016 | 42,486 | 33,257 | 37,681 | 24,501 | 65,113 |
| Total Population-% change | 0.9% | 1.4% | 2.3% | 2.5% | 3.2% | 2.5% |
| Age 65+ Population-2012 | 7,520 | 7,637 | 5,393 | 6,201 | 3,735 | 10,281 |
| Age 65+ Population-2016 | 8,106 | 8,435 | 6,167 | 7,039 | 4,193 | 11,305 |
| Age 65+ Population-% change | 7.8% | 10.5% | 14.4% | 13.5% | 12.3% | 9.9% |
| Age 65+ Population as % of Total (2012) | 10.1% | 18.3% | 16.6% | 16.8% | 15.7% | 16.2% |
| Median Household Income (2011-2016) | $ 42,583 | $ 29,135 | $ 29,775 | $ 28,647 | $ 31,483 | $ 36,530 |
| TennCare Enrollees (2011) | 14,176 | 12,054 | 8,007 | 9,878 | 4,936 | 13,198 |
| TennCare Enrollees as % of Total Pop. (2011) | 19.1% | 28.8% | 24.7% | 27.1% | 20.9% | 20.8% |
| Families Below Poverty Level (2011) | 2,813 | 2,575 | 1,461 | 1,843 | 799 | 2,210 |
| Families Below Poverty Level as % of Total Pop. (2011) | 12.6% | 20.5% | 15.3% | 16.8% | 11.1% | 11.8% |

| Demographic Variable/Geographic Area | Jefferson | Knox | Scott | Sevier | Union | TN |
|---|---|---|---|---|---|---|
| Total Population-2012 | 53,483 | 429,161 | 23,253 | 88,941 | 20,863 | 6,361,070 |
| Total Population-2016 | 56,061 | 440,468 | 24,086 | 93,612 | 21,970 | 6,575,165 |
| Total Population-% change | 4.8% | 2.6% | 3.6% | 5.3% | 5.3% | 3.4% |
| Age 65+ Population-2012 | 8,095 | 59,556 | 3,267 | 14,240 | 2,761 | 878,496 |
| Age 65+ Population-2016 | 8,845 | 67,102 | 3,750 | 16,563 | 3,142 | 987,074 |
| Age 65+ Population-% change | 9.3% | 12.7% | 14.8% | 16.3% | 13.8% | 12.4% |
| Age 65+ Population as % of Total (2012) | 15.2% | 13.8% | 14.1% | 16.1% | 13.3% | 13.8% |
| Median Household Income (2011-2016) | $ 37,889 | $ 46,613 | $ 26,830 | $ 40,032 | $ 30,855 | $ 43,840 |
| TennCare Enrollees (2011) | 10,363 | 63,153 | 7,213 | 15,619 | 4,421 | 1,211,113 |
| TennCare Enrollees as % of Total Pop. (2011) | 19.6% | 14.8% | 31.3% | 17.8% | 21.5% | 19.2% |
| Families Below Poverty Level (2011) | 2,172 | 12,322 | 1,249 | 2,822 | 989 | 223,224 |
| Families Below Poverty Level as % of Total Pop. (2011) | 14.1% | 10.2% | 19.0% | 10.7% | 17.0% | 12.6% |

SUPPLEMENTAL

**Attachment C.Need.1.6.d**

# CURRICULUM VITAE

2012 JUN 13 AM 10: 17

NAME: John Douglas Simmons, M.D.

BIRTHDATE: April 22, 1951

BIRTHPLACE: Rhinelander, Wisconsin

MARITAL STATUS: Married May 21, 1977; one daughter born September 1978

EDUCATION: Stanford University, 1969-1973, B.S. in Biology 6/73

Case Western Reserve School of Medicine
1973-1977, M.D. 6/77

INTERNSHIP: Mount Sinai Hospital, Cleveland, Ohio
7/1/77 - 6/30/78; Rotating Medical Internship

RESIDENCY: Cincinnati General Hospital, Cincinnati, Ohio
7/1/77 - 6/30/81; Diagnostic Radiology

FELLOWSHIP: University of California at San Francisco, Moffitt Hospital
7/1/81 - 6/30/82; Neuroradiology

BOARD CERTIFICATION:
Diagnostic Radiology, 6/81
Certificate for Added Qualifications in Neuroradiology – 1996
Certificate for Added Qualifications in Neuroradiology – 2006
Maintenance of Certification in Neuroradiology 2006 -2016

MILITARY: 2-M

LICENSURE: State of Tennessee – Active
State of California – Inactive
State of Ohio – Inactive
State of Oklahoma - Inactive

AWARDS/HONORS: Biology Honors Scholar, Stanford University, 1973

Merck Foundation Research Grant for Development of a Teaching Module on Chest Radiology for Second Year Medical Students, 1975

Senior Clinical Science Preceptor, Case Western Reserve University School of Medicine, 1976-1977

Outstanding Resident Radiology Display of the Year, Department of Radiology, Cincinnati General Hospital, 1979-1980

Chief Resident, University of Cincinnati, Department of Radiology, July1, 1980 – June 30, 1981

EXHIBIT PRESENTATIONS
AND AWARDS:

Carcinoid of Apudomas. (Simmons JD)
University of Cincinnati Department of Radiology
21st Annual Refresher Course, 1979

American Roentgen Ray Society, Las Vegas, NV
80th Annual Meeting

The Anterior and Posterior Junction Lines. (Proto AV, Simmons JD, Zylak C)

GOLD MEDAL: American Roentgen Ray, Las Vegas, NV
April 19 – 25, 1980

GOLD AWARD: Canadian Association of Radiologists,
Montreal, May 11-15, 1980

MAGNA CUM LAUDE AWARD: RSNA, Dallas, TX, November 1980

Best Doctors of America 2000 - 2010

SCIENTIFIC PRESENTATIONS:

Western Neuroradiology Society Annual Meeting, 1982
South Lake Tahoe, CA. "Metrizamide CT Scanning in Post-inflammatory Syringomyelia".

Oklahoma Neurologic Science Meeting, Tulsa OK, May 1982
"Clinical Utility of Digital Radiography and Magnetic Resonance".

Radiologic Society of North America Annual Meeting, November 1982, Chicago, IL "Preoperative Demonstration of Post-inflammatory Syringomyelia".

Knoxville Academy of Medicine, "CT and Myelography" 1983
"Digital Subtraction Angiography" 1983

PUBLICATIONS:

Updike S, Simmons J: Gel entrapment of antibody: facilitating RIA. Clinical Chemistry 19:1339-1344, 1973

Simmons J: Gamut-Solitary or multiple nodular lesions in the gastrointestinal tract with central ulceration (bull's eye or target lesion), Seminars in Roentgenology 15 (4):267-268, 1980

Proto AV, Simmons JD, and Zylak CJ: The anterior junction anatomy. Crit. Rev. Diagnos.Imag. 20:121-173, 1983

Simmons JD, Norman D, and Newton TH: Preoperative demonstration of post-inflammatory syringomyelia. American Journal of Neuroradiology. 4 (3):625-628, 1983

Proto AV, Simmons JD, and Zylak CJ: The posterior junction anatomy. Crit. Rev. Diagnos. Imag. 20:121-173, 1983

Fardon DF, Herzog RJ, Mink JH, Simmons JD, Kahanovitz N, Holderman S: Nomenclature of lumbar disc disorders. In Garfin SR, Vacero AR, (ed): Orthopedic knowledge update, spine, American Academy of Orthopedic Surgery, Rosemont, IL; A3-6, 1997

Fardon DF, Simmons JD. When advanced techniques are needed to confirm a commonplace diagnosis, Focus of Spine Care, The Spinal Journal, 5:117, 2005

REVIEWS: The Spine Journal 2004-2007, Book Reviewer

PRACTICE: Tulsa Ray Laboratories, Hillcrest Medical Center, Tulsa, OK, 1982-1983

Abercrombie Radiological Consultants, Inc., St. Mary's Health Systems, 1983 – present

LEADERSHIP: President, Abercrombie Radiological Consultants, Inc., 1992 – present
Chief of Radiology, St.Mary's Medical Center, 1996 – present
Chairman, Mercy Medical Center, Vascular Committee 2008 – 2010

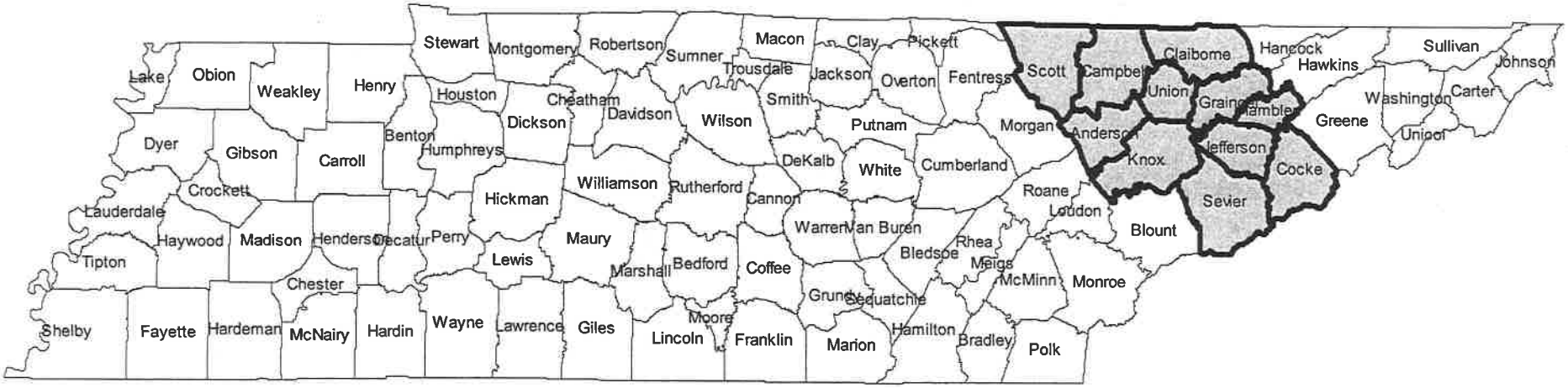
ASSOCIATIONS: American Society of Neuroradiology - Senior Member, 1983 – present
Radiology Society of North America, 1981 – present
American College of Radiology, 1983 – present
North American Spine Society, 1989 – 2008
American Academy of Medicine 1983 - present
American Society of Spine Radiologists, 1995 – 2005
Tennessee Medical Association 1983 – present
Knoxville Academy of Medicine 1983 - present

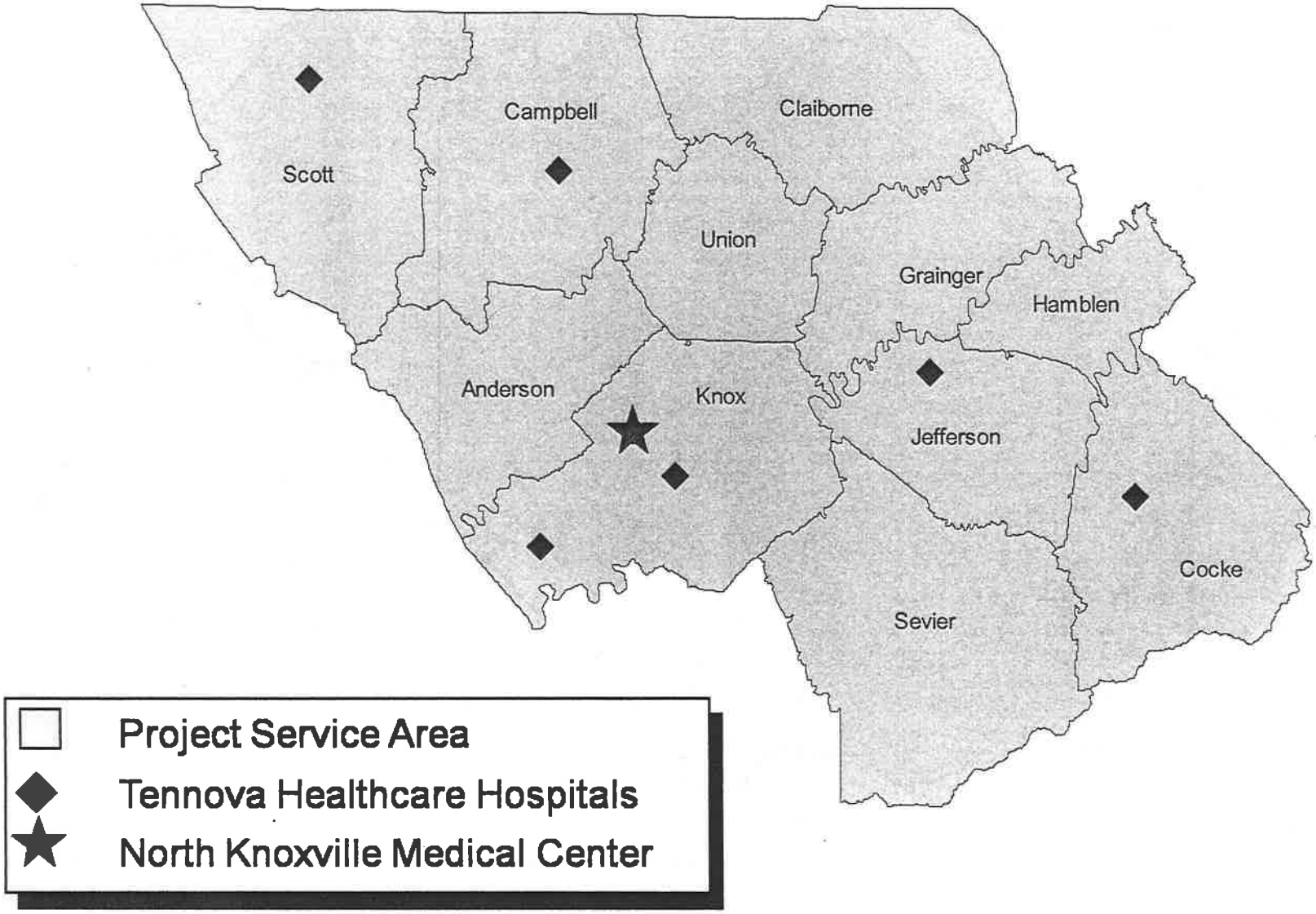
COMMITTEES: Executive Committee, St. Mary's Medical Center 1996 – present
North American Spine Society, Nomenclature Committee 2001
North American Spine Society, Coding Committee 2002 – 2003
American College of Radiology, Alternate Councilor 2005 -2007
American College of Radiology, Councilor 2008 – 2010
Abercrombie Radiology, Executive Committee 1990 – present
St. Mary Medical Center, Vascular Committee 2008 – present

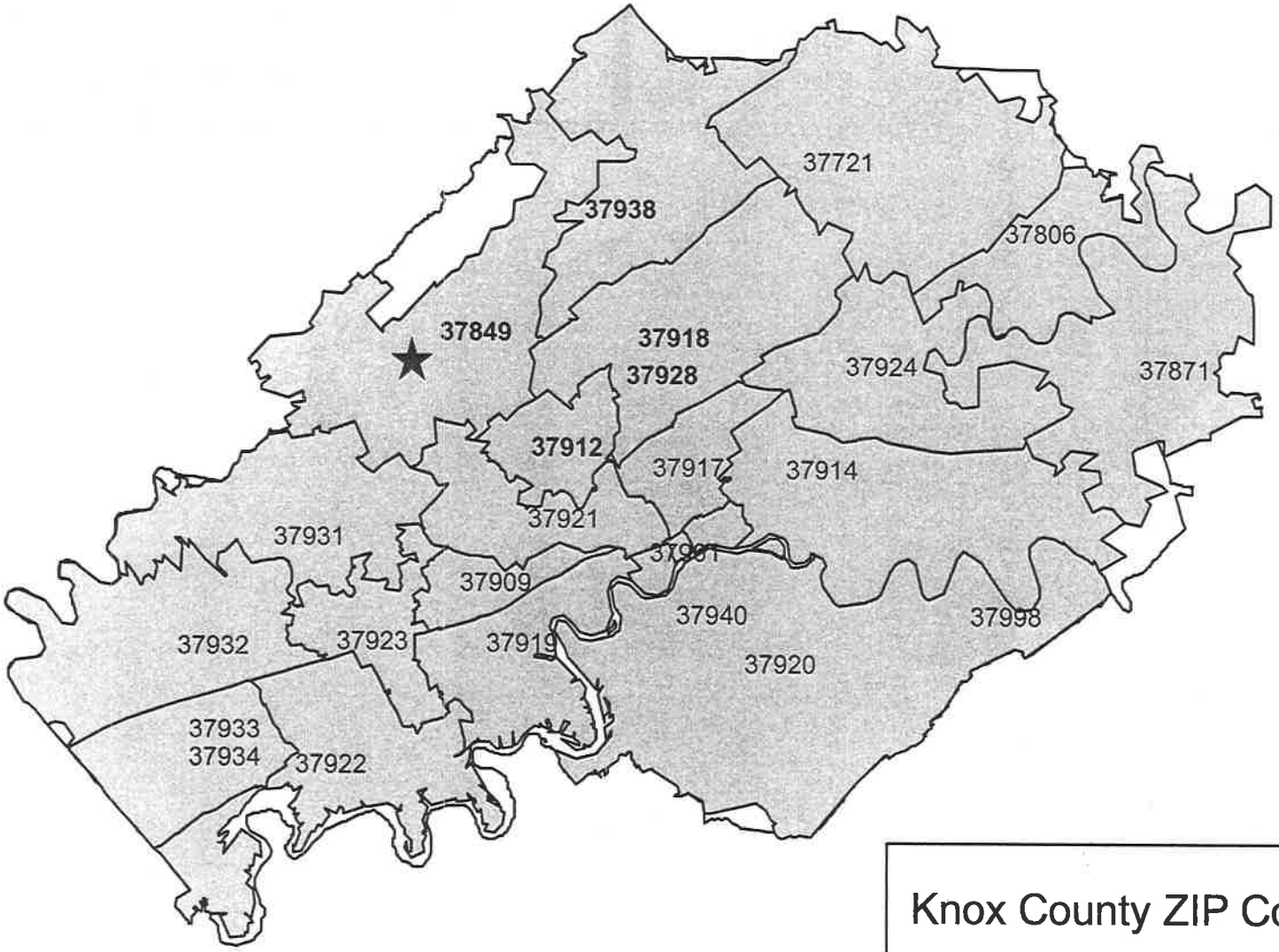
APPOINTMENTS: University of Tennessee Medical Center
Clinical Assistant Professor of Radiology 1983 – present

Lincoln Memorial University
Clinical Adjunct Faculty 8/01/09 - present

**Attachment C.Need.6**


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


Scott
Campbell
Claiborne
Union
Grainger
Hamblen
Anderson
Knox
Jefferson
Cocke
Sevier
Project Service Area
Tennova Healthcare Hospitals
North Knoxville Medical Center




Knox County ZIP Codes

2012 JUN 13 AM 10: 17

## Attachment C.Economic Feasibility.1

# JOHNSON&GALYON
CONSTRUCTION

2012 JUN 13 AM 10: 17

June 12, 2012

Mr. Barney Rhyne
Tennova Healthcare
900 E. Oak Hill Avenue
Knoxville, TN 37917

Re: Tennova – NKMC
Mobile PET
Budget Estimate

Dear Barney,

We are pleased to provide and estimated price of Thirty Seven Thousand Two Hundred Sixty Nine dollars ($37,279.00) to provide minor grading, concrete, 6' chain link fencing, removable bollards, canopy & sidewalls for the proposed Mobile PET at NKMC. Pricing is based on plan sheets A1.1 dated 6-9-11 & S1 dated 6-14-11 by George Armour Ewart Architect.

Canopy and sidewalls are assumed to be no more than 10' tall with sidewalls creating a tunnel that is open on two ends. A $10,000 budget has been allowed for the canopy and sidewalls based on the same system used for the mobile hyperbaric unit at NKMC. Concrete "sidewalk" areas are assumed to be 4" thick, and all disturbed lawn areas are to be reseeded with standard grass seed and straw. We have allowed $700 for the County permit and review fee. Mechanical and electrical work is by others.

A pricing breakdown is attached for your use. If you have any questions, or if we can be of any further assistance, please don't hesitate to call.

Sincerely,

JOHNSON & GALYON, INC.

Mark Halcomb
Estimator

Attachment
Cc: Hugh Boling, J&G



Johnson & Galyon, Inc. 1130 Atlantic Ave., Knoxville, TN 37917 www.johnsongalyon.com

| Group | Phase | Description | Grand Total | Percent of Total | Notes |
|---|---|---|---|---|---|
| 01000 | | **GENERAL CONDITIONS** | | | |
| | 01312 | Supervision | 3,740 | 10.034 | |
| | 01335 | Testing | 500 | 1.342 | |
| | 01340 | CONSTRUCTION EQUIPMENT | 560 | 1.503 | |
| | 01403 | Temp Barricades - J&G | 900 | 2.415 | |
| | 01720 | Layout | 560 | 1.503 | |
| | 01740 | Clean Up | 1,641 | 4.402 | |
| 02000 | | **SITEWORK** | | | |
| | 02010 | Site Equipment | 1,871 | 5.019 | |
| | 02315 | EXCAVATION & FILL | 1,277 | 3.427 | |
| | 02320 | BUILDING EXCAVATION | 930 | 2.495 | |
| | 02820 | FENCES & GATES | 820 | 2.200 | |
| | 02920 | LAWNS & GRASS | 333 | 0.893 | |
| | 02995 | SITE CONCRETE | 183 | 0.490 | |
| 03000 | | **CONCRETE** | | | |
| | 03110 | FORMWORK | 637 | 1.710 | |
| | 03150 | CONCRETE ACCESSORIES | 152 | 0.407 | |
| | 03210 | REINFORCING | 1,543 | 4.141 | |
| | 03220 | WIRE MESH | 217 | 0.582 | |
| | 03310 | CAST IN PLACE CONCRETE | 2,602 | 6.981 | |
| | 03350 | CEMENT FINISHING | 2,467 | 6.619 | |
| | 03390 | CURING & PROTECTING | 78 | 0.208 | |
| 05000 | | **METALS** | | | |
| | 05510 | MISC. METALS | 610 | 1.636 | |
| 10000 | | **SPECIALTIES** | | | |
| | 10530 | Protective Walkway Covers | 10,000 | 26.832 | |

## Estimate Totals

| Description | Amount | Totals | Rate | Percent of Total |
|---|---|---|---|---|
| Labor | 5.870 | | | 15.75% |
| Material | 5.119 | | | 13.74% |
| Subcontract | 16.027 | | | 43.00% |
| Equipment | 2.631 | | | 7.06% |
| Other | | | | |
| | 29,648 | 29,648 | | 79.55 |
| Labor Burden - 25.5% | 1,497 | | 25.500 % | 4.02% |
| Matl & P O (Other) SalesTax | 474 | | 9.250 % | 1.27% |
| | 1,970 | 31,619 | | 5.29 |
| General Liability - 0.24% | 89 | | 0.240 % | 0.24% |
| | 89 | 31,708 | | 0.24 |
| Knox County Permit | 600 | | | 1.61% |
| Knox Review Fee | 100 | | | 0.27% |
| | 700 | 32,408 | | 1.88 |
| Fee | 4,861 | | 15.000 % | 13.04% |
| *Total* | | *37,269* | | |

7511 Taggart Lane
(865) 524-3686
Knoxville, Tennessee 37938
Fax (865) 522-1553
www.tn-associated.com
**Tennessee Associated Electric**

June 11, 2012

Tennova PRMC
900 East Oak Hill Avenue ]
Knoxville, TN 37917
Attention:
Mr. Barney Rhyne

RE: NORTH KNOXVILLE MEDICAL CENTER - MOBILE PET UNIT

Barney:

We quote $19,599.00 (cost plus not to exceed quoted amount) for electrical modifications and additions required to install a mobile PET unit at North Knoxville Medical Center. We include:

- 200-amp Russelstoll MaxGard outdoor receptacle and back box
- 200-amp N3R disconnect and fuses
- Three (3) outdoor telephone outlets and three (3) outdoor data outlets
- Grounding and bonding of receptacle and MRI unit
- Connection to spare 225-amp breaker in existing switchboard
- Necessary conduit, wire, wall penetrations, fire sealing and accessories

Thanks for requesting our quotation. Please advise if we may be of further assistance.

Respectfully,
TENNESSEE ASSOCIATED ELECTRIC
Eddie Asbury
Eddie Asbury

**DEL•AIR** Mechanical Contractors, Inc.

Barney Rhyne
Tennova-North Knox Medical Center

Re: Mobile Pet Unit

June 12, 2012

Mr. Rhyne,

Per the drawing you sent me via email, P1.1 dated June 10, 2011, please consider $8,972.00 for the following:

- New sanitary sewer
- Domestic cold water
- All materials (pipe fittings, valves, etc.)
- Core drilling
- floor sawing
- All labor

Exclusions: electrical, concrete forming or pouring, med-gas work, trench rock removal, dumpster, exterior or interior wall cut or patch

** If a bond is required, please add 1.5% to our total lump sum**

Regards,

Gregg Jones
Project Manager/Estimator



www.delairmechanical.com

135 Chickamauga Avenue • Knoxville Tennessee 37917 • (865) 525-4119 • (865) 521-7043 Fax

## Attachment C.Economic Feasibility.2

SUPPLEMENTAL

June 21, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Dear Ms. Hill:

This letter is confirmation that as the Chief Financial Officer of Tennova Healthcare we have sufficient cash reserves to fully fund the capital costs of $107,500 associated with the preparation of the site for mobile PET/CT services at North Knoxville Medical Center (estimate includes legal and administrative costs, construction costs, and a contingency fund). These costs will be funded through Tennova Healthcare's disbursement account, which is funded daily by Health Management Associates.

We are a part of Health Management Associates, a proprietary health system operating in 15 states. As part of its purchase of Tennova Healthcare, formerly Mercy Health Partners, Health Management committed to invest $180 million of capital in this region over five years. The capital for this project is part of that commitment.

Sincerely,

Bill Ziesmer
Chief Financial Officer



Tennova Healthcare • 200 Blount Ave, Suite 600 • Knoxville, TN 37920 • Ph: 865-632-5600 • TennovaHealthcare.com

SUPPLEMENTAL

2012 JUN 22 AM 10: 18

**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF KNOX

NAME OF FACILITY: Tennova Healthcare – North Knoxville Medical Center

I, Jeffrey D. Potter, 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.

/SVP

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 21 day of June, 2012, witness my hand at office in the County of Knox, State of Tennessee.

Susan E England

NOTARY PUBLIC

My commission expires July 7, 2015.

SUSAN E. ENGLAND STATE TENNESSEE NOTARY PUBLIC KNOX COUNTY

HF-0043

Revised 7/02

# Attachment 5

**Locations and Days of Operation - Mobile PET/CT Unit Provided by Alliance Imaging**

| Site (including address) | Monday (Hours of Operation) | Tuesday (Hours of Operation) | Wednesday (Hours of Operation) | Thursday (Hours of Operation) | Friday (Hours of Operation) |
|---|---|---|---|---|---|
| | Open | | | | |
| Salisbury VA Clinic, 8601 University Drive East, Charlotte, NC 28213 | | 8:00 a.m. - 5:00 p.m. | | | |
| The James Quillen VA Medical Center, 99 Veterans Way, Johnson City, TN 37604 | | | 8:00 a.m. - 5:00 p.m. | | |
| Asheville VA Hospital, 1100 Tunnel Road, Asheville, NC 28805 | | | | 8:00 a.m. - 5:00 p.m. | |
| North Knoxville Medical Center, 7551 Dannaher Way, Powell, TN 37849 | | | | | 8:00 a.m. - 5:00 p.m. |

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

# FORM 10-K

(Mark One)

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2011

or

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the transition period from _____ to _____

Commission File Number: **001-11141**

# HEALTH MANAGEMENT ASSOCIATES, INC.

(Exact name of registrant as specified in its charter)

| | |
|---|---|
| **Delaware**<br>(State or other jurisdiction of incorporation or organization) | **61-0963645**<br>(I.R.S. Employer Identification No.) |
| **5811 Pelican Bay Boulevard, Suite 500**<br>**Naples, Florida**<br>(Address of principal executive offices) | **34108-2710**<br>(Zip Code) |

Registrant's telephone number, including area code: **(239) 598-3131**

**Securities registered pursuant to Section 12(b) of the Act:**

| **Title of each class** | **Name of each exchange on which registered** |
|---|---|
| Class A Common Stock, $0.01 par value | New York Stock Exchange |

**Securities registered pursuant to Section 12(g) of the Act:**
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

As of June 30, 2011, the aggregate market value of the registrant's voting stock held by non-affiliates was approximately $2.63 billion, as determined by reference to the listed price of the registrant's Class A common stock as of the close of business on such day. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of February 17, 2012, there were 254,435,258 shares of the registrant's Class A common stock, par value $0.01 per share, outstanding.

Portions of the registrant's definitive proxy statement, to be issued in connection with the Annual Meeting of Stockholders of the registrant to be held on May 22, 2012, have been incorporated by reference into Part III, Items 10, 11, 12, 13 and 14 of this Annual Report.

**Item 8. Financial Statements and Supplementary Data.**

## INDEX TO FINANCIAL STATEMENTS

**Page**

**Health Management Associates, Inc. Consolidated Financial Statements:**


Report of Independent Registered Public Accounting Firm ..... 61

Consolidated Statements of Income for the years ended December 31, 2011, 2010 and 2009 ..... 62

Consolidated Statements of Comprehensive Income for the years ended December 31, 2011, 2010 and 2009 ..... 63

Consolidated Balance Sheets as of December 31, 2011 and 2010 ..... 64

Consolidated Statements of Stockholders' Equity for the years ended December 31, 2011, 2010 and 2009 ..... 65

Consolidated Statements of Cash Flows for the years ended December 31, 2011, 2010 and 2009 ..... 66

Notes to Consolidated Financial Statements ..... 68

## REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders
Health Management Associates, Inc.

We have audited the accompanying consolidated balance sheets of Health Management Associates, Inc. as of December 31, 2011 and 2010, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2011. Our audits also included the financial statement schedule listed in the Index at Item 15. These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (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 includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Health Management Associates, Inc. at December 31, 2011 and 2010, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2011, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Health Management Associates, Inc.'s internal control over financial reporting as of December 31, 2011, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 27, 2012 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Certified Public Accountants
Miami, Florida
February 27, 2012

**HEALTH MANAGEMENT ASSOCIATES, INC.**
**CONSOLIDATED STATEMENTS OF INCOME**
**(in thousands, except per share amounts)**

2012 JUN 13 AM 10: 18

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2011 | 2010 | 2009 |
| Net revenue | $ 5,804,451 | $ 5,092,166 | $ 4,536,106 |
| Salaries and benefits | 2,302,844 | 2,016,967 | 1,779,440 |
| Supplies | 776,598 | 703,426 | 637,663 |
| Provision for doubtful accounts | 716,856 | 624,753 | 553,639 |
| Rent expense | 154,279 | 122,983 | 100,990 |
| Other operating expenses | 1,067,980 | 892,465 | 788,051 |
| Medicare and Medicaid HCIT incentive payments | (39,982) | - | - |
| Depreciation and amortization | 267,900 | 241,873 | 234,883 |
| Interest expense | 222,747 | 211,673 | 217,938 |
| Gains on early extinguishment of debt, net | - | - | (16,202) |
| Write-offs of deferred debt issuance costs and related other | 24,595 | - | 444 |
| Other | (1,771) | (8,797) | (4,980) |
| | 5,492,046 | 4,805,343 | 4,291,866 |
| Income from continuing operations before income taxes | 312,405 | 286,823 | 244,240 |
| Provision for income taxes | (106,071) | (101,049) | (82,937) |
| Income from continuing operations | 206,334 | 185,774 | 161,303 |
| Income (loss) from discontinued operations, including gains/losses on disposals, net of income taxes (see Notes 4 and 10) | (2,409) | (13,526) | 2,638 |
| Consolidated net income | 203,925 | 172,248 | 163,941 |
| Net income attributable to noncontrolling interests | (25,215) | (22,179) | (25,759) |
| Net income attributable to Health Management Associates, Inc. | $ 178,710 | $ 150,069 | $ 138,182 |
| Earnings (loss) per share attributable to Health Management Associates, Inc. common stockholders: | | | |
| Basic | | | |
| Continuing operations | $ 0.72 | $ 0.66 | $ 0.55 |
| Discontinued operations | (0.01) | (0.05) | 0.01 |
| Net income | $ 0.71 | $ 0.61 | $ 0.56 |
| Diluted | | | |
| Continuing operations | $ 0.71 | $ 0.65 | $ 0.55 |
| Discontinued operations | (0.01) | (0.05) | 0.01 |
| Net income | $ 0.70 | $ 0.60 | $ 0.56 |
| Weighted average number of shares outstanding: | | | |
| Basic | 251,541 | 248,272 | 245,381 |
| Diluted | 255,037 | 251,106 | 246,965 |

See accompanying notes.

**HEALTH MANAGEMENT ASSOCIATES, INC.**
**CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME**
**(in thousands)**

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2011 | 2010 | 2009 |
| Consolidated net income | $ 203,925 | $ 172,248 | $ 163,941 |
| Components of other comprehensive income (loss) before income taxes attributable to: | | | |
| Interest rate swap contract | | | |
| Changes in fair value | 47,735 | (17,646) | 85,923 |
| Reclassification adjustments for amortization of expense into net income | 10,384 | - | - |
| Net activity attributable to the interest rate swap contract | 58,119 | (17,646) | 85,923 |
| Available-for-sale securities | | | |
| Unrealized gains (losses) on available-for-sale securities, net | (117) | 2,473 | 2,086 |
| Adjustments for net (gains) losses reclassified into net income | (1,020) | (2,143) | - |
| Net activity attributable to available-for-sale securities | (1,137) | 330 | 2,086 |
| Other comprehensive income (loss) before income taxes | 56,982 | (17,316) | 88,009 |
| Income tax (expense) benefit related to items of other comprehensive income (loss) | (21,298) | 6,434 | (38,337) |
| Other comprehensive income (loss), net | 35,684 | (10,882) | 49,672 |
| Total consolidated comprehensive income | 239,609 | 161,366 | 213,613 |
| Total comprehensive income attributable to noncontrolling interests | (25,215) | (22,179) | (25,759) |
| Total comprehensive income attributable to Health Management Associates, Inc. common stockholders | $ 214,394 | $ 139,187 | $ 187,854 |

See accompanying notes.

**HEALTH MANAGEMENT ASSOCIATES, INC.**
**CONSOLIDATED BALANCE SHEETS**
**(in thousands, except per share amounts)**

2012 JUN 13 AM 10: 18

| | December 31, 2011 | December 31, 2010 |
|---|---|---|
| **ASSETS** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 64,143 | $ 101,812 |
| Available-for-sale securities | 122,277 | 57,327 |
| Accounts receivable, less allowances for doubtful accounts of $578,972 and $495,486 at December 31, 2011 and 2010, respectively | 903,517 | 759,131 |
| Supplies, at cost (first-in, first-out method) | 156,529 | 137,214 |
| Prepaid expenses | 59,066 | 46,867 |
| Prepaid and recoverable income taxes | 61,756 | 44,961 |
| Restricted funds | 28,289 | 39,684 |
| Assets of discontinued operations | 14,561 | 11,384 |
| Total current assets | 1,410,138 | 1,198,380 |
| Property, plant and equipment: | | |
| Land and improvements | 249,842 | 201,278 |
| Buildings and improvements | 2,848,185 | 2,431,910 |
| Leasehold improvements | 259,048 | 200,538 |
| Equipment | 1,565,236 | 1,332,064 |
| Construction in progress | 164,185 | 99,645 |
| | 5,086,496 | 4,265,435 |
| Accumulated depreciation and amortization | (1,823,324) | (1,602,488) |
| Net property, plant and equipment | 3,263,172 | 2,662,947 |
| Restricted funds | 96,244 | 51,067 |
| Goodwill | 999,380 | 909,470 |
| Deferred charges and other assets | 235,255 | 88,221 |
| Total assets | $ 6,004,189 | $ 4,910,085 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | |
| Accounts payable | $ 198,120 | $ 172,501 |
| Accrued payroll and related taxes | 80,281 | 83,286 |
| Accrued expenses and other liabilities | 368,790 | 226,125 |
| Due to third party payors | 20,658 | 11,921 |
| Deferred income taxes | 50,466 | 27,052 |
| Current maturities of long-term debt and capital lease obligations | 85,509 | 34,745 |
| Total current liabilities | 803,824 | 555,630 |
| Deferred income taxes | 234,080 | 157,177 |
| Long-term debt and capital lease obligations, less current maturities | 3,489,489 | 2,983,719 |
| Other long-term liabilities | 491,037 | 478,586 |
| Total liabilities | 5,018,430 | 4,175,112 |
| Redeemable equity securities | 200,643 | 201,487 |
| Stockholders' equity: | | |
| Health Management Associates, Inc. equity: | | |
| Preferred stock, $0.01 par value, 5,000 shares authorized, none issued | - | - |
| Common stock, Class A, $0.01 par value, 750,000 shares authorized, 254,156 shares and 250,880 shares issued at December 31, 2011 and 2010, respectively | 2,542 | 2,509 |
| Accumulated other comprehensive income (loss), net of income taxes | (95,440) | (131,124) |
| Additional paid-in capital | 156,859 | 123,040 |
| Retained earnings | 705,180 | 526,470 |
| Total Health Management Associates, Inc. stockholders' equity | 769,141 | 520,895 |
| Noncontrolling interests | 15,975 | 12,591 |
| Total stockholders' equity | 785,116 | 533,486 |
| Total liabilities and stockholders' equity | $ 6,004,189 | $ 4,910,085 |

See accompanying notes.

98

## HEALTH MANAGEMENT ASSOCIATES, INC.
## CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
### Years Ended December 31, 2011, 2010 and 2009
### (in thousands)

| | Health Management Associates, Inc. | | | | | | |
|---|---|---|---|---|---|---|---|
| | Common Stock | | Accumulated Other Comprehensive | Additional Paid-in | Retained | Noncontrolling | Total Stockholders' |
| | Shares | Par Value | Income (Loss), Net | Capital | Earnings | Interests | Equity |
| Balances at January 1, 2009 | 244,221 | $ 2,442 | $ (169,914) | $ 108,374 | $ 238,219 | $ 106,690 | $ 285,811 |
| Net income | - | - | - | - | 138,182 | 25,759 | 163,941 |
| Unrealized gains (losses) on available-for-sale securities and reclassifications into net income, net | - | - | 1,351 | - | - | - | 1,351 |
| Change in fair value of interest rate swap contract and amortization of expense into net income, net | - | - | 48,321 | - | - | - | 48,321 |
| Exercises of stock options and related tax matters | 1,632 | 16 | - | 10,734 | - | - | 10,750 |
| Issuances of deferred stock and restricted stock and related tax matters | 2,664 | 27 | - | (1,376) | - | - | (1,349) |
| Stock-based compensation expense | - | - | - | 10,867 | - | - | 10,867 |
| Distributions to noncontrolling shareholders | - | - | - | - | - | (29,227) | (29,227) |
| Incremental costs of certain transactions with noncontrolling shareholders | - | - | - | (1,054) | - | - | (1,054) |
| Restructuring of a joint venture with Novant Health, Inc., net (see Note 4) | - | - | - | (31,014) | - | (28,206) | (59,220) |
| Reclassification to redeemable equity securities | - | - | - | - | - | (68,571) | (68,571) |
| Balances at December 31, 2009 | 248,517 | 2,485 | (120,242) | 96,531 | 376,401 | 6,445 | 361,620 |
| Net income | - | - | - | - | 150,069 | 22,179 | 172,248 |
| Unrealized gains (losses) on available-for-sale securities and reclassifications into net income, net | - | - | 221 | - | - | - | 221 |
| Change in fair value of interest rate swap contract and amortization of expense into net income, net | - | - | (11,103) | - | - | - | (11,103) |
| Exercises of stock options and related tax matters | 1,094 | 11 | - | 11,328 | - | - | 11,339 |
| Issuances of deferred stock and restricted stock and related tax matters | 1,269 | 13 | - | (3,185) | - | - | (3,172) |
| Stock-based compensation expense | - | - | - | 18,366 | - | - | 18,366 |
| Distributions to noncontrolling shareholders | - | - | - | - | - | (19,598) | (19,598) |
| Noncontrolling shareholder interests in an acquired business | - | - | - | - | - | 3,565 | 3,565 |
| Balances at December 31, 2010 | 250,880 | 2,509 | (131,124) | 123,040 | 526,470 | 12,591 | 533,486 |
| Net income | - | - | - | - | 178,710 | 25,215 | 203,925 |
| Unrealized gains (losses) on available-for-sale securities and reclassifications into net income, net | - | - | (741) | - | - | - | (741) |
| Change in fair value of interest rate swap contract and amortization of expense into net income, net | - | - | 36,425 | - | - | - | 36,425 |
| Exercises of stock options and related tax matters | 1,563 | 16 | - | 16,237 | - | - | 16,253 |
| Issuances of deferred stock and restricted stock and related tax matters | 1,713 | 17 | - | (7,587) | - | - | (7,570) |
| Stock-based compensation expense | - | - | - | 25,169 | - | - | 25,169 |
| Distributions to noncontrolling shareholders | - | - | - | - | - | (25,394) | (25,394) |
| Noncontrolling shareholder interests in acquired businesses | - | - | - | - | - | 3,563 | 3,563 |
| Balances at December 31, 2011 | 254,156 | $ 2,542 | $ (95,440) | $ 156,859 | $ 705,180 | $ 15,975 | $ 785,116 |

See accompanying notes.

## HEALTH MANAGEMENT ASSOCIATES, INC.
## CONSOLIDATED STATEMENTS OF CASH FLOWS
**(in thousands)**

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2011 | 2010 | 2009 |
| Cash flows from operating activities: | | | |
| Consolidated net income | $ 203,925 | $ 172,248 | $ 163,941 |
| Adjustments to reconcile consolidated net income to net cash provided by continuing operating activities: | | | |
| Depreciation and amortization | 274,526 | 248,583 | 241,683 |
| Amortization related to interest rate swap contract | 10,384 | - | - |
| Fair value adjustment related to interest rate swap contract | 5,979 | - | - |
| Provision for doubtful accounts | 716,856 | 624,753 | 553,639 |
| Stock-based compensation expense | 25,169 | 18,366 | 10,867 |
| Losses (gains) on sales of assets, net | 1,325 | (711) | (1,228) |
| Gains on sales of available-for-sale securities, net | (518) | (4,328) | (1,384) |
| Gain on early extinguishment of debt, net | - | - | (16,202) |
| Write-offs of deferred debt issuance costs | 24,045 | - | 444 |
| Deferred income tax expense | 79,159 | 20,311 | 90,467 |
| Changes in assets and liabilities of continuing operations, net of the effects of acquisitions: | | | |
| Accounts receivable | (870,898) | (731,607) | (595,780) |
| Supplies | (3,108) | (14,250) | (3,917) |
| Prepaid expenses | (8,271) | (6,393) | (348) |
| Prepaid and recoverable income taxes | (18,987) | 31,020 | 881 |
| Deferred charges and other long-term assets | (5,785) | 5,382 | (12,025) |
| Accounts payable | 23,380 | 31,699 | (21,296) |
| Accrued expenses and other liabilities | 87,431 | 27,370 | 27,690 |
| Equity compensation excess income tax benefits | (2,999) | (1,278) | (218) |
| (Income) loss from discontinued operations, net | 2,409 | 13,526 | (2,638) |
| Net cash provided by continuing operating activities | 544,022 | 434,691 | 434,576 |
| Cash flows from investing activities: | | | |
| Acquisitions of hospitals and other ancillary health care businesses | (582,090) | (191,454) | (138,764) |
| Additions to property, plant and equipment | (302,046) | (209,108) | (198,878) |
| Proceeds from sales of assets and insurance recoveries | 2,765 | 3,150 | 5,326 |
| Proceeds from sales of discontinued operations | 4,851 | 26,360 | - |
| Purchases of available-for-sale securities | (1,385,580) | (921,724) | (86,527) |
| Proceeds from sales of available-for-sale securities | 1,321,398 | 904,881 | 50,000 |
| Decrease (increase) in restricted funds, net | (35,309) | (5,758) | 11,590 |
| Net cash used in continuing investing activities | (976,011) | (393,653) | (357,253) |

See accompanying notes.

## HEALTH MANAGEMENT ASSOCIATES, INC.
## CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)
## (in thousands)

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2011 | 2010 | 2009 |
| Cash flows from financing activities: | | | |
| Proceeds from long-term borrowings | $ 3,356,970 | $ - | $ 38,000 |
| Principal payments on debt and capital lease obligations | (2,869,380) | (40,147) | (127,073) |
| Payments of debt issuance costs | (75,149) | - | - |
| Repurchases of convertible debt securities in the open market | - | - | (67,714) |
| Proceeds from exercises of stock options | 14,067 | 7,469 | 9,699 |
| Cash received from noncontrolling shareholders, net of certain costs | - | 2,547 | 54,796 |
| Cash payments to noncontrolling shareholders | (28,284) | (20,630) | (35,377) |
| Equity compensation excess income tax benefits | 2,999 | 1,278 | 218 |
| Net cash provided by (used in) continuing financing activities | 401,223 | (49,483) | (127,451) |
| Net decrease in cash and cash equivalents before discontinued operations | (30,766) | (8,445) | (50,128) |
| Net increases (decreases) in cash and cash equivalents from discontinued operations: | | | |
| Operating activities | 5,991 | 5,672 | 14,593 |
| Investing activities (see Note 10) | (12,894) | (1,433) | (1,503) |
| Financing activities | - | - | (558) |
| Net decrease in cash and cash equivalents | (37,669) | (4,206) | (37,596) |
| Cash and cash equivalents at the beginning of the year | 101,812 | 106,018 | 143,614 |
| Cash and cash equivalents at the end of the year | $ 64,143 | $ 101,812 | $ 106,018 |
| Supplemental disclosures of cash flow information: | | | |
| Cash paid during the year for: | | | |
| Interest, net of amounts capitalized | $ 188,734 | $ 204,576 | $ 204,718 |
| Income taxes | $ 50,651 | $ 69,443 | $ 32,124 |

See accompanying notes.

## Attachment C.Orderly Development.7.c

# Board for Licensing Health Care Facilities

State of Tennessee

0000000045

No. of Beds 0903

## DEPARTMENT OF HEALTH

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

METRO KNOXVILLE HMA, LLC *to conduct and maintain a*

*Hospital* TENNOVA HEALTHCARE

*Located at* 900 EAST OAK HILL AVENUE, KNOXVILLE

*County of* KNOX *, Tennessee.*

*This license shall expire* JUNE 30 *,* 2012 *, 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* 1ST *day of* JULY *,* 2011 *.*

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

2012 JUN 13 AM 10: 18

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

*By* [illegible]
COMMISSIONER

103

DC5011

## Attachment C.Orderly Development.7.d

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St, Suite. 4T20
Atlanta, Georgia 30303-8909

Ref: Mercy Medical Center compliance w/stds 440120

February 13, 2012

# Important Notice, Read Carefully

Mr. Jeffery Ashin, CEO
Mercy Medical Center
900 East Oak Hill Avenue
Knoxville, Tennessee 37917

RE: Acute Care Hospital - CMS Certification Number (CCN) 44-0120

Dear Mr. Ashin:

Based on a report by the Tennessee State Survey Agency of the fill Medicare survey of Mercy Medical Center, ending January 11, 2012, we find your institution to be in compliance with all Medicare Conditions of Participation. However, there were standard level deficiencies cited, for which you have addressed through the submitting on January 26, 2012, a plan of correction to the Tennessee State Agency.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have questions, please contact Joe Ann Hollingsworth at (404) 562-7510.

Sincerely,

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

Cc: State Agency
The Joint Commission

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | A. BUILDING _____<br>B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| A 000 | INITIAL COMMENTS<br><br>A full Certification survey was completed on January 9-11, 2012, at Mercy Medical Center located at 900 East Oak Hill Avenue, Knoxville, TN, and two satellite hospitals, Mercy Medical Center North, located at 7565 Dannaher Way, Powell, TN, and Mercy Medical Center West, located at 10820 Parkside Dr, Knoxville, TN.<br><br>For identification purposes, Building A will refer to Mercy Medical Center located at 900 East Oak Hill Avenue, Knoxville, TN; Building B will refer to Mercy Medical Center North, located at 7565 Dannaher Way, Powell, TN; and Building C will refer to Mercy West, located at 10820 Parkside Dr, Knoxville, TN. | A 000 | | |
| A 167 | 482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>[The use of restraint or seclusion must be--]<br>(ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of facility policy, medical record review, and interview, the facility failed to ensure physician's orders for the use of a physical restraint were consistent with facility policy for two patients (#16, #35) of four restraint records reviewed.<br><br>The findings included:<br><br>Building A<br><br>Review of facility policy titled "Restraints" dated | A 167 | A 167: Patient Rights/Restraints:<br><br>Facility A, patient # 16: A late entry was made by the physician clarifying the type and duration intended for the restraint. This patient's subsequent days in restraints revealed complete orders. Facility C, patient # 35: A late entry was made to clarify duration of the restraint; however the patient required restraints for total of 3 hours and restraints had already been removed. A log of all patients in restraints is provided to the clinical leadership daily. The clinical leader/ designee is responsible for reviewing physician and nursing documentation by end of each shift for opportunities to clarify documentation. Staff is required to notify clinical leader or designee before application of restraint to help assure the least restrictive device is used | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO - Tennova

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 167 | Continued From page 1<br>February 7, 2011, revealed,"...To provide guidelines to ensure that the use of restraint...is safe and limited to those situations with adequate, appropriate clinical justification...Before implementing a restraint intervention...a physician's order...must be obtained...The order for restraint must include the type of restraint used, duration of the restraint, and specific behavior that led to the use of restraint..."<br><br>Patient #16 was admitted to the facility on December 20, 2012, with diagnoses including Respiratory Failure.<br><br>Medical record review of a Restraint Order dated December 23, 2011, revealed no documentation regarding the duration and type of release used. Medical record review of a Restraint Order dated December 24, 2011, revealed no documentation regarding the type of restraint. Medical record review of a Restraint Order dated December 25, 2011, revealed no documentation regarding the duration and type of restraint used.<br><br>Interview with Registered Nurse (RN #7) on January 10, 2012, at 10:00 a.m., confirmed the facility failed to implement the facility's Restraint Policy for Patient #16.<br>Building C<br><br>Patient #35 was admitted to the facility on December 22, 2011 with diagnoses to include Myocardial Infarction, Respiratory Failure, and Acute Renal Failure.<br><br>Medical record review of a Physician's Order, dated January 3, 2012, at 1:00 a.m., revealed the patient was to be in wrist restraints for pulling out | A 167 | and initial order is complete. The Restraint Order Set was revised to provide a clear, concise and easier to read format. The draft was approved at the Medical Executive Committee on January 19, 2012. Staff and physician education for the new order set will begin during the week of January 27, 2012 and will be implemented on February 14, 2012. Each patient in restraint is monitored for completeness of documentation record monthly as well as overall numbers of patients in restraints and restraint hours and reported through the Quality/Safety Committee. Opportunities for improvement are discussed at the Quality/Safety meeting monthly. Physician documentation compliance is discussed at the Quality Management Committee on a scheduled basis. Individual staff and physician opportunities are trended for review. Patient Rights is a topic covered in every new employee orientation. The restraint policy and orders are included in new physician and new employee clinical orientation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | 2012 JUN 13 AM 10: 18 | 01/11/2012 |

NAME OF PROVIDER OR SUPPLIER
MERCY MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
900 EAST OAK HILL AVENUE
KNOXVILLE, TN 37917

| (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 167 | Continued From page 2<br>tubes and catheters. Continued review revealed no documentation regarding the time limit for use of the restraint.<br><br>Interview with the Chief Nursing Officer at the 300 hall nursing station on January 9, 2012, at 3:00 p.m., confirmed the facility failed to implement the facility's Restraint Policy for Patient #35. | A 167 | | |
| A 404 | 482.23(c) ADMINISTRATION OF DRUGS<br><br>Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.<br><br>This STANDARD is not met as evidenced by: Based on observation, policy review, standards review, and interview, the facility failed to provide dialysis treatments in compliance with facility policy and industry standards.<br><br>The findings included:<br><br>Building A.<br><br>Observation, on January 10, 2012, at 1:45 p.m., of the Dialysis Unit's water treatment system, on the second floor of Building A, revealed the system consisted of a source of city water, two carbon filter tanks, a water softener, and a reverse osmosis (RO) unit.<br><br>Review of the facility's policy titled, "Water Treatment: Maintenance and Use of Central RO and Water Treatment System", last revised April 28, 2011, revealed, "The water quality...will be | A 404 | A 404: Administration of Drugs—Dialysis<br>The Staff Member observed was re-educated on January 18, 2012, by Terrie Lane, RN Team Leader of Dialysis. Policies and Practices were reviewed with AAMI standards. Validation of education was completed by return demonstration of practices. The entire dialysis department had a review of the water testing and treatment policies and practices according to AAMI standards completed by Clint Foster, RN, Dialysis. Validation of this review was completed by return demonstration. Random peer observations will be completed by Dialysis staff monthly. Quality Assurance logs will be reviewed for compliance and reported through the Quality Patient Safety Committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 404 | Continued From page 3<br>according to the AAMI (American Association of Medical Instrumentation) standards". Further review of the policy revealed, "Test the water for chlorine/chloramines at valve #T2 (access port between the first and second carbon filter tanks), after the first set of carbon filters".<br><br>Review of AAMI standard RD52:2004 revealed, "Two carbon beds shall be installed with a sample port following the first bed" and "performance is monitored by measuring free chlorine and/or chloramines concentrations in the water exiting the first carbon bed of a series connected pair."<br><br>Interview with Registered Nurse #1 (RN#1) on January 10, 2012, at 1:45 p.m., in the water treatment room, revealed RN#2 had tested the water for chlorine that morning prior to starting dialysis. RN#1 stated that, "had rechecked the chlorine level again four hours later, as the water is tested prior to beginning dialysis and every four hours while dialysis is being provided." RN#2 demonstrated how the water was tested for chlorine by obtaining product water from a port on the RO unit. Further interview with RN#2 confirmed this nurse always obtained the test sample from the RO unit and never tested water from the port between the carbon tanks.<br><br>Interview with RN#8, in the Dialysis Unit, on January 11, 2012, at 9:00 a.m., confirmed it was facility policy to obtain the water specimen from the port between the first and second carbon tanks, for chlorine testing. | A 404 | | |
| A 450 | 482.24(c)(1) MEDICAL RECORD SERVICES<br><br>All patient medical record entries must be legible, complete, dated, timed, and authenticated in | A 450 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 450 | Continued From page 4<br>written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.<br><br>This STANDARD is not met as evidenced by:<br>Building A<br><br>Based on review of facility policy, review of medical records, and interview, the facility failed to ensure a medical record was completed consistent with hospital policy for one patient (#1) of fifty sampled patients.<br><br>The findings included:<br><br>Building A<br><br>Review of facility policy "Physicians Orders" dated July 25, 2011, revealed,"...Physician orders will be managed according to the following protocols"...Required elements: All medication orders...must be complete, accurate, and must include:...Dose and dosage form...Strength...Route of Administration...Dosage regimen (frequency)...Orders that are...incomplete will be clarified with the prescriber...Preprinted Orders: If a physician...adopts 'routine orders', a copy of the orders should be timed, dated and signed by the physician...Standing Orders: these orders are developed for use...for a procedure or process..."<br><br>Patient #1 was admitted to the facility on January 1, 2012. Medical record review of a Physician's Orders form dated January 2, 2012, at 3:50 p.m., revealed nine of thirty-two orders preceded with a blackened check box, and included, "...Lactated | A 450 | A 450: Medical Records Services<br>The order set referenced in finding with patient #1 at Facility A has been revised to assure completion of orders and an infusion rate has been added. All surgery patients have been identified as having this same potential incomplete order, and as a result, all order sets used within the ODS/Pre-Op area have been revised. This revision was completed on January 20, 2012. The Pharmacy Director has re-educated the pharmacy staff regarding the "Physician's Order" policy to include proper methods for handling incomplete orders. Orders not meeting the criteria for a complete order will be verified with the prescriber. Education was completed by January 26, 2012.<br>An order set revision policy is in place to assure orders are reviewed on a tri-annual schedule to assure regulatory requirements are met. Any orders identified by departments or pharmacy requiring clarification will be immediately reviewed and corrected. Clarifications of unclear or incomplete orders are part of the employee clinical orientation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 440120 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 01/11/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | |

| (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 450 | Continued From page 5<br>ringers 1000 ml (milliliters) or (and a blank line)..." Continued review revealed no documentation regarding the route or dose regimen. Continued review revealed twenty-three possible orders preceded by a blank check box, with no indication whether the orders were to be implemeneted or deleted.<br><br>Interview with Vice President of Quality on January 9, 2012, at 10:33 a.m., in a 3 Central work space, revealed the "Physician's Orders" form was a "standing orders" form. Interview with the Vice President of Quality on January 11, 2012, at 10:30 a.m., in the the Chief Nursing Officer's (CNO) conference room, confirmed the physician's order for Lactated Ringers was incomplete.<br><br>Interview with the Director of Pharmacy on January 11, 2012, at 10:43 a.m., in the CNO's conference room, revealed pharmacy reviewed orders daily and followed up the prescriber when an issue was identified. Continued interview revealed the Physician's Orders dated January 1, 2012, required clarification, and confirmed the facility failed to ensure the orders dated January 1, 2012, were completed consistent with hospital policy. | A 450 | | |
| A 454 | 482.24(c)(1) ORDERS DATED AND SIGNED<br><br>(i) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section.<br>(ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is | A 454 | A 454: Orders Dated and Signed<br>The order sets in regards to Patient # 7 and Patient # 8 at Facility A, the "Laminectomy "and"Anterior Fusion" order sets were revised for clarity concerning the pre-admission testing. Physicians utilizing those order sets were specifically educated as to the requirement of dating/timing/signing orders on | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 454 | Continued From page 6<br>responsible for the care of the patient as specified under §482.12(c) and authorized to write orders by hospital policy in accordance with State law.<br><br>This STANDARD is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to ensure physician's orders were authenticated, dated, and timed for two patients (#7 and #8) of fifty patients reviewed.<br><br>The findings included:<br><br>Building A<br><br>Patient #7 was admitted to the facility on January 9, 2012, for a Discectomy.<br><br>Medical record review of the pre-printed physician's orders Pre-Op Laminectomy/Fusion revealed "CBC" (Complete Blood Count) and "PT/PTT" (Prothrombin Time and Partial Thromboplastin Time) had been circled to indicate the labwork was to be completed prior to surgery. Continued review of the pre-printed physician's order sheet revealed the orders had not been signed, dated, or timed by the physician. Further medical record review revealed the labwork had been obtained on December 28, 2011.<br><br>Patient #8 was admitted to the facility on January 9, 2012, for an ACD&F (Anterior Cervical Discectomy and Fusion).<br><br>Medical record review of the pre-printed physician's orders Pre-Op Laminectomy/Fusion revealed orders for labwork, and preoperative | A 454 | January 20, 1012 by the ODS/PACU clinical leader. The ODS/PACU staff were educated as to the requirement to assure orders have been obtained and confirmed with signature or verbal order prior to initiation by January 20, 2012. The ODS/ PACU Clinical Leader or designee will monitor compliance with the dating/timing and signature's on physician orders, specifically the two order sets that were revised, as well as other orthopedic patients for signature/dating/timing during the time frame of January 23, 2012 through February 17, 2012. Results will be discussed with the physician's utilizing these order sets within the Department of Surgery meeting and Quality Management Committee in March 2012. Compliance of 95% is the target, if < 95%, the specific physicians and staff will be reeducated and monitor will continue until compliance target is met. The complete medical record documentation, which includes dating and timing and signature requirements are covered in new clinical employee orientation. The Health Information Management (HIM) department will complete random monitoring of physician signatures/dating and timing twice annually and will report to the Quality Management Committee in February/November. The HIM department will include missing signatures as part of the monthly deficiency monitoring and report through the Quality Management Committee (QMC) in the months of February and November. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 454 | Continued From page 7<br>antibiotics of Cefazolin 2 grams. Continued review of the pre-printed physician's order sheet revealed the orders had not been signed, dated, or timed by the physician. Further medical record review revealed the labwork was obtained and resulted in the chart and the antibiotic was administered on January 9, 2012, at 12:28 p.m.<br><br>Observation on January 9, 2012, at 3:10 p.m., revealed the patient was in bed in the recovery room, with a cervical collar present, and was answering the recovery room nurse's questions regarding post-operative pain.<br><br>Review of the facility's policy Physicians Orders, no policy number, revised July 25, 2011, revealed, "...Preprinted Orders: If a physician or group of physicians adopts 'routine orders', a copy of the orders should be timed, dated and signed by the physician and included in the patient's record..."<br><br>Interview with the Manager of ODS/PACU (One Day Surgery/Post Anesthesia Care Unit) on January 9, 2012, at 2:50 p.m., in the ODS pre-operative area, and at 3:30 p.m., in Phase I PACU, confirmed the orders had not been authenticated, timed, or dated by the physicians for patient #7 or patient #8. | A 454 | | |
| A 466 | 482.24(c)(2)(v) CONTENT OF RECORD - INFORMED CONSENT<br><br>[All records must document the following, as appropriate:]<br>Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. | A 466 | A 466: Consent<br>The medical record for patient #2 in Facility A was updated with late entry by physician as to the circumstance of emergency placement needed and the fact there had been no family | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 466 | Continued From page 8<br><br>This STANDARD is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to obtain informed consent for one patient (#2) of fifty patients reviewed.<br><br>The findings included:<br><br>Building A<br><br>Patient #2 was admitted to the facility on January 8, 2012, with diagnoses including Respiratory Failure, Congestive Heart Failure, and Osteomyelitis.<br><br>Medical record review of the physician's orders and an Operative Summary dated January 8, 2012, revealed a central line (catheter placed in a major vessel for administration of medications) was placed in the left subclavian vein (major vessel) on January 8, 2012.<br><br>Observation of the patient on January 9, 2012, at 11:00 a.m., revealed the patient in bed in the Intensive Care Unit (ICU), with a dressing present over the left subclavian area (chest area) dated January 8, 2012.<br><br>Review of the facility's policy Central Venous Catheters - Regional, no policy number, revised April 7, 2011, revealed, "...An informed consent must be obtained prior to insertion..."<br><br>Interview with Registered Nurse (RN) #1 and the Chief Nursing Officer on January 9, 2012, at 10:55 a.m., at the ICU nursing station, and with RN #1 at 11:00 a.m., in the patient's room, | A 466 | available. Physician education reminders were posted in the physician lounges on January 25, 2012 and was added as an agenda item for discussion at physician department meetings for January and February and will be added as a topic of discussion at the Quality Management Committee on February 9, 2012. A reminder letter will be sent to all physicians on staff from the Chief of Staff as to the requirement of documentation. Consent assuring risks, benefits and alternatives, and risk and benefits of alternatives are monitored randomly by the Quality Department and reported through the Quality Management Committee (QMC) in February and November each year. The QMC chairman will address each opportunity with physicians with a letter of education and a copy of the letter will go into the physician's quality file. The use of the consent form for verification of signature signifying discussion is the preferred document, but this information may be found in other parts of the physician documentation. New physicians receive a copy of the bylaws and rules and regulations that addresses the requirements of documentation for consent upon credentialing with the facility | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | A. BUILDING ____ B. WING ____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 |

| (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 466 | Continued From page 9 confirmed the patient had a central line placed; the patient was unable to consent to treatments; and no family had been present in the facility. Continued interview confirmed there was no documentation of attempts to contact the family and consent for the central line placement had not been obtained. | A 466 | | |
| A 503 | 482.25(b)(2)(ii) CONTROLLED DRUGS KEPT LOCKED<br><br>Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a secure area.<br><br>This STANDARD is not met as evidenced by: Based on observation, interview and review of facility policy, the facility failed to secure medications for one of two Operating Rooms (OR) observed.<br><br>The findings included:<br><br>Building A<br><br>Observation on January 9, 2012, at 2:05 p.m., in Operating Room #16, revealed an anesthesia box in the unlocked anesthesia cart containing the following medications: Albuterol inhaler, Phenylephrine, Levophed, Epinephrine, Naloxone, Hydralazine, Ephedrine, Famotidine, Diphenhydramine,Decadron, and Lasix, which may be used during surgery and anesthesia.<br><br>Review of facility policy Storage, with last revision dated June 24, 2009, revealed "...when not in use, nursing medication carts, anesthesia carts or other medication carts containing drugs or | A 503 | A 503: Controlled Drugs Kept Locked<br>There were no controlled substances within the Emergency Boxes found unattended. However, the Anesthesia Emergency boxes referenced in this finding in Facility A have been pulled from use. Contents of Anesthesia Emergency boxes have been added to the General Anesthesia bags and labeled appropriately. The General Anesthesia bags are patient specific kits used on a single patient only. These kits are assigned to a provider for a particular patient and are not left in the room following the procedure. The OR pharmacy staff is responsible for making these additions to the General Anesthesia bags and have pulled from use any remaining Anesthesia Emergency boxes.<br>These changes will be completed by January 26, 2012. Each new clinical licensed employee is oriented to the medication safety process during their time in clinical orientation while spending four hours in the facility pharmacy department. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 503 | Continued From page 10<br>biologicals must be locked or stored in a locked storage room...all drugs and biologicals must be secure..."<br><br>Interview with the OR manager revealed OR #16 had not been used since the previous weekend. Further interview with Operating Room (OR) Manager and the Director of Surgery, at 2:05 p.m., in OR room #16, confirmed the anesthesia box, with medications, was unsecured in the anesthesia cart and the cart was not locked. Further interview with the OR manager revealed OR #16 had not been used since the previous weekend. | A 503 | | |
| A 505 | 482.25(b)(3) UNUSABLE DRUGS NOT USED<br><br>Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, policy review, and interview, the facility failed to remove expired drugs from patient use.<br><br>The findings included:<br><br>Building B<br><br>Observations, on January 9, 2012, at 1:00 p.m., of Building B's Intensive Care Unit (ICU) Medication Room, revealed three 250 milliliters (ml) bags of Intravenous (IV) Dextrose 5% with Water (D5W), with expiration date of October 2011.<br><br>Review of facility policy titled, "Storage:General", last revised June 24, 2009, revealed, | A 505 | A 505: Unusable Drugs<br>The identified expired IV solutions were immediately removed from the shelf in Facility B. The Storeroom already has a practice in place to rotate supplies within the central supply carts in the departments.<br>A protocol was developed and department leaders were educated as to the departments' responsibility for the monthly review and accountability of supplies not kept in the central supply cart. A monthly signature log was created for tracking. The department leaders were educated to the new protocol on January 25, 2012. The assignment and accountability log will begin in February 2012. The accountability log will be monitored by department leaders for signatures for three consecutive months with an expectation of 100% compliance. If 100% is met within an individual department, the monitoring will be reduced to quarterly spot checks and follow up as necessary. Routine Environmental | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 505 | Continued From page 11<br>"Medications shall be stored under proper conditions of sanitation..."<br><br>Interview with the Clinical Leader, on January 9, 2012, at 1:00 p.m., in the medication room, confirmed the three IV bags were expired and available for patient use. | A 505 | Rounding will incorporate the monitoring of expired IV supplies and will begin during the week of January 23, 2012. The protocol is covered with new employees during their clinical orientation. | |
| A 724 | 482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE<br><br>Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure supplies were not avaliable beyond the expiration date in the Interventional Radiology department.<br><br>The findings included:<br><br>Building A<br><br>Observation on January 10, 2012, at 2:35 p.m., in the Interventional Radiology Department, revealed twenty tongue depressors with an expiration date of June, 2009 and four #11 Scalpel Blades with an expiration date of May, 2006, in an emesis basin in the cabinet.<br><br>Interview with Radiology Technician (RT) #1, on January 10, 2012, at 2:35 p.m., in the Interventional Radiology Department, confirmed twenty tongue depressors with an expiration date | A 724 | A 724: Facilities, Supplies, Equipment Maintenance.<br>The supplies from Facility A, Radiology Department were immediately disposed of. The Storeroom already has a practice in place to rotate supplies within the central supply carts in the departments. A protocol was developed and department leaders were educated as to the departments' responsibility for the monthly review and accountability of supplies not kept in the central supply cart. A monthly signature log was created for tracking. The department leaders were educated to the new protocol on January 25, 2012. The assignment and accountability log will begin in February 2012. The accountability log will be monitored by department leaders for signatures for three consecutive months with an expectation of 100% compliance. If 100% is met within an individual department, the monitoring will be reduced to quarterly spot checks and follow up as necessary. Routine Environmental Rounding will incorporate the monitoring of all supplies will begin during the week of January 23, 2012. The protocol is covered with new employees during their clinical orientation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 724 | Continued From page 12<br>of June, 2009 and four #11 Scalpel Blades with an expiration date of May, 2006 in the cabinet and were expired.<br><br>Interview with the Chief Nursing Officer (CNO), at 2:40 p.m., in the conference room, confirmed the tongue depressors and scalpel blades were expired and available for patient use. | A 724 | | |
| A 749 | 482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES<br><br>The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, policy review, and interview, the facility failed to ensure single use patient care items were not used for more than one patient in the Interventional Radiology Department of building A; failed to ensure unclean linens were properly handled in two medical surgical units (3 central and 1 central) in building A; failed to ensure the cleanliness of clothing items provided by the facility for newborn infants in the nursery of building A; failed to ensure the facility hand washing policy was followed while preparing medications by one nurse in the emergency room of building A; failed to ensure the facility hand washing policy was followed while administering medications by one nurse on the 200 hall medical surgical unit of building C; failed to ensure the continuation of Neutropenic Precautions (reverse isolation precautions are generally indicated to prevent exposure of a patient to infections for a patient | A 749 | A 749: Infection Control Officer Responsibilities<br>1. The Clinical Leader for Radiology met with specific associate on January 10, 2012 to discuss findings. This was deemed to be an isolated incident related to specific associate's practice and the disciplinary process was initiated.<br>A sterile syringe is to be used for each entry into the multi-dose vial of Heparin, and sterilely packaged syringes were placed by the Heparin vial with a reminder. As an additional precaution, all Interventional Radiology staff will be re-educated by the Clinical Leader for Radiology on the topics of preparing medication and the Safe Injection Practices policy. This will be completed by February 2, 2012 and compliance documented on sign-in sheet. The re-education will occur prior to the next shift worked for any staff unable to attend prior to February 2, 2012. Safe Injection Practices signage available on the CDC website will be added to procedure rooms for additional visual education on proper procedure. This will be completed by January 27, 2012. All new licensed employees receive education on Safe Injection Practices during their facility orientation. Process and practice compliance will be monitored by | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION. A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 749 | Continued From page 13<br>with a low blood neutrophil count which is the most common type of white blood cell that fights infections) on the 300 hall medical surgical unit of building C; and failed to ensure items recommended for single patient use were not cleaned and used on multiple patients in the outpatient surgery center's pre-operative area of building C.<br><br>The findings included:<br><br>Building A<br><br>Observation on January 10, 2012, at 2:35 p.m, in the Interventional Radiology Department, revealed one multi-dose vial of Heparin (10,000 unit per 1 milliters) with a connector device and one three ml syringe in the locked cabinet.<br><br>Interview with Radiology Technician (RT) #1, at 2:35 p.m., in the Interventional Radiology Department hallway, confirmed the 3milliliter (ml) syringe was reused multiple times to withdraw the Heparin from the multi-dose vial and then add 1ml into 1000ml's of Normal Saline for a Heparin drip.<br><br>Review of facility policy Safe Injection Practices, with original date June 1, 2011, revealed "...needles, cannulae, and syringes are sterile, single-use items...needles, cannulae and syringes will not be used for another patient nor to access a medication or solution that might be used for subsequent patient...if multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial must be sterile..." | A 749 | departmental observations on a weekly basis until 100% compliance is assured for three consecutive months.<br>2. Patient #1 was in Contact Isolation. Gloves and gown are to be worn when in contact with the patient or the patient's immediate environment. Specific education on Contact Isolation, with emphasis on personal protective equipment (PPE) and linen handling will be provided to all certified nursing assistants (CNAs) on 3 Central and 1 Central by February 10, 2012. The education will occur prior to the next shift worked for any staff unable to attend prior to February 10, 2012. As an additional corrective measure, Contact Isolation content, with emphasis on personal protective equipment and linen handling, will be added as an annual competency for all nursing staff, to include CNAs beginning with January 2012 competencies. All new employees receive education on Contact Isolation during their facility orientation. Observations for Contact Isolation compliance will be conducted monthly as part of regularly scheduled Environmental Rounding. These results will be shared with departmental leadership as collected and reported to the Quality Safety Committee on a quarterly basis.<br>3. Hand-knitted or hand-crocheted items will not be given to patient (mother) until time of discharge. Each item will have a label affixed with the following wording, "It is recommended that you launder this item, as you would | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | 2012 JUN 13 AM 10:18 | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 749 | Continued From page 14<br>Interview with the Chief Nursing Officer (CNO) on January 10, 2012, at 2:40p.m., in the conference room, confirmed the reuse of a 3ml syringe did not follow facility policy.<br><br>Review of facility policy titled "Linen Utilization - Regional" dated July 30, 2010, revealed, "...Torn, stained, or otherwise unusable linen should be placed in a designated receptacle...Standard Precautions will be used when handling all linen..."<br><br>Medical record review revealed Patient #1 was admitted to the facility on January 1, 2012, with diagnoses including Methicillin Resistant Staph Aureus (MRSA, an infectious organism resistant to treatment by most antibiotics).<br><br>Medical record review of a physician's progress note dated January 5, 2012, revealed, "...MRSA facial abcess."<br><br>Observation with the Vice President of Quality on medical surgical hall 3 central, on January 9, 2012, at 9:56 a.m., revealed the patient in bed, a dressing on the left wrist/hand, and unclean linen on the floor beside a red storage receptacle.<br><br>Interview with the Vice President of Quality on January 9, 2012, at 9:56 a.m., confirmed the facility failed to store the unclean linen in a manner to prevent the spread of infection.<br><br>Medical record review revealed Patient #15 was admitted to the facility on January 5, 2012, with diagnoses including Altered Mental Status. Observation on January 9, 2012, at 2:32 p.m., revealed the patient in a bed and unclean linen in | A 749 | any new newborn clothing, prior to using on infant." Women's Pavilion/OB nursing staff will verbally review these instructions with patient at time of discharge. Women's Pavilion/OB nursing staff will be instructed in new process and not to place hand-knitted or hand-crocheted items provided by the Auxiliary on infants while in the hospital. This instruction will be completed by February 10, 2012. The instruction will occur prior to next shift worked for any staff unable to attend prior to February 10, 2012. Observation of process compliance will be added to department Environmental Rounding on a monthly basis until 100% process compliance is assured for three consecutive months. These results will be shared with departmental leadership as collected and reported to the Quality Safety Committee.<br>4. & 5. Individual counseling was provided to nurse preparing (Facility A) and to nurse administering (Facility C) medication without properly conducting hand hygiene. This was done on January 11 and January 9, 2012, respectively. Facility A, B, & C clinical leaders/designee will provide patient care staff education reminders as to the individual responsibility for hand hygiene by February 17, 2012. The education will occur prior to the next shift worked for any staff unable to attend prior to February 17, 2012. All new employees receive education on hand hygiene during their facility orientation. Random monthly observations are completed for hand hygiene on each | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 440120 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/11/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | |

| (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 749 | Continued From page 15<br>a chair in the room. Continued observation revealed a Certified Nursing Assistant (CNA #1) picked up the linen with ungloved hands and the linen made contact with the CNA's uniform.<br><br>Interview with CNA #1 on medical surgical hall 1 central, on January 9, 2012, at approximately 2:34 p.m., outside the patient's room, revealed the CNA is to wear gloves when handling unclean linen.<br><br>Interview with Registered Nurse (RN #6) on January 9, 2012, at 2:35 p.m., outside the patient's room, confirmed the facility failed to handle the linen in a manner to prevent the spread of infection.<br><br>Observation of the newborn nursery of building A with the Manager of the Women's Center and the Clinical Leader of the Women's Center of building A, on January 10, 2012, at 2:00 p.m., revealed several drawers contained homemade hand crocheted infant hats and blankets.<br><br>Interview with the Manager of the Women's Center and the Clinical Leader of the Women's Center of building A, on January 10, 2012, at 2:00 p.m., confirmed the cleanliness of the homemade items provided by the facility to the newborns could not be ascertained.<br><br>Observation of Registered Nurse (RN) # 4 in the Emergency Department (ED) of building A with the Manager of the ED on January 11, 2012, at 9:30 a.m., revealed RN #4 standing at the ED nursing station with the hands tucked down into the waist band of the scrub pants RN #4 was wearing. Continued observation revealed RN #4, | A 749 | clinical area and reported on Quality Nursing Scorecards. This data is reported to the Quality Safety Committee on a quarterly basis. Staff has been encouraged to address any noted non-compliance of hand hygiene directly with their peers. Hand Hygiene is part of annual Infection Control education for all employees.<br>6. A new policy for Neutropenic Precautions / Protective Care was developed by the Infection Control Practitioners. A copy of this policy will be added to the Infection Control Policy section of the policy database by January 27, 2012. This policy will be presented at the Quality Safety Committee with instructions for education for clinical leaders on January 25, 2012. Education on the new policy will be provided to nursing staff at Hospital A, B, & C by clinical leaders/ designee. This will be completed by February 17, 2012. The education will occur prior to next shift worked for any staff unable to attend prior to February 17, 2012. All new employees receive education on types of isolation that might be encountered when dealing with hospitalized patients during their facility orientation. Observation of process compliance on any patients placed in Neutropenic Precautions will be completed by the clinical leader of the nursing unit and will be conducted until 100% compliance is assured for three consecutive months.<br>7. Emesis basins were immediately removed from nursing work areas on | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 749 | Continued From page 16<br>without washing or sanitizing the hands, entered the medication area and entered information on the keyboard on the medication storage cabinet. RN #4 opened the medication storage cabinet; opened a medication drawer; extracted two containers of medication; obtained a disposable drinking cup; filled the cup with ice and water; and proceeded down the hall with the medication.<br><br>Interview in the medication area of the ED of building A with RN #4 and the ED Manager on January 11, 2012, at 9:30 a.m., confirmed the RN did not wash or sanitize the hands prior to obtaining and preparing patient fluids and medications.<br><br>Review of the facility policy, Hand Hygiene, no number, dated revised September 21, 2010, revealed "...to reduce, as low as possible, the number of viable microorganisms on the hands in order to prevent transmission of pathogens from one patient to another...use anti-microbial soap...or alcohol based hand rub...before contact with intact patient skin..."<br><br>Building C<br><br>Observation on the 200 hall of the medical surgical unit of building C with the Chief Nursing Officer (CNO) on January 9, 2012, at 2:20 p.m., revealed RN #3 exited the medication room and without washing or sanitizing the hands. The RN entered the room of a patient; handled the wrist area of the patient's left arm then walked to the right side of the bed and handled the tubing for the patient's IV (intravenous) line. The RN reached into the pocket of the scrubs withdrawing a syringe; injected the medication in the syringe | A 749 | January 9, 2012. Emesis basins will be used for the purpose in which they were intended to be used and as a single patient use item. Observations for single patient use items used according to manufacturer's labeling will be added to ongoing Environmental Rounding. Results from Rounding are reported to departmental leadership at the time of Rounding and to the Quality Safety Committee on a quarterly basis. The department orientation will include the proper use of single use items. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 440120 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/11/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | |

| (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 749 | Continued From page 17 into the port on the IV tubing then reached into the pocket of the scrubs again, and injected another syringe of medication into the port of the patient's IV line.<br><br>Interview in the medication room of the 200 hall medical surgical unit of building C on January 9, 2012, at 2:25 p.m., with RN #3 and the Chief Nursing Officer confirmed the hands had not been washed or sanitized prior to entering the patient's room and injecting medications into the patient's IV port. Continued interview confirmed the facility policy called for the hands to be washed or sanitized prior to entering a patient's room and administering IV medications.<br><br>Patient #34 was admitted to the facility on January 5, 2012 with diagnoses to include Neutropenia. Review of the Physician's Admit Orders, dated January 5, 2012, at 5:30 p.m., revealed "...Neutropenic Precautions..."<br><br>Observation of the doorway to patient #34's room with the CNO on January 9, 2012, at 3:30 p.m., revealed no signage to indicate patient #34 was on Neutropenic Precautions and no isolation equipment outside the patient's door.<br><br>Interview at the nursing station of the 300 hall of the medical surgical unit of building C on January 9, 2012, at 3:30 p.m., with RN #5 revealed RN #5 had received information in the morning report the Neutropenic Precautions had been discontinued.<br><br>Medical record review of patient #34 revealed the White Blood Cell (WBC) count on January 5 - 1.8 MM3; January 6 -1.9 MM3; January 7 - 1.9 MM3; | A 749 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 749 | Continued From page 18<br>January 8 - 2.3 MM3; and January 9 - 2.0 MM3 (normal ranges: WBC - 3.7 - 10.7 MM3) - (MM3 is, in brief, the measurement by micrometers according to the National Institution of Health).<br><br>Continued medical record review revealed no order to discontinue the Neutropenic Precautions.<br><br>Interview at the nursing station of the 300 hall of the medical surgical unit of building C on January 9, 2012, at 3:30 p.m., with RN #5 revealed, the physician wanted to continue the Neutropenic Precautions.<br><br>Interview at the nursing station of the 300 hall of the medical surgical unit of building C on January 9, 2012, at 3:30 p.m., with the CNO confirmed the Neutropenic Precautions had been discontinued without a written physician's order.<br><br>Observation in the outpatient surgery center of building C with the Chief Nursing Officer (CNO) on January 9, 2012, at 1:10 p.m., revealed the pre-operative area contained 10 patient beds. Continued observation revealed each bed area had a rolling nurse's work area with a work space of three feet by one and one half feet and an attachment hanging from the side with storage spaces. Continued observation revealed each nurse's work area contained an emesis basin (disposable pink plastic kidney shaped container manufactured for containment of vomitus) with "DO NOT DISCARD" written in permanent marker on each emesis basin.<br><br>Interview in the pre-operative area with the CNO and Charge Nurse of the pre-operative area on January 9, 2012, at 1:10 p.m., confirmed the | A 749 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 749 | Continued From page 19<br>emesis basins were cleaned after each patient and utilized to hold such things as the IV (intravenous) catheters and discarded IV items utilized after starting an IV. Continued interview revealed the manufacturer had not provided instructions indicating the emesis basins could be cleaned; could not be used on more than one patient; and were single patient use items. | A 749 | | |
| A 951 | 482.51(b) OPERATING ROOM POLICIES<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and review of manufacturer's recommendations, the facility failed to follow manufacturer's recommendations for processing (high level disinfection and/or sterilization) and storage of endoscopes for one of two operating rooms observed in the surgery department.<br><br>The findings included:<br><br>Building A<br><br>Observation of Operating Room (OR) #13 on January 9, 2012, at 1:10 p.m., revealed a cabinet contained five closed rigid containers with endoscopes, cameras, light cords, and instrumentation, with visible moisture on the inside of the containers. Observation of the containers revealed cardboard cards set on top of the containers with dates and times of January 9, 2012, 9:00 a.m., and 9:10 a.m., (four hours | A 951 | A 951: Operating Room Policies<br>Facility A Cystoscopes were found in cabinet after Steris 1 processing in the Steris pan, with notes designating the process time and date. Scopes and instrumentation were found to be stored wet. On the same day as the survey, the OR and SPD consulted together and decided to have SPD process all cystoscopes and cysto instrumentation. Even though cystoscopes are usually considered a clean procedure, this equipment is maintained sterile. All cystoscopes, etc., are now packaged separately and sterilized appropriately according to manufacturer guidelines. OR associates have been instructed to do a preliminary cleaning of scopes, then send to SPD for further processing. All cystoscopes and cysto-instruments are maintained in terminally sterilized containers and stored with sterile instrumentation in the OR. The SPD and OR staff department orientation has been revised to reflect the change in practice. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 951 | Continued From page 20<br>earlier) on two trays.<br><br>Interview with Scrub Tech #1 on January 9, 2012, at 1:10 p.m., in OR #13, revealed the scopes were processed in the rigid trays using an automatic processor in the mornings and then stored in the rigid containers, stacked in the cabinet, for use during "clean" procedures (not sterile surgeries) scheduled during the day.<br><br>Interviews with the Director and the Manager of the OR on January 9, 2012, at 1:20 p.m., in OR #13, and at 1:50 p.m., in the substerile room, confirmed staff process the endoscopes in the mornings, and store the scopes in the rigid containers, without drying the scopes or instrumentation, for use throughout the day and within 24 hours.<br><br>Review of the automatic processor manufacturer's recommendations revealed, "...Devices are sterilized, rinsed, and ready for immediate use upon the successful completion of the sterile processing cycle...The processing chamber and the processing containers/trays are also sterilized during the cycle to provide a sterile environment for the devices during the brief time between the completion of sterilization and the removal of the devices for use. The use of devices sterile processed in a SYSTEM 1 Processor should be in a manner consistent with 'Just In Time' processing and delivery. Devices, properly processed in SYSTEM 1 are sterile and ready for immediate use in patient procedures. Neither the Processor nor the processing containers/trays are intended for storage of devices. Storage of medical devices post-processing should be conducted per the | A 951 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 951 | Continued From page 21<br>user facility's procedures. (Organizations such as AORN [Association of periOperative Nurses] and SGNA [Society of Gastroenterology Nurses and Associates] offer post-processing guidelines.) Devices stored overnight, for extended periods of time, or otherwise not properly removed and transported to the sterile field for immediate use (JIT) must be re-sterilized prior to use in patient procedures..."<br><br>Interviews with the Director and the Manager of the OR on January 9, 2012, at 1:50 p.m., in the substerile room and outside OR #13, and with the Director of Sterile Processing on January 9, 2012, at 2:35 p.m., in the Sterile Processing Department, confirmed the facility had not reviewed manufacturer's recommendations for the automatic processor or the endoscopes, before implementing the process of storing the endoscopes in the rigid containers during the day. Further interviews confirmed the endoscopes were only used in "clean" procedures requiring high level disinfection of the scopes and instrumentation, and not procedures where sterile cavities were entered and sterile instrumentation was required. Further interviews confirmed manufacturer's recommendations and society standards were not followed in processing and storing the endoscopes. | A 951 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | A. BUILDING 01 - MAIN<br>B. WING | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 |
|---|---|---|---|---|
| K 020 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure corridor vertical shafts were maintained.<br>The findings include:<br>Observation and interview with the Maintenance Director, on January 9, 2012 at 2:20 p.m. confirmed the Electrical room on LL1 had a dumbwaiter shaft that was open on one side through to the ground floor above. | K 020 | [redacted]<br>DUMBWAITER SHAFT PERMANENTLY SEALED AND RATED 1-20-12<br>[redacted] | |
| K 025 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br><br>This STANDARD is not met as evidenced by: | K 025 | | |

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: 01/12/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | A. BUILDING 01 - MAIN<br>B. WING | 01/11/2012 |

NAME OF PROVIDER OR SUPPLIER: MERCY MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 900 EAST OAK HILL AVENUE, KNOXVILLE, TN 37917

| (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 |
|---|---|---|---|---|
| K 025 | Continued From page 1<br>Based on observation and interview, the facility failed to assure smoke barrier fire ratings are maintained.<br>The findings include:<br>Observation and interview with the Maintenance Director, on January 9, 2012 between 9:30 am and 2:00 p.m. confirmed unsealed penetrations in the LL2 A-wing corridor above the ceiling outside the electrical room, The " Disaster Supply Room " corridor wall, and The connector hallway behind ICU electrical room corridor wall | K 025 | Repaired & sealed All penetrations on LL2 A-Wing @ Disaster Supply Room Day of survey 1-9-12 BL | |
| K 045 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 | K 045 | | |
| | This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure the exit discharges from the building were not illuminated such that the failure of any single lighting fixture (bulb) would not leave the area in darkness (NFPA 101, 7.8.1.4).<br>The findings include:<br>Observation and interview with the Maintenance Director, on January 9, 2012 at 3:20 p.m. confirmed the outside lights at the exits from the women ' s pavilion 3rd floor by room 024 was not provided with multiple fixtures. | | New multi-lamp fixture installed 1-12-12 BL | |
| K 072 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Means of egress are continuously maintained free of all obstructions or impediments to full instant | K 072 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | A. BUILDING 01 - MAIN<br>B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 |
|---|---|---|---|---|
| K 072 | Continued From page 2<br>use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure the corridors in the means of egress were maintained clear of all obstructions (NFPA 101- 7.1.10.2.1.)<br>The findings include:<br>Observation and interview with the Maintenance Director and Radiology Manager, on January 10, 2012 confirmed the Emergency Department back corridor and Radiology department corridor had furniture, carts, linen bins, and portable blood pressure equipment stored (not in use). | K 072 | Furniture removed day of survey 1-10-12 [illegible] | |
| K 075 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 | K 075 | [redacted] | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | A. BUILDING 01 - MAIN<br>B. WING | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 |
|---|---|---|---|---|
| K 075 | Continued From page 3<br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to assure combustible decorations were fire retardant (NFPA 110, 19.7.5.4).<br>The findings include:<br>Observation and interview with the Maintenance Director, on January 10, 2012 at 2:00 p.m. confirmed the facility failed to treat the quilt hanging in the corridor across room C391. | K 075 | Quilt was removed day of survey 1-10-12 BH | |
| K 147 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure electrical junction boxes had their covers installed. (NFPA 70, 314.28 (C).<br>The findings include:<br>Observation and interview with the Maintenance Director, on January 9, 2012 at 2:00 p.m. confirmed junction boxes without covers in ceiling by Tower 4 Nurses Station vestibule above light, Dialysis equipment room, 2W across from storage room with exposed wires, LL2 between stairwell and elevator, Women ' s Pavillion 1st floor outside elevator equipment room, and ICU in the corridor by 15-20. | K 147 | Junction Box Covers were installed ~~[illegible]~~ day of survey 1-9-12 BH | |

PRINTED: 01/12/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2012 JUN 13 AM 10: 18

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | A. BUILDING 03 - EMORY ROAD NORTH HC<br>B. WING | 01/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>During the Life Safety portion of the survey conducted on January 11, 2012, no deficiencies were cited under 42CFR Part 482 Requirements for Hospitals. | K 000 | | |

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: 01/12/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 440120 | A. BUILDING 04 - TURKEY CREEK MEDICAI<br>B. WING _____ | 01/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERCY MEDICAL CENTER | 900 EAST OAK HILL AVENUE<br>KNOXVILLE, TN 37917 |

| (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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>During an annual recertification survey on January 11, 2012, the Mercy West Hospital (Turkey Creek Medical Center) was found to be in compliance with the LSC 2000 Health Existing Regulations. | K 000 | | |

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.

FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53145 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/11/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | | |

| (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<br><br>This Rule is not met as evidenced by:<br>A full Licensure survey was completed on January 9-11, 2012, at Mercy Medical Center located at 900 East Oak Hill Avenue, Knoxville, TN, and two satellite hospitals, Mercy Medical Center North, located at 7565 Dannaher Way, Powell, TN, and Mercy Medical Center West, located at 10820 Parkside Dr, Knoxville, TN.<br><br>For identification purposes, Building A will refer to Mercy Medical Center located at 900 East Oak Hill Avenue, Knoxville, TN; Building B will refer to Mercy Medical Center North, located at 7565 Dannaher Way, Powell, TN; and Building C will refer to Mercy West, located at 10820 Parkside Dr, Knoxville, TN. | H 001 | | |
| H 605 | 1200-8-1-.06 (1)(b)4. Basic Hospital Functions<br><br>(1) Performance Improvement.<br><br>(b) The performance improvement program must be ongoing and have a written plan of implementation which assures that:<br><br>4. The competency of all staff is evaluated at least annually; and<br><br>This Rule is not met as evidenced by:<br>Based on review of employee records the facility failed to ensure employees received annual competency testing for one (#7) of fifteen | H 605 | | |

FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53145 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/11/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | | |

| (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 605 | Continued From page 1<br>employees reviewed.<br><br>The findings included:<br><br>Building A<br><br>Review of the record of employee #7 revealed no documentation of completion of annual unit-based competency testing for 2011.<br><br>Review of the policy entitled "Educational Requirements - Regional" revealed "...All associates who utilize patient equipment for patient diagnosis, treatment, monitoring, and care must be oriented to the equipment upon employment and receive annual continuing education as determined by the Leader...".<br><br>During interview on January 10, 2012, at 10:45 a.m., in the administrative conference room, the Clinical Educator confirmed employee #7 had not completed annual competency testing for 2011 and it was a requirement for all employees. | H 605 | | |

Division of Health Care Facilities

FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53145 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 01/11/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | | |

| (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 |
|---|---|---|---|---|
| P 002 | 1200-8-30 No Deficiencies<br><br>During the licensure survey conducted at Mercy Medical Center (referred to as building A) conducted on January 9 - 11, 2012, no deficient practices were cited under Chapter 1200-8-30, Standards for Pediatric Emergency Care Facilities.<br><br>During the licensure survey conducted at Mercy Medical Center North (referred to as building B) conducted on January 9 - 11, 2012, no deficient practices were cited under Chapter 1200-8-30, Standards for Pediatric Emergency Care Facilities.<br><br>During the licensure survey conducted at Mercy Medical Center West (referred to as building C) conducted on January 9 - 11, 2012, no deficient practices were cited under Chapter 1200-8-30, Standards for Pediatric Emergency Care Facilities. | P 002 | | |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

PRINTED: 01/12/2012
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53145 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING | (X3) DATE SURVEY COMPLETED 01/11/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | | |

| (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 002 | 1200-8-1 No Deficiencies<br><br>During the Life Safety portion of the survey conducted on January 9-10, 2012, no licensure deficiencies were cited under chapter 1200-8-1, Standards for Hospitals. | H 002 | | |

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 01/12/2012
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53145 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - EMORY ROAD NORTH HC B. WING | (X3) DATE SURVEY COMPLETED 01/11/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | | |

| (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 002 | 1200-8-1 No Deficiencies<br><br>During the Life Safety portion of the survey conducted on January 11, 2012, no licensure deficiencies were cited under chapter 1200-8-1, Standards for Hospitals. | H 002 | | |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATE FORM 6899 53FU21 If continuation sheet 1 of 1

PRINTED: 01/12/2012
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53145 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - TURKEY CREEK MEDICAI B. WING | (X3) DATE SURVEY COMPLETED 01/12/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917 | | |

2012 JUN 13 AM 10: 18

| (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 002 | 1200-8-1 No Deficiencies<br><br>During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-1, Standards for Hospitals. | H 002 | | |

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 53FU21 If continuation sheet 1 of 1

SUPPLEMENTAL

# Mercy Health System, Inc.

Knoxville, TN

has been Accredited by

# The Joint Commission

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

## Hospital Accreditation Program

July 23, 2011

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

**Organization ID #: 7852**
Print/Reprint Date: 09/21/11

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

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

**This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.**

The Joint Commission

SUPPLEMENTAL

July 25, 2011

2012 JUN 22 AM 10: 19

Jeffrey A. Ashin
CEO
Mercy Health System, Inc.
900 East Oak Hill Avenue
Knoxville, TN 37917

Joint Commission ID #: 7852
Program: Hospital Accreditation
Accreditation Activity: Unannounced Full Event
Accreditation Activity Completed: 07/22/2011

Dear Mr. Ashin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

SUPPLEMENTAL

December 30, 2011

Jeffrey A. Ashin
CEO Physicians Regional Medical Center
Tennova Healthcare
900 East Oak Hill Avenue
Knoxville, TN 37917

Joint Commission ID #: 7852
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 12/30/2011

Dear Mr. Ashin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning July 23, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

# SUPPLEMENTAL

SUPPLEMENTAL

2012 JUN 22 AM 10: 18

June 21, 2012

Jeffrey D. Potter
Senior Vice President
Tennova Healthcare.
200 E. Blount Street, Suite 600
Knoxville, TN 37920

RE: Certificate of Need Application CN1206-027
Metro Knoxville HMA, LLC d/b/a Tennova Healthcare - North Knoxville Medical Center

Dear Mr. Potter:

This will acknowledge our June 13, 2012 receipt of your application for a Certificate of Need for the initiation of mobile Positron Emission Tomography/ Computerized Tomography (PET/CT) and acquisition of a mobile PET/CT scanner through lease to be located and utilized in at North Knoxville Medical Center, 7551 Dannaher Way, Powell (Knox County), TN, 37849.

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 PM, Monday, June 25, 2011.** 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. **Filing the Application**

   **The format of the application is difficult to read due to the applicant using the same font for both the application's questions and the applicant's responses. To make the application easier to read for Agency members, please resubmit the application (only), using bold or *italics* for the application's questions and regular font for the applicant's responses in order to *differentiate* the responses from the application's questions.**

   The Certificate of Need application has been reformatted and is included in this package, in triplicate.

3. **Section B, Project Description, Item II. B. (Square Footage & Cost/SF Chart)**

   **Is the square footage listed on the chart the square footage of the mobile PET/CT trailer or the square footage of the canopies walkway? If not both, please identify**

   **Does the area within the ACC immediate to the walkway and trailer include a reception, registration and waiting area? If not, how will this be handled?**

   The square footage listed on the chart is the square footage of the pad that will be constructed for the mobile unit. The area within the ACC does include a reception, registration and waiting area. Patients who come to NKMC for a PET scan will be registered and utilize the waiting room located in the Cancer Center, adjacent to the mobile scanner.

4. **Section B, Project Description, Item II. C. (Applicant's Need) & Section c. Item 4 (Service Area Population Demographics)**

   **Your responses are noted. The applicant makes reference to population projections from 2011 and 2015. Please update your population projections to incorporate 2012 and 2016. Please update any projections within your application which utilizes 2011 and 2015 in your planning analyses which need to incorporate 2012 and 2016 (See question 9 below).**

   Population projections have been updated to incorporate data from 2012 and projections for 2016. The updated population growth chart is attached as Attachment 4. In addition, the enclosed updated CON application has been updated to reflect the 2012 to 2016 projections.

   In the original CON application, it was stated that population growth in the 11 county project service area was projected to grow by 3%. The updated 2012 to 2016 projections are very close, with a projected growth of 2.9%. Population growth in the 65+ age demographic is also projected to continue to be strong, at 12.4%.

5. **Section B, Project Description, Item II. E.2.a and b. (Mobile Major Medical Equipment Sites and proposed schedule of operations)**

   **The applicant is proposing to utilize a mobile PET/CT scanner one day per week. Please provide a schedule of the day of the week the applicant is planning to have the mobile PET/CT at its site as well as the days of the week at which the PET/CT unit is scheduled at other locations.**

   The mobile PET/CT at NKMC will be scheduled for Fridays. The mobile unit that will be utilized at NKMC is open on Mondays and currently in use on Tuesdays, Wednesdays, and Thursdays. The chart below showing locations and hours of operation has been completed as an attachment, Attachment 5.

| Site (including address) | Monday (Hours of Operation) | Tuesday (Hours of Operation) | Wednesday (Hours of Operation) | Thursday (Hours of Operation) | Friday (Hours of Operation) |
|---|---|---|---|---|---|
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

6. **Section C Need Item 1- Principles of the State Health Plan**

**Please discuss how the project addresses the Five Principles for Achieving Better of the 2010 State Health Plan.**

The Five Principles to Achieving Better Health in the 2010 State Health Plan are:

- Healthy Lives
- Access to Care
- Economic Efficiencies
- Quality of Care
- Healthcare Workforce

This application contributes to several of the Five Principles, most notably:

- *Access to Care.* Quoting from the State Health Plan regarding Access to Care, "According to the Institute of Medicine, having access to health care means "the timely use of personal health services to achieve the best health outcomes."" (2010 State Health Plan, p. 20-21) By placing a mobile PET/CT at NKMC, in close proximity to the Cancer Center, Tennova is supporting ease of access to patients for whom navigating another hospital campus, in a downtown or urban area, is a significant hardship. Particularly for patients in the rural portions of the service area north of the hospital off I-75, NKMC is located closer to their homes than any other hospital offering PET/CT services.

  The plan directly identifies strategies that are in keeping with this project to help promote access to care, including ensuring that geography is not a barrier to critical health services, and utilizing mobile units of health care when appropriate.

- *Economic Efficiencies.* By utilizing mobile services one day per week, Tennova is adding a needed service in the most cost-efficient way possible. By implementing a service that will be profitable by the end of the first year, Tennova is supporting the stated health plan goal to "Improve the efficient use of health care resources without sacrificing quality." (2010 State Health Plan, p. 25)

- *Quality of Care.* The 2010 State Health Plan describes high-quality healthcare as care that is:

  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - Equitable (2010 State Health Plan, p. 29)

This project seeks to provide needed PET/CT services utilizing a machine that has been certified as clinically safe and effective for its intended uses.

The project is patient-centered by ensuring convenient access within the Cancer Center where the majority of the patients who will receive PET/CT scans are already being treated. It is efficient in terms of avoiding waste, by only providing as much service as is needed. Tennova is committed to providing care in an equitable way, providing the same level of care regardless of race, gender, ethnicity, or socioeconomic status. In fact, at North Knoxville Medical Center there is a strong commitment to providing services that are accessible to those patients living in rural, underserved areas.

7. **Section C Need Item 1 (Specific Criteria for PET/CT Services Item 1)**

**Reference is made to National and State PET utilization rates per 1000 population. Please identify the source for this information along with the period of time for which these rates were calculated.**

The Utilization rate statistics provided per 1,000 population were taken from data compiled by IMV. IMV (IMVinfo.com) is a recognized leader in market research and online publishing for the medical imaging and clinical diagnostic instruments markets. With offices in Washington, D.C., Chicago, Tucson and San Francisco, IMV offers a broad range of market research products, including MRI, PET/CT, Nuclear Medicine and CT. IMV's research reports are produced utilizing service-specific databases and comprehensive market reports.

IMV calculated the utilization statistics using 2011 data.

8. **Section C Need Item 1 (Specific Criteria for PET/CT Services Item 8.b.)**

**On page 21 of the application the applicant makes reference to cancer rates from 2002-2006 and 2003-2007. If available, please update your cancer rates to incorporate more recent time periods. Please update any projections within your application which utilizes cancer rates in your planning analyses which need to incorporate 2012 and 2016.**

The cancer incidence rates provided through 2007 were the most recent cancer incidence rates available from credible sources.

9. **Section C, Need, Item 4.b. (Special Needs of the Service area Population)**

**A) Your response to this item is noted. Please complete the following chart.**

The following chart is completed and is provided as Attachment 9.

| Demographic Variable/Geographic Area | Knox County | Anderson | List a column for each of the other 9 Co's | State of TN Total |
|---|---|---|---|---|
| Total Population-2012 | | | | |
| Total Population-2016 | | | | |
| Total Population-% change | | | | |
| Age 65+ Population-2012 | | | | |

| | | | | |
|---|---|---|---|---|
| Age 65+ Population-2016 | | | | |
| Age 65+ Population-% change | | | | |
| Age 65+ Population as % of Total | | | | |
| Median Household Income | | | | |
| TennCare Enrollees | | | | |
| TennCare Enrollees as % of Total Pop. (2010) | | | | |
| Persons Below Poverty Level | | | | |
| Persons Below Poverty Level as % of Total Pop. (2008) | | | | |

**10. Section C, Need, Item 5. (PET Utilization)**

**The applicant notes that utilization has fallen in the service area due to the tightening of criteria for approval of PET/CT scans by managed care payors as well as Medicare. In fact, based on the statistics provided by the applicant, the utilization of PET scans has fallen 23.2% from 2009 to 2011. Given the tightening of criteria for approval of PET/CT scans, please discuss the future utilization trends for PET/CT for cancer, cardiac and neurology, other applications.**

The most recently approved application for PET/CT scans involves Amyvid, a radiopharmaceutical recently approved by the FDA for the purposes of utilizing PET/CT for Alzheimer's detection. Amyvid is administered intravenously prior to a PET/CT brain scan. It tags beta-amyloid neuritic plaque density in adult patients with cognitive impairment who are being evaluated for Alzheimer's Disease and other causes of cognitive decline. Amyvid has been shown to detect early-stage Alzheimer's as well as aid in the detection of other types of memory impairments, allowing treatment to begin earlier than was previously possible.

Another recent application is the use of F-18 radiopharmaceuticals for bone scans. This application is predominantly used as an alternative to traditional bone scans to identify bone metastasis, evaluate the extent of the disease, evaluate complications of the malignancy, and monitor response to therapy.

Clinical trials for other PET/CT uses and applications are underway, but are still in the early stages.

**11. Section C, Need, Item 6 (Applicant's Projected Utilization)**

**Your response is noted. The applicant has projected the number of PET/CTs for the project site. Please provide the projected utilization for both North Knoxville Medical Center site and Physicians Regional Medical Center's PET/CT.**

| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|
| Physicians Regional | 1,703 | 1,469 | 1,180 | 1,200 | 1,050 | 1,100 |
| North Knoxville | 0 | 0 | 0 | 0 | 250 | 320 |
| Tennova Total | 1,703 | 1,469 | 1,180 | 1,200 | 1,300 | 1,420 |

**12. Section C, Economic Feasibility, Item 2 (Funding Letter)**

**The funding letter is noted. Please resubmit the funding letter with the author identifying the cost of the project and the specific sources of funding for its implementation.**

An updated funding letter from Tennova Healthcare's CFO is attached as Attachment 12.

**13. Section C, Economic Feasibility, Item 4. (Historic Data Chart)**

**Please identify for what entity the Historic Data Chart provided: North Knoxville Medical Center site only?**

Yes, the Historic Data Chart provided in the original application is for North Knoxville Medical Center only.

**14. Section C. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)**

**The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised information Historical and Projected Data Charts provided at the end of this requests for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.**

The more detailed Historical and Projected Data Charts are attached as Attachment 14.

Please note that there was a change in the 2011 Historical Data Chart, to correct an inadvertent error in the Chart during the initial submission.

**16. Section C, Need, Item 9**

**Your response is noted. Please provide the North Knoxville's PET/CT estimated Gross Revenues for both Medicare and TennCare/Medicaid for the first year of operation of the project and their respective percentages of the department's Total Gross Revenues.**

Estimated Gross Revenues – Medicare (2013) - $724,372

Estimated Gross Revenues – TennCare (2013) - $142,500

**17. Section C, Contribution to Orderly Development, Item 7**

**A) Please provide a copy of the applicant's JCAHO accreditation certificate.**
**B) Please provide a copy of the most recent JCAHO survey report and the facility's responses.**

A copy of Metro Knoxville HMA, LLC's JCAHO accreditation certificate is attached, as well as the most recent JCAHO survey report, as Attachment 17.

**18. Update on Tennova Healthcare's approved, but yet to be fully implemented Certificate of Need projects.**

**Please provide a brief update (one or two sentences) on the status, progress and anticipated completion dates for all Tennova Healthcare's outstanding Certificates of Need, including, but not exclusively, CN1106-019A.**

The only outstanding, unimplemented Certificate of Need held by Tennova Healthcare is CN1106-019-A, a project to add a second linear accelerator to North Knoxville Medical Center's Cancer Center. There were several actions that were discussed in the Certificate of Need application and the subsequent hearing, including the relocation of the linear accelerator at the Tennova Riverside campus (formerly Baptist Hospital of East Tennessee) to Physicians Regional Medical Center (formerly St. Mary's Medical Center). In order to successfully relocate the linear accelerator as well as expand its capabilities, moderate construction and electrical work was required to the vault. These unexpected upgrades took more time than anticipated., thereby delaying the start of construction at NKMC.

Another action that was discussed during the CON hearing for CN1106-019A was restarting the radiation therapy services at Turkey Creek Medical Center (formerly Baptist Hospital West). Radiation therapy has been restarted on the Turkey Creek campus and patients are being treated both there and at North Knoxville Medical Center. In the interest of patient safety as well as ensuring that Tennova maintains highly trained staff within the radiation therapy centers, it was decided to delay the initiation of the vault construction for the NKMC 2nd linear accelerator until the Physicians Regional Medical Center project is complete and patients can once again be treated there.

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." 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 and additional examination fee." **For this application, the sixtieth (60th) day after written notification is August 15, 2012. If this application is not deemed complete by this date, the**

**application will be deemed void.** 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. ɜ 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,

Philip M. Wells, FACHE
Health Planner III

PMW
Enclosure

3. All providers should document that alternate shared services and lower cost technology applications have been investigated and found less advantageous in terms of accessibility, availability, continuity, cost, and quality of care.

*Mobile PET/CT services allow NKMC, a comprehensive Cancer Center, to provide this key service to oncology patients without incurring significant costs involved with a fixed unit. Because of Health Management's national relationship with Alliance, NKMC is able to take advantage of a contract with favorable terms related to pricing and volumes. For $75,000 of capital investment, the campus will be prepared to accept the mobile unit. Mobile services are clearly the lowest cost alternative for providing PET/CT services. By building the covered sidewalk with sidewalls from the Cancer Center to the mobile unit, access will be very easy for patients who are used to navigating the Cancer Center. The Siemens 6 unit that will be provided by Alliance is FDA approved and the machine is currently in service and providing quality images.*

4. Any provider proposing a new mobile PET unit should demonstrate that it offers or has established referral agreements with providers that offer as a minimum, cancer treatment services, including radiation, medical and surgical oncology services.

*PET/CT's primary application is for cancer patients. The greatest percentage of referrals to PET/CT comes from medical oncologists and radiation oncologists. There are currently five medical oncologists and two radiation oncologists treating patients on the NKMC campus.*

5. A need likely exists for one additional stationary PET unit in a service area when the combined average utilization of existing PET service providers is at or above 80% of the total capacity of 2,000 procedures during the most recent twelve month period reflected in the provider medical equipment report maintained by the HSDA. The total capacity per PET unit is based upon the following formula:

Stationary Units: Eight (8) procedures /day x 250 days/year = 2,000 procedures/year

Mobile Units: Eight (8) procedures /day x 50 days/year= 400 procedures/year

The provider should demonstrate that its acquisition of an additional stationary or mobile PET unit in the service area has the means to perform at least 1,000 stationary PET procedures or 133 mobile PET procedures per day of operation per week in the first full one-year period of service operations, and at least 1,600 stationary PET procedures or 320 mobile PET procedures per day of operation per week for every year thereafter.

*The applicant states most cancer patients undergoing treatments at NKMC's Cancer Center and requiring PET/CT scans are being sent to Physicians Regional Medical Center for those scans. For patients from Cocke, Hamblen, Jefferson, Sevier, and portions of Knox County, Physicians Regional Medical Center is a convenient location and does not necessarily create a hardship for the patient to travel there for their scan. However, the applicant reports for patients residing in northern Knox County, Campbell, Claiborne, Grainger, Scott, and Union counties, as well as eastern portions of Anderson County, NKMC is closer and easier to find. With a dedicated entrance just off the main parking lot, NKMC's Cancer Center is easy to access.*

*According to the applicant, analysis of the patient origin of those patients being referred from NKMC oncology offices for PET/CT scans, approximately 25% of the patients currently receiving scans at Physicians Regional Medical Center would benefit from the reduced travel time and ease of access to NKMC. Over the past three years, Physicians Regional Medical Center has averaged 1,450 PET scans annually. Approximately 20%, or an average of 290 of those scans have been cardiac scans. Another 5% or an average of 73 of those scans has been neurological brain scans. The remaining 1,087 scans are cancer scans. With approximately 20-25% of the patients coming from a portion of the*

**CERTIFICATE OF NEED**
**REVIEWED BY THE DEPARTMENT OF HEALTH**
**DIVISION OF HEALTH STATISTICS**
615-741-1954

**DATE:** August 31, 2012

**APPLICANT:** Summit Medical Center
5655 Frist Boulevard
Hermitage, Tennessee 37076

**CONTACT PERSON:** John L. Wellborn
Development Support Group
4219 Hillsboro Road, Suite 203
Nashville, Tennessee 37215

**COST:** $2,500,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

**SUMMARY:**

The applicant, Summit Medical Center, located in Hermitage (Davidson County), Tennessee, seeks Certificate of Need (CON) approval to establish a twenty bed acute care inpatient rehabilitation unit and service in its hospital facility at 5655 Frist Boulevard. The unit will be created by converting 20 adult psychiatric beds to inpatient rehabilitation beds and reclassifying the adult psychiatric unit as an inpatient rehabilitation unit. The adult inpatient psychiatric patients will be transferred to the existing adult inpatient psychiatric program at Skyline Medical Center, Madison, a sister facility.

Summit Medical Center is a general hospital licensed by the Tennessee Department of Health, Board of Licensing Healthcare Facilities, for 188 hospital beds. This project will not change its licensed hospital bed complement or initiate any other health service or include any major medical equipment.

The projected involves the renovation of 9,626 square feet at an estimated cost of $1,500,000, or approximately $161.02 per square foot. The average renovation costs for CON hospital construction for years 2009 - 2011 range from $125.84 to $273.69 per square foot.

The project will require major renovation and minor renovation on the hospital's third floor, which currently contains a 20-bed inpatient psychiatric unit with support spaces. The project will replace the psychiatric services with an inpatient rehabilitation service of the same bed compliment.

The completed rehabilitation service will include 20 private patient bedrooms with handicapped-accessible/ADA compliant private bathrooms; activities daily living suite with a kitchen, bedroom, and bath; a day room/dining room multi-purpose room, gym, and other patient and staff support spaces.

Summit Medical Center is an HCA TriStar facility owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains an organizational chart and information on Tennessee facilities owned by HCA.

The total estimate project cost is $2,500,000 and will be funded by a cash transfer of the required cost, from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System). Documentation of financing is provided in Attachment C, Economic Feasibility-2.

## GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

**NEED:** The applicant's service area includes Davidson and Wilson counties. The following charts illustrate the 2012 and 2016 total population and age 65 and older population projections.

**Service Area Total Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase or (Decrease) |
|---|---|---|---|
| Davidson | 602,257 | 618,202 | 2.6% |
| Wilson | 114,437 | 121,203 | 5.9% |
| **Total** | **716,694** | **739,405** | **3.2%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision*, Tennessee Department of Health, Division of Health Statistics

**Service Area Age 65 and Older Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase or (Decrease) |
|---|---|---|---|
| Davidson | 70,698 | 78,799 | 11.5% |
| Wilson | 13,646 | 15,998 | 17.2% |
| **Total** | **84,344** | **94,797** | **12.4%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision*, Tennessee Department of Health, Division of Health Statistics

**2010 Service Area Rehabilitation Bed Utilization**

| Facility | Rehab Beds | Patient Days | 2010 Occupancy |
|---|---|---|---|
| Baptist Hospital | 24 | 6,578 | 75.1% |
| Nashville Rehabilitation Hospital | 0 | 0 | 0% |
| Skyline Medical Center | 41 | 10,804 | 72.2% |
| Skyline Madison Medical Center | 0 | 0 | 0% |
| Vanderbilt Stallworth | 80 | 22,671 | 77.6% |
| Southern Hills Medical Center | 12 | 0 | 0 |
| McFarland Hospital | 26 | 2,641 | 27.8 |
| **Total** | ***171** | **42,694** | **Average: 68.4%** |

Source: *Joint Annual Report of Hospitals 2010,* Division of Health Statistics, Tennessee Department of Health
*The 171 total beds represent only the operational beds as of the 2010 JAR. See note below.

*Note to Agency Members: The average bed percentage does not include the nonoperational beds. Southern Hills Hospital opened 12 rehabilitation beds on June 1, 2011 and will have 16 beds by September 2012. The applicant reports that from June 1, 2011 through December 31, 2012, Southern Hills Medical Center had 1,765 patient days and occupancy of 69.2%. Nashville Rehabilitation Hospital 31 beds are licensed "in abeyance" and have been nonoperational for several years. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational for several years. There are 228 total licensed or approved beds in the service area in 2012.*

According to the applicant, in recent years, HCA TriStar community hospitals on the north and south sides of the Nashville area have been granted CONs to add rehabilitation beds, through conversions of existing hospital beds. These CONS's allowed the applicant to improve their continuum of care without constructing costly new beds. The applicant states this is the third such project. Summit's conversion of its psychiatric beds to acute rehabilitation beds will not increase its bed licensed complement; but it will improve patient access to rehabilitation in the eastern part of the urban area.

The applicant states the location and timing of the project are appropriate for the following reasons:

- Rehabilitation utilization in Davidson County has been shifting to suburban locations that are closer to patient's homes. Between 2008 and 2011, the applicant reports the total rehabilitation days provided in the downtown area (Baptist, Vanderbilt, and NRH) decreased 15%, while rehabilitation days provided in the Davidson County suburbs (at Skyline and Southern Hills) increased 56%. The share of rehabilitation days that were provided in a suburban location increased from 20% to almost 38%.

- The applicant reports that while northern and southern Davidson County hospitals have been granted CON's for acute care rehabilitation beds, eastern Davidson County is the only place acute care rehabilitation beds can be opened in that sector, because Summit is the only hospital between downtown Nashville and the city of Lebanon, in Wilson County-a distance of 32 miles.

- The project will complete HCA TriStar's plan to offer acute inpatient rehabilitation programs to patients of four suburban hospitals surrounding downtown. It already has in place at HCA TriStar hospitals to the North (Skyline Medical Center), to the West (horizon Medical Center), and the South (Southern Hills Medical Center); but not yet at Summit Medical Center in Eastern Davidson County.

- Summit reports discharges of rehabilitation-appropriate patients are rapidly increasing, due not only to area population growth, but also to the hospital's CY2011 Emergency Department expansion and its designation as a Certified Stroke Center. Summit believes their growth will ensure that this refocused 20-bed unit will be reasonably utilized and will not shift costs of rehabilitation care to other types of hospital patients.

- According to the applicant, the utilization of existing rehabilitation beds in Davidson County is at efficient levels. The beds in the county's four operational acute rehabilitation providers provided 41,292 days of care in 2011. The applicant states this is equal to 70.5% occupancy on the 161 usable beds that will be open in the county by the summer of 2012. The applicant reports there are more rehabilitation beds that exist "on paper" but are older and for years have not been open.

Additionally, the applicant believes this project is good for patients. Acute rehabilitation is an important part of the continuum of high quality care for a wide range of conditions. Summit is the only hospital located in the growing eastern sector of the Nashville urban area; and is committed to continuous improvement in the services they provide. Many persons need inpatient rehabilitation after an initial hospital stay in order to regain acceptable functionality in activities of daily living and working. Having the option to receive this kind of care on the same campus which they have chosen for their initial hospitalization is efficient, and makes sense when it does not require excessive new bed construction costs.

According to the applicant, this project will not have any significant impact on other non-HCA providers of this type of care either in Davidson or Wilson counties. The applicant states for the past two years, HCA's own rehabilitation programs at Skyline and Southern Hills have been retaining approximately 81% of HCA discharges into their rehabilitation units. Last year, the applicant reports Summit discharged 47 patients to rehabilitation programs other that those of HCA. Most of the admissions to Summit will be a shift of care within the HCA TriStar network, all of it reflecting patient preferences and convenience. While there is still available bed capacity at existing rehabilitation providers in the service area, the programs in Davidson County are operating at approximately 70% utilization, which is financially sound.

The applicant states Medicare-approved acute rehabilitation units are now required to have 60% of their patient population classified in one of thirteen "Rehabilitation Impairment Categories", or RICs. The other 40% of patients may be other types of conditions that are deemed medically appropriate for rehabilitation. Failure to maintain the 60% standard will result in decertification by Medicare. Summit's projected unit will be managed to have no less than 62% of its patients in RIC

categories at any time.

The applicant states it should be noted that more than a third of the patients in acute rehabilitation units are there for significant conditions other than the thirteen RIC conditions. Utilization for this unit was projected considering both RIC and non-RIC patients.

The applicant provides Table 12-B on page 31 on the application detailing their projected utilization for year one and two of the project. The applicant's methodology is as follows:

Summit identified in its 2012 discharge base 256 patients that met RIC criteria and projected 256 eligible for an acute rehabilitation admission;

The applicant assumed that the RIC number would be 62% of total admissions, a non-RIC potential admission number was calculated to be 157;

The RIC and Non-RIC were added to project 413 potential admissions from Summit's own 2012 internal discharges;

Summit then assumed that only 74% of the 413 potential patients would actually be discharged to any hospital rehabilitation program. Application of the 74% factor reduced the potential Summit discharges to 306;

Using a weighted average of experience at HCA TriStar's Skyline and Southern Hills rehabilitation programs, Summit projected that they would retain 81% of its 306 internal discharges, or 248 admissions;

Summit projected an annual increase in its available rehabilitation patients over the next two years. Summit projected an increase of 10% in available admission in year one and a 14.5% in year two as the programs quality become known to the community and to medical staff. Additionally, HCA rehabilitation units in Nashville also receive 20% of their total referrals from non-HCA hospitals. This was assumed to continue in years one and two of this project, resulting in a projection of 328 admissions in year one and 374 admission in year two of the project. The applicant estimates an average length of stay of 13.5 days and believes the unit would be approaching 70% occupancy by the end of the second year of operation.

**TENNCARE/MEDICARE ACCESS:**
The applicant is certified in both Medicaid and Medicare programs. Summit has contracts with AmeriGroup, United Community Healthcare Plan, and TennCare Select.

The following chart illustrates the TennCare enrollees in the applicant's service area.

**TennCare Enrollees in the Proposed Service Area**

| County | 2012 Population | TennCare Enrollees | % of Total Population |
|---|---|---|---|
| Davidson | 602,257 | 118,728 | 19.7% |
| Wilson | 114,437 | 14,067 | 12.3% |
| **Total** | **716,694** | **132,795** | **18.5%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics and *Tennessee TennCare Management Information System, Recipient Enrollment,* Bureau of TennCare

The applicant estimates gross Medicare revenues of $7,504,640 or 52% of total gross revenues and TennCare/Medicaid revenues of $432,960 or 3% of total gross revenues.

**ECONOMIC FACTORS/FINANCIAL FEASIBILITY:**
In the Project Costs Chart, the total estimated project cost is $2,500,000, which includes $110,000 for architectural and engineering fees; $50,000 for legal, administrative, and consultant fees;

$1,550,000 for construction costs; $607,388 for moveable equipment; $150,000 for IT, telecommunications, misc.; $27,000 for interim financing; and $5,612 for CON filing fees.

In the Historical Data Chart, the applicant reported 42,614, 41,759, and 39,877 discharge days in 2009, 2010, and 2011 with gross operating revenues of $577,541,928, $626,094,465, and $657,778,519 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $148,908,326, $151,126,498, and $153,051,246 each year. The applicant reported $10,328,173, $10,942,208, and $10,588,601 in management fees to affiliates each year. The applicant reported a net operating income of $12,755,852, $10,890,220, and $12,414,115 each year, respectively.

In the Projected Data Chart, the applicant projects 328 admissions and 4,428 discharge days in year one and 374 admissions and 5,049 discharge days in year two with gross operating revenues of $14,432,000 and $17,205,760 each year respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $5,832,380 and $6,849,561 each year. The applicant projects management fees to affiliates of $404,524 and $482,117 each year. The applicant projects a net operating income of $2,757,512 in year one and $3,320,550 in year two.

The applicant's estimated year one average gross charge per day is $3,259, with an average deduction of $1,933, resulting in an average net charge per day of $1,317. In year two, the applicant's estimated average gross charge per day is $2,051, with an average deduction of $2,051, resulting in an average net charge per day of $1,357. The applicant compares their estimated charges with other area inpatient rehabilitation services on page 46 of the application.

The applicant states there is no alternative way to make acute impatient rehabilitation more accessible to residents of the eastern urban area of Nashville. Acute rehabilitation is a hospital-based program and Summit is the only hospital between the rehabilitation units of Baptist Hospital in Central Davidson County, and McFarland Hospital in central Wilson County, a distance of approximately 32 miles. The applicant states deployment of rehabilitation at Summit parallels HSDA decisions for suburban hospitals on the north side of the county (skyline Medical Center, 41 beds) and the south side of the county (Southern Hills, 16 rehabilitation beds).

The applicant notes rehabilitation is available in nursing home programs in the service area, but hospital-based acute rehabilitation allows for more intensive therapies and is appropriate for patients who are in need of those services. The project also permits Summit to offer and control a complete continuum of care for its patients whose discharge from the initial stay needs to proceed seamlessly into acute rehabilitation with their medical team conveniently close by.

**CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:**
The applicant provides a listing of the facilities they most frequently utilize in discharge planning on page 51 of the application.

According to the applicant, this project will provide easier access to acute inpatient rehabilitation for residents of eastern Davidson County and western Wilson County who are being discharge from initial acute care stays in Davidson County hospitals especially Summit Medical Center and who prefer the Hermitage location to downtown or the Wilson County location.

The project also consolidates HCA TriStar's psychiatric care resources in Nashville at its two central Davidson County campuses (Skyline Madison and Centennial Pavilion), freeing up beds in Davidson County suburban hospitals for broader-based healthcare programs.

The project adds rehabilitation beds to the service area without increasing licensed beds, because it merely reassigns existing bed areas on the hospital's third floor.

The impact on non-HCA rehabilitation providers will be minimal. In CY2011, 70% of Summit's discharges to acute rehabilitation programs in Nashville were to sister HCA hospitals. Only 47 patients from Summit were discharged to other service area programs.

The applicant projects 26 FTE staff in year one and 29 FTE staff in year two of the project. The applicant provides a listing of these positions and salary ranges in Table 18, page 54 of the application.

The applicant provides a listing of schools with which Summit has student affiliation agreements on page 56 of the application. In Cy2011, Summit Medical Center served as a training rotation for 415 students from the listed schools in the areas of nursing, EMT/paramedic, anesthesia tech, pharmacy tech, nutrition, respiratory therapy, medical imaging, physician's assistants, and physical therapy.

Summit Medical Center is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited by the Joint Commission.

## SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

## COMPREHENSIVE INPATIENT REHABILITATION SERVICES

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

2. The need shall be based upon the current year's population and projected four years forward.

   *The Division of Health Statistic calculated the bed need to be 74 beds based on the 2016 service area population.*

   *Southern Hills Hospital opened 12 rehabilitation beds on June 1, 2011 and will have 16 beds by September 2012. The applicant reports that from June 1, 2011 through December 31, 2012, Southern Hills Medical Center had 1,765 patient days and occupancy of 69.2%. Nashville Rehabilitation Hospital 31 beds are licensed "in abeyance" and have been nonoperational for several years. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational for several years. There are 228 total licensed or approved beds in the service area in 2012. Taking into account all licensed or approved beds, there is a surplus of 154 beds in the service area.*

   *According to the applicant, this review criterion should not be applied against this project because rehabilitation beds located in tertiary referral areas such as Davidson County are regional, multi-county resources. The applicant states the THA data base indicates that in CY2011, only 47.5% of rehabilitation patients in Davidson and Wilson County programs were residents of Davidson and Wilson counties. The applicant reports more than half the beds used in these two counties were used by residents of other counties.*

   *The applicant provides a correct Table 11, page 27 in Supplemental 1, which shows a 2012 total of 228 licensed or approved beds. Of these, 41 are older beds that are not open and are not likely to reopen. The number of operational beds in the service area is 183 and 4 more will become operational at Southern Hills Medical Center by September 2012 for a total of 187.*

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

*The applicant states approximately 85% of Summit's admissions come from Davidson and Wilson counties; and the majority of Summit's rehabilitation unit admissions will come from Summit discharges. Therefore, Davidson and Wilson counties are an appropriate primary service area.*

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

   *The project will have 20 beds.*

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

   *This project is not for a freestanding rehabilitation hospital.*

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:

| | |
|---|---|
| 20-30 bed unit | ~ 75% |
| 31-50 bed unit/facility | ~ 80% |
| 51 bed plus unit/facility | ~ 85% |

***2010 Service Area Rehabilitation Bed Utilization***

| Facility | Rehab Beds | Patient Days | 2010 Occupancy |
|---|---|---|---|
| Baptist Hospital | 24 | 6,578 | 75.1% |
| Nashville Rehabilitation Hospital | 0 | 0 | 0% |
| Skyline Medical Center | 41 | 10,804 | 72.2% |
| Skyline Madison Medical Center | 0 | 0 | 0% |
| Vanderbilt Stallworth | 80 | 22,671 | 77.6% |
| Southern Hills Medical Center | 0 | 0 | 0 |
| McFarland Hospital | 26 | 2,641 | 27.8 |
| **Total** | ***171** | **42,694** | **Average: 68.4%** |

*Source: Joint Annual Report of Hospitals 2010, Division of Health Statistics, Tennessee Department of Health*
**The 171 total beds represent only the operational beds as of the 2010 JAR. See note below.*

*Note to Agency Members: The average bed percentage does not include the nonoperational beds. Southern Hills Hospital opened 12 rehabilitation beds on June 1, 2011 and will have 16 beds by September 2012. The applicant reports that from June 1, 2011 through December 31, 2012, Southern Hills Medical Center had 1,765 patient days and occupancy of 69.2%. Nashville Rehabilitation Hospital 31 beds are licensed "in abeyance" and have been nonoperational for several years. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational for several years. There are 228 total licensed or approved beds in the service area in 2012.*

*The applicant reports 2011 occupancy of 69.0% for Baptist Hospital; 76.0% for Vanderbilt Stallworth; 75.5% for Skyline Medical Center; 69.2 for Southern Hills Medical Center; and 29.4% for McFarland Hospital. The applicant states the service providers are not yet at the target occupancies of the criterion, nonetheless those located in Davidson County are efficiently utilized at 71.5% collectively.*

*HealthSouth's recently approved application to build a Vanderbilt-led rehabilitation hospital in Williamson County stated that Vanderbilt Stallworth in central Davidson County can not achieve much higher occupancy than its current level because of its semi-private rooms, which require gender separation that often prevents a second admission to a semi-private room. The applicant reports that Stallworth recently declined a number of Summit's request for admissions to a rehabilitation bed.*

*Southern Hills unit has grown in utilization so rapidly that HSDA recently approved the addition of 4 more rehabilitation beds by conversion despite these criteria.*

*Skyline's rehabilitation program has also grown rapidly with the growth of their neurosciences programs (stroke; neurosurgery; spinal surgery).*

*The applicant reports only UMC McFarland's facility in Lebanon, almost a half-hour drive from Summit, has low occupancy in its rehabilitation beds. Once a general hospital, and now a psychiatric and rehabilitation facility, McFarland long ago was allowed to assign far more licensed rehabilitation beds than its service area can now fill. The applicant states it is not a reasonable option for Davidson and western Wilson County residents who obtain care in Davidson County, and are not inclined to drive miles into a rural are for their care. Davidson County is not even in McFarland's primary service area: only 3% of McFarland's admissions (both psychiatric and rehabilitation) come from Davidson County, according to its most recent Joint Annual Report.*

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board certified physiatrist.

   *The applicant states they comply with licensure staffing requirements and provide the projected staffing in response C.15.*

**HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING**
**SEPTEMBER 26, 2012**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | Summit Medical Center |
| PROJECT NUMBER: | CN1206-029 |
| ADDRESS: | 5655 Frist Boulevard<br>Hermitage (Davidson County), TN 37076 |
| LEGAL OWNER: | HCA Health Services of Tennessee, Inc.<br>5655 Frist Boulevard<br>Hermitage (Davidson County), TN 37076 |
| OPERATING ENTITY: | NA |
| CONTACT PERSON: | John Wellborn<br>(615) 665-2022 |
| DATE FILED: | June 14, 2012 |
| PROJECT COST: | $2,500,000.00 |
| FINANCING: | Cash Reserves of the parent corporation, HCA |
| REASON FOR FILING: | 1) Initiation of Inpatient Rehabilitation Services<br>2) Conversion of (20) Adult Psychiatric beds to (20) Rehabilitation beds |

DESCRIPTION:

Summit Medical Center (SMC) is seeking approval for initiation of inpatient rehabilitation services and conversion of (20) adult psychiatric beds to (20) rehabilitation beds. The proposed conversion will not change the hospital's total licensed bed complement of one hundred and eighty-eight (188) acute care beds at its main campus at 5655 Frist Boulevard in Hermitage (Davidson County), TN.

The project will require major and minor renovation of approximately 9,626 square feet on the hospital's 20,294 square foot third floor, which currently contains a 20-bed inpatient psychiatric unit and its support spaces. The third floor will, then, be converted to a 17,030 square foot inpatient rehabilitation unit

which will house 20 rehabilitation beds. The remaining 3,264 square feet of office space in one wing will remain as offices (*their future use has not yet been determined)*. The completed rehabilitation service will include all private patient bedrooms with handicapped-accessible/ADA-compliant private bathrooms; and ADL (Activities of Daily Living) suite with a kitchen, bedroom, and bath; a Day Room/Dining Room multipurpose room, gym, and other patient and staff support spaces (*See page 8 as well as Attachments B.III and B. IV of the original application*).

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

**COMPREHENSIVE INPATIENT REHABILITATION SERVICES**

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

   *See criterion #2 below.*

2. The need shall be based upon the current year's population and projected four years forward.

   *The applicant has chosen Davidson and Wilson Counties as the service area for its inpatient rehabilitation service. The 2016 population of these two counties is 739,405 residents. Applying the Guidelines for Growth's "ten beds per 100,000 population", the need for inpatient rehabilitation beds in this two county service area is 73.9, or rounded up, 74 beds. There are currently 224 licensed beds certified as inpatient rehabilitation beds within Davidson and Wilson Counties. Southern Hills Medical Center also has an unimplemented Certificate of Need for four (4) additional rehabilitation beds with an expiration date of April 1, 2015. Thus, there currently exists a net surplus of 154 licensed beds (see table on page 7 of this summary). It appears that the application does not meet criteria 1 and 2.*

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

   *The applicant has chosen Davidson and Wilson Counties as the service area for its inpatient rehabilitation service, which has received 85.4% of its admissions from residents of these two counties in 2011. It appears that the application does meet this criterion.*

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

*The SMC application for a Rehab Unit is for 20 beds.*

*It appears that the application meets this criterion.*

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

*This criterion is not applicable.*

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HSDA, unless all existing units or facilities are utilized at the following levels:

| | |
|---|---|
| 20-30 bed unit | ~ 75% |
| 31-50 bed unit/facility | ~ 80% |
| 51 bed plus unit/facility | ~ 85% |

*Currently, there are five inpatient rehabilitation services operating in Davidson and Wilson Counties. Below is a comparison of how the utilization of the current 183 operating and staffed beds compared with the 2000 Edition of the Guidelines for Growth's occupancy standards. Overall, only one inpatient rehabilitation unit per year met the occupancy standards: Baptist Hospital in 2010 and Skyline Medical Center's main campus unit in 2011.*

| Bed Unit Range | G of G* Occupancy Standard | Hospital | Rehab Bed Capacity | 2010 Occupancy | 2011 Occupancy | Meets G of G* Standard |
|---|---|---|---|---|---|---|
| 20-30 beds | ~ 75% | Southern Hills Medical Ctr | 12 beds | Not open | 69.2% | No |
| 20-30 beds | ~ 75% | Baptist Hospital | 24 beds | 75.1% | 69.0% | Only 1st of 2 years |
| 20-30 beds | ~ 75% | McFarland Hospital | 26 beds | 27.8% | 29.4% | No |
| 31-50 bed unit/facility | ~ 80% | Skyline Medical Center | 41 beds | 72.2% | 75.1% | Only 2nd of 2 years |
| 51 beds plus | ~ 85% | Vanderbilt Stallworth | 80 beds | 77.6% | 76% | No |

**G of G = Guidelines for Growth*

*It appears that the application does not meet this criterion.*

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the

proposal. It is preferred that the medical director of a rehabilitation hospital be a board certified physiatrist.

*The applicant intends to staff the 20 bed unit with 26.0 FTE nursing and therapy staff in the first year and plans to add 3.0 FTE nursing staff in the second year of operation. The applicant intends to recruit a physician with Board Certification in Physical Medicine and Rehabilitation (a physiatrist) for the medical director of its inpatient rehabilitation service. It appears that the application intends to meet this criterion.*

SUMMARY:

Summit Medical Center's proposal to establish a 20-bed acute inpatient rehabilitation unit will be certified as a "distinct part unit" by Medicare. The applicant states this will not increase hospital bed complement, because it will be a conversion of an existing 20-bed inpatient adult psychiatric unit on the hospital's third floor. Current psychiatric patients remaining in that unit, or presenting subsequently at Summit's Emergency Department, will be stabilized and transported to Skyline Medical Center's behavioral medicine facility in Madison, which has sufficient capacity to admit them.

The objective of the proposed reassignment of beds is to improve access to acute rehabilitation care in Summit's service area, while concentrating behavioral medicine care at HCA TriStar's Skyline Madison facility. According to the applicant, Summit Medical Center discharges a large number of patients who need rehabilitation, but has no beds approved for that purpose. Because Skyline Madison has the bed capacity to serve adult psychiatric patients now being admitted to Summit, it makes sense to concentrate those psychiatric admissions at Skyline Madison, freeing up Summit's third floor beds for reassignment to an acute rehabilitation program.

The applicant indicates Summit Medical Center has proposed this in-house acute rehabilitation service for several reasons:

1) Acute rehabilitation in an inpatient setting is an important part of the continuum of high quality care for a wide range of conditions. Summit is the only hospital located in the growing eastern sector of the Nashville urban area; and Summit is committed to continuous improvement in the services it provides. Many persons need inpatient rehabilitation after an initial hospital stay, in order to regain acceptable functionality in activities of daily living and working. Patients who have undergone amputation, stroke, burns, major traumas, hip and knee replacements, shoulder and back surgery, or

other events, or who are treated for serious arthritic or neurological issues, and many other conditions, all benefit from having access to acute inpatient rehabilitation immediately upon discharge from their initial hospital stay. Having the option to receive this kind of care on the same campus which they have chosen for their initial hospitalization is efficient, and makes sense when it does not require excessive new bed construction costs.

2) Distribution of rehabilitation services to suburban locations such as Summit's is a trend favored by the consumer. Patients in Nashville have shown a desire to access such services not just in tertiary downtown hospitals, but also in suburbs closer to where they live, and where they often receive their hospital care. The applicant claims that there has been a significant shift of rehabilitation admissions recently, from downtown centers to suburban locations. The applicant uses the table below to show that from 2008 to 2011, downtown rehabilitation admissions declined by 15%, while suburban rehabilitation admissions rose 56%. The applicant states the suburban market share increased from 20% in 2008 to 32% in 2011, while the central Davidson County share decreased from 80% to 68% in that period. And during this, the total days of rehabilitation provided in Davidson County has remained stable. The applicant states there has been an orderly redistribution of resources.

**Applicants Illustration of Movement of Rehabilitation Patient Days**

| Movement of Rehabilitation Patient Days in Davidson County CY2008-CY2011 | | | |
|---|---|---|---|
| Location | CY 2008 | CY 2011 | Change '08-'11 |
| Central County* | 33,199 (80%) | 28,221 (68%) | -15% |
| Suburban County Areas | 8,329 (20%) | 13,071 (32%) | +56% |
| Totals | 41,528 | 41,292 | |

*Central providers were Vanderbilt Stallworth, Baptist, & Nashville Rehabilitation Hospital (which is now closed).

** Suburban providers were Skyline and Southern Hills Medical Centers.

Source: Joint Annual Reports, 2008-2011.

*Note to Agency members: An analysis of the Central County demonstrates that the movement of rehabilitation patient days appears to be an amplification of the shift in numbers of only a few facilities. Baptist's and Vanderbilt Stallworth's patient days have remained relatively stable. The inactivation of Nashville Rehabilitation Hospital's 31 licensed beds accounted for 97% of the drop in patient days for the "Central County" category. The inactivation of Skyline-Madison's rehabilitation unit permitted the redistribution of 22 beds to Skyline Medical Center's main campus' rehabilitation unit (10 beds) in 2009 and Southern Hills Medical Center's*

*rehabilitation unit (12 beds) in 2010, thus permitting growth of these two HCA Tri-Star facilities (see the table and its footnotes on page 10 of this Summary for details).*

3) Distribution of this type of care to Summit Medical Center is especially needed as the hospital increases its healthcare role in the community. In the second half of CY2011, Summit opened a major Emergency Department expansion, and became a Certified Stroke Center. These and other service improvements have dramatically increased the number of its discharged patients who go immediately into an inpatient rehabilitation program elsewhere. With such transfers up 41% this year (on an annualized basis), such a program on Summit's own campus will be financially feasible and efficiently utilized.
4) The applicant's fourth reason for the project is consistency: Summit's large service area on the east side of greater Nashville is the only suburban sector of Nashville whose local hospital does not offer inpatient acute rehabilitation care. Certificates of Need for this program have been granted to the other suburban hospitals north, south, and even west (Dickson) of Nashville. The eastern side of the urban area needs a comparable option.
5) Finally, this project will not have any significant adverse impact on other non-HCA providers of this type of care in either Davidson or Wilson Counties. For the past two years, HCA's own rehabilitation programs at Skyline and Southern Hills have been retaining approximately 81% of HCA discharges into rehabilitation units. Last year, Summit discharged only 47 patients to rehabilitation programs other than those of HCA. Thus, most of the admissions to Summit will be a shift of care within the HCA TriStar network, all of it reflecting patient preferences and convenience. And while there is still some available bed capacity at existing rehabilitation providers in the service area, the programs in Davidson County are operating at approximately 70% utilization, which is financially sound.

*Note to Agency Members: The average occupancy for all licensed rehabilitation beds within the applicant's declared service area is 61.4%. Currently there are 10 licensed rehabilitation beds at Skyline Madison's campus which the applicant indicates are unstaffed, have not been open for years and are not likely to re-open for this type of service. Note the applicant's explanation to retain these unused beds on pages 2-3 of the supplemental response.*

Summit Medical Center is 100 percent owned by HCA Health Services of Tennessee, whose parent organization is (through several corporate entities) HCA, Inc of Nashville, Tennessee. HCA is composed of locally owned facilities

that include approximately 190 hospitals and 82 outpatient surgery centers in 23 states, England and Switzerland. Summit Medical Center is part of the locally managed HCA TriStar Group which operates hospitals in South Central Kentucky, Northern Georgia, and fourteen (14) hospitals in Tennessee. An organizational chart is enclosed in the Attachment A.4. *Note to Agency members: Two other HCA TriStar hospitals located in the applicant's proposed service area (Davidson and Wilson Counties) operate rehabilitation units: Skyline Medical Center (41 beds at its main campus in north Nashville, TN; 10 licensed, but not operating beds at its Madison campus); 12 beds (+4 CON approved beds for a total of 16) at Southern Hills Medical Center in Antioch; totaling 63 licensed inpatient rehabilitation plus 4 CON approved beds in Davidson County for a total of 67 approved inpatient rehabilitation beds. In addition, HCA TriStar's Horizon Medical Center also operates 12 inpatient rehabilitation beds at its Dickson (Dickson County), TN campus, bringing the total of HCA TriStar's licensed rehabilitation capacity to 79 beds serving Middle Tennessee.*

According to the Joint Annual Report, Summit Hospital is licensed for 188 beds and staffs all of its beds. The licensed and staffed hospital bed occupancy at Summit Medical Center was 58% respectively in 2011. The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

*Licensed Beds- The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).*

*Staffed Beds-The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.*

SMC's primary service area is Davidson and Wilson Counties, from which approximately 85.4% of SMC's admissions originated in 2011. Davidson County contributed 56.6% of SMC admissions, while Wilson County added another 28.8% in 2011.The applicant indicates that HCA TriStar's experience is the great majority of its rehabilitation units' admissions are patients discharged from the hospital of which they are a part, and, therefore, they believe Davidson and Wilson Counties will also be the primary service area for the proposed rehabilitation service. Population data from the Tennessee Department of Health's Division of Health Statistics indicates that the general population of the applicant's primary service area in 2012 is estimated to be 716,694 and is expected to grow 3.2% to 739,405 by 2016. This growth rate compares to the State's growth rate of 3.4% for the same time period. The age 65+ population in

the service area is expected to increase by 12.4% from 84,344 to 94,797 individuals during this time period compared to a statewide growth rate of 12.4%. In 2016, individuals age 65+ are expected to account for approximately 12.8% of the two county service area population compared to 15.0% for Tennessee. The number of TennCare enrollees residing in the service area equates to 18.7% of the population, with Davidson County having the largest population proportion of TennCare enrollees (19.8%) and Wilson County having the lowest proportion (12.4%).

In applying the *Guidelines for Growth's* bed need formulas, the following calculations result: the need for rehabilitation beds is 74 beds, while the current supply of licensed beds which are certified and approved as rehabilitation beds is 228, leaving a surplus of 154 beds.

Presented below is the inventory of the acute care licensed beds which currently have been certified by HSDA for use as the inpatient rehabilitation beds:

**Inventory of Inpatient Rehabilitation Beds in Davidson and Wilson Counties**

| Hospital | Licensed Acute Care Beds Certified as Inpatient Rehabilitation Beds | Current Status |
|---|---|---|
| Southern Hills Medical. Center | 12 | Licensed & Operational |
| Baptist | 24 | Licensed & Operational |
| Vanderbilt Stallworth | 80 | Licensed & Operational |
| Skyline Medical Center | 41 | Licensed & Operational |
| McFarland Hospital | 26 | Licensed & Operational |
| **Subtotal - Operational** | **183** | **Currently Licensed & Operational** |
| Skyline Medical Center - Madison | 10 | Licensed, but not operational |
| Nashville Rehabilitation Hosp. | 31 | Licensed, but inactive |
| **Subtotal – Licensed, not operating** | **41** | **Licensed, but not operational** |
| **Total Licensed, Certified Rehab Beds** | **224** | Licensed & Certified Rehab Beds |
| CON Approved, but not operational | 4 at Southern Hills | |
| **Total Approved Rehab Beds** | **228** | **Licensed, Certified & Approved** |

Source: Tennessee Department of Health and Health Services and Development Agency Records

*Note to Agency members: Nashville Rehabilitation Hospital closed in December 2009. The license for the 31 bed facility was placed in an inactive status for 24 months by the Tennessee Department of Health, Board for Licensing Health Care Facilities. The inactive status has been extended until January 2013. Nashville Rehabilitation Hospital and its 31 beds are subject to an option to purchase by Middle Tennessee Rehabilitation Hospital; contingent upon the issuance of a CON for the relocation and replacement of the facility, an application for which has been denied by the Agency and is the subject of a contested case appeal. These beds are included by the Department of Health in the licensed bed complement until surrendered or the inactive status is not renewed. Skyline Medical Center has increased their rehabilitation beds on the main campus to 41 beds, while simultaneously reducing the Skyline Medical Center - Madison satellite campus to 22*

*rehabilitation beds per CN0808-062A. As part of the Southern Hills Medical Center's initial application to initiate a 12 bed inpatient rehabilitation service (CN1003-014A), Skyline-Madison campus agreed to delicense 12 additional inpatient rehabilitation beds, reducing the number to 10 rehab beds. Skyline Medical Center – Madison's 10 licensed rehab beds remain unstaffed at this time. The applicant indicates these beds are not likely to re-open for this type of care on page 18 of the original application. On pages 2-3 of the supplemental response the applicant states it would like to retain licensure for these 10 rehabilitation beds.*

The applicant provides a chart on page 16 of the application of the driving distances and times from Summit Medical Center to the other hospitals with inpatient rehabilitation programs. None of the hospitals are further than 21 miles, nor more than 27 minutes driving time. A summary of the historical utilization of inpatient rehab services is below:

**Service Area Inpatient Rehabilitation Bed Utilization Trends**

| Hospital | County | 2008 | 2009 | 2010 | 2011 | 2008-2011 % Change |
|---|---|---|---|---|---|---|
| Baptist - Beds | Davidson | 24 | 24 | 24 | 24 | 0% |
| -Patient Days | | 6,135 | 6,783 | 6,578 | 6,041 | -1.5% |
| - % Occupancy | | 70% | 77.4% | 75% | 69.0% | -1.4% |
| Nashville Rehab - Beds | Davidson | 34 | 31*** | 31*** | 31*** | |
| -Patient Days | | 4,831 | 0 | 0 | 0 | -100% |
| - % Occupancy | | 39% | 0 | 0 | 0 | -100% |
| Skyline Main - Beds | Davidson | 31 | 41* | 41 | 41 | +32.3%% |
| - Patient Days | | 8,329 | 10,150 | 10,804 | 11,306 | +35.8% |
| - % Occupancy | | 74% | 68.0% | 72.2% | 75.5% | 2.0% |
| Skyline – Madison -Beds** | Davidson | 32 | 22* | 22** | 10** | -54.6% |
| -Patient Days | | 0 | 0 | 0 | 0 | -100% |
| - % Occupancy | | 0 | 0 | 0 | 0 | -100% |
| Vanderbilt Stallworth - Beds | Davidson | 80 | 80 | 80 | 80 | 0% |
| -Patient Days | | 22,233 | 22,393 | 22,671 | 22,180 | -0.2% |
| - % Occupancy | | 76% | 75.9% | 77.6% | 76.0% | 0% |
| Southern Hills – Beds**** | Davidson | 0 | 0 | 0 | 12 | 100% |
| -Patient Days | | - | - | - | 1,765 | 100% |
| - % Occupancy | | - | - | - | 69.2% | 100% |
| McFarland Hospital | Wilson | 26 | 26 | 26 | 26 | 0% |
| -Patient Days | | 2,762 | 2,529 | 2,641 | 2,794 | 1.2% |
| - % Occupancy | | 29.1% | 26.6% | 27.8% | 29.4% | 1.0% |
| **Service Area - Rehab Beds** | | **227** | **224** | **224** | **224** | **-1.3%** |
| **-Patient Days** | | **44,290** | **41,855** | **42,645** | **44,086** | **-0.5%%** |
| **- % Occupancy** | | **53.5%** | **51.2%** | **52.2%** | **53.9%** | **+0.8%** |

** Skyline Medical Center – Madison transferred 10 certified/licensed inpatient rehabilitation beds in 2009 to Skyline Medical Center –Main Campus (CN0808-062A)*

*** Skyline Medical Center – Madison transferred 12inpatient rehabilitation beds to Southern Hills Medical Center (CN1003-014A) granted in 2010, but implemented in 2011(see below)*

**** Licensed Beds, but unused*

***** Southern Hills Medical Center opened 12 rehabilitation beds 6/1/2011*

Source: TN Department of Health, Joint Annual Report, 2008-2011

Of the nine (9) short-term, acute care hospitals within SMC's declared service area, the number of hospitals which have been providing inpatient rehab services during the six year 2004-11 timeframe declined from six to five. In 2004, the six

rehab units provided 51,725 patient days of rehab care in 235 beds. By 2011, the number of operating units had fallen to five, the number of licensed beds fell from 235 to 224 and the number of operating rehab beds had dropped by 22.1% from 235 to 183 beds. The seven year utilization trend shows a 14.8% decline in utilization from 51,725 patient days in 2004 to 44,086 patient days in 2011. The occupancy rate has also declined: 60.3% in 2004 to 53.9% in 2011. None of the five operating units are performing above the percentage occupancy levels as recommended by *Guidelines for Growth.*

*Note to Agency members: During the seven year period, a significant contributing factor to the change in utilization, occupancy and drop in inpatient rehabilitation beds has been the change in Medicare reimbursement implemented by the Centers for Medicare and Medicaid Services (CMS). As a participant in the Medicare program, the inpatient rehabilitation facility is required to show a minimum percentage of the facility's total patient population must meet one of thirteen (13) medical conditions. Initially the compliance threshold was 75% (known as the "75% rule'), but was later modified in 2006 to "60% threshold" of the rehabilitation unit's patient population. The CMS' "threshold Rule" for rehabilitation facilities essentially divided rehab patients into two categories: (1) those who are being treated for one or more of 13 specified conditions, i.e., acute care patients and (2) those not receiving treatment for any of the 13 specified conditions, or non-acute rehab patients. Under the new 60% Rule, Medicare reimbursement is available to an inpatient rehabilitation facility only if, on an annual basis, 60% of its patients are acute rehab patients. The 13 specified conditions include: Stroke; Spinal Cord Injury; Amputation; Major Multiple Trauma; Fracture of the Femur (hip fracture); Brain Injury; Neurological Disorders; Burns; Active Polyarticular Rheumatoid Arthritis; Congenital Deformities; Systemic Vasculidities; Severe or Advanced Osteoarthritis; Hip and Knee Replacements accompanied by extreme obesity with a body mass index of at least 50, or be 85 years of age or older.*

***Source: CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements***
***S.2499 2007 Medicare, Medicaid, and SCHIP Extension Act***

With the opening of the 12 bed Southern Hills rehab unit in June 2011, the number of operating acute care rehabilitation facilities increased to five units with 183 staffed rehabilitation beds: Baptist (24 beds), Skyline (41 beds) and Vanderbilt Stallworth (80 beds), McFarland (26 beds), and then Southern Hills (12 beds). CN1111-048A approved an additional 4 beds for Southern Hills, bringing the total to 187 currently operating and CON approved beds. Should this application for 20 additional rehabilitation beds be approved, the total number of currently operating and CON approved rehabilitation beds would grow to 207. Currently, HCA TriStar's rehabilitation bed capacity is 30.5% of the operating inpatient rehabilitation bed capacity in Davidson and Wilson Counties. Should this application be approved, HCA TriStar's share of the staffed operating inpatient rehabilitation bed capacity would increase to 37.2%. Its share

of the licensed inpatient rehabilitation bed capacity (including non-operational and inactive beds) would be 35.1%

The applicant projects that the project will experience 328 admissions and 4,428 patient days (60.7% occupancy) in the first year and 374 admissions and 5,049 patient days (69.2% occupancy) in the second year.

Summit indicates its average gross charge per day will be $3,259 in year one and $3,408 in the second year. With the average deduction from operating revenue of approximately 60% of charges, SMC anticipates the Average Operating Net Revenue per day will be $1,317 in the first year and $1,357 in year two. Gross inpatient revenues for the 20 beds are estimated to generate $14,432,000 in the first year of the project and $17,205,760 in year two. Contractual adjustments of 60% reduce the net operating revenue projections to $5,832,380 in year one and $6,849,561 in the second year. Expenses reduce the Net Operating Income less Capital Expenditures to a projected $2,757,512 gain in the first year and $3,320,550 profit by the second year.

The applicant indicates it plans to staff the unit with 26.0 FTEs of clinical and rehabilitation staff in year one, adding 3.0 nursing staff to the staffing mix in year two.

The applicant anticipates Medicare will generate $7,504,640 in gross revenues and constitute 52% of its payor mix in year one, while TennCare will contribute gross revenues of $432,960 and comprise 3% of its gross revenues the first year. The applicant indicates they have contracts with all three TennCare MCOs available to its service area population: United HealthCare Community Plan (formerly AmeriChoice), TennCare Select and AmeriGroup.

Review of SMC's Historical Data Chart indicates the hospital has experienced several profitable years during the 3 years reported (2009-11). Net Operating Income less Capital Expenditures has been $12,755,852 in 2009, $10,890,220 for 2010, and $12,414,115 for 2011.

The source of funding for the project is identified as cash reserves of HCA. A 06/12/12 letter from HCA TriStar's Chief Financial Officer attests to HCA's ability to finance the project. Review of the HCA's Holdings financial statement as of 12/31/11 revealed current assets of $7.233 billion and current liabilities $5.554 billion for a favorable current ratio of 1.30:1.

The total estimated project cost is $2,500,000. The majority of the cost (62%) is the renovation cost ($1,550,000). The applicant estimates the cost of the renovation is

$161.02/sq.ft., which is in the second quartile of the HSDA's data base for hospital renovation construction projects approved in 2009-2011. Another $607,388 is budgeted for movable equipment, $150,000 for information technology and telecommunications, $27,000 for interim financing, while the remainder of the project's costs ($165,612) is budgeted for fees.

*The applicant has submitted the required corporate documentation and real estate title. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.*

Should the Agency vote to approve this project, the CON would expire in three years.

**CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:**

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for this applicant.

*HCA has financial interests in this project and the following:*

Denied Applications:

**Spring Hill Hospital, Spring Hill (Maury County), TN, CN0804-031D,** was denied at the July 23, 2008 Agency Meeting. The application was for the acquisition of a linear accelerator and the initiation of linear accelerator services at an unaddressed site on the NE corner of the intersection of Saturn Parkway and Kedron Road in Spring Hill, (Maury County), Tennessee. This project was filed as a simultaneous review of Vanderbilt Maury Radiation Oncology, L.L.C., CN0804-024. The estimated cost was projected to be **$7,500,614.00.** Reason for Denial: *The approval of Vanderbilt Maury Radiation Oncology, LLC has satisfied the need for additional capacity.*

**Stonecrest Medical Center, CN0809-072D,** was denied at the December 17, 2008 Agency meeting. The application was for the construction of a six (6) bed neonatal intensive care unit (NICU) and the initiation of Level II-B NICU services. Stonecrest Medical Center is authorized for one hundred one (101) hospital beds. This project was to add another six (6) licensed NICU beds increasing the hospital's authorized bed complement to one hundred seven (107) beds. Estimated project cost was **$2,774,900.** *Reason for Denial: The application did not meet statutory criteria. Note to Agency members: Since this denial an eight (8) bed NICU was approved, CN1107-026A, which is further described in the "Outstanding Certificate of Need" section below.*

Outstanding Certificates of Need

**Natchez Surgery Center, CN1002-011A,** has an outstanding Certificate of Need which will expire on June 1, 2012. It was approved at the May 26, 2010 Agency meeting for the establishment of an ambulatory surgical treatment center (ASTC) with three (3) operating rooms and three (3) procedure rooms. After approval, CN801-001A was surrendered which is a similar facility for this site at 107 Natchez Park Drive, Dickson (Dickson County), TN. The intent of this application is to change the organizational form to permit physician ownership participation. The estimated cost of the project is **$13,073,892.00.** *Project Status: The applicant requested a modification at the March 2012 Agency meeting to extend the expiration date for three (3) years from July 1, 2012 to July 1, 2015,; reduce the number of operating rooms from three (3) to two (2) and procedure rooms from three (3) to one (1); reduce project costs by $4,201,823 from $13,073,892 to $8,872,069; and reduce square footage by 4,965 from 15,424 to 10,459 square feet. The Agency approved the modifications and extension of the expiration date to July 1, 2015.*

**Centennial Medical Emergency Center Department at Spring Hill, CN1006-023A,** has an outstanding Certificate of Need that will expire on January 1, 2014. The CON was approved at the November 17, 2010 Agency meeting for the establishment of a satellite emergency department facility of Centennial Medical Center in Nashville, a licensed 606-bed general hospital, at an unaddressed site on the NE corner of the intersection of Saturn Parkway and Kedron Road in Spring Hill, (Maury County), Tennessee. This satellite facility will provide emergency diagnostic and treatment services for which all necessary diagnostic services will be available, including laboratory, X-ray, ultrasound, and CT scanning. It will not contain any major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements. The estimated project cost is **$9,095,546.00.** *Project Status: Groundbreaking occurred in April 2012 and construction began in May 2012. Targeted completion date is March 2013.*

**StoneCrest Medical Center, CN1107-026A,** has an outstanding Certificate of Need that will expire on December 1, 2014. The CON was approved at the October 26, 2011 Agency meeting to modify its existing facility and add eight (8) licensed Level IIB Neonatal Intensive Care Unit (NICU) beds to its existing one hundred and one (101) licensed acute care bed complement. Upon completion of this project, the total licensed acute care bed capacity of the hospital will be one hundred and nine (109) beds. Upon licensure of these eight (8) beds, eight (8) beds at other HCA facilities will be delicensed. The estimated project cost is **$2,991,463.00**. *Project Status Update: The project final working drawings are about to be submitted for TDH review and is expected to be implemented within a year.*

**Skyline Medical Center (Madison Campus), CN1110-040A,** has an outstanding Certificate of Need which will expire on March 1, 2015. It was approved at the January 25, 2012 Agency meeting for expansion of an existing inpatient adolescent psychiatric unit by eleven (11) beds through the conversion of eleven (11) existing Medical/Surgical beds at its Madison Campus. The result will be a twenty-one (21) adolescent psychiatric bed unit while the hospital's total licensed bed complement of four hundred forty-six (446) acute care beds will remain unchanged. The estimated cost of the project is **$2,412,504.00.** *Project Status Update: The final plans and specs completed and approved; contractor is selected; awaiting capital release for construction, estimated September start of construction; estimated opening during first quarter 2013.*

**Southern Hills Medical Center, CN1111-048A,** has an outstanding Certificate of Need that will expire on April 1, 2015. The CON was approved at the February 22, 2012 Agency meeting to convert four (4) medical surgical beds to four (4) inpatient rehabilitation beds. The proposed conversion will increase the bed complement of SHMC's inpatient rehabilitation unit from twelve (12) to sixteen (16) beds, but will not change the hospital's total licensed bed complement of one hundred and thirty-two (132) acute care beds at its main campus at 391 Wallace Road in Nashville (Davidson County), TN. The estimated project cost is **$700,105.00.** *Project Status: According to the COO of Southern Hills, the plans for renovation have been approved, and a building permit has been issued. Renovation is expected to begin in September and should take approximately 3 months to complete.*

**Parkridge Medical Center, CN1202-005,** has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the relocation of 16 of 25 currently licensed geriatric psychiatric beds to a new satellite campus, (2) the conversion of the remaining 9 geriatric psychiatric beds to medical/surgical, and (3) the addition of 16 acute medical surgical beds. The licensed bed complement at Parkridge Medical Center will remain at 275 beds. The net result of this application is that this site will operate as a general acute hospital with no psychiatric services on site. Estimated project cost is **$1,010,500.** *Project Status Update: The project was recently approved.*

**Parkridge Valley Hospital, CN1202-006** has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the addition of sixteen (16) additional child and adolescent psychiatric beds to the sixty-eight (68) beds currently located on the satellite campus at 2200 Morris Hill Road, Chattanooga (Hamilton County) and (2) the relocation of all forty-eight (48) of its licensed adult psychiatric beds to a new campus. The current licensed hospital bed complement at Parkridge Valley Hospital, which is a satellite location of Parkridge Medical Center, will decrease

from one hundred sixteen (116) beds to eighty-four (84) beds. The net result of this application is that only child and adolescent psychiatric beds will operate at this location. Estimated project cost is **$143,000.** *Project Status Update: The project was recently approved.*

**Parkridge Valley Adult Services, CN1202-007,** has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the relocation of forty-eight (48) adult psychiatric beds from Parkridge Valley Hospital to a new campus to be called Parkridge Valley Adult Services located at 7351 Standifer Gap Road, Chattanooga (Hamilton County); and (2) the relocation of sixteen (16) geriatric psychiatric beds from Parkridge Medical Center to the new Adult Services campus. Parkridge Valley Adult Services will operate as a sixty-four (64) bed satellite hospital of Parkridge Medical Center. The net result of this application is that all adult (including Geriatric) psychiatric services will operate at this site. Estimated project cost is **$6,762,622.** *Project Status Update: The project was recently approved.*

**Horizon Medical Center Emergency Department, CN1202-008,** has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting to establish a satellite emergency department facility located at its Natchez Medical Park campus located at 109 Natchez Park Drive, Dickson (Dickson County). Estimated project cost is **$7,475,395.** *Project Status Update: The project was recently approved.*

**CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:**

There are no other Letters of Intent, denied or pending applications or outstanding Certificates of Need for other entities proposing this type of service.

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**

PMW/ (08/21/12)

# LETTER OF INTENT

## LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

2012 JUN -7 PM 11:09

The Publication of Intent is to be published in the Nashville Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before June 10th, 2012, 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. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to establish a twenty (20) bed acute inpatient rehabilitation unit and service in its hospital facility at 5655 Frist Boulevard, Hermitage, TN 37076, at a capital cost estimated at $2,500,000. The unit will be created by converting 20 adult psychiatric beds to inpatient rehabilitation beds and reclassifying the adult psychiatric unit as an inpatient rehabilitation unit. The adult psychiatric patients will be transferred to the existing adult inpatient psychiatric program at Skyline Medical Center, Madison, a sister facility.

Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will not change its licensed hospital bed complement or initiate any other health service or include any major medical equipment.

The anticipated date of filing the application is on or before June 15, 2012. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 6-5-12 jwdsg@aol.com

(Signature) (Date) (E-mail Address)

# ORIGINAL APPLICATION

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

Summit Medical Center
Name

5655 Frist Boulevard
Street or Route

Davidson
County

Hermitage
City

TN
State

37076
Zip Code

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

John Wellborn
Name

Title

Development Support Group
Company Name

jwdsg@comcast.net
Email address

4219 Hillsboro Road, Suite 203
Street or Route

Nashville
City

TN
State

37215
Zip Code

CON Consultant
Association with Owner

615-665-2022
Phone Number

615-665-2042
Fax Number

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

HCA Health Services of Tennessee, Inc.
Name

615-441-2357
Phone Number

c/o Summit Medical Center, 5655 Frist Boulevard
Street or Route

Davidson
County

Hermitage
City

TN
State

37076
Zip Code

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

A. Sole Proprietorship
B. Partnership
C. Limited Partnership
D. Corporation (For Profit) ✔
E. Corporation (Not-for-Profit)

F. Government (State of TN or Political Subdivision)
G. Joint Venture
H. Limited Liability Company
I. Other (Specify)_____

**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)***

NA
Name

Street or Route | County

City | State | 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 [✓]
B. Option to Purchase [ ]
C. Lease of _____ Years [ ]
D. Option to Lease [ ]
E. Other (Specify) _____ [ ]

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

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

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

**9. Bed Complement Data**

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

| | | Current Beds Licensed | *CON | Staffed Beds | Beds Proposed | TOTAL Beds at Completion |
|---|---|---|---|---|---|---|
| A. | Medical | | | | | |
| B. | Surgical | 110 | | 110 | 110 | 110 |
| C. | Long-Term Care Hospital | | | | | |
| D. | Obstetrical | 24 | | 20 | | 24 |
| E. | ICU/CCU | 24 | | 18 | | 24 |
| F. | Neonatal | 10 | | 10 | | 10 |
| G. | Pediatric | | | | | |
| H. | Adult Psychiatric | 20 | | 20 | - 20 | 0 |
| I. | Geriatric Psychiatric | | | | | |
| J. | Child/Adolescent Psychiatric | | | | | |
| K. | Rehabilitation | | | | + 20 | 20 |
| 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** | 188 | | 178 | NC | 188 |

*CON-Beds approved but not yet in service

2012 AUG 13 AM 10: 22

**10. Medicare Provider Number** 440150

**Certification Type** general hospital

**11. Medicaid Provider Number** 44-0205

**Certification Type** general hospital

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

**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?** p. 4 **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.***

**A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?**

This is an existing facility already certified for both programs. In CY2011, Summit Medical Center had an overall payor mix of 59.0% Medicare and 9.0% TennCare.

**A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) 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 MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.**

**DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.**

Summit Medical Center is fully contracted with all available TennCare MCO's in the Middle Tennessee Region. They are as follows:

| **Table One: Contractual Relationships with Service Area MCO's** | |
|---|---|
| **Available TennCare MCO's** | **Applicant's Relationship** |
| AmeriGroup | contracted |
| United Community Healthcare Plan (formerly AmeriChoice) | contracted |
| Select | contracted |

## SECTION B: PROJECT DESCRIPTION

**B.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.**

Proposed Services and Equipment

• Summit Medical Center is a busy 188-bed community hospital located beside I-40 in Hermitage, Tennessee, in far eastern Davidson County. It is the only general hospital between downtown Nashville (Davidson County) and Lebanon (Wilson County)--which are respectively, 20 and 27 minutes' drive time away.

• Summit proposes to establish a 20-bed acute inpatient rehabilitation unit, certified as a "distinct part unit" by Medicare. This will not increase hospital or service area bed complements, because it will be a conversion of an existing 20-bed inpatient adult psychiatric unit on the hospital's third floor. Psychiatric patients remaining in that unit, or presenting subsequently at Summit's Emergency Department, will be stabilized and transported to Skyline Medical Center's behavioral medicine facility at Madison in East Nashville, which has sufficient capacity to admit them.

Ownership Structure

• Summit Medical Center is an HCA TriStar facility owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains more details, an organization chart, and information on Tennessee facilities owned by HCA.

Service Area

• The project's primary service area will reflect the hospital's primary service area. That area consists of Davidson and Wilson Counties. Approximately 85% of Summit's admissions come from those counties, with no other county contributing as much as 3%.

Need

• In recent years, HCA TriStar community hospitals on the north and south sides of the Nashville area have been granted CON's to add rehabilitation beds, through conversions of existing hospital beds. These CON's allowed them to improve their continuum of care without constructing costly new beds. This is the third such project. Summit's conversion of its psychiatric beds into acute rehabilitation beds will not increase its bed license. But it will improve patient access to rehabilitation in the eastern part of the urban area.

• The location and timing of the project are appropriate for several reasons:

a. Rehabilitation utilization in Davidson County has been shifting to suburban locations that are closer to many patients' homes. Between 2008 and 2011, the total rehabilitation days provided in the downtown area (at Baptist, Vanderbilt, and NRH) decreased 15%, while the rehabilitation days provided in the Davidson County suburbs (at Skyline and Southern Hills) increased 56%. The share of rehabilitation days that were provided in a suburban location increased from 20% to almost 38%.

b. While northern and southern Davidson County hospitals have been granted CON's for acute rehabilitation beds, eastern Davidson County has not. Summit Medical Center in eastern Davidson County is the only place acute rehabilitation beds can be opened in that sector, because Summit is the only hospital between downtown Nashville and the city of Lebanon, in Wilson County--a thirty-two mile distance.

c. The project will complete HCA TriStar's plan to offer acute inpatient rehabilitation programs to patients of four suburban TriStar hospitals surrounding downtown Nashville. It is already in place at HCA TriStar hospitals to the north (Skyline Medical Center), the west (Horizon) Medical Center, and the south (Southern Hills Medical Center); but not yet at Summit Medical Center in eastern Davidson County.

d. Summit's discharges of rehabilitation-appropriate patients are rapidly increasing, due not only to area population growth, but also to the hospital's CY2011 Emergency Department expansion and its designation as a Certified Stroke Center. Summit's growth will ensure that this refocused 20-bed unit will be reasonably utilized, and will not shift costs of rehabilitation care to other types of hospital patient.

e. The utilization of existing rehabilitation beds in Davidson County is at efficient levels. The beds at the county's four operational acute rehabilitation providers provided 41,292 days of care in 2011. This is equal to 70.5% occupancy on the 161 usable rehabilitation beds that will be open in this county, by the summer of 2012. More rehabilitation beds exist "on paper" but are older and for years have not open.

Existing Resources

• There are seven hospitals in the primary service area with licensed rehabilitation beds. But only five of those services are open for patient care. The five facilities with operational rehabilitation beds will have 161 such beds available in the summer of 2012 (157 are open and 4 are under construction). The two facilities with non-operational rehabilitation units have 41 such beds, which are not likely to be open for admissions in the foreseeable future.

Project Cost, Funding, Financial Feasibility, and Staffing

• The estimated cost of the project is $2,500,000, which will be provided through a cash transfer from Summit's parent company, HCA.

• As shown in the Projected Data Chart, the proposed rehabilitation service will operate with a positive financial margin. The unit will have approximately the same charge structure as the unit operating at Southern Hills Medical Center since 2011.

• The project will require the addition of 29 FTE's (nurses, therapists, social workers, and unit management and clerical support). See Table Eighteen in Section C(III).3.

**B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.**

**B.II.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 AREAS, ROOM CONFIGURATION, ETC.**

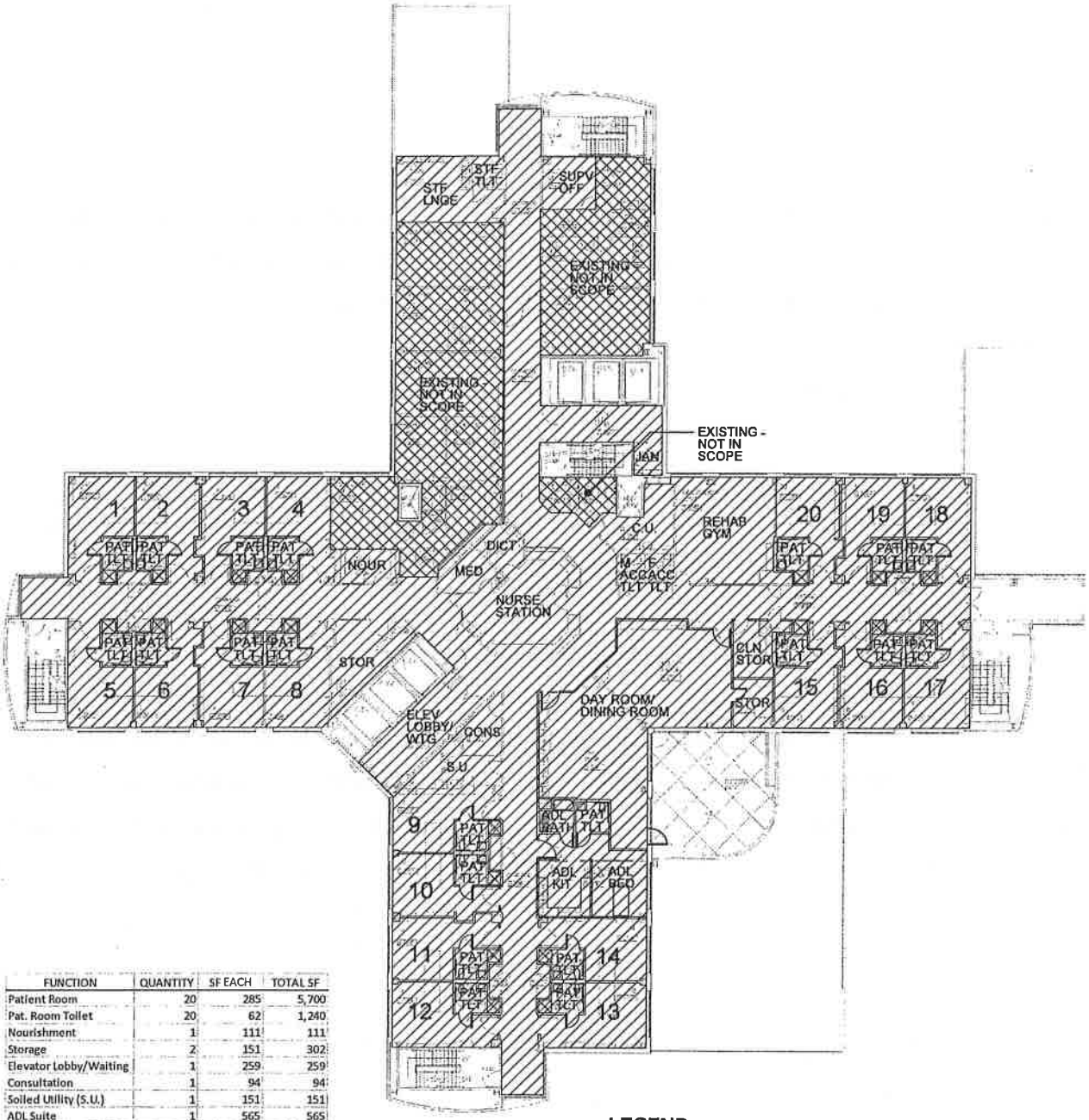
Physical Description

The project will require major and minor renovation on the hospital's third floor, which currently contains a 20-bed inpatient psychiatric unit with support spaces. The project will replace the psychiatric service with an inpatient rehabilitation service of the same bed complement, so it will not change Summit Medical Center's 188-bed license. It will only reassign or reclassify 20 beds. Offices in one wing will remain; their future use has not yet been determined.

The completed rehabilitation service will include 20 private patient bedrooms with handicapped-accessible/ADA-compliant private bathrooms; and ADL (Activities of Daily Living) suite with a kitchen, bedroom, and bath; a Day Room/Dining Room multi-purpose room, gym, and other patient and staff support spaces. The tables below, and the floor plan following this page, identify changes in use and in square footages on the third floor, and provide a detailed space program and preliminary layout for the proposed unit.

| Table Two-A: Summary of Construction and Changes in Size | |
|---|---|
| | **Total Square Feet** |
| Hospital Third Floor Before Project | 20,294 SF (not including elevator, stairs, or mechanical chases |
| Hospital Third Floor After Project | no change |
| | |
| Area of New Construction | none |
| Area of Renovation | 9,626 SF |

| Table Two-B: Proposed Changes in Third Floor Space | | | |
|---|---|---|---|
| | **Existing SF/Area** | **SF To Be Added or Reduced** | **Resulting Total SF/Area** |
| **Nursing Unit and Support Space** | 20,294 SF Psychiatric Unit | (3,264 SF) | 17,030 SF Rehabilitation Unit |
| **Miscellaneous Office Space** | 0 SF | + 3,264 SF | 3,264 SF |




| FUNCTION | QUANTITY | SF EACH | TOTAL SF |
|---|---|---|---|
| Patient Room | 20 | 285 | 5,700 |
| Pat. Room Toilet | 20 | 62 | 1,240 |
| Nourishment | 1 | 111 | 111 |
| Storage | 2 | 151 | 302 |
| Elevator Lobby/Waiting | 1 | 259 | 259 |
| Consultation | 1 | 94 | 94 |
| Soiled Utility (S.U.) | 1 | 151 | 151 |
| ADL Suite | 1 | 565 | 565 |
| Day Room/Dining Room | 1 | 1,328 | 1,328 |
| Clean Storage | 1 | 107 | 107 |
| Male Acc. Toilet | 1 | 43 | 43 |
| Female Acc. Toilet | 1 | 43 | 43 |
| Clean Utility (C.U.) | 1 | 185 | 185 |
| Nurse Station | 1 | 478 | 478 |
| Meds | 1 | 115 | 115 |
| Dictation | 1 | 103 | 103 |
| Janitor Closet | 1 | 47 | 47 |
| Staff Lounge | 1 | 322 | 322 |
| Staff Toilet | 1 | 38 | 38 |
| Supervisor Office | 1 | 146 | 146 |
| Rehab Gym | 1 | 550 | 550 |
| TOTAL NET SQUARE FOOTAGE | | | 11,927 |
| CIRCULATION GROSSING FACTOR | | | 0.43 |
| TOTAL GROSS SQUARE FOOTAGE (Hatched Area) | | | 17,030 |

LEGEND

Rehab Unit

Miscellaneous Office Space

# SUMMIT MEDICAL CENTER
# HERMITAGE, TENNESSEE

Third Floor Rehab Unit

## PROPOSED - ENLARGED THIRD FLOOR PLAN

8

GS&P #28973.00
06.11.2012

G S & P

## Operational Schedule

This is an inpatient acute care unit that will provide medical care and supervision 24 hours daily, throughout the year. The applicant intends to open the unit on or before January 1, 2013. CY2013 will be its first full year of operation.

## Cost and Funding

The project cost is estimated at $2,500,000. This will be entirely funded by HCA, Inc., Summit Medical Center's ultimate parent company, through a cash transfer to TriStar Health System, HCA's regional office in this area.

## Medical Direction and Supervision

To provide medical direction for the rehabilitation program, Summit intends to recruit a Board-certified physical medicine and rehabilitation specialist ("physiatrist"). Both the Medical Directors at HCA TriStar's rehabilitation programs at Skyline Medical Center and Southern Hills Medical Center in Nashville are physiatrists.

**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 COSTS PER SQUARE FOOTAGE CHART...**

Not applicable.

**PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.**

The estimated $1,550,000 renovation construction cost for the project is approximately $161 PSF overall:

| Table Three: Construction Cost PSF | | |
|---|---|---|
| **Construction Cost** | **SF of Renovation** | **Construction Cost PSF** |
| $1,550,000 | 9,626 USF | $161.02 |

The 2009-2011 hospital construction projects approved by the HSDA had the following costs per SF. This project is very consistent with those ranges, being below the median for hospital renovation projects.

**Hospital Construction Cost Per Square Foot**
**Applications Approved by the HSDA**
**Years: 2009 – 2011**

| | Renovated Construction | New Construction | Total Construction |
|---|---|---|---|
| **1st Quartile** | $125.84/sq ft | $235.86/sq ft | $167.99/sq ft |
| **Median** | $177.60/sq ft | $274.63/sq ft | $249.32/sq ft |
| **3rd Quartile** | $273.69/sq ft | $324.00/sq ft | $301.74/sq ft |

*Source: Health Services and Development Agency, 2012*

**IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.**

Not applicable.

**B.II.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 EXISTING SERVICES.**

| **Table Four: Proposed Changes in Assignment of Licensed Hospital Beds Summit Medical Center** | | |
|---|---|---|
| **Bed Assignment** | **Current Assignment** | **Proposed Assignment** |
| General Medical-Surgical, Obstetric, ICU, NICU | 168 | 168 |
| Rehabilitation | 0 | 20 |
| Adult Psychiatric | 20 | 0 |
| *Total Licensed Complement* | *188* | *188* |

The resulting utilization and occupancies for the affected categories of beds are projected in Attachment Four, Section C(II)4 of the application.

The objective of the proposed reassignment of beds is to improve access to acute rehabilitation care in Summit's service area, while concentrating behavioral medicine care at HCA TriStar's Skyline Madison facility. Summit discharges a large number of patients who need rehabilitation, but has no beds approved for that purpose. Because Skyline Madison has the bed capacity to serve adult psychiatric patients now being admitted to Summit, it makes sense to concentrate those psychiatric admissions at Skyline Madison, freeing up Summit's third floor beds for reassignment to an acute rehabilitation program.

**B.II.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 ADOLESCENTS >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. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

Summit Medical Center has proposed this in-house acute rehabilitation service for several reasons.

First, it is good for patients. Acute rehabilitation in an inpatient setting is an important part of the continuum of high quality care for a wide range of conditions. Summit is the only hospital located in the growing eastern sector of the Nashville urban area; and Summit is committed to continuous improvement in the services it provides. Many persons need inpatient rehabilitation after an initial hospital stay, in order to regain acceptable functionality in activities of daily living and working. Patients who have undergone amputation, stroke, burns, major traumas, hip and knee replacements, shoulder and back surgery, or other events, or who are treated for serious arthritic or neurological issues, and many other conditions, all benefit from having access to acute inpatient rehabilitation immediately upon discharge from their initial hospital stay. Having the option to receive this kind of care on the same campus which they have chosen for their initial hospitalization is efficient, and makes sense when it does not require excessive new bed construction costs.

Second, distribution of this service to suburban locations such as Summit's is a trend favored by the consumer. Patients in Nashville have shown a desire to access such services not just in tertiary downtown hospitals, but also in suburbs closer to where they live, and where they often receive their hospital care. Table Five below illustrates that there has been a significant shift of rehabilitation admissions recently, from downtown centers to suburban locations. From 2008 to 2011, downtown rehabilitation admissions shrank by 15% while suburban rehabilitation admissions increased 56%. The suburban market share increased from 20% in 2008 to 32% in 2011, while the central Davidson County share decreased from 80% to 68% in that period. And during this, the total days of rehabilitation provided in Davidson County has remained stable. This has been an orderly redistribution of resources.

**Table Five: Movement of Rehabilitation Patient Days in Davidson County CY2008-CY2011**

| Location | CY 2008 | CY 2011 | Change '08-'11 |
|---|---|---|---|
| Central County | 33,199 (80%) | 28,221 (68%) | -15% |
| Suburban County Areas | 8,329 (20%) | 13,071 (32%) | +56% |
| Totals | 41,528 | 41,292 | |

Source: Joint Annual Reports, 2008-2013. Central providers were Vanderbilt Stallworth, Baptist, and Nashville Rehabilitation Hospital (closed). Suburban providers were Skyline and Southern Hills Medical Centers. See Table Eleven for detailed data.

Third, distribution of this type of care to Summit Medical Center is especially needed as the hospital increases its healthcare role in the community. In the second half of CY2011, Summit opened a major Emergency Department expansion, and became a Certified Stroke Center. These and other service improvements have dramatically increased the number of its discharged patients who go immediately into an inpatient rehabilitation program elsewhere. With such transfers up 41% this year (on an annualized basis), such a program on Summit's own campus will be financially feasible and efficiently utilized.

The fourth reason for the project is consistency: Summit's large service area on the east side of greater Nashville is the only suburban sector of Nashville whose local hospital does not offer inpatient acute rehabilitation care. Certificates of Need for this

program have been granted to the other suburban hospitals north, south, and even west (Dickson) of Nashville. The eastern side of the urban area needs a comparable option.

Finally, this project will not have any significant adverse impact on other non-HCA providers of this type of care in either Davidson or Wilson Counties. For the past two years, HCA's own rehabilitation programs at Skyline and Southern Hills have been retaining approximately 81% of HCA discharges into rehabilitation units. Last year, Summit discharged only 47 patients to rehabilitation programs other than those of HCA. So most of the admissions to Summit will be a shift of care within the HCA TriStar network, all of it reflecting patient preferences and convenience. And while there is still some available bed capacity at existing rehabilitation providers in the service area, the programs in Davidson County are operating at approximately 70% utilization, which is financially sound.

**B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.**

Not applicable. The project does neither of those things.

**B.II.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 SCANNER (MRI), 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 schedule of operations.**
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.**
3. **Indicate applicant's legal interest in equipment (e.g., 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.**

Not applicable. There is no major medical equipment proposed in this project.

**B.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;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS 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.**

See Attachment B.III.A.

**B.III.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.**

Summit Medical Center is located in Hermitage, on the far eastern edge of Davidson County near the Wilson County line. The hospital is on the west side of Old Hickory Boulevard / Highway 45, approximately one mile north of Exit 221 from I-40, and is visible from that exit. Summit serves patients primarily from eastern Davidson County and western Wilson County. Interstate I-40 and U.S. Highway 70, which run east and west between Nashville and Lebanon, are the service area's principal east-west roadways; Old Hickory Boulevard is one of the service area's major roadways running north-south by the Summit campus.

Summit is very accessible to western Wilson County, as well as to eastern Davidson County between Old Hickory Lake (the Cumberland River) and the areas west, north, and east of Percy Priest Lake. The rapidly growing Mt. Juliet community is the fastest growing sector of western Wilson County; and Mt. Juliet is much closer to Summit Medical Center (8.5 miles) than it is to Lebanon (16.9 miles), where Wilson County's only existing acute rehabilitation beds are located (at McFarland Hospital).

**Table Six: Mileage and Drive Times Between Summit Medical Center and Acute Rehabilitation Providers and Communities In the Primary Service Area**

| Acute IP Rehabilitation Provider | County | Distance (Mileage) | Drive Time (Minutes) |
|---|---|---|---|
| 1. Baptist Hospital, Nashville | Davidson (Central) | 14.3 mi. | 22 min. |
| 2. Stallworth Rehabilitation Hospital, Nashville | Davidson (Central) | 14.5 mi. | 23 min. |
| 3. Nashville Rehabilitation Hospital (closed; license in abeyance) | Davidson (Central) | 13.8 mi. | 23 min. |
| 4. Southern Hills Medical Center, Nashville | Davidson (South) | 14.8 mi. | 23 min. |
| 5. Skyline Medical Center, Nashville | Davidson (North) | 15.6 mi. | 21 min. |
| 6. City of Mt. Juliet | Wilson | 8.5 mi. | 14 min. |
| 7. McFarland Hospital, Lebanon, Wilson County | Wilson | 20.6 mi. | 27 min. |

Source: Google Maps, June 14 (10 am), 2012. See Miscellaneous Attachments.

**B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.**

See attachment B.IV.

**IV. FOR A HOME CARE ORGANIZATION, IDENTIFY**

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

**C(I) NEED**

**C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO 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 CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.**

**B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).**

**Project-Specific Review Criteria: Comprehensive IP Rehabilitation Services**

**1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.**

**2. The need shall be based upon the current year's population and projected four years forward.**

Summit's primary service area counties are Davidson and Wilson Counties. Their combined CY2016 population will be 739,405 persons. At 10 beds per 100,000 persons, criteria #1 and #2 above would identify a need for 74 beds for that population--62 for Davidson County and 12 for Wilson County.

However, this review criterion should not be applied against this project, because rehabilitation beds located in tertiary referral areas such as Davidson County are regional, multi-county resources. The THA database indicates that in CY2011, only 47.5% of rehabilitation patients in Davidson and Wilson County programs were residents of Davidson and Wilson Counties. More than half of the beds used in these two counties were used by residents of other counties.

At present, there are 202 approved rehabilitation beds in Davidson and Wilson counties. Of these, 41 are older beds that are not open and are not likely to re-open for this type of care. A total of 161 beds will actually be available by September 2012 (4 are still under construction and 157 are fully operational).

**3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.**

Approximately 85% of Summit's admissions come from Davidson and Wilson counties; and the majority of Summit's rehabilitation unit admissions will come from Summit discharges. So these counties are an appropriate primary service area.

**4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.**

The project complies, having 20 beds.

**5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.**

Not applicable.

**6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:**

**20-30 bed unit 75%**
**31-50 bed unit/facility 80%**
**51+-bed unit/facility 85%**

The term "existing units or facilities" should be interpreted to include only those that are operational or likely to be operational in the foreseeable future. There are seven total acute rehabilitation units licensed for this service; but two are older units that have been closed for several years. In the applicant's opinion neither is likely to re-open. This leaves five providers, whose current occupancies are shown in Table Seven below:

**Table Seven: CY2011 Occupancies of Rehabilitation Providers in the Service Area**

| Provider / December 2011 Beds | CY2011 Occupancy |
|---|---|
| Baptist Hospital / 24 beds | 69.0% |
| VU Stallworth Rehab'n Hospital / 80 beds | 76.0% |
| Skyline Medical Center / 41 beds | 75.5% |
| Southern Hills Medical Center / 12 beds | 69.2% |
| McFarland Hospital / 26 beds (Wilson Co.) | 29.4% |

Source: Joint Annual Report data from Table Eleven, Section C.(I).5 of this application.

Although service area providers are not yet at the target occupancies of the criterion, nonetheless those located in Davidson County are efficiently utilized--at 71.5%, collectively. See Table Eleven in this application, section C.(I).5 below.

HealthSouth's recently approved application to build a Vanderbilt-led rehabilitation hospital in Williamson County stated that Stallworth in central Davidson County can not achieve much higher occupancy than its current level, because of its semiprivate rooms, which require gender separation that often prevents a second admission to a semi-private room. Stallworth has recently declined a number of Summit's requests for admissions to a rehabilitation bed.

Southern Hills' unit has grown in utilization so rapidly that the HSDA recently approved it to add four more rehabilitation beds (by conversion) despite these criteria.

Skyline's rehabilitation program has also grown rapidly, with the growth of their neurosciences programs (stroke; neurosurgery; spinal surgery).

Only the UMC McFarland facility in Lebanon, almost a half-hour drive from Summit, has low occupancy on its rehabilitation beds. Once a general hospital, and now a psychiatric and rehabilitation facility, McFarland long ago was allowed to assign far more licensed rehabilitation beds than its service area can now fill. It is not a reasonable option for Davidson and western Wilson County residents who obtain care in Davidson County, and are not inclined to drive miles into a rural area for their care. Davidson County is not even in McFarland's primary service area: only 3% of McFarland's total admissions (both psychiatric and rehabilitation) come from Davidson County, according to its most recent Joint Annual Report posted on the Department of Health website.

**7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board-certified physiatrist.**

Complies. Staffing requirements and resources for the project are set forth in response C.15 below. The staffing conforms to licensure requirements.

## The Framework for Tennessee's Comprehensive State Health Plan
## Five Principles for Achieving Better Health

**The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.**

### 1. Healthy Lives

***The purpose of the State Health Plan is to improve the health of Tennesseans.***
**Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.**

In this project, the applicant's parent organization (HCA) proposes to use its local TriStar hospital network to better address healthcare needs by coordinating two of its hospitals' scopes of service. Skyline Madison Medical Center will more efficiently and completely utilize its psychiatric beds by absorbing psychiatric patients now at Summit. This will enable Summit Medical Center to broaden its continuum of care by adding a rehabilitation program that is appropriate for the only designated Stroke Center and emergency care resource on the eastern side of the county.

### 2. Access to Care

***Every citizen should have reasonable access to health care.***
**Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.**

This application proposes that the HSDA continue to support the distribution of acute rehabilitation services to suburban communities surrounding Nashville, to improve public access time to acute rehabilitation care.

### 3. Economic Efficiencies

***The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.*** **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

This project is consistent with past CON decisions to distribute acute rehabilitation

programs to suburban sectors of the Nashville area, without increasing total licensed hospital beds. The public's need for this has been demonstrated by the rapid growth in utilization of such units, and by the operational closure of inpatient rehabilitation beds in central Davidson County. This is an improvement in access for suburban patients, accomplished in an efficient manner by re-assignment of existing bed units.

**4. Quality of Care**

***Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.*** **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

TriStar hospitals such as Summit Medical Center pursue and maintain high quality standards in their services, as defined by best practices standards within HCA as well as by standards promulgated by State licensure.

**5. Health Care Workforce**

***The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.*** **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

The project will provide an additional clinical rotation site for students in physical therapy programs of Tennessee educational institutions. Summit already participates in the training of therapists and this will be a major expansion of that role.

**C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.**

As stated, this project continues to implement HCA TriStar's plan to distribute acute rehabilitation services to suburban locations closer to many patients' homes.

**C(I).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 A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).**

Summit Medical Center receives approximately 82% of its admissions from Davidson and Wilson Counties. Under HSDA definitions, they are the hospital's primary service area. On a sub-county level, Summit receives most of its admissions from eastern Davidson County and western Wilson County, for whom it is an important hospital resource. Because HCA TriStar's experience is that the great majority of its rehabilitation units' admissions are patients discharged from the hospital of which they are a part, it is logical to assume that Davidson and Wilson Counties will also be the primary service area for the proposed rehabilitation service. Table Eight below reflects that assumption; its percentages mirror the experience of the hospital in CY2011.

A service area map and a map showing the location of the service within the State of Tennessee are provided as Attachments C, Need--3 at the back of the application.

**Table Eight: Projected Patient Origin**
**Summit Medical Center Acute Inpatient Rehabilitation Unit**

| PSA County | Percent of Total | Yr. 1 Admissions | Yr. 2 Admissions |
|---|---|---|---|
| Davidson | 56.6% | 186 | 212 |
| Wilson | 28.8% | 94 | 108 |
| **PSA Subtotal** | **81.9%** | **280** | **320** |
| Other Counties or States (<3% each) | 14.6% | 48 | 54 |
| **Total** | **100.0%** | **328** | **374** |

Source: Applicant's CY2011 Provisional Joint Annual Report; admissions from Projected Data Chart.

## C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

The county-based primary service area is increasing in population. The State projects that the total population will increase by 3.4% between 2012 and 2016, and that the elderly 65+ population will increase by 12.4%. This is very similar to the projections for the State as a whole. The primary service area's income, poverty and TennCare profiles are not very different from the State average. But within the primary service area, Wilson County has higher median income, a lower poverty rate, and a lower percentage of its residents enrolled in TennCare than does Davidson County.

**Table Nine: Primary Service Area Demographic Data With State of Tennessee Comparison**

| Demographic/ Geographic Area | Davidson County | Wilson County | Primary Service Area Total | State of TN Total |
|---|---|---|---|---|
| Median Age in Years-2010 US Census | 37.4 | 36.3 | 36.9 | 41.3 |
| Total Population-Current Year -2012 | 602,257 | 114,437 | 716,694 | 6,361,070 |
| Total Population-Projected Year -2016 | 618,202 | 121,203 | 739,405 | 6,575,165 |
| Total Population-% change | +2.6% | +5.9% | +3.2% | +3.4% |
| Age 65 & over Population - 2012 | 70,698 | 13,646 | 84,344 | 878,496 |
| Age 65 & over Population - 2016 | 78,799 | 15,998 | 94,797 | 987,074 |
| Age 65 & over Population - % change | +11.5% | +17.2% | +12.4% | +12.4% |
| Age 65 & over Population as % of Total (2012) | 11.7% | 11.9% | 11.8% | 13.8% |
| Age 65 & 0ver Population as % of Total (2016) | 12.7% | 13.2% | 12.8% | 15.0% |
| Median Household Income | $45,668 | $60,678 | $53,173 | $43,314 |
| TennCare Enrollees | 119,539 | 14,174 | 133,713 | 1,211,113 |
| TennCare Enrollees as % of Total | 19.8% | 12.4% | 18.7% | 19.0% |
| Persons Below Poverty Level | 104,190 | 8,697 | 112,888 | 1,049,577 |
| Persons Below Poverty Level as % of Total | 17.3% | 7.6% | 15.8% | 16.5% |

Sources: TDH Population Projections, Feb. 2008; U.S. Census QuickFacts; TennCare Bureau. PSA data is unweighted average, or total, of county data.

**C(I).4.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.**

Like other services of Summit Medical Center, this proposed inpatient acute rehabilitation unit will be accessible to the above groups. It will accept both Medicare and TennCare patients. Like most other such units, the large majority of its services will be for elderly patients.

**C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, 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.**

The table below shows the acute inpatient rehabilitation providers in the two-county service area, and their drive times and distances from the project site (Summit).

**Table Ten: Mileage and Drive Times Between Summit Medical Center and Acute Rehabilitation Providers In the Primary Service Area**

| Acute IP Rehabilitation Provider and City | County | Distance (Mileage) | Drive Time (Minutes) |
|---|---|---|---|
| 1. Baptist Hospital, Nashville | Davidson (Central) | 14.3 mi. | 22min. |
| 2. Stallworth Rehabilitation Hospital, Nashville | Davidson (Central) | 14.5 mi. | 23 min. |
| 3. Nashville Rehabilitation Hospital, Nashville (closed; license in abeyance) | Davidson (Central) | 13.8 mi. | 23 min. |
| 4. Southern Hills Medical Center, Nashville | Davidson (South) | 14.8 mi. | 23 min. |
| 5. Skyline Medical Center, Nashville | Davidson (North) | 15.6 mi. | 21 min. |
| 6. McFarland Hospital, Lebanon | Wilson | 20.6 mi. | 27 min. |

Source: Google Maps, June 10 (10 am), 2012. See Miscellaneous Attachments.

Table Eleven on the following page shows the utilization they reported during the past four years. While all five providers in the two counties averaged 67.8% in CY2011, the four that were open and available in Davidson County averaged 70.5%. And the applicant again points out that the 41 designated rehabilitation beds in Davidson County that were not open and available are very unlikely to become open and available in the foreseeable future, due to licensing issues and other issues.

**Table Eleven: Utilization of Acute Inpatient Rehabilitation Beds (Revised on Supplemental Cycle)**
**Primary Service Area of Summit Medical Center**
**2008-2011**

| ACUTE INPATIENT REHABILITATION PROVIDER | REHAB BEDS IN 2012 | | 2008 | | | | 2009 | | | | 2010 | | | | 2011 (Provisional) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | IN OPERATION | LICENSED OR APPROVED | BEDS | DAYS | ADC | OCC'Y | BEDS | DAYS | ADC | OCC'Y | BEDS | DAYS | ADC | OCC/Y | BEDS | DAYS | ADJUSTED ADC (NOTE 1) | ADJUSTED OCC'Y (NOTE 1) |
| Baptist Hospital | 24 | 24 | 24 | 6,135 | 16.8 | 70.0% | 24 | 6,783 | 18.6 | 77.4% | 24 | 6,578 | 18.0 | 75.1% | 24 | 6,041 | 16.6 | 69.0% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| VU Stallworth Rehabilitation Hospital | 80 | 80 | 80 | 22,233 | 60.9 | 76.1% | 80 | 22,393 | 61.4 | 76.7% | 80 | 22,671 | 62.1 | 77.6% | 80 | 22,180 | 60.8 | 76.0% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| Nashville Rehabilitation Hospital | 0 | 31 | 34 | 4,831 | 13.2 | 38.9% | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| Skyline Madison Medical Center | 0 | 10 | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% |
| Madison / Davidson County | | | | | | | | | | | | | | | | | | |
| Skyline Medical Center | 41 | 41 | 31 | 8,329 | 22.8 | 73.6% | 41 | 10,150 | 27.8 | 67.8% | 41 | 10,804 | 29.6 | 72.2% | 41 | 11,306 | 31.0 | 75.5% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| Southern Hills Medical Center | 12 | 16 | 0 | 0 | 0.0 | 0.0% | 0 | | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% | 12 | 1,765 | 8.3 | 69.2% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| McFarland Hospital | 26 | 26 | 26 | 2,762 | 7.6 | 29.1% | 26 | 2,529 | 6.9 | 26.6% | 26 | 2,641 | 7.2 | 27.8% | 26 | 2,794 | 7.7 | 29.4% |
| Lebanon / Wilson County | | | | | | | | | | | | | | | | | | |
| **PRIMARY SERVICE AREA TOTALS** | 183 | 228 | 195 | 44,290 | 121.3 | 62.2% | 171 | 41,855 | 114.7 | 67.1% | 171 | 42,694 | 117.0 | 68.4% | 183 | 44,086 | 120.8 | 67.8% |

| OPERATIONAL REHABILITATION PROVIDERS BY COUNTY | Licensed & Approved Beds in Operation By Dec 2012 | CY2011 Days | CY2011 Occ'y |
|---|---|---|---|
| Davidson County Providers (4 open) | 161 | 41,292 | 70.5% |
| Wilson County Provider (1 open) | 26 | 2,794 | 29.4% |

Source: Joint Annual Reports of Hospitals, TDH, HSDA, and TriStar HCA records

Notes:

1. Southern Hills opened 12 beds June 1, 2011. Their ADC during June through December 2011 was 8.3: 1765 rehab days / 214 calendar days =8.3 ADC. Their occupancy during that period was 69.2%: 8.3 / 12 beds = 69.2%. The 2011 Southern Hills utilization data reflects those adjustments. The 2011 PSA Total occupancy has also been adjusted to take Southern Hills into account:
   - Southern Hills Capacity: 12 beds X 214 days = 2,568 days
   - Other Providers Capacity: 171 beds X 365 days = 64,983 days
   - 2011 Total PSA Capacity: 64,983 days
   - 2011 Rehabilitation Days: 44,086 patient days
   - 2011 Occupancy: 44,086 / 64,983 = 67.8%

   Southern Hills will have all 16 approved beds operational in September 2012.
2. Nashville Rehabilitation Hospital's beds are licensed "in abeyance", and have been nonoperational for several years.
3. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational for several years.
4. The lower chart shows the 161 licensed rehabilitation beds that will be operational by the end of 2012: 202 approved beds minus 41 old and nonoperational beds at Skyline Madison (10) and NRH (31).



SUPPLEMENTAL- # 1
June 22, 2012
3:48 pm

**C(I).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.**

Summit Medical Center on Interstate 40 is the only hospital located in the populous and growing communities of eastern Davidson County and western Wilson County. Summit opened a major Emergency Department Expansion in July 2011, and received Accreditation as a Primary Stroke Care Center in November 2011. As a result of these and other service improvements, the hospital's discharges of patients with conditions requiring rehabilitation have soared upward.

Table Twelve-A below shows the annualized increase in Summit's actual discharges to acute rehabilitation programs at all locations, between 2011 and 2012. The 2012 projection is an annualization of the first quarter's actual discharges to rehabilitation programs.

**Table Twelve-A: Annual Discharges to Acute Rehabilitation Programs by Summit Medical Center**

| | CY2011 | CY2012 (Ann'd) | Percent Increase |
|---|---|---|---|
| **Discharges to Acute Rehabilitation Services** | 176 | 248 | +41% |

Source: Hospital records.
Note: At HCA TriStar hospitals, over the past two years Q1 discharges to rehabilitation have averaged 23% of the annual volume. Summit discharged 57 patients to acute rehabilitation programs in Q1 of 2012. (57 / .23 = 248)

Utilization Projection for the Project

Medicare-approved acute rehabilitation units are now required to have 60% of their patient population classified in one of thirteen "Rehabilitation Impairment Categories", or "RIC's". The other 40% of a unit's patients may be other types of conditions that are deemed medically appropriate for rehabilitation. Failure to maintain

the 60% standard will result in decertification by Medicare. Providers work very hard not to violate that objective. Summit's projected unit will be managed to have no less than 62% of its patients in the RIC categories at any time. The RIC group of conditions includes stroke, spinal cord injury, amputation, major multiple trauma, hip fracture, brain injury, neurological disorders, burns, active rheumatoid arthritis, congenital deformity, systemic vasculidities, severe or advanced osteoarthritis, hip and knee replacements with patient obesity and BMI of 50+, and any patient 85 years of age or older.

It should be noted that more than a third of the patients in acute rehabilitation units are there for significant conditions other than the thirteen RIC conditions. An often-cited example is rehabilitation following shoulder surgery. So utilization for this unit was projected considering both RIC and non-RIC patients.

Table Twelve-B below (on the second following page) sets out the projection. It was made by annualizing 2012 data, projecting a hypothetical CY2012 admissions figure for a Summit rehabilitation unit (were it open in 2012), and then projecting annual increases over the next two years.

Step 1: Summit identified in its CY2012 discharge base the number of patients that met RIC criteria, and thus were eligible for an acute rehabilitation admission (256).

Step 2: Assuming that the RIC number would be 62% of total admissions, a non-RIC potential admissions number was calculated: Non-RIC = 38% of the total = 157.

Step 3: The RIC and non-RIC potential patients were added to project 413 potential admissions from Summit's own CY2012 internal discharges.

Steps 4-5: Summit then made an assumption that only 74% of the 413 potential patients would actually be discharged to any hospital rehabilitation program. This was based on HCA experience locally with its own hospitals. It reflects many factors, including patient choice, payor willingness to cover rehabilitative care, the experience of case management personnel, etc. Application of the 74% factor reduced the potential Summit discharges to 306.

Steps 6-7: Using a weighted average of experience at HCA TriStar's Skyline and Southern Hills rehabilitation programs, Summit projected that a Summit program would retain 81% of its 306 internal discharges, or 248 admissions. That is the number of admissions that would be available to a Summit program in CY2012, were the unit open already.

Also at Step 7, Summit projected an annual increase in its available rehabilitation patients over the next two years. Summit projected a 10% increase in available admissions in CY2013 (which is Year One of the proposed unit), and 14.5% increase in CY2014 (Year Two)--as the program's quality becomes increasingly known to the community and to the medical staff. This is a conservative assumption. The increase in the hospital's discharges to all rehabilitation units has been 41% greater this year than last year, on an annualized basis.

Steps 8-9: HCA rehabilitation units in Nashville also receive 20% of their total referrals from non-HCA hospitals. This was assumed to continue in CY2013 and CY2014, resulting in a projection of 328 and 374 admissions those two years. At an average length of stay of 13.5 days (HCA's experience in Nashville), the unit would be approaching 70% occupancy by the end of its second year of operation. This is comparable to today's occupancy on functioning programs at Davidson County's other acute rehabilitation programs.

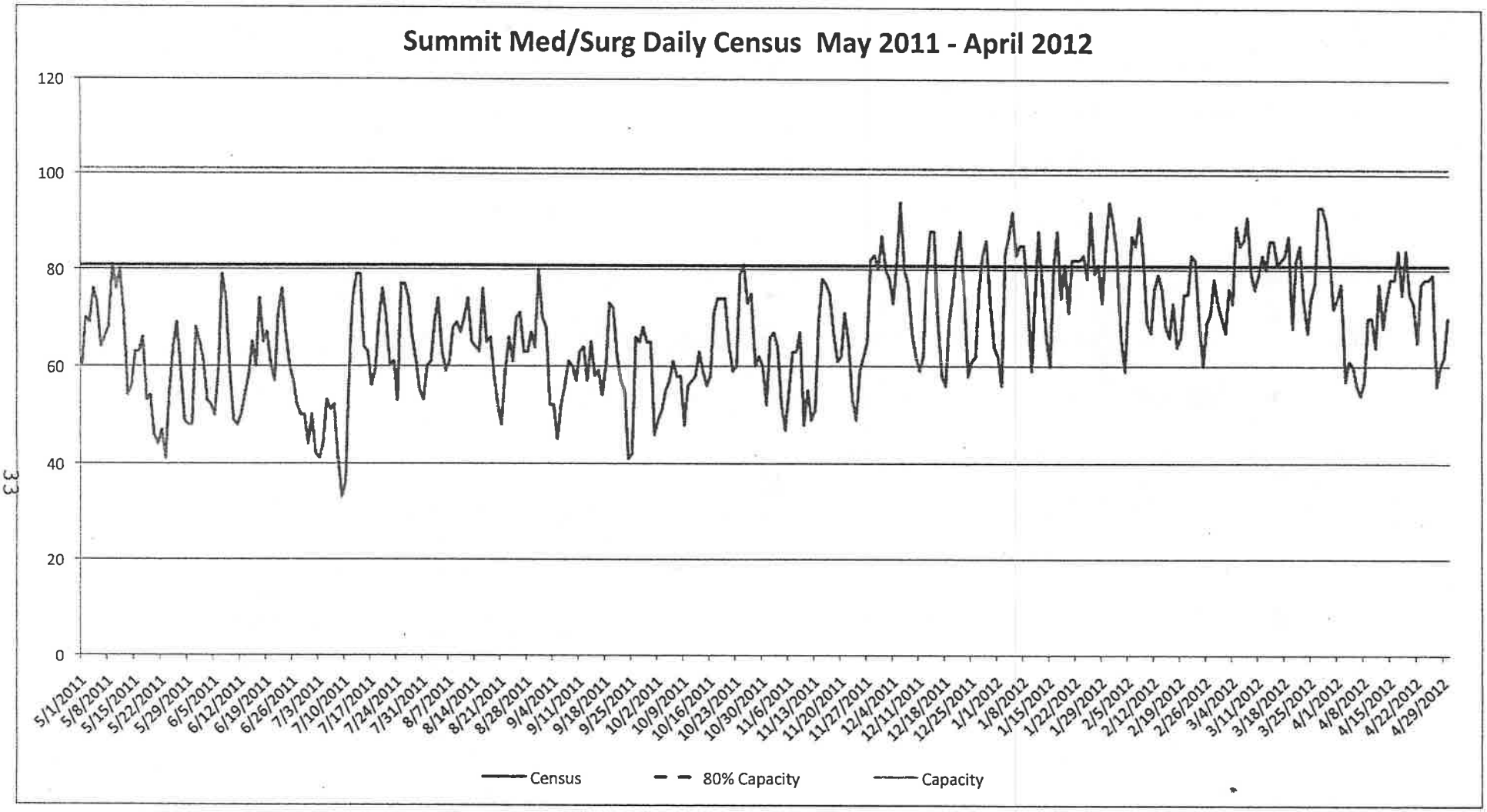
Following Table Twelve-B is Summit's Table Twelve-C, the historical and projected utilization of its beds by service. The project will not affect any bed assignments other than the third floor psychiatric beds, and will not change the hospital's licensed complement. Following Table Twelve-C are graphs of the hospital's recent increases in medical-surgical admissions and Emergency Department Admissions.

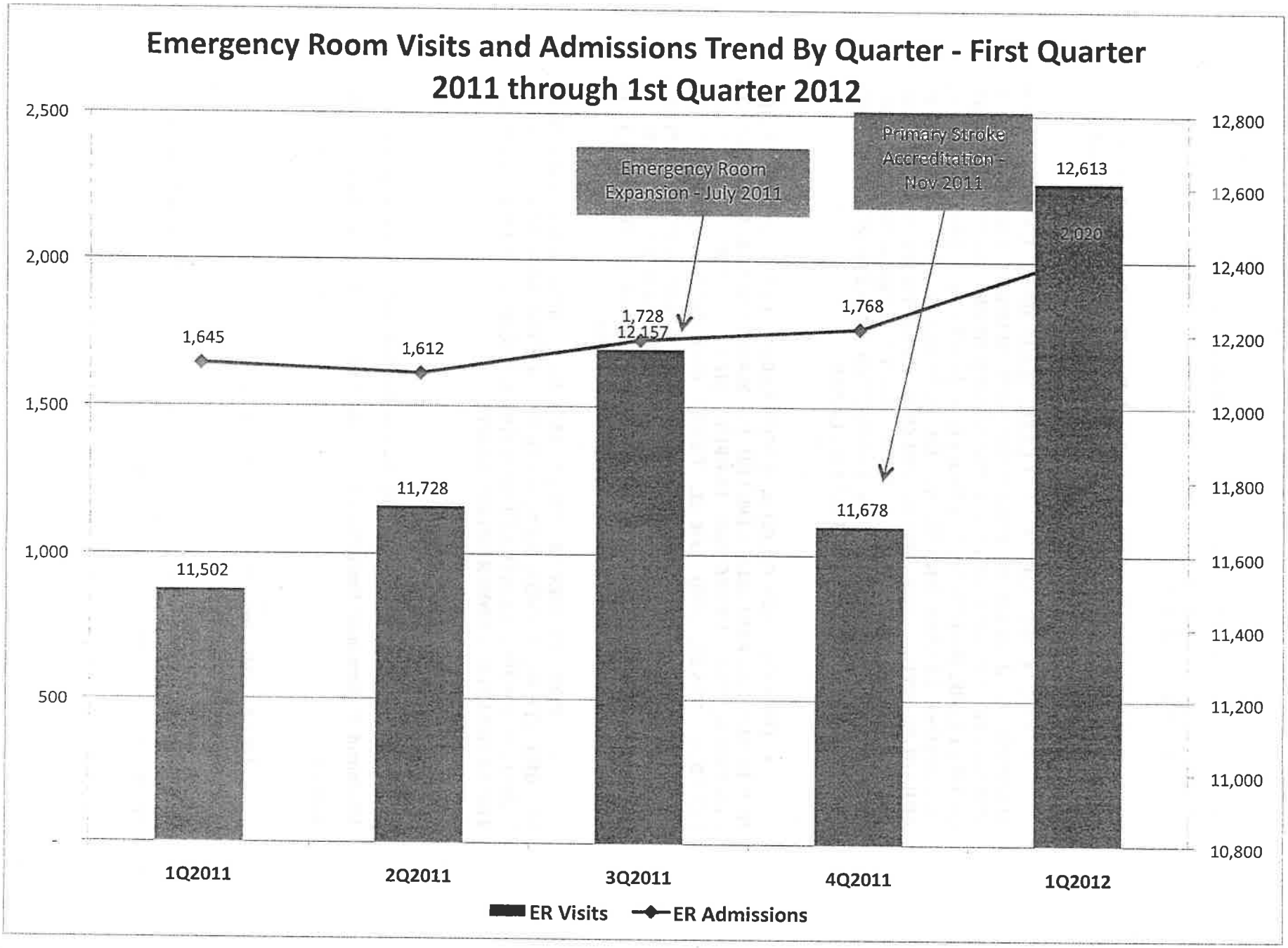
| Table 12-B: Projected Utilization of Rehabilitation Unit<br>Summit Medical Center (SMC)<br>CY2013-CY2014 | | | |
|---|---|---|---|
| | **Annualized CY2012** | **Year 1 CY2013** | **Year 2 CY2014** |
| 1. Summit Medical Center (SMC) Discharges of RIC Patients | 256 | 282 | 294 |
| 2. Other SMC Non-RIC Discharges Appropriate for Rehabilitation | 157 | 173 | 181 |
| 3. Total Potential SMC Discharges of Patients Appropriate for Rehabilitation | 413 | 455 | 475 |
| 4. Percent of Total That Will be Discharged to Rehabilitation | 74% | 74% | 74% |
| 5. Actual SMC Internal Discharges to Rehabilitation at Any Facility | 306 | 337 | 351 |
| 6. Percent of SMC's Discharges to Rehabilitation Retained by SMC | 81% | 81% | 81% |
| 7. SMC Internal Discharges to SMC Rehabilitation (Annual Change) | 248 | 273 (+10%) | 312 (+14.5%) |
| 8. Referrals to SMC Rehabilitation From Other Facilities (20% of Total) | -- | 55 | 62 |
| 9. Total SMC Admissions | -- | 328 | 374 |
| 10. ALOS (Average Length of Stay) | -- | 13.5 days | 13.5 days |
| 11. Patient Days | -- | 4,428 | 5,049 |
| 12. ADC (Average Daily Census) | -- | 12.1 | 13.8 |
| 13. Rehabilitation Bed Occupancy | -- | 60.7% | 69.2% |

**Table Twelve-C: Summit Medical Center**
**Utilization of Licensed Beds, CY 2009 - CY 2011**
**Projected Utilization of Licensed Beds, CY 2012-2014**

| | Actual 2009 | Actual 2010 | Actual 2011 | Projected 2012 | Rehabilitation Year One Projected 2013 | Rehabilitation Year Two Projected 2014 |
|---|---|---|---|---|---|---|
| **Total Beds** | 188 | 188 | 188 | 188 | 188 | 188 |
| Admissions | 9,356 | 9,850 | 9,984 | 10,709 | 10,580 | 10,818 |
| Patient Days | 36,755 | 39,921 | 38,552 | 39,663 | 40,793 | 42,132 |
| ALOS on Admissions | 4 | 4 | 3.9 | 4 | 4 | 4 |
| ADC on Admissions | 100.7 | 109.4 | 105.6 | 108.7 | 111.8 | 115.4 |
| Occupancy on Admissions | 53.6% | 58.2% | 56.2% | 57.8% | 59.4% | 61.4% |
| 23-Hour Observation Days | 5,508 | 5,207 | 4,676 | 5,215 | 5,314 | 5,420 |
| Total Bed Days | 45,651 | 48,710 | 46,367 | 47,829 | 49,087 | 50,562 |
| Total ADC | 125.1 | 133.5 | 127.0 | 131.0 | 134.5 | 138.5 |
| Total Occupancy | 66.5% | 71.0% | 67.6% | 69.7% | 71.5% | 73.7% |
| | | | | | | |
| **Medical-Surgical Beds** | 110 | 110 | 110 | 110 | 110 | 110 |
| Admissions | 6,086 | 6,671 | 6,713 | 7,586 | 7,737 | 7,892 |
| Patient Days | 26,243 | 30,099 | 27,134 | 29,847 | 30,444 | 31,053 |
| ALOS on Admissions | 4.3 | 4.5 | 4.0 | 3.9 | 3.9 | 3.9 |
| ADC on Admissions | 71.9 | 82.5 | 74.3 | 81.8 | 83.4 | 85.1 |
| Occupancy on Admissions | 65.4% | 75.0% | 67.6% | 74.3% | 75.8% | 77.3% |
| 23-Hour Observation Days | 4,562 | 4,670 | 4,427 | 4,735 | 4,830 | 4,926 |
| Total Bed Days | 30,805 | 34,769 | 31,561 | 34,582 | 35,274 | 35,979 |
| Total ADC | 84.4 | 95.3 | 86.5 | 94.7 | 96.6 | 98.6 |
| Total Occupancy | 76.7% | 86.6% | 78.6% | 86.1% | 87.9% | 89.6% |
| | | | | | | |
| **Critical & Intermediate Care Beds** | 24 | 24 | 24 | 24 | 24 | 24 |
| Admissions | 1,011 | 1,082 | 1,163 | 1,233 | 1,257 | 1,283 |
| Patient Days | 5,080 | 5,105 | 5,601 | 4,877 | 4,975 | 5,074 |
| ALOS on Admissions | 5.0 | 4.7 | 4.8 | 4.0 | 4.0 | 4.0 |
| ADC on Admissions | 13.9 | 14.0 | 15.3 | 13.4 | 13.6 | 13.9 |
| Occupancy on Admissions | 58.0% | 58.3% | 63.9% | 55.7% | 56.8% | 57.9% |
| 23-Hour Observation Days | | | | 156 | 159 | 162 |
| Total Bed Days | 5,080 | 5,105 | 5,601 | 5,033 | 5,134 | 5,236 |
| Total ADC | 13.9 | 14.0 | 15.3 | 13.8 | 14.1 | 14.3 |
| Total Occupancy | 58.0% | 58.3% | 63.9% | 57.5% | 58.6% | 59.8% |
| | | | | | | |
| **NICU Beds** | 10 | 10 | 10 | 10 | 10 | 10 |
| Admissions | 69 | 69 | 62 | 62 | 63 | 63 |
| Patient Days | 786 | 825 | 814 | 937 | 946 | 956 |
| ALOS on Admissions | 11.4 | 12.0 | 13.1 | 15.1 | 15.0 | 15.2 |
| ADC on Admissions | 2.2 | 2.3 | 2.2 | 2.6 | 2.6 | 2.6 |
| Occupancy on Admissions | 21.5% | 22.6% | 22.3% | 25.7% | 25.9% | 26.2% |
| 23-Hour Observation Days | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Bed Days | 786 | 825 | 814 | 937 | 946 | 956 |
| Total ADC | 2.2 | 2.3 | 2.2 | 2.6 | 2.6 | 2.6 |
| Total Occupancy | 21.5% | 22.6% | 22.3% | 25.7% | 25.9% | 26.2% |
| | | | | | | |
| **Rehabilitation Beds** | 0 | 0 | 0 | 0 | 20 | 20 |
| Admissions | 0 | 0 | 0 | 0 | 328 | 374 |
| Patient Days | 0 | 0 | 0 | 0 | 4,428 | 5,049 |
| ALOS on Admissions | 0.0 | 0.0 | 0.0 | #DIV/0! | 13.5 | 13.5 |
| ADC on Admissions | 0.0 | 0.0 | 0.0 | 0.0 | 12.1 | 13.8 |
| Occupancy on Admissions | 0.0% | 0.0% | 0.0% | #DIV/0! | 60.7% | 69.2% |
| 23-Hour Observation Days | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Bed Days | 0 | 0 | 0 | 0 | 4,428 | 5,049 |
| Total ADC | 0.0 | 0.0 | 0.0 | 0.0 | 12.1 | 13.8 |
| Total Occupancy | 0.0% | 0.0% | 0.0% | #DIV/0! | 60.7% | 69.2% |
| | | | | | | |
| **Obstetrical Beds** | 24 | 24 | 24 | 24 | 24 | 24 |
| Admissions | 1,435 | 1,395 | 1,232 | 1,183 | 1,195 | 1,206 |
| Patient Days | 3,388 | 3,582 | 3,139 | 2,951 | 2,980 | 3,010 |
| ALOS on Admissions | 2.4 | 2.6 | 2.5 | 2.5 | 2.5 | 2.5 |
| ADC on Admissions | 9.3 | 9.8 | 8.6 | 8.1 | 8.2 | 8.2 |
| Occupancy on Admissions | 38.7% | 40.9% | 35.8% | 33.7% | 34.0% | 34.4% |
| 23-Hour Observation Days | 946 | 537 | 249 | 319 | 325 | 332 |
| Total Bed Days | 4,334 | 4,119 | 3,388 | 3,270 | 3,305 | 3,342 |
| Total ADC | 11.9 | 11.3 | 9.3 | 9.0 | 9.1 | 9.2 |
| Total Occupancy | 49.5% | 47.0% | 38.7% | 37.3% | 37.7% | 38.2% |
| | | | | | | |
| **Pediatric Beds** | 0 | 0 | 0 | 0 | 0 | 0 |
| Admissions | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Days | 0 | 0 | 0 | 0 | 0 | 0 |
| ALOS on Admissions | 0.0 | 0.0 | 0.0 | #DIV/0! | #DIV/0! | #DIV/0! |
| ADC on Admissions | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Occupancy on Admissions | 0.0% | 0.0% | 0.0% | #DIV/0! | #DIV/0! | #DIV/0! |
| 23-Hour Observation Days | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Bed Days | 0 | 0 | 0 | 0 | 0 | 0 |
| Total ADC | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total Occupancy | 0.0% | 0.0% | 0.0% | #DIV/0! | #DIV/0! | #DIV/0! |
| | | | | | | |
| **Psychiatric Beds** | 20 | 20 | 20 | 20 | 0 | 0 |
| Admissions | 755 | 633 | 814 | 645 | 0 | 0 |
| Patient Days | 4,646 | 3,892 | 5,003 | 4,002 | 0 | 0 |
| ALOS on Admissions | 6.2 | 6.1 | 6.1 | 6.2 | #DIV/0! | #DIV/0! |
| ADC on Admissions | 12.7 | 10.7 | 13.7 | 11.0 | 0.0 | 0.0 |
| Occupancy on Admissions | 63.6% | 53.3% | 68.5% | 54.8% | #DIV/0! | #DIV/0! |
| 23-Hour Observation Days | 0 | 0 | 0 | 5 | 0 | 0 |
| Total Bed Days | 4,646 | 3,892 | 5,003 | 4,007 | 0 | 0 |
| Total ADC | 12.7 | 10.7 | 13.7 | 11.0 | 0.0 | 0.0 |
| Total Occupancy | 63.6% | 53.3% | 68.5% | 54.9% | #DIV/0! | #DIV/0! |

Note:
Med Surg: 3,176 admissions Jan-May 2012 annualizes to 7,622 per year, which is 13.5% over CY2011. Table projects 13% increase; then 2% per year.


Summit Med/Surg Daily Census May 2011 - April 2012
120
100
80
60
40
20
0
5/1/2011
5/8/2011
5/15/2011
5/22/2011
5/29/2011
6/5/2011
6/12/2011
6/19/2011
6/26/2011
7/3/2011
7/10/2011
7/17/2011
7/24/2011
7/31/2011
8/7/2011
8/14/2011
8/21/2011
8/28/2011
9/4/2011
9/11/2011
9/18/2011
9/25/2011
10/2/2011
10/9/2011
10/16/2011
10/23/2011
10/30/2011
11/6/2011
11/13/2011
11/20/2011
11/27/2011
12/4/2011
12/11/2011
12/18/2011
12/25/2011
1/1/2012
1/8/2012
1/15/2012
1/22/2012
1/29/2012
2/5/2012
2/12/2012
2/19/2012
2/26/2012
3/4/2012
3/11/2012
3/18/2012
3/25/2012
4/1/2012
4/8/2012
4/15/2012
4/22/2012
4/29/2012
Census
80% Capacity
Capacity


Emergency Room Visits and Admissions Trend By Quarter - First Quarter 2011 through 1st Quarter 2012
2,500
2,000
1,500
1,000
500
-
12,800
12,600
12,400
12,200
12,000
11,800
11,600
11,400
11,200
11,000
10,800
Emergency Room Expansion - July 2011
Primary Stroke Accreditation - Nov 2011
1,645
1,612
1,728
12,157
1,768
2,020
11,502
11,728
11,678
12,613
1Q2011
2Q2011
3Q2011
4Q2011
1Q2012
ER Visits
ER Admissions

**C(II)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 ON LINE D.**

**• 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.**

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1. On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of an administrative appeals hearing.

Line A.5, construction cost, was calculated at approximately $161 PSF overall renovation cost, by HCA Corporate Design and Construction staff. This includes a contingency.

Line A.8 includes both fixed and moveable equipment costs, estimated by HCA Corporate Design and Construction staff.

Line A.9 includes such costs as information systems and telecommunications upgrades and replacements.

## PROJECT COSTS CHART -- SUMMIT MEDICAL CENTER REHABILITATION UNIT

2012 JUN 14 PM 4 28

A. Construction and equipment acquired by purchase:

| | | |
|---|---|---|
| 1. Architectural and Engineering Fees | (8% of A5) | $ 110,000 |
| 2. Legal, Administrative, Consultant Fees (Excl CON Filing) | | 50,000 |
| 3. Acquisition of Site | | 0 |
| 4. Preparation of Site | | 0 |
| 5. Construction Cost | | 1,550,000 |
| 6. Contingency Fund | (included in A.5) | 0 |
| 7. Fixed Equipment (Not included in Construction Contract) | | 0 |
| 8. Moveable Equipment (List all equipment over $50,000) | | 607,388 |
| 9. Other (Specify) | IT, telecommunications, misc. | 150,000 |

B. Acquisition by gift, donation, or lease:

| | |
|---|---|
| 1. Facility (inclusive of building and land) | 0 |
| 2. Building only | 0 |
| 3. Land only | 0 |
| 4. Equipment (Specify) | 0 |
| 5. Other (Specify) | 0 |

C. Financing Costs and Fees:

| | |
|---|---|
| 1. Interim Financing | 27,000 |
| 2. Underwriting Costs | 0 |
| 3. Reserve for One Year's Debt Service | 0 |
| 4. Other (Specify) | 0 |

D. Estimated Project Cost (A+B+C) 2,494,388

E. CON Filing Fee 5,612

F. Total Estimated Project Cost (D+E) TOTAL $ 2,500,000

Actual Capital Cost 2,500,000
Section B FMV 0

**C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.**

**a. 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 ALPHANUMERIC 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 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;**

**__x__E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or**

**_____F. Other--Identify and document funding from all sources.**

The project will be funded by a cash transfer of the required cost, from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System). Documentation of financing is provided in Attachment C, Economic Feasibility--2.

**C(II).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 HSDA.**

The estimated $1,550,000 renovation construction cost for the project is approximately $161 PSF overall:

| Table Three (repeated): Construction Cost PSF | | |
|---|---|---|
| **Construction Cost** | **SF of Renovation** | **Construction Cost PSF** |
| $1,550,000 | 9,626 USF | $161.02 |

The 2009-2011 hospital construction projects approved by the HSDA had the following costs per SF. This project is very consistent with those ranges, being below the median for hospital renovation projects.

**Hospital Construction Cost Per Square Foot**
**Years: 2009 – 2011**

| | Renovated Construction | New Construction | Total Construction |
|---|---|---|---|
| **1st Quartile** | $125.84/sq ft | $235.86/sq ft | $167.99/sq ft |
| **Median** | $177.60/sq ft | $274.63/sq ft | $249.32/sq ft |
| **3rd Quartile** | $273.69/sq ft | $324.00/sq ft | $301.74/sq ft |

*Source: CON approved applications for years 2009 through 2011*

**C(II).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 YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE 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).**

See the following pages for these charts, with notes where applicable.

## HISTORICAL DATA CHART -- SUMMIT MEDICAL CENTER

2012 JUN 14 PM 4 28

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

| | | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|---|
| A. | Utilization Data ( JAR discharge days) | 42,614 | 41,759 | 39,877 |
| B. | Revenue from Services to Patients | | | |
| 1. | Inpatient Services | $ 311,364,654 | 340,144,880 | 371,674,202 |
| 2. | Outpatient Services | 225,484,925 | 240,272,739 | 236,798,113 |
| 3. | Emergency Services | 38,855,183 | 43,587,757 | 46,936,541 |
| 4. | Other Operating Revenue | 1,837,166 | 2,089,089 | 2,369,663 |
| | (Specify) See notes | | | |
| | **Gross Operating Revenue** | $ 577,541,928 | $ 626,094,465 | $ 657,778,519 |
| C. | Deductions for Operating Revenue | | | |
| 1. | Contractual Adjustments | $ 393,868,036 | 424,831,830 | 456,728,007 |
| 2. | Provision for Charity Care | 1,684,364 | 2,281,357 | 3,723,069 |
| 3. | Provisions for Bad Debt | 33,081,202 | 47,854,780 | 44,276,197 |
| | **Total Deductions** | $ 428,633,602 | $ 474,967,967 | $ 504,727,273 |
| **NET OPERATING REVENUE** | | $ 148,908,326 | $ 151,126,498 | $ 153,051,246 |
| D. | Operating Expenses | | | |
| 1. | Salaries and Wages | $ 40,937,360 | 42,362,204 | 42,613,777 |
| 2. | Physicians Salaries and Wages | 0 | 0 | 0 |
| 3. | Supplies | 24,892,000 | 25,195,000 | 29,427,000 |
| 4. | Taxes | 1,322,417 | 1,257,530 | 1,202,224 |
| 5. | Depreciation | 7,080,267 | 7,020,600 | 7,017,441 |
| 6. | Rent | 1,989,000 | 1,826,000 | 1,911,000 |
| 7. | Interest, other than Capital | 269,748 | 251,487 | 243,557 |
| 8. | Management Fees | | | |
| | a. Fees to Affiliates | 10,328,173 | 10,942,208 | 10,588,601 |
| | b. Fees to Non-Affiliates | 0 | 0 | 0 |
| 9. | Other Expenses (Specify) See notes | 49,333,509 | 51,381,249 | 47,633,531 |
| | **Total Operating Expenses** | $ 136,152,474 | 140,236,278 | 140,637,131 |
| E. | Other Revenue (Expenses) -- Net (Specify) | $ | $ | $ |
| **NET OPERATING INCOME (LOSS)** | | $ 12,755,852 | $ 10,890,220 | $ 12,414,115 |
| F. | Capital Expenditures | | | |
| 1. | Retirement of Principal | $ 0 | $ 0 | $ 0 |
| 2. | Interest | 0 | 0 | 0 |
| | **Total Capital Expenditures** | $ 0 | $ 0 | $ 0 |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | | $ 12,755,852 | $ 10,890,220 | $ 12,414,115 |

Notes to historical data

| | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|
| Other expenses: | | | |
| Employee Benefits | 10,984,000 | 11,268,000 | 12,925,000 |
| Pro Fees | 1,554,000 | 1,078,000 | 2,400,000 |
| Ancillary Clinical Services | 24,519,509 | 25,782,249 | 18,117,531 |
| Contract Services (all) | 12,276,000 | 13,253,000 | 14,191,000 |
| Total | 49,333,509 | 51,381,249 | 47,633,531 |
| Management Fee | 10,328,000 | 10,942,000 | 11,019,000 |
| | 6.9% | 7.2% | 7.2% |

# PROJECTED DATA CHART -- SUMMMIT REHABILITATION UNIT

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

2012 JUN 14 PM 4 28

| | | Year 2013 | Year 2014 |
|---|---|---|---|
| A. | Utilization Data (discharge days) | 328 / 4,428 | 374 / 5049 |
| B. | Revenue from Services to Patients | | |
| 1. | Inpatient Services | $ 14,432,000 | $ 17,205,760 |
| 2. | Outpatient Services | 0 | 0 |
| 3. | Emergency Services | 0 | |
| 4. | Other Operating Revenue (Specify) | 0 | 0 |
| | **Gross Operating Revenue** | $ 14,432,000 | $ 17,205,760 |
| C. | Deductions for Operating Revenue | | |
| 1. | Contractual Adjustments | $ 8,339,844 | $ 10,046,495 |
| 2. | Provision for Charity Care | 115,456 | 137,646 |
| 3. | Provisions for Bad Debt | 144,320 | 172,058 |
| | **Total Deductions** | $ 8,599,620 | $ 10,356,199 |
| NET OPERATING REVENUE | | $ 5,832,380 | $ 6,849,561 |
| D. | Operating Expenses | | |
| 1. | Salaries and Wages | $ 1,386,168 | $ 1,566,918 |
| 2. | Physicians Salaries and Wages | 0 | 0 |
| 3. | Supplies | 309,964 | 365,821 |
| 4. | Taxes | 0 | 0 |
| 5. | Depreciation | | |
| 6. | Rent | 0 | 0 |
| 7. | Interest, other than Capital | 0 | 0 |
| 8. | Management Fees | 0 | 0 |
| | a. Fees to Affiliates | 404,524 | 482,117 |
| | b. Fees to Non-Affiliates | 0 | 0 |
| 9. | Other Expenses (Specify) See notes | 974,212 | 1,114,155 |
| | **Total Operating Expenses** | $ 3,074,868 | $ 3,529,011 |
| E. | Other Revenue (Expenses) -- Net (Specify) | $ | $ |
| NET OPERATING INCOME (LOSS) | | $ 2,757,512 | $ 3,320,550 |
| F. | Capital Expenditures | | |
| 1. | Retirement of Principal | $ 0 | $ 0 |
| 2. | Interest | 0 | 0 |
| | **Total Capital Expenditures** | $ 0 | $ 0 |
| NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES | | $ 2,757,512 | $ 3,320,550 |

62

Notes to projected data

| | Year 2013 | Year 2014 |
|---|---|---|
| Other expenses: | | |
| Employee Benefits | 375,651 | 424,635 |
| Pro Fees | 85,000 | 85,000 |
| Ancillary Clinical Services | 88,561 | 104,520 |
| Parallon Allocations | 425,000 | 500,000 |
| | 974,212 | 1,114,155 |
| Management Fee (6.9 % of Net Revenue) | 404,524 | 475,074 |
| | 6.9% | 6.9% |

**C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.**

| Table Thirteen: Average Charges, Deductions, Net Charges, Net Operating Income | | |
|---|---|---|
| | **CY2013** | **CY2014** |
| Admissions | 328 | 374 |
| Patient Days | 4,428 | 5,049 |
| Average Gross Charge Per Day | $3,259 | $3,408 |
| Average Gross Charge Per Admission | $44,000 | $46,005 |
| Average Deduction from Operating Revenue Per Day | $1,933 | $2,051 |
| Average Deduction from Operating Revenue Per Admission | $26,218 | $27,690 |
| Average Net Charge (Net Operating Revenue) Per Day | $1,317 | $1,357 |
| Average Net Charge (Net Operating Revenue) Per Admission | $17,782 | $18,314 |
| Average Net Operating Income after Expenses, Per Day | $623 | $658 |
| Average Net Operating Income after Expenses, Per Admission | $8,407 | $8,878 |

**C(II).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.**

The project's most frequent charges are shown in response to C(II).6.B below. The introduction of this unit will not affect any other hospital charges because it will operate with a strong positive revenue margin, making it unnecessary to shift costs to other hospital services.

**C(II).6.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 HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).**

The projected average gross charge for this project will be consistent with the average gross charges for similar area projects approved by the Agency or in operation already. No charge information is publicly available for rehabilitation units in hospitals because the Joint Annual Reports do not contain revenue data specific to inpatient rehabilitation services. It is available for a rehabilitation hospital, however, as shown below. Following is available charge data. (Cases are discharges or admissions.)

**Table Fourteen: Year One Charges of Similar Facilities Compared to CY2013 Charge of This Project**

| Provider | Gross / Net Charges | Cases | Days | Gross/Net Charges Per Case (NOR) | Gross/Net Charges Per Day |
|---|---|---|---|---|---|
| HealthSouth Rehab'n Hospital Williamson County (CN1002-059) | $18,447,324/ **$8,231,016** | 537 | 7,245 | $34,353 / **$15,327** | $2,546 / **$1,136** |
| VU Stallworth Rehabilitation Hospital (2011 JAR) | $56,921,124 / **$25,001,544** | 1,713 | 22,671 | $33,228 / **$14,595** | $2,511 / **$1,103** |
| Southern Hills Medical Center (CN 1111-048) | $19,085,892 / $5,522,620 | 347 | 4,530 | $55,003 / **$15,915** | $4,213 / **$1,220** |
| **THIS PROJECT (2013)** | $14,432,000 / **$5,832,380** | 328 | 4,428 | $44,000 / **$17,782** | $3,259 / **$1,317** |

Source: HSDA Records; Joint Annual Reports; Projected Data Chart

The following page contains a table showing the most frequent procedures to be performed, with their current Medicare reimbursement, and their projected Years One and Two utilization and average gross charges.

| Table Fifteen: Summit Medical Center<br>Charge Data for Most Frequent Admissions to Rehabilitation Unit | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Average Gross Charge | | | Utilization (Admissions) | | |
| Admission Code | Descriptor | Current Medicare Allowable | Current | Year 1 | Year 2 | Current | Year 1 | Year 2 |
| | | | | | | | | |
| 1 | Stroke | $49,091 | N/A | $50,254 | $52,264 | N/A | 86 | 100 |
| 2 | Traumatic Brain Injury | $37,646 | N/A | $38,538 | $40,080 | N/A | 18 | 20 |
| 6 | Neurological | $37,345 | N/A | $38,230 | $39,759 | N/A | 53 | 60 |
| 7 | Fracture of Lower Extremity | $39,152 | N/A | $40,080 | $41,683 | N/A | 31 | 35 |
| 10 | Amputation, Lower Extremity | $42,766 | N/A | $43,779 | $45,530 | N/A | 8 | 9 |
| 17 | Mult Trauma w/o Brain or Sp Cord Inj | $40,658 | N/A | $41,621 | $43,286 | N/A | 7 | 8 |
| | Subtotal, Most Frequent | | | $43,969 | $45,813 | N/A | 203 | 232 |
| | | | | | | | | |
| | All Other | | | $44,000 | $45,600 | N/A | 125 | 142 |
| | Total Admissions | | | | | | 328 | 374 |
| | | | | | | | | |

**C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.**

The Projected Data Chart and charge information in the application demonstrate that the program will be cost-effective, operating with a healthy positive financial margin, while maintaining a competitive charge structure for area payors.

**C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.**

Summit generates a large number of referrals to acute rehabilitation programs each year. An even larger number of discharges have been identified, who are eligible for such transfers. It seems certain that the proposed unit will be sufficiently utilized in its first two years to operate with a strong financial margin, at charges that are comparable to those of other such programs in the area.

**C(II).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.**

Like Summit Medical Center, this proposed unit will serve the groups listed above. Indigent care is projected at approximately .8% of services annually and Medicare and TennCare/Medicaid are projected at a combined 55% of services.

| Table Sixteen: Medicare and TennCare/Medicaid Gross Revenues, Year One | | |
|---|---|---|
| | **Medicare** | **TennCare/Medicaid** |
| Gross Revenue | $7,504,640 | $432,960 |
| Percent of Gross Revenue | 52% | 3% |

**C(II).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 ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.**

These are provided as Attachment C, Economic Feasibility--10.

**C(II)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 DISCUSSSION 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.**
**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.**

With respect to construction, the project requires no new construction. It will be done entirely by renovation. The only major renovation is changing the patient bathrooms on the third floor from psychiatric design bathrooms to ADA-compliant, handicapped-accessible bathrooms as specified by licensing regulations.

With respect to alternatives, there is no alternative way to make acute inpatient rehabilitation more accessible to residents of the eastern urban area of Nashville. Acute rehabilitation is a hospital-based program and Summit is the only hospital between the rehabilitation units at Baptist Hospital in central Davidson County, and UMC McFarland Hospital in central Wilson County--a distance of approximately 32 miles. Deployment of rehabilitation at Summit parallels HSDA decisions for suburban hospitals on the north side of the county (Skyline Medical Center, 41 rehab beds) and the south side of the county (Southern Hills, 16 rehab beds).

Of course, rehabilitation is available in nursing home programs in the service area, but hospital-based acute rehabilitation allows for more intensive therapies and is appropriate for patients who need that. Otherwise, payors and patients would not be using the more expensive hospital-based acute rehabilitation care. The project also permits Summit to offer and control a complete continuum of care for its patients whose discharge from the initial stay needs to proceed seamlessly into acute rehabilitation, with their medical team conveniently close.

**C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.**

Following are the facilities most frequently utilizes in its discharge planning:

Skilled Nursing- McKendree, Mt. Juliet Healthcare, Donelson Place, Lebanon Health and Rehabilitation

Hospice- Alive Hospice, Odyssey, Avalon, Asera Care

Home Health- Suncrest, Gentevia, and Amedysis Home Health Care of Middle

Home Infusion- Walgreens, IV Solutions, Coram

DME- Medical Necessities, At Home Medical, Apria, All-Star

**C(III).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.**

The project will provide easier access to acute inpatient rehabilitation, for residents of eastern Davidson County and western Wilson County who are being discharged from initial acute care stays in Davidson County hospitals--especially Summit Medical Center--and who would prefer the Hermitage location to a downtown or Wilson County location.

The project consolidates HCA TriStar's psychiatric care resources in Nashville, at its two central Davidson County campuses (Skyline Madison and Centennial Pavilion), freeing up beds in its Davidson County suburban hospitals for broader-based healthcare programs.

The project adds rehabilitation beds to the service area without increasing licensed beds--because it merely reassigns existing bed areas on the hospital's third floor.

The impact on non-HCA rehabilitation providers will be minimal. In CY2011, 70% of Summit's discharges to acute rehabilitation programs in Nashville were to sister HCA hospitals. Only 47 patients from Summit were discharged to other service area programs.

**C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, 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.**

Please see the following page for Table Eighteen, showing projected FTE's and salary ranges.

The Department of Labor and Workforce Development website indicates the following Upper Central Tennessee region's annual salary information for clinical employees of this project:

**Table Seventeen: TDOL Surveyed Average Salaries for the Region**

| Position | Entry Level | Mean | Median | Experienced |
|---|---|---|---|---|
| RN | $44,569 | $63,102 | $59,662 | $72,368 |
| Physical Therapist | $57,012 | $74,117 | $73,472 | $82,669 |
| Physical Therapy Assistant | $40,515 | $50,048 | $54,814 | $48,674 |
| Occupational Therapist | $60,560 | $70,045 | $68,908 | $74,787 |
| Certified OT Assistant | $39,499 | $48,716 | $45,335 | $53,325 |
| Social Worker | $26,032 | $46,919 | $45,110 | $57,363 |

## Table Eighteen: Summit Medical Center
## Acute Rehabilitation Service
## Staffing Requirements

| Position Type (RN, etc.) | Current FTE's | Year One FTE's | Year Two FTE's | Salary Range (Hourly) |
|---|---|---|---|---|
| | | | | |
| RN | N/A | 7.0 | 8.5 | 22.74 - 27.00 |
| LPN | N/A | 1.7 | 2.1 | 15.40 - 17.00 |
| Program Director | N/A | 1.0 | 1.0 | 35.00 - 50.00 |
| Nurse Manager | N/A | 1.0 | 1.0 | 25.00 - 40.00 |
| Unit Secretary | N/A | 1.0 | 2.0 | 15.36 - 16.96 |
| Admission Coordinator | N/A | 1.0 | 1.0 | 14.42 - 15.92 |
| Physical Therapists | N/A | 2.0 | 2.0 | 37.11 - 39.00 |
| Physical Therapy Assistant | N/A | 1.0 | 1.0 | 18.00 - 20.00 |
| Occupational Therapy | N/A | 2.0 | 2.0 | 37.11 - 40.00 |
| COTA | N/A | 1.0 | 1.0 | 18.00 - 20.00 |
| Speech Therapy | N/A | 2.0 | 2.0 | 37.11 - 41.00 |
| Case Manager/Social Worker | N/A | 1.5 | 1.5 | 31.48 - 35.00 |
| Outreach Liaisons/PPS Coordinator | N/A | 3.8 | 3.8 | 19.00 - 23.00 |
| | | | | |
| | | | | |
| **Total FTE's** | | 26.0 | 29.0 | |
| | | | | |
| | | | | |
| | | | | |

**C(III).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.**

HCA hospitals nationwide and in Middle Tennessee have established numerous acute inpatient rehabilitation programs and TriStar anticipates no difficulties in attracting the nursing, therapy, support staff, and Medical Director required for an effective program at Summit Medical Center.

**C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.**

The applicant so verifies.

**C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).**

StoneCrest is a clinical rotation site for numerous students in the health professions. The schools with which Summit has student affiliation agreements are:

Absolute Medical
Austin Peay University
Belmont University
Cardiac and Vascular Institute
Cedar Crest College
Columbia State Community College
Cumberland University
ITT Technical
Middle TN School of Anesthesia
Middle Tennessee State University
Southeastern University
South University
Tennessee State University
Tennessee Tech
University of Houston
Trevecca Nazarene
University of Phoenix
University of Tennessee
Vanderbilt University
Weber State University
West Virginia Wesleyan College
Western KY University
Volunteer State Community College

In CY2011, Summit Medical Center served as a training rotation site for 415 students from these schools, in the following disciplines and programs: Nursing (174); EMT/Paramedic (68); Anesthesia Tech (72); Pharmacy Tech (35); Nutrition (3); Respiratory Therapy (25); Medical Imaging (31); Physician's Assistant (2); and Physical Therapy (5).

**C(III).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.**

The applicant so verifies.

**C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION**

| | |
|---|---|
| **LICENSURE:** | Board for Licensure of Healthcare Facilities<br>Tennessee Department of Health |
| **CERTIFICATION:** | Medicare Certification from CMS<br>TennCare Certification from TDH |
| **ACCREDITATION:** | Joint Commission |

**C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.**

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission.

**C(III).7(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.**

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

**C(III)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.**

None.

**C(III)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.**

None.

**C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.**

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

**PROOF OF PUBLICATION**

Attached.

**DEVELOPMENT SCHEDULE**

**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.**

The Project Completion Forecast Chart is provided after this page.

**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.**

Not applicable. The applicant anticipates completing the project within the period of validity.

## PROJECT COMPLETION FORECAST CHART

2012 JUN 14 PM 4 28

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

September 26, 2012

Assuming the CON decision 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.

| PHASE | DAYS REQUIRED | Anticipated Date (MONTH /YEAR) |
|---|---|---|
| 1. Architectural & engineering contract signed | 1 | 9/2012 |
| 2. Construction documents approved by TDH | 26 | 10/2012 |
| 3. Construction contract signed | 30 | 10/2012 |
| 4. Building permit secured | 31 | 10/2012 |
| 5. Site preparation completed | na | na |
| 6. Building construction commenced | 35 | 10/2012 |
| 7. Construction 40% complete | 45 | 11/2012 |
| 8. Construction 80% complete | 75 | 12/2012 |
| 9. Construction 100% complete | 85 | 12/2012 |
| 10. * Issuance of license | 90 | 12/2012 |
| 11. *Initiation of service | 96 | 1/2013 |
| 12. Final architectural certification of payment | 126 | 2/2013 |
| 13. Final Project Report Form (HF0055) | 186 | 4/2013 |

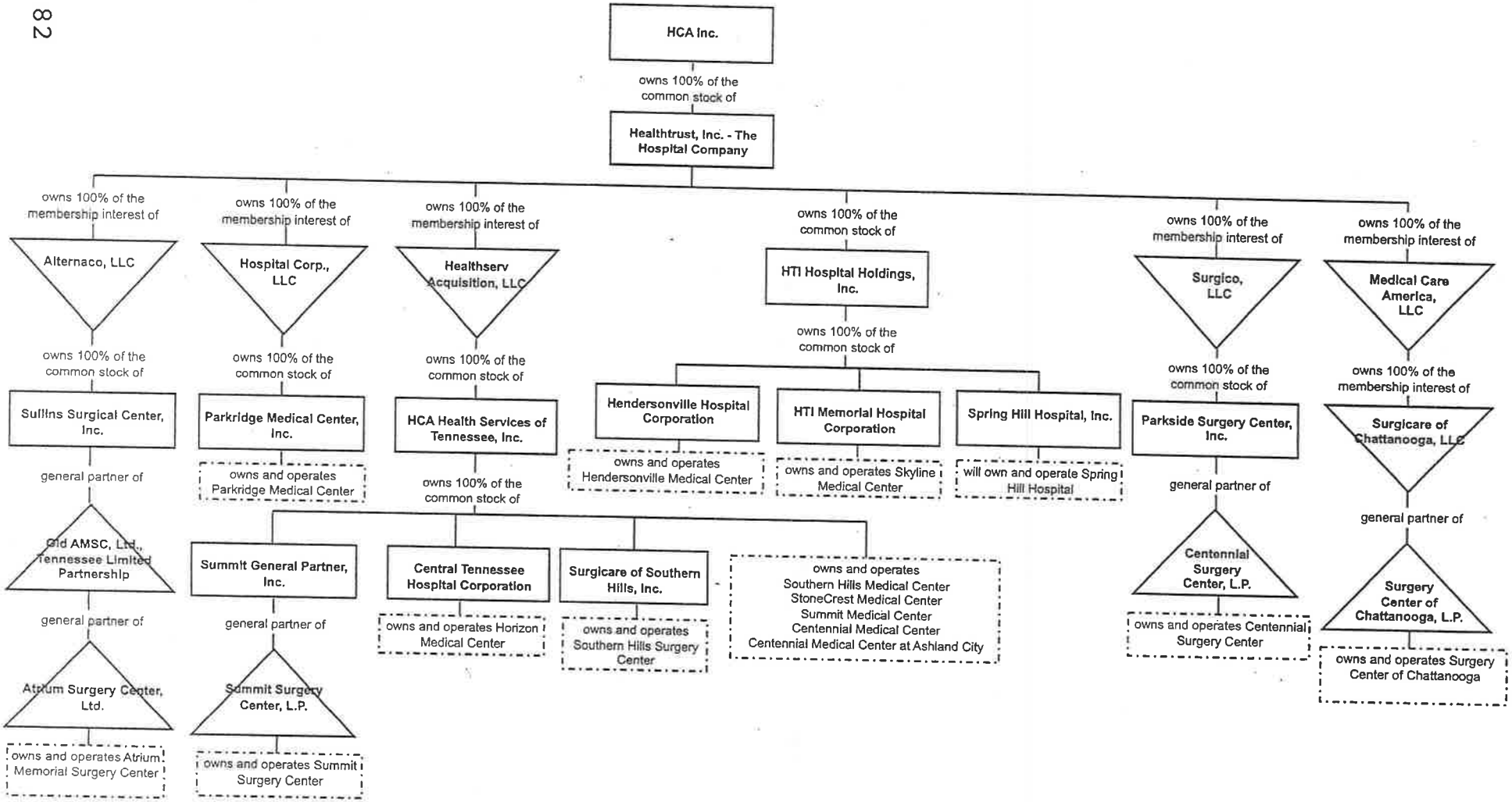
*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

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

# INDEX OF ATTACHMENTS


| | |
|---|---|
| A.4 | Ownership--Legal Entity and Organization Chart (if applicable) |
| A.6 | Site Control |
| B.III. | Plot Plan |
| B.IV. | Floor Plan |
| C, Need--3 | Service Area Maps |
| C, Economic Feasibility--1 | Documentation of Construction Cost Estimate |
| C, Economic Feasibility--2 | Documentation of Availability of Funding |
| C, Economic Feasibility--10 | Financial Statements |
| C, Orderly Development--7(C) | TDH Inspection & Plan of Correction |
| Miscellaneous Information | |
| Support Letters | |

# A.4--Ownership
# Legal Entity and Organization Chart


HCA Inc.
owns 100% of the common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of the membership interest of
Alternaco, LLC
owns 100% of the common stock of
Sullins Surgical Center, Inc.
general partner of
Old AMSC, Ltd., Tennessee Limited Partnership
general partner of
Atrium Surgery Center, Ltd.
owns and operates Atrium Memorial Surgery Center
owns 100% of the membership interest of
Hospital Corp., LLC
owns 100% of the common stock of
Parkridge Medical Center, Inc.
owns and operates Parkridge Medical Center
owns 100% of the membership interest of
Healthserv Acquisition, LLC
owns 100% of the common stock of
HCA Health Services of Tennessee, Inc.
owns 100% of the common stock of
Summit General Partner, Inc.
general partner of
Summit Surgery Center, L.P.
owns and operates Summit Surgery Center
Central Tennessee Hospital Corporation
owns and operates Horizon Medical Center
Surgicare of Southern Hills, Inc.
owns and operates Southern Hills Surgery Center
owns and operates
Southern Hills Medical Center
StoneCrest Medical Center
Summit Medical Center
Centennial Medical Center
Centennial Medical Center at Ashland City
owns 100% of the common stock of
HTI Hospital Holdings, Inc.
owns 100% of the common stock of
Hendersonville Hospital Corporation
owns and operates Hendersonville Medical Center
HTI Memorial Hospital Corporation
owns and operates Skyline Medical Center
Spring Hill Hospital, Inc.
will own and operate Spring Hill Hospital
owns 100% of the membership interest of
Surgico, LLC
owns 100% of the common stock of
Parkside Surgery Center, Inc.
general partner of
Centennial Surgery Center, L.P.
owns and operates Centennial Surgery Center
owns 100% of the membership interest of
Medical Care America, LLC
owns 100% of the membership interest of
Surgicare of Chattanooga, LLC
general partner of
Surgery Center of Chattanooga, L.P.
owns and operates Surgery Center of Chattanooga

## TENNESSEE FACILITIES OWNED BY HCA, INC.

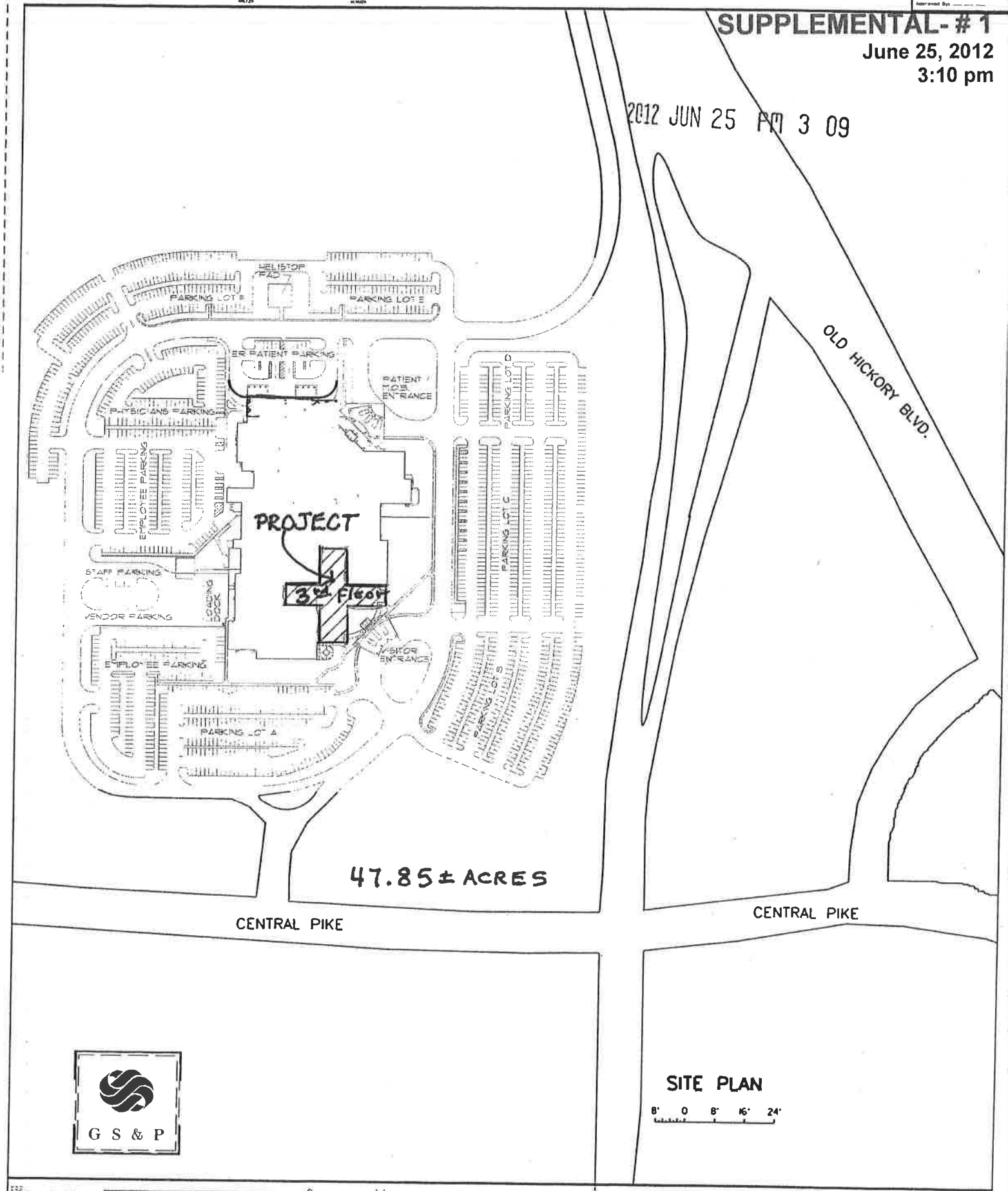
| | | | | | |
|---|---|---|---|---|---|
| Centennial Medical Center | 2300 Patterson Str | | Nashville | TN | 37203 |
| Parthenon Pavilion | 2401 Parman Place | | Nashville | TN | 37203 |
| Sarah Cannon Cancer Center | 250 25th Avenue North | Suite 110 | Nashville | TN | 37203 |
| Sarah Cannon Research Institute | 3322 West End Avenue | Suite 900 | Nashville | TN | 37203 |
| Women's Hospital | 2221 Murphy Avenue | | Nashville | TN | 37203 |
| Centennial Surgery Center | 345 23rd Ave N | Suite 201 | Nashville | TN | 37203-1524 |
| Greenview Regional Hospital | 1801 Ashley Circle | | Bowling Green | KY | 42104-9024 |
| Hendersonville Medical Center | 355 New Shackle Island Road | | Hendersonville | TN | 37075 |
| Horizon Medical Center | 111 Highway 70 East | | Dickson | TN | 37055 |
| Natchez Imaging | 101 Natchez Park Drive | | Dickson | TN | 37055 |
| Radiation Oncology @ SCCC | 105 Natchez Park Drive | | Dickson | TN | 37055 |
| TN Oncology @ SCCC | 103 Natchez Park Drive, | | Dickson | TN | 37055 |
| Parkridge East Hospital | 941 Spring Creek Road | | Chattanooga | TN | 37412 |
| Parkridge Medical Center | 2333 McCallie Avenue | | Chattanooga | TN | 37404 |
| Parkridge Valley Hospital | 2200 Morris Hill Road | | Chattanooga | TN | 37421 |
| Portland Medical Center | 105 Redbud Drive | | Portland | TN | 37148 |
| Skyline Medical Center | 3441 Dickerson Pike | | Nashville | TN | 37207 |
| Skyline Madison Campus | 500 Hospital Drive | | Madison | TN | 37115 |
| Southern Hills Medical Center | 391 Wallace Road | | Nashville | TN | 37211 |
| Southern Hills Surgical Center | 360 Wallace Road | | Nashville | TN | 37212 |
| StoneCrest Medical Center | 200 StoneCrest Boulevard | | Smyrna | TN | 37167 |
| Summit Medical Center | 5655 Frist Boulevard | | Hermitage | TN | 37076 |
| Summit Surgery Center | 3901 Central Pike | Suite 152 | Hermitage | TN | 37076 |

FEB. 27, 2012

# B.III.--Plot Plan

SUPPLEMENTAL- # 1
June 25, 2012
3:10 pm

2012 JUN 25 PM 3 09




G S & P

SITE PLAN

8' 0 8' 16' 24'

| REVISION | | |
|---|---|---|
| No. | Date | Revision |

PRELIMINARY NOT FOR CONSTRUCTION

SUMMIT MEDICAL CENTER

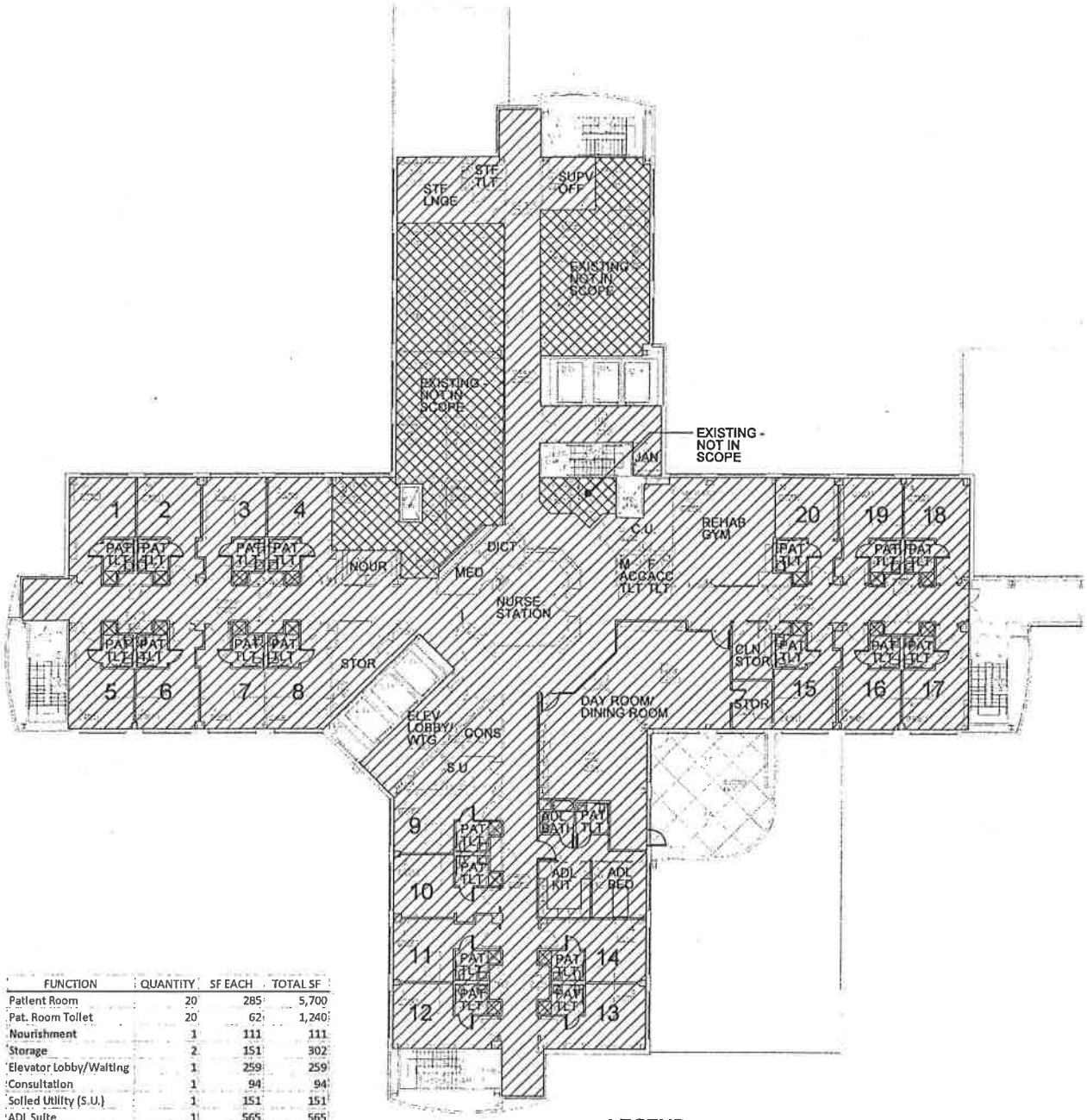
GRESHAM SMITH AND PARTNERS

Design Services For The Built Environment

Atlanta Birmingham Charlotte Cincinnati Columbus Dallas Fort Lauderdale Knoxville Jackson Jacksonville Louisville Memphis Nashville Richmond Tampa

G S & P

# B.IV.--Floor Plan




| FUNCTION | QUANTITY | SF EACH | TOTAL SF |
|---|---|---|---|
| Patient Room | 20 | 285 | 5,700 |
| Pat. Room Toilet | 20 | 62 | 1,240 |
| Nourishment | 1 | 111 | 111 |
| Storage | 2 | 151 | 302 |
| Elevator Lobby/Waiting | 1 | 259 | 259 |
| Consultation | 1 | 94 | 94 |
| Soiled Utility (S.U.) | 1 | 151 | 151 |
| ADL Suite | 1 | 565 | 565 |
| Day Room/Dining Room | 1 | 1,328 | 1,328 |
| Clean Storage | 1 | 107 | 107 |
| Male Acc. Toilet | 1 | 43 | 43 |
| Female Acc. Toilet | 1 | 43 | 43 |
| Clean Utility (C.U.) | 1 | 185 | 185 |
| Nurse Station | 1 | 478 | 478 |
| Meds | 1 | 115 | 115 |
| Dictation | 1 | 103 | 103 |
| Janitor Closet | 1 | 47 | 47 |
| Staff Lounge | 1 | 322 | 322 |
| Staff Toilet | 1 | 38 | 38 |
| Supervisor Office | 1 | 146 | 146 |
| Rehab Gym | 1 | 550 | 550 |
| TOTAL NET SQUARE FOOTAGE | | | 11,927 |
| CIRCULATION GROSSING FACTOR | | | 0.43 |
| TOTAL GROSS SQUARE FOOTAGE (Hatched Area) | | | 17,030 |

## LEGEND

Rehab Unit

Miscellaneous Office Space

# SUMMIT MEDICAL CENTER
# HERMITAGE, TENNESSEE

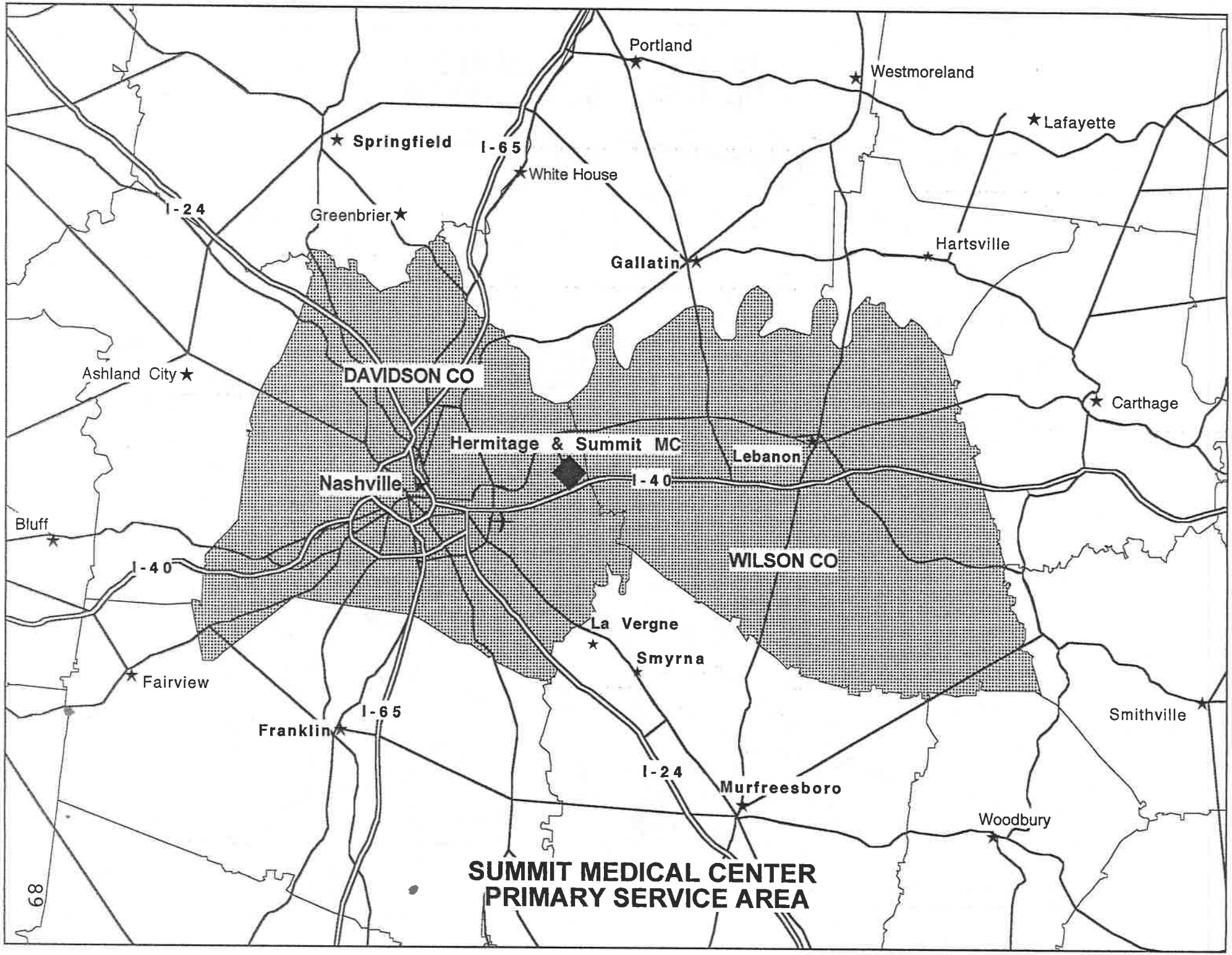
Third Floor Rehab Unit

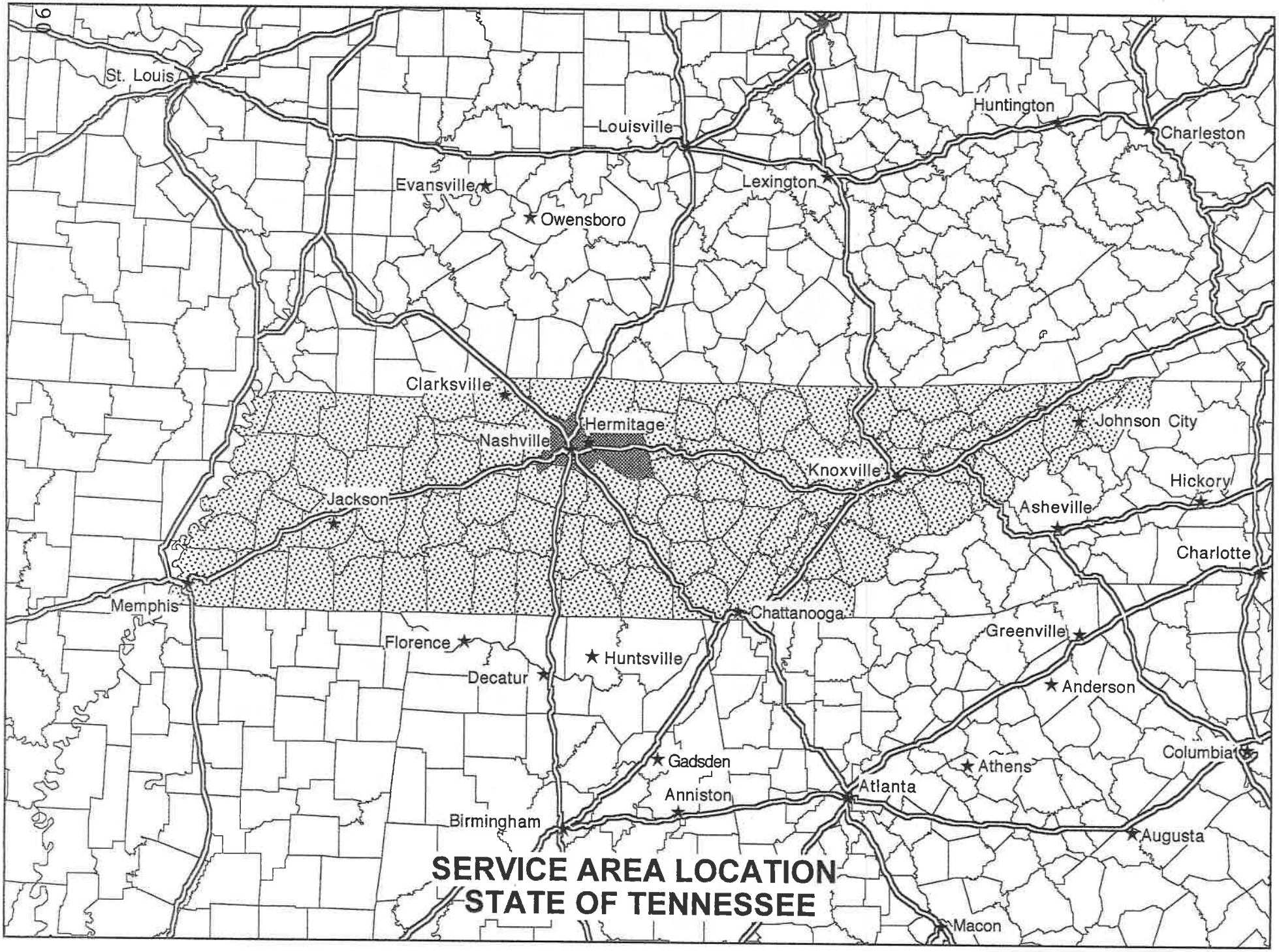
## PROPOSED - ENLARGED THIRD FLOOR PLAN

GS&P #28973.00
06.11.2012

G S & P

# C, Need--3
# Service Area Maps


Portland
Westmoreland
Lafayette
Springfield
I-65
White House
I-24
Greenbrier
Hartsville
Gallatin
Ashland City
DAVIDSON CO
Carthage
Hermitage & Summit MC
Lebanon
Nashville
I-40
Bluff
WILSON CO
I-40
La Vergne
Smyrna
Fairview
I-65
Franklin
Smithville
I-24
Murfreesboro
Woodbury
SUMMIT MEDICAL CENTER
PRIMARY SERVICE AREA




**SERVICE AREA LOCATION**
**STATE OF TENNESSEE**

# C, Economic Feasibility--1
# Documentation of Construction Cost Estimate

GRESHAM
SMITH AND
PARTNERS

June 5, 2012

Mr. Jeff Whitehorn, CHE
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

**Subject:** **Verification of Construction Cost Estimates**
**3rd Floor InPatient Rehabilitation Unit**
**Summit Medical Center**
**Hermitage, Tennessee**
GS&P Project No. 28973.00 / 00.3

Gresham Smith and Partners, Inc., an architectural/engineering firm in Nashville, Tennessee, has reviewed the cost data provided by HCA for the above referenced project, for which this firm has provided a preliminary design. The stated renovated construction cost for this 9,626 SF area is $1,550,000. [In providing opinions of probable construction cost, the Client understands that the Consultant has no control over the cost or availability of labor, equipment or materials, or over market conditions or the Contractor's method of pricing, and that the Consultant's opinions of probable construction costs are made on the basis of the Consultant's professional judgment and experience. The Consultant makes no warranty, express or implied, that the bids or the negotiated cost of the Work will not vary from the Consultant's opinion of probable construction cost.]

It is our opinion that at this time, the projected renovated construction cost is reasonable for this type and size of project and compares appropriately with similar projects in this market.

The building codes applicable to this project will be:

International Building Code, 2006
NFPA 101 Life Safety Code, 2006
FGI Guidelines for Design & Construction of Healthcare Facilities, 2010
ANSIA-117.1, 2003

Sincerely,

Kenneth A. Priest, AIA, NCARB, LEED AP
License No. 16010

bma



Design Services For The Built Environment
1400 Nashville City Center / 511 Union Street / Nashville, Tennessee 37219-1733 / Phone 615.770.8100 / www.greshamsmith.com

# C, Economic Feasibility--2
# Documentation of Availability of Funding

# HCA

TriStar Health System
110 Winners Circle, 1st Floor
Brentwood, TN
37027

Hospital Corporation of America

P 615-886-4900

June 12, 2012

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

RE: CON Application for Acute Rehabilitation Unit
Summit Medical Center

Dear Mrs. Hill:

Summit Medical Center is applying for a Certificate of Need to add the subject service beginning next January.

As Chief Financial Officer of the TriStar Health System, the HCA Division Office to which this facility will belong, I am writing to confirm that HCA Holdings, Inc. will provide through TriStar the approximately $2,500,000 in capital costs required to implement this project. HCA Holdings, Inc.'s financial statements are provided in the application.

Sincerely,

Chris Taylor
CFO
TriStar Division of HCA

# C, Economic Feasibility--10
# Financial Statements

## Financial Statements - Balance Sheet

| Month | | | | Year to Date | | |
|---|---|---|---|---|---|---|
| Begin | Change | Ending | | Begin | Change | Ending |
| | | | **CURRENT ASSETS** | | | |
| 50,410 | -140,390 | -89,980 | Cash & Cash Equivalents | 54,570 | -144,550 | -89,980 |
| | | | Marketable Securities | | | |
| | | | **PATIENT ACCOUNTS RECEIVABLES** | | | |
| 38,783,786 | 3,177,793 | 41,961,579 | Patient Receivables | 40,543,243 | 1,418,336 | 41,961,579 |
| | | | Less Allow for Govt Receivables | | | |
| -20,450,325 | -480,135 | -20,930,460 | Less Allow - Bad Debt | -21,690,707 | 760,247 | -20,930,460 |
| 18,333,461 | 2,697,658 | 21,031,119 | Net Patient Receivables | 18,852,536 | 2,178,583 | 21,031,119 |
| | | | **FINAL SETTLEMENTS** | | | |
| 217,738 | 0 | 217,738 | Due to/from Govt Programs | 113,086 | 104,652 | 217,738 |
| | | | Allowances Due Govt Programs | | | |
| 217,738 | 0 | 217,738 | Net Final Settlements | 113,086 | 104,652 | 217,738 |
| 18,551,199 | 2,697,658 | 21,248,857 | Net Accounts Receivables | 18,965,622 | 2,283,235 | 21,248,857 |
| 5,072,189 | -84,775 | 4,987,414 | Inventories | 5,266,378 | -278,964 | 4,987,414 |
| 640,894 | 340,423 | 981,317 | Prepaid Expenses | 903,792 | 77,525 | 981,317 |
| 75,750 | -38,168 | 37,582 | Other Receivables | 107,158 | -69,576 | 37,582 |
| 24,390,442 | 2,774,748 | 27,165,190 | Total Current Assets | 25,297,520 | 1,867,670 | 27,165,190 |
| | | | **PROPERTY, PLANT & EQUIPMENT** | | | |
| 6,124,510 | 0 | 6,124,510 | Land | 6,124,510 | 0 | 6,124,510 |
| 48,018,314 | 0 | 48,018,314 | Bldgs & Improvements | 46,232,338 | 1,785,976 | 48,018,314 |
| 83,764,594 | 736,608 | 84,501,202 | Equipment - Owned | 76,882,641 | 7,618,561 | 84,501,202 |
| 1,411,670 | 0 | 1,411,670 | Equipment - Capital Leases | | 1,411,670 | 1,411,670 |
| 709,520 | -709,520 | | Construction in Progress | 494,454 | -494,454 | |
| 140,028,608 | 27,088 | 140,055,696 | Gross PP&E | 129,733,943 | 10,321,753 | 140,055,696 |
| -88,409,185 | -584,523 | -88,993,708 | Less Accumulated Depreciation | -83,629,932 | -5,363,776 | -88,993,708 |
| 51,619,423 | -557,435 | 51,061,988 | Net PP&E | 46,104,011 | 4,957,977 | 51,061,988 |
| | | | **OTHER ASSETS** | | | |
| | | | Investments | | | |
| 0 | 0 | 0 | Notes Receivable | 0 | 0 | 0 |
| 10,027,657 | 0 | 10,027,657 | Intangible Assets - Net | 10,027,657 | 0 | 10,027,657 |
| | | | Investments in Subsidiaries | | | |
| | | | Other Assets | | | |
| 10,027,657 | 0 | 10,027,657 | Total Other Assets | 10,027,657 | 0 | 10,027,657 |
| 86,037,522 | 2,217,313 | 88,254,835 | Grand Total Assets | 81,429,188 | 6,825,647 | 88,254,835 |
| | | | **CURRENT LIABILITIES** | | | |
| 3,194,402 | 257,552 | 3,451,954 | Accounts Payable | 3,254,037 | 197,917 | 3,451,954 |
| 3,584,063 | 237,151 | 3,821,214 | Accrued Salaries | 3,972,479 | -151,265 | 3,821,214 |
| 1,330,865 | 54,470 | 1,385,335 | Accrued Expenses | 1,494,224 | -108,889 | 1,385,335 |
| 18,493 | -161 | 18,332 | Accrued Interest | 20,167 | -1,835 | 18,332 |
| | | | Distributions Payable | | | |
| 860,185 | 4,325 | 864,510 | Curr Port - Long Term Debt | 298,465 | 566,045 | 864,510 |
| 20,466 | -8,237 | 12,229 | Other Current Liabilities | 38,311 | -26,082 | 12,229 |
| | | | Income Taxes Payable | | | |
| 9,008,474 | 545,100 | 9,553,574 | Total Current Liabilities | 9,077,683 | 475,891 | 9,553,574 |
| | | | **LONG TERM DEBT** | | | |
| 3,500,250 | -74,047 | 3,426,203 | Capitalized Leases | 2,980,758 | 445,445 | 3,426,203 |
| -213,248,238 | 3,662,582 | -209,585,656 | Inter/Intra Company Debt | -194,483,871 | -15,101,785 | -209,585,656 |
| | | | Other Long Term Debts | | | |
| -209,747,988 | 3,588,535 | -206,159,453 | Total Long Term Debts | -191,503,113 | -14,656,340 | -206,159,453 |
| | | | **DEFFERED CREDITS AND OTHER LIAB** | | | |
| | | | Professional Liab Risk | | | |
| | | | Deferred Incomes Taxes | | | |
| 91,329 | 3,345 | 94,674 | Long-Term Obligations | 101,530 | -6,856 | 94,674 |
| 91,329 | 3,345 | 94,674 | Total Other Liabilities & Def | 101,530 | -6,856 | 94,674 |
| | | | **EQUITY** | | | |
| 1,000 | 0 | 1,000 | Common Stock - par value | 1,000 | 0 | 1,000 |
| 23,562,553 | 0 | 23,562,553 | Capital in Excess of par value | 23,562,553 | 0 | 23,562,553 |
| 223,890,799 | 0 | 223,890,799 | Retained Earnings - current yr | 261,202,489 | 0 | 261,202,489 |
| 39,231,355 | -1,919,667 | 37,311,688 | Net Income Current Year | | | |
| | | | Distributions | | | |
| | | | Other Equity | | | |
| 286,685,707 | -1,919,667 | 284,766,040 | Total Equity | 263,753,088 | 21,012,952 | 284,766,040 |
| 86,037,522 | 2,217,313 | 88,254,835 | Total Liabilities and Equity | 81,429,188 | 6,825,647 | 88,254,835 |

F00025 - SUMMIT MED CTR-TOT HOS OPS - S031

Dec - 2011

6/12/2012 04:45:06 PM

**Financial Statements - Income Statement**

All Entities

Report ID: ALCFS008

| Month | | | | | | | | Year to Date | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Bud Var | Var % | Prior Year | PY Var | Var % | | Actual | Budget | Bud Var | Var % | Prior Year | PY Var | Var % |
| | | | | | | | **REVENUES** | | | | | | | |
| 6,192 | 5,372 | 820 | 15.26% | 5,230 | 962 | 18.39% | Inpatient Revenue Routine Services | 62,552 | 59,281 | 3,272 | 5.52% | 55,645 | 6,907 | 12.41% |
| 30,930 | 28,483 | 2,447 | 8.59% | 29,216 | 1,714 | 5.87% | Inpatient Revenue Ancillary Services | 309,122 | 308,438 | 684 | 0.22% | 284,499 | 24,622 | 8.65% |
| 37,122 | 33,855 | 3,267 | 9.65% | 34,446 | 2,676 | 7.77% | Inpatient Gross Revenue | 371,674 | 367,719 | 3,955 | 1.08% | 340,145 | 31,529 | 9.27% |
| 26,716 | 28,740 | (2,024) | -7.04% | 24,195 | 2,521 | 10.42% | Outpatient Gross Revenue | 283,735 | 315,688 | (31,954) | -10.12% | 283,860 | (126) | -0.04% |
| 63,838 | 62,595 | 1,243 | 1.99% | 58,641 | 5,197 | 8.86% | Total Patient Revenue | 655,409 | 683,407 | (27,998) | -4.10% | 624,005 | 31,403 | 5.03% |
| 86 | 88 | (3) | -2.89% | 100 | (15) | -14.48% | Other Revenue | 1,088 | 1,070 | 19 | 1.77% | 1,144 | (56) | -4.86% |
| 63,924 | 62,684 | 1,240 | 1.98% | 58,741 | 5,183 | 8.82% | Gross Revenue | 656,497 | 684,477 | (27,979) | -4.09% | 625,149 | 31,348 | 5.01% |
| | | | | | | | **DEDUCTIONS** | | | | | | | |
| 14,996 | 15,113 | (117) | -0.77% | 14,088 | 909 | 6.45% | Total CY CA - Medicare (1,2) | 166,932 | 163,201 | 3,731 | 2.29% | 145,773 | 21,159 | 14.52% |
| 85 | 92 | (7) | -7.40% | 53 | 33 | 62.35% | Total CY CA - Medicaid (3) | 1,697 | 1,027 | 670 | 65.25% | 1,199 | 498 | 41.55% |
| 806 | 585 | 221 | 37.73% | 469 | 337 | 71.92% | Total CY CA - Champus (6) | 6,740 | 6,301 | 439 | 6.96% | 5,483 | 1,257 | 22.92% |
| (67) | | (67) | | (138) | 71 | 51.48% | Prior Year Contractuals | (1,281) | (890) | (391) | -43.92% | (945) | (336) | -35.57% |
| 28,237 | 26,841 | 1,396 | 5.20% | 25,692 | 2,544 | 9.90% | Total CY CA - Mgd Care (7,8,9,12,13) | 272,657 | 288,407 | (15,750) | -5.46% | 263,561 | 9,096 | 3.45% |
| 859 | 329 | 530 | 161.20% | 419 | 441 | 105.31% | Charity | 3,824 | 3,573 | 250 | 7.01% | 2,489 | 1,335 | 53.63% |
| 1,695 | 1,942 | (247) | -12.73% | 12 | 1,683 | 14,389.04% | Bad Debt | 13,078 | 21,092 | (8,014) | -37.99% | 15,424 | (2,346) | -15.21% |
| 2,591 | 4,119 | (1,529) | -37.11% | 4,815 | (2,224) | -46.19% | Other Deductions | 39,800 | 44,573 | (4,773) | -10.71% | 41,040 | (1,240) | -3.02% |
| 49,202 | 49,022 | 180 | 0.37% | 45,408 | 3,794 | 8.36% | Total Revenue Deductions (incl Bad Debt) | 503,446 | 527,283 | (23,837) | -4.52% | 474,023 | 29,423 | 6.21% |
| 14,722 | 13,662 | 1,060 | 7.76% | 13,334 | 1,388 | 10.41% | Cash Revenue | 153,051 | 157,194 | (4,143) | -2.64% | 151,126 | 1,925 | 1.27% |
| | | | | | | | **OPERATING EXPENSES** | | | | | | | |
| 3,770 | 3,705 | 65 | 1.77% | 3,677 | 94 | 2.55% | Salaries and Wages | 42,614 | 42,946 | (332) | -0.77% | 42,362 | 252 | 0.59% |
| | | | | | | | Contract Labor | | | | | 6 | (6) | -100.00% |
| 958 | 978 | (20) | -2.01% | 1,061 | (103) | -9.68% | Employee Benefits | 11,539 | 11,337 | 201 | 1.78% | 11,268 | 270 | 2.40% |
| 2,450 | 2,195 | 255 | 11.61% | 2,542 | (92) | -3.62% | Supply Expense | 25,181 | 25,214 | (33) | -0.13% | 25,195 | (14) | -0.06% |
| 241 | 249 | (8) | -3.32% | 152 | 89 | 58.81% | Professional Fees | 2,316 | 2,991 | (675) | -22.57% | 1,554 | 762 | 49.01% |
| 1,204 | 1,200 | 3 | 0.27% | 1,191 | 13 | 1.10% | Contract Services | 13,570 | 14,093 | (524) | -3.72% | 13,253 | 316 | 2.39% |
| 330 | 260 | 70 | 26.82% | 309 | 20 | 6.58% | Repairs and Maintenance | 3,455 | 3,336 | 119 | 3.58% | 3,361 | 95 | 2.82% |
| 137 | 135 | 1 | 0.79% | 151 | (15) | -9.68% | Rents and Leases | 1,911 | 1,649 | 262 | 15.86% | 1,826 | 85 | 4.66% |
| 170 | 147 | 23 | 15.55% | 146 | 25 | 16.85% | Utilities | 2,079 | 2,066 | 13 | 0.65% | 1,977 | 102 | 5.18% |
| (356) | (436) | 81 | 18.53% | (260) | (96) | -36.92% | Insurance | 1,772 | 1,716 | 56 | 3.27% | 1,336 | 437 | 32.68% |
| | | | | | | | Investment Income | | | | | | | |
| 94 | 107 | (13) | -12.14% | (229) | 322 | 141.02% | Non-Income Taxes | 1,041 | 1,282 | (241) | -18.80% | 1,121 | (80) | -7.10% |
| 272 | 220 | 52 | 23.74% | 312 | (40) | -12.73% | Other Operating Expense | 2,564 | 2,653 | (89) | -3.36% | 2,443 | 120 | 4.91% |
| 9,271 | 8,761 | 510 | 5.82% | 9,053 | 218 | 2.41% | Cash Expense | 108,041 | 109,284 | (1,243) | -1.14% | 105,702 | 2,339 | 2.21% |
| 5,451 | 4,901 | 550 | 11.23% | 4,281 | 1,170 | 27.33% | EBITDA | 45,010 | 47,910 | (2,900) | -6.05% | 45,424 | (414) | -0.91% |
| | | | | | | | **CAPITAL AND OTHER COSTS** | | | | | | | |
| 626 | 556 | 70 | 12.67% | 532 | 94 | 17.70% | Depreciation & Amortization | 7,017 | 6,681 | 336 | 5.03% | 7,021 | (3) | -0.04% |
| | | | | | | | Other Non-Operating Expenses | | | | | | | |
| 7,856 | (1,641) | 9,496 | 578.85% | (1,551) | 9,407 | 606.44% | Interest Expense | (9,907) | (18,487) | 8,580 | 46.41% | (16,656) | 6,748 | 40.52% |
| (1,111) | 1,064 | (2,175) | -204.47% | 30 | (1,141) | -3,864.78% | Mgmt Fees and Markup Cost | 10,589 | 12,763 | (2,175) | -17.04% | 10,942 | (354) | -3.23% |
| | | | | | | | Minority Interest | | | | | | | |
| 7,371 | (21) | 7,392 | 14,799.90% | (990) | 8,360 | 844.73% | Total Capital and Others | 7,699 | 958 | 6,741 | 703.76% | 1,307 | 6,391 | 488.93% |
| (1,920) | 4,922 | (6,842) | -139.00% | 5,271 | (7,190) | -136.42% | Pretax Income | 37,312 | 46,952 | (9,640) | -20.53% | 44,117 | (6,805) | -15.43% |
| | | | | | | | **TAXES ON INCOME** | | | | | | | |
| | | | | | | | Federal Income Taxes | | | | | | | |
| | | | | | | | State Income Taxes | | | | | | | |
| | | | | | | | Total Taxes on Income | | | | | | | |
| (1,920) | 4,922 | (6,842) | -139.00% | 5,271 | (7,190) | -136.42% | Net Income | 37,312 | 46,952 | (9,640) | -20.53% | 44,117 | (6,805) | -15.43% |

**HCA Holdings, Inc.**

**Condensed Consolidated Income Statements**

**For the Years Ended December 31, 2011 and 2010**

**(Dollars in millions, except per share amounts)**

2012 JUN 19 PM 4 29

| | 2011 | | 2010 | |
|---|---|---|---|---|
| | **Amount** | **Ratio** | Amount | Ratio |
| Revenues before provision for doubtful accounts | **$32,506** | | $30,683 | |
| Provision for doubtful accounts | **2,824** | | 2,648 | |
| Revenues | **29,682** | **100.0 %** | 28,035 | 100.0 % |
| Salaries and benefits | **13,440** | **45.3** | 12,484 | 44.5 |
| Supplies | **5,179** | **17.4** | 4,961 | 17.7 |
| Other operating expenses | **5,470** | **18.5** | 5,004 | 17.9 |
| Electronic health record incentive income | **(210)** | **(0.7)** | - | - |
| Equity in earnings of affiliates | **(258)** | **(0.9)** | (282) | (1.0) |
| Depreciation and amortization | **1,465** | **4.9** | 1,421 | 5.0 |
| Interest expense | **2,037** | **6.9** | 2,097 | 7.5 |
| Gains on sales of facilities | **(142)** | **(0.5)** | (4) | - |
| Gain on acquisition of controlling interest in equity investment | **(1,522)** | **(5.1)** | - | - |
| Impairments of long-lived assets | **-** | **-** | 123 | 0.4 |
| Losses on retirement of debt | **481** | **1.6** | - | - |
| Termination of management agreement | **181** | **0.6** | - | - |
| | **26,121** | **88.0** | 25,804 | 92.0 |
| Income before income taxes | **3,561** | **12.0** | 2,231 | 8.0 |
| Provision for income taxes | **719** | **2.4** | 658 | 2.4 |
| Net income | **2,842** | **9.6** | 1,573 | 5.6 |
| Net income attributable to noncontrolling interests | **377** | **1.3** | 366 | 1.3 |
| Net income attributable to HCA Holdings, Inc. | **$2,465** | **8.3** | $1,207 | 4.3 |
| Diluted earnings per share | **$4.97** | | $2.76 | |
| Shares used in computing diluted earnings per share (000) | **495,943** | | 437,347 | |

**HCA Holdings, Inc.**
**Supplemental Non-GAAP Disclosures**
**Operating Results Summary**
**(Dollars in millions, except per share amounts)**

| | Fourth Quarter | | For the Years Ended December 31, | |
|---|---|---|---|---|
| | 2011 | 2010 | 2011 | 2010 |
| Revenues | $7,769 | $7,161 | $29,682 | $28,035 |
| Net income attributable to HCA Holdings, Inc. | $1,935 | $283 | $2,465 | $1,207 |
| Gains on sales of facilities (net of tax) | (84) | (3) | (80) | (2) |
| Gain on acquisition of controlling interest in equity investment (net of tax) | (1,424) | - | (1,424) | - |
| Impairments of long-lived assets (net of tax) | - | 2 | - | 77 |
| Losses on retirement of debt (net of tax) | - | - | 303 | - |
| Termination of management agreement (net of tax) | - | - | 149 | - |
| Net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement (a) | 427 | 282 | 1,413 | 1,282 |
| Depreciation and amortization | 387 | 359 | 1,465 | 1,421 |
| Interest expense | 465 | 526 | 2,037 | 2,097 |
| Provision for income taxes | 253 | 169 | 769 | 702 |
| Net income attributable to noncontrolling interests | 107 | 111 | 377 | 366 |
| Adjusted EBITDA (a) | $1,639 | $1,447 | $6,061 | $5,868 |
| Diluted earnings per share: | | | | |
| Net income attributable to HCA Holdings, Inc. | $4.25 | $0.65 | $4.97 | $2.76 |
| Gains on sales of facilities | (0.18) | (0.01) | (0.16) | (0.01) |
| Gain on acquisition of controlling interest in equity investment | (3.13) | - | (2.87) | - |
| Impairments of long-lived assets | - | - | - | 0.18 |
| Losses on retirement of debt | - | - | 0.61 | - |
| Termination of management agreement | - | - | 0.30 | - |
| Net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement (a) | $0.94 | $0.64 | $2.85 | $2.93 |
| Shares used in computing diluted earnings per share (000) | 455,460 | 437,568 | 495,943 | 437,347 |

(a) Net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA should not be considered as measures of financial performance under generally accepted accounting principles ("GAAP"). We believe net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are important measures that supplement discussions and analysis of our results of operations. We believe it is useful to investors to provide disclosures of our results of operations on the same basis used by management. Management relies upon net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA as the primary measures to review and assess operating performance of its hospital facilities and their management teams.

Management and investors review both the overall performance (including; net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and GAAP net income attributable to HCA Holdings, Inc.) and operating performance (Adjusted EBITDA) of our health care facilities. Adjusted EBITDA and the Adjusted EBITDA margin (Adjusted EBITDA divided by revenues) are utilized by management and investors to compare our current operating results with the corresponding periods during the previous year and to compare our operating results with other companies in the health care industry. It is reasonable to expect that gains on sales of facilities, impairments of long-lived assets and losses on retirement of debt will occur in future periods, but the amounts recognized can vary significantly from period to period, do not directly relate to the ongoing operations of our health care facilities and complicate period comparisons of our results of operations and operations comparisons with other health care companies.

Net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are not measures of financial performance under GAAP, and should not be considered as alternatives to net income attributable to HCA Holdings, Inc. as a measure of operating performance or cash flows from operating, investing and financing activities as a measure of liquidity. Because net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are not measurements determined in accordance with GAAP and are susceptible to varying calculations, net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

**HCA Holdings, Inc.**
**Condensed Consolidated Balance Sheets**
**(Dollars in millions)**

| | December 31, 2011 | September 30, 2011 | December 31, 2010 |
|---|---|---|---|
| **ASSETS** | | | |
| Current assets: | | | |
| Cash and cash equivalents | $373 | $359 | $411 |
| Accounts receivable, net | 4,533 | 3,925 | 3,832 |
| Inventories | 1,054 | 891 | 897 |
| Deferred income taxes | 594 | 643 | 931 |
| Other | 679 | 875 | 848 |
| Total current assets | 7,233 | 6,693 | 6,919 |
| Property and equipment, at cost | 28,075 | 26,647 | 25,641 |
| Accumulated depreciation | (15,241) | (15,002) | (14,289) |
| | 12,834 | 11,645 | 11,352 |
| Investments of insurance subsidiaries | 548 | 545 | 642 |
| Investments in and advances to affiliates | 101 | 837 | 869 |
| Goodwill and other intangible assets | 5,251 | 2,701 | 2,693 |
| Deferred loan costs | 290 | 297 | 374 |
| Other | 641 | 1,038 | 1,003 |
| | $26,898 | $23,756 | $23,852 |
| **LIABILITIES AND STOCKHOLDERS' DEFICIT** | | | |
| Current liabilities: | | | |
| Accounts payable | $1,597 | $1,334 | $1,537 |
| Accrued salaries | 965 | 876 | 895 |
| Other accrued expenses | 1,585 | 1,336 | 1,245 |
| Long-term debt due within one year | 1,407 | 725 | 592 |
| Total current liabilities | 5,554 | 4,271 | 4,269 |
| Long-term debt | 25,645 | 25,871 | 27,633 |
| Professional liability risks | 993 | 993 | 995 |
| Income taxes and other liabilities | 1,720 | 1,683 | 1,608 |
| Total liabilities | 33,912 | 32,818 | 34,505 |
| Equity securities with contingent redemption rights | - | - | 141 |
| **EQUITY (DEFICIT)** | | | |
| HCA Holdings, Inc. stockholders' deficit | (8,258) | (10,194) | (11,926) |
| Noncontrolling interests | 1,244 | 1,132 | 1,132 |
| Total deficit | (7,014) | (9,062) | (10,794) |
| | $26,898 | $23,756 | $23,852 |

# C, Orderly Development--7(C)
# TDH Inspection & Plan of Correction

# Board for Licensing Health Care Facilities

State of Tennessee

0000000033

No. of Beds 0188

## DEPARTMENT OF HEALTH

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

HCA HEALTH SERVICES OF TENNESSEE, INC. *to conduct and maintain a*

*Hospital* SUMMIT MEDICAL CENTER

*Located at* 5655 FRIST BOULEVARD, HERMITAGE

*County of* DAVIDSON *, Tennessee.*

*This license shall expire* APRIL 20 *,* 2013 *, 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* 1ST *day of* JULY *,* 2012 *.*

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

*By* Vincent T. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

*By* [illegible]

COMMISSIONER

# Summit Medical Center

Hermitage, TN

has been Accredited by

## The Joint Commission

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

Hospital Accreditation Program

**April 25, 2009**

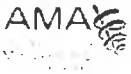
Accreditation is customarily valid for up to 39 months.

David L. Nahrwold, M.D.
Chairman of the Board

Organization ID #7806
Print/Reprint Date: 7/10/09

Mark Chassin, M.D.
President

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



# CERTIFICATE OF DISTINCTION

*has been awarded to*

## Summit Medical Center
## Hermitage, TN

*for Advanced Certification as a*

## Primary Stroke Center

*by*

## The Joint Commission

*based on a review of compliance with national standards, clinical guidelines and outcomes of care*

## November 29, 2011

*Certification is customarily valid for up to 24 months.*

Organization ID#7806

Print/Reprint Date: 01/10/12

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

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

AMA

# Summit Medical Center

## Hermitage, TN

has been Accredited by

# The Joint Commission

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

Hospital Accreditation Program

## April 25, 2009

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold, M.D.
Chairman of the Board

Organization ID #7806
Print/Reprint Date: 7/10/09

Mark Chassin, M.D.
President

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

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

**Organization Identification Number: 7806**

**Program(s)**
Hospital Accreditation Program

**Surveyor(s) and Survey Date(s)**
John E. Eiland, MSN, RN - (04/21 - 04/23/2009)
(04/24 - 04/24/2009)
William J. Elberson, MD - (04/21 - 04/23/2009)
(04/24 - 04/24/2009)
Thomas M. Messer, CHFM, MBA - (04/21 - 04/21/2009)

**Executive Summary**

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

# The Joint Commission
## Summary of Findings

**DIRECT Impact Standards:**

| | | |
|---|---|---|
| **Program:** | Hospital Accreditation Program | |
| **Standards:** | EC.02.01.01 | EP8 |
| | MM.05.01.01 | EP8 |

**INDIRECT Impact Standards:**

| | | |
|---|---|---|
| **Program:** | Hospital Accreditation Program | |
| **Standards:** | LD.04.01.07 | EP2 |
| | LS.02.01.10 | EP5,EP9 |
| | MM.04.01.01 | EP13 |

# The Joint Commission
# Findings

**Chapter:** Environment of Care

**Program:** Hospital Accreditation Program

**Standard:** EC.02.01.01

**Standard Text:** The hospital manages safety and security risks.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

8. The hospital controls access to and from areas it identifies as security sensitive.

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s)**

EP 8
Observed in Tracer Activity at Summit Imaging site.
It was noted that nuclear material was delivered to the Nuclear Laboratory before the clinic was opened and the delivery personnel had complete and unmonitored access to the entire clinic. The delivery personnel were provided the combination to the lab by clinic personnel. The landlord of the building provided at least one key to the delivery agency. It was unclear if or how many extra keys to the clinic were distributed to nonemployees or what other non-organizational entities had access to the clinic.

Additionally, there were times when the individual opening the clinic at the beginning of the day would unlock a side door to the clinic to allow other staff to enter the clinic. This would permit nonemployees an unmonitored access to the clinic as well.

Permitting nonemployees to have open and unmonitored access to the entire clinic as well as secure areas within the clinic exposes the organization to potential security risks.

---

**Chapter:** Leadership

**Program:** Hospital Accreditation Program

**Standard:** LD.04.01.07

**Standard Text:** The hospital has policies and procedures that guide and support patient care, treatment, and services.

**Primary Priority Focus Area:** Communication

**Element(s) of Performance:**

2. The hospital manages the implementation of policies and procedures. (See also NR.02.03.01, EP 2)

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s)**

EP 2
Observed in Infection Control Session at Summit Medical Center site.
During the document review and Infection Control Session, it was noted that the previous annual summary only addressed seven surveillance activities. Likewise the current annual risk assessment included only those seven points which required no prioritization due to the minimal resources required. This represented only a fraction of the activities conducted by the Infection Control Department; some of which were critical elements to the execution of an effective infection control program. As a result, the annual summaries, the program's general goals and the committee's interventions as evidenced in meeting minutes were not congruent and not interrelated.

---

**Chapter:** Life Safety

**Program:** Hospital Accreditation Program

**Standard:** LS.02.01.10

**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

5. Doors required to be fire-rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)

**Scoring Category :** C
**Score :** Insufficient Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

**Scoring Category :** C
**Score :** Insufficient Compliance

**Observation(s)**

EP 5
Observed in environmental tours at Summit Medical Center site.
The smoke door on 6th floor South had a vertical gap greater than 1/8 inch.

Observed in environmental tours at Summit Medical Center site.
While tracing a patient, it was noted that the fire door leading to the imaging suites was ajar. The door was prevented from closing by a malfunctioning latch. The latch was repaired before the end of the survey.

Observed in environmental tours at Summit Medical Center site.
While tracing a patient, it was noted that a fire door leading to the imaging suite did not latch positively when closed.

EP 9
Observed in the building tour at Summit Medical Center site.
A three inch sleeve used to allow wiring to pass through in the smoke barrier located adjacent to room 710 did not have fire rated material installed to a sufficient quantity to prevent the passage of smoke.

Observed in the building tour at Summit Medical Center site.
A three inch sleeve used to allow wiring to pass through in the smoke barrier located adjacent to room 402 did not have fire rated material installed to a sufficient quantity to prevent the passage of smoke.

Observed in the building tour at Summit Medical Center site.
A one inch sleeve used to allow wiring to pass through in the smoke barrier located adjacent to room 301 did not have fire rated material installed to a sufficient quantity to prevent the passage of smoke.

---

**Chapter:** Medication Management

**Program:** Hospital Accreditation Program

**Standard:** MM.04.01.01

**Standard Text:** Medication orders are clear and accurate.

**Primary Priority Focus Area:** Medication Management

**Element(s) of Performance:**

13. The hospital implements its policies for medication orders.

**Scoring Category :** C
**Score :** Insufficient Compliance

**Observation(s)**

EP 13
Observed in a patient record at Summit Medical Center site.
While tracing a patient, it was noted that an order for medication used to treat airway constriction lacked a dose. The order was filled and the medication administered without clarification.

Observed in tracer activity at Summit Medical Center site.
Organization policy requires medications to be re-ordered when a patient is transferred to a different level of care, A patient was transferred to the MICU and a medication was continued despite the fact that an order to continue the medication was not obtained.

Observed in 5th Floor at Summit Medical Center site.
During an individual patient tracer activity, it was noted that a medication order "continue previous orders" was written 4/14/2009 following a surgical procedure.

Observed in 5th Floor at Summit Medical Center site.
Further, similar orders were rewritten by the surgeon two more times following additional surgical interventions. There was no indication that the orders were clarified by Medical, Nursing nor Pharmacy staff.

---

**Chapter:** Medication Management

**Program:** Hospital Accreditation Program

**Standard:** MM.05.01.01

**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

**Element(s) of Performance:**

8. All medication orders are reviewed for the following: Therapeutic duplication.

**Scoring Category :** C
**Score :** Partial Compliance

**Observation(s)**

EP 8
Observed in 5th Floor at Summit Medical Center site.
During an individual patient tracer activity, it was noted that two oral pain medications, Lortab and Percocet, were both ordered prn pain with no delimiting criteria to aid the nurse in choosing one medication over the other.

Observed in 5th Floor at Summit Medical Center site.
Additionally, besides the initial order for the two oral narcotics, the medications were reordered following three surgical interventions without further clarification by Medical, Pharmacy or Nursing staff.

---

# SUPPORT LETTERS

Continued from last column

see and must be acceptable to the **City of Murfreesboro**.

If a check is offered as guaranty, the check of the successful bidder will be cashable at the discretion of the **City of Murfreesboro**, pending the satisfactory execution and acceptance of the contract and the contract bond.

**ISSUANCE OF BIDDING DOCUMENTS**

This **City of Murfreesboro** and the Tennessee Department of Transportation are on a cash basis for sales of Plans, Proposal Contracts, Standard Specifications, Standard Drawings, Standard Drawing Books and Tabulations of Bids. Requests for documents must be accompanied by cash, check, money order, or they may be mailed to the buyer month period will be furnished at **$10.00** per sheet. Individual Plan sheets and individual Standard Drawings will be furnished at **$10.00** per sheet. Tabulations of bids will be furnished at **$10.00** per sheet. Tennessee Department of Transportation Standard Drawing Books will be furnished by the Tennessee Department of Transportation at **$100.00** per book plus **9.25%** sales tax, for in-state delivery. Tennessee Department of Transportation Standard Specifications for Road and Bridge Construction, dated March 1, 2006, will be furnished by the Tennessee Department of Transportation at **$12.00** per book plus **9.25%** sales tax, for in-state delivery. There will be a minimum charge of $2.00 on any purchase. All documents will be furnished without refund and transmitted at your risk.

When two or more contractors wish to bid together in a joint venture, each contractor will be required to make a written request for such a proposal to the City of Murfreesboro. This request shall be signed by an authorized signatory of each firm.

Requests for joint venture proposals may be made in person or by telephone. However, the proposal for said joint venture will not be issued until the request in writing, as

Continued to next column

Continued from last column

set forth above, is received by the **City of Murfreesboro**.

**REJECTION OF PROPOSALS**

Proposals will be rejected as irregular if prior to the formal opening of the Proposal all of the following documents have not been signed: (1) the bidder shall sign by written signature the Proposal form, (2) the bidder shall sign by written signature the Proposal Certification form, (3) the bidder shall sign by written signature the Proposal Bond form or the Proposal Guarantee, whichever is applicable, (4) the Agent or Attorney-in-Fact representing a Surety Company shall sign by written signature the Proposal Bond, if applicable. In addition, Proposals will be rejected if any of the above signatures are a repro-

"Proposals shall be completed on the forms as issued. Please review a part of Subsection 102.02 of the Tennessee Department of Transportation Standard Specifications stating: "All of the documents that are bound therein are part of the Proposal and shall not be detached." Proposals shall not be taken apart. Proposals taken apart may be subject to rejection. Also, please review a part of Subsection 102.09 of the Tennessee Department of Transportation Standard Specifications stating: "Proposals will be rejected as being irregular if they are not prepared on the prescribed forms; if they show any omissions, alterations of form, additions, or conditions not called for, unauthorized alternate bids, or ir-

Continued to next column

Continued from last column

regularities of any kind; or if they fail to contain a unit price for each item listed." Proposals shall be completed on the forms as issued. Photostatic or facsimile copies of Proposal sheets may not be attached to the Proposal. Proposals containing forms not issued by the **City of Murfreesboro** may be subject to rejection.

2012 JUN 14 PM 1 23

**ADDENDA**

Addenda to the Proposal will be acknowledged by all bidders. Failure to acknowledge receipt of Addendum Letters is grounds for rejection.

**RETAINAGE**

Effective for all contracts, the City of Murfreesboro will not hold retainage. In addition, the Contractor will not be able to hold retainage from the subcontractor.

**PRE-BID MEETING**

A Mandatory Pre-bid meeting will be held at **10:00 AM on June 19, 2012** at Room 218, City Hall, 111 West Vine Street, Murfreesboro, TN. Representatives of Owner and Engineer shall be present to discuss the project.

**Rob Lyons**
**City of Murfreesboro Officer**

Continued to next column

0101560443

**MEETING NOTICE**

"Mid-Cumberland Area Development will have their Annual Meeting and Luncheon on Thursday June 14th at The Palm Restaurant, 140 5th Avenue South, Nashville, TN 37203 from 11:30 to 1:30. The regularly scheduled meetings will resume at Pathway Lending, 201 Venture Circle, Nashville, TN 37228 at 1:30 on the 1st

Continued to next column

Continued from last column

and 3rd Thursday of the month starting in July. Should you have any questions do not hesitate to call."

cars.com

Also search Tennessean Classifieds at www.tennessean.com, click on Classifieds.

Automotive

SUNDT

Sundt Construction, Inc. is soliciting certified Small Disadvantaged, Veteran-Owned, Service Disabled Veteran-Owned, Women-Owned, and HUBZone Small Business Companies, who are interested in proposing on Sundt Construction's UEPH Barracks Project at Fort Campbell, KY

Interested companies must be capable of being certified as a Small Business Enterprise.

For more information regarding this project please contact Casey Sundt via e-mail @ cjsundt@sundt.com

Equal Employment Opportunity Employer

TN-0101560312

0101560298

## 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. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to establish a twenty (20) bed acute inpatient rehabilitation unit and service in its hospital facility at 5655 Frist Boulevard, Hermitage, TN 37076, at a capital cost estimated at $2,500,000. The unit will be created by converting 20 adult psychiatric beds to inpatient rehabilitation beds and reclassifying the adult psychiatric unit as an inpatient rehabilitation unit. The adult psychiatric patients will be transferred to the existing adult inpatient psychiatric program at Skyline Medical Center, Madison, a sister facility.

Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will not change its licensed hospital bed complement or initiate any other health service or include any major medical equipment.

The anticipated date of filing the application is on or before June 15, 2012. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

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**
**500 Deaderick Street, Suite 850**
**Nashville, Tennessee 37243**

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection 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.

**Antique/Classic Vehicles**

**CADILLAC ELDORADO '98** 2 door, Black interior, Black exterior, 31,000 mi., V8, Cyl., 2WD AM/FM Stereo, A/C, alloy wheels, bucket seating, cassette, cruise, Side Airbag, leather int., PDL, Power Seats, Power Sliding Doors, PW, rear A/C Classic car in mint condion! $8000.00 Call(615)794-5348 or(615)957-7990

**CHEVROLET CAMARO '92**, 25th Anniv Ed. 5.0 V8. 42,515 1-owner miles. Carport kept. All pwr, T-Tops, $6500. 615-794-7887

**FORD TAURUS SE, '99, 4dr, V6 auto, cold ac, failed Marta, good tires, 166k. $1000 Cash +TTL. TNDL 17049. 615-569-6646**

**MERCURY COUGAR '67 XR7**, restored original automobile. 68K mi, dark metallic green, tan leather inter. 289 cu in V-8 auto trans. New tires. Styled wheels, lots of original rec. $11,000. **615-457-6435**

**TRIUMPH TR6 '74**, 77,450 mi, carmine, tan int, tires almost new, new Weber carb, electronic ingition $12,500. 615-654-4819

**Cars**

**123 AUTO RECYCLING**
We buy cars, trucks, vans in any cond. Free pick up. No title needed. We beat any reasonable offer. Cash paid on spot. 615-935-5023

**#1 CASH AUTO BUYER**
Maximum Ca$h Paid
We Beat Competitor $$
Minimum Paid $300-$750
Any Make/Model Condition
615-767-3484
Instant Cash

**ACCURA TL '08**, w/nav. Bronz w/lt gray leather. Nice car w/great gas mileage. Non smoker. $19,500. 615-370-1374

should be on everyone. $32,500. (615)873-0542

**AUDI S4 CABRIOLET '08** Brilliant Black w/Black, 35K, 6 spd, loaded, warr, **$33,900**+ttl, no doc fee. A3225. 615-300-6001 cox-motorcars.com

**BENTLEY ARNAGE '05 R 4 dr, black/black, 15,300 mi, locally owned. Service recs. Pristine! $84,500 615-777-AUTO (2886) www.neatcars.com**

**BMW 335i Sport Convertible '08** Platinum Bronze w/Beige, 17K, nav, loaded, warr, **$33,900**+ttl, no doc fee. B7112. 615-300-6001 cox-motorcars.com

**BMW 528i '09** Monaco w/Natural Brown, 56K mi, loaded, warr., **$24,900**+ttl, no doc fee. B4412. 615-300-6001 cox-motorcars.com

**BMW 528i SPORT '09** Monaco w/Natural Brown, 26K, loaded, warranty. **$30,900** +ttl, no doc fee. B5661. 615-300-6001 cox-motorcars.com

**BMW 535i '09** Black w/Charcoal, 24K, loaded, warr. **$32,900**+ttl, no doc fee. B2311. 615-300-6001 cox-motorcars.com

**BMW 535xi '09** Black Sapphire w/Natural Brown, 60K mi., loaded, warr., **$25,900**+ttl, no doc fee. B4212. 615-300-6001 cox-motorcars.com

**BMW 535xi SPORT '09** Deep Sea w/Natural Brown, 44K mi., loaded, warr., **$29,900**+ttl, no doc fee. B8136. 615-300-6001 cox-motorcars.com

**BMW 750 Li '07**, blue, black leather, sport pkg, premium sound, DVD. Certified pre-owned. 58K mi. $33,000. 615-804-4934.

**BMW X3.3 SI '08 Black, 58k mi, AWD, 4 dr, auto, loaded, clean CarFax, lady driven, garaged, MINT! $25,900. Call 615-423-8989**

**BUICK PARK AVE '00** Ultra, 157K mi, pewter, everything in good working cond, sunroof, good tires, all electric. $3900. Call Mark, 615-556-8878

**Cars**

**FORD ESCORT '99, 4 cyl auto gas saver wagon. New ac, tires, roof rack. 129k. $2999 Cash +TTL. TNDL 17049. 615-569-6646**

**FORD FOCUS '06 SES** Auto, PW, PL, remote entry, safety pkg, alloy wheels, sporty & economical $4,780. 615-330-3152

**FORD MUSTANG '06 GT**, 2DR, auto, leather, adult owned, low miles, new tires. Excellent cond. $13,500. Call 615-865-7809

**FORD MUSTANG '97 GT** roof, exc cond, garage kept, 196k mi, $4500, 615-824-7389 or 615-545-6422

**LEXUS ES330 '06** immaculate, 80k, 2nd owner, gar kept, non-smoker, 100K mi bumper-bumper warr, clean carfax. $20,500 obo. 615-336-1843

**LINCOLN TOWN CAR '07** cruise, pw, proportional power steering 615-591-5060 $16,901 $299 doc fee plus TTL P5851 TNDL#3955

**MERCEDES-BENZ 450SL '76** 2dr Convertible, cass./am/fm 2 WD, 8 cyl, 109,500 mi., Silver, $7,500, 615-758-3685

**MERCEDES-BENZ C300 AMG SPORT '11** Black w/Light Gray, 22K, loaded, warr. **$27,900**+ttl, no doc fee. M0911. 615-300-6001 cox-motorcars.com

**MERCEDES BENZ E350 '06**, 64K mi, Gray w/charcoal int. Excellent condition! $19,950 obo. Call 615-496-6005.

**MERCEDES BENZ E350 AMG SPORT '09** Barolo Red w/Cashmere, 25K mi, NAV, loaded, warr., **$31,900**+ttl, no doc fee. M7243. 615-300-6001 cox-motorcars.com

**MERCEDES-BENZ E350 SPORT '08** Iridium Silver w/ Charcoal, 53K, loaded, warr. **$24,900**+ttl, no doc fee. M4412. 615-300-6001 cox-motorcars.com

**MERCEDES-BENZ E350 SPORT '11** Arctic White w/Charcoal, 29K, loaded, warr. **$43,900**+ttl, no doc fee. M7782. 615-300-6001 cox-motorcars.com

**MERCEDES-BENZ S550 '07** Flint Gray w/Charcoal, 66K mi, loaded, warr. **$33,900**+ttl, no doc fee. M8210. 615-300-6001 cox-motorcars.com

**MERCEDES-BENZ S550 AMG SPORT '08** Black w/Savanna, 33K, loaded, warr. **$48,900**+ttl, no doc fee. M3655. 615-300-6001 cox-motorcars.com

**MERCURY GRAND MARQUIS 07 LS**, Local Trade, 46K Miles, White w/Leather. Call Danny

ADMIT ONE

tic...

Ticke...

TITANS S... 2012. ... 234, ... Level, ... Parking ... $2570 ea...

Your ticke... every Fr...

TOYOTA ... auto, 138... CD/cass. ... New timi... Runs/driv... 559-772-1...

TOYOTA ... Black, 39... kt, keyles... CD, alloy... $11,999...

TOYOTA ... 4dr, SUV, ... tow pkg, ... Roomy & ... great! $2... TNDL 1704...

Mot...

IMPOR... Use cauti... to wire mo... In some ca... been tra... no vehicle...

HARLE... HERITAG... 11K+ mi, ... New Tire... $9300, ...

HARLEY ... Softail ... Black, 145... rage kept, ... mi, $12,000...

HARLEY DA... '06, Black ... Screaming ... kit, small ... $4900, 6...

HARLEY O... CHOPPER ... 1200 cc. ... $2900.00 C... 5468. Ride ...

HONDA 750 ... '03 5500 m... garage kept... dle bags, lik... OBO. Call 61...

HONDA GO... MUS... ited '85 New... kept 23000 ... sell becaus... health $250... 615-672-168...

KAWASAKI Z... 1 owner, like... garage kept, ... rear tire, $45... 615-405-4788...

Sport ... Vehi...

IMPORTA... Use caution ... to wire money... In some case... been trans... no vehicle w...

BMW X3.3 S... 58k mi, AWD... loaded, clean ... driven, gara... $25,900. Call 6...

CHEVROLET ... 6-Speed,, T... Green exteri...

# Skyline Medical Center

TRI STAR HEALTH SYSTEM

2012 JUN 14 PM 4 37

June 11, 2012

Greg Caples
Chief Operating Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076-2053

Dear Greg,

Please accept this letter of support for the consolidation of Summit's adult psychiatric patients at Skyline Madison Campus.

Please be assured that we have the capacity at Skyline Madison Campus to absorb your current annual admissions and inpatient days.

I look forward to working with your team during this process.

Respectfully,

Steve Otto
Chief Executive Officer

SAO/th



3441 Dickerson Pike • Nashville, TN 37207 • 615-769-2000
www.tristarhealth.com

**AFFIDAVIT**

2012 JUN 14 PM 4 29

STATE OF TENNESSEE

COUNTY OF DAVIDSON

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

SIGNATURE/TITLE

Sworn to and subscribed before me this 14th day of June (Month), 2012 (Year) a Notary Public in and for the County/State of Davidson Co. Tennessee.

RANDAL P. WALL STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY MY COMMISSION EXPIRES 9-9-2014

NOTARY PUBLIC

My commission expires September 9 (Month/Day), 2014 (Year).

# SUPPLEMENTAL

DSG Development Support Group

2012 JUN 22 PM 3 48

June 22, 2012

Philip M. Wells, FACHE, Health Planner III
Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

RE: CON Application CN1206-029
Summit Medical Center--Initiation of Inpatient Rehabilitation Services & Conversion of 20 Psychiatric Beds to 20 Inpatient Rehabilitation Beds

Dear Mr. Wells:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section B, Project Description, Item III (Plot Plan)**

   **Your response is noted. However the outline of the building's first floor footprint is blacked-in, not allowing for the display of where the project's construction is proposed to occur on the third floor. Please provide a revised drawing displaying the outline of the patient tower where the third floor remodeling is proposed to occur.**

   An improved plot plan with the requested information will be submitted under separate cover.

2. **Section B, Project Description, Item II B.**

   **The applicant indicates the adult inpatient psychiatric patients who would be admitted to the current adult inpatient psychiatric unit will be transferred and referred to TriStar's Skyline Madison's adult behavior unit.**

   **In order to affirm Skyline Madison's capacity to absorb the patient volumes by the closing of Summit's adult psych unit, please provide the following information regarding Summit's and Skyline's adult psychiatric programs.**



4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

The requested table is provided below. We have added two rows to demonstrate that the psychiatric bed complements at Skyline Madison Medical Center are sufficient to absorb the current census at Summit, which is at its highest in three years.

| | 2009 | 2010 | 2011 |
|---|---|---|---|
| Summit's Adult Psych Unit | | | |
| Beds | 20 | 20 | 20 |
| ADC | 12.7 | 10.7 | 13.7 |
| Occupancy (%) | 64% | 53% | 69% |
| Skyline Madison's Adult Psych Unit | | | |
| Beds | 100 | 100 | 100 |
| ADC | 58.5 | 55.4 | 61.5 |
| Occupancy (%) | 59% | 55% | 62% |
| | | | |
| COMBINED SUMMIT/SKYLINE MADISON ADC | -- | -- | 75.2 |
| COMBINED OCCUPANCY (ON 100 BEDS AND 2011 DAYS) | -- | -- | 75% |

**3. Section C, Need, Item 1 (Specific Criteria- Inpatient Rehabilitation Services, Item2) and Item 5 (Existing Facilities Capacities and Utilization)**

**The applicant notes there is currently a surplus of rehabilitation beds in Davidson and Wilson Counties, its declared service area. The applicant also notes in several places on pages 18 and 26 of the application, "there are 41 older beds which are designated as rehabilitation beds that are not open and available and are unlikely to become open and available in the foreseeable future, due to licensing issues and other issues." Ten (10) of these forty-one (41) licensed and designated as rehabilitation beds are located at the Skyline-Madison facility. Since the applicant, Summit Medical Center, and Skyline Medical Center–Madison are both HCA facilities and Skyline – Madison will benefit from Summit's willingness to shift its adult psychiatric patients and programming to Skyline-Madison facility, has HCA and Skyline-Madison considered relinquishing the bed licensing for the 10 Skyline-Madison rehabilitation beds which will not be used in the foreseeable future as a partial relief to the Davidson County rehabilitation bed surplus?**

2012 JUN 22 PM 3 48



The applicant understands and appreciates the Agency's efforts to reduce the number of currently unused beds in the market. In recognition of that concern, TriStar hospitals have agreed to voluntarily relinquish a total of 59 licensed beds since 2007. In addition, Skyline Madison recently received approval to convert 11 unused med/surg beds to much-needed C & A psych beds, rather than ask for new C & A beds at the Madison campus. Similarly, the Summit application does not add to areawide hospital bed complements; instead it converts existing beds.

Skyline prefers to retain the 10 currently unused Rehab beds at its Madison campus to allow it flexibility to meet future needs, and feels this preference for flexibility is reasonable in light of the uncertainty in the larger healthcare industry, and in light of the demonstrated need for the rehabilitation beds requested in the Summit application.

4. **Section C, Need, Item 5 (Existing Facilities Capacities and Utilization) Please check the math summation on the first two columns regarding facility bed capacities on the chart on page 27 of the application.**

Thank you for noting that due to an error in the totaling formula in the chart, the beds at UMC MacFarland in Lebanon were not included in the totals of existing and approved beds in those first two columns. However, the utilization data and percentages in the other columns and totals were correct, so the narrative and analysis are not affected by the error.

A corrected Supplemental Table Eleven, page27R, is attached following this page.

2012 JUN 22 PM 3 48

5. **Section C, Economic Feasibility, Item 4 (Projected Data Chart)**
**Under "other expense", please explain what "Parallon Allocations" are.**

Parallon is a wholly owned subsidiary of HCA that provides support services for the hospitals and allocates the costs of those services back to the hospitals. The services provided by Parallon include:
--All normal Business Office functions (billing, collections, cashiering, etc)
--Central Scheduling
--Revenue Integrity (chart auditing, charge capture, chargemaster maintenance)
--Credentialing Functions
--Supply Chain - Materials Management, Accounts Payable & Warehouse
--Payroll functions
--Health Information Management (Medical Records) functions

6. **Outstanding CON Project Status Reports**
**Please provide a brief two - three sentence update for the following outstanding CON projects, outlining what stage the project currently stands in its implementation schedule, its projected completion date and whether the project is on schedule to be completed by the completion date and/or CON expiration date:**

Centennial Medical Center, CN0710-079A
The last portion of this project was completed and approved by TDOH in May, 2012. The final report to the HSDA is being prepared.

Centennial Med. Cntr. Satellite Emergency Dept. at Spring Hill, CN1006-023A
The project is under construction with a completion target no later than March, 2012, before the CON expiration date.

StoneCrest Medical Center, CN1107-026A
Final working drawings are about to be submitted for TDH review; the project is scheduled to open within a year, long before the CON expiration date.

Southern Hills Medical Center, CN111-048A
This was approved in February 2012, less than 90 days ago. The applicant is completing final architectural plans and expects to open the project well before its CON expiration date.

**SUPPLEMENTAL- # 1**
**June 22, 2012**
**3:48 pm**



Additional Item From Applicant

Attached is a revised cover page for the application changing the description of the project to a 20-bed application consistent with all the other pages of the application.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

**HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING**
**SEPTEMBER 26, 2012**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | Summit Medical Center |
| PROJECT NUMBER: | CN1206-029 |
| ADDRESS: | 5655 Frist Boulevard<br>Hermitage (Davidson County), TN 37076 |
| LEGAL OWNER: | HCA Health Services of Tennessee, Inc.<br>5655 Frist Boulevard<br>Hermitage (Davidson County), TN 37076 |
| OPERATING ENTITY: | NA |
| CONTACT PERSON: | John Wellborn<br>(615) 665-2022 |
| DATE FILED: | June 14, 2012 |
| PROJECT COST: | $2,500,000.00 |
| FINANCING: | Cash Reserves of the parent corporation, HCA |
| REASON FOR FILING: | 1) Initiation of Inpatient Rehabilitation Services<br>2) Conversion of (20) Adult Psychiatric beds to (20) Rehabilitation beds |

DESCRIPTION:

Summit Medical Center (SMC) is seeking approval for initiation of inpatient rehabilitation services and conversion of (20) adult psychiatric beds to (20) rehabilitation beds. The proposed conversion will not change the hospital's total licensed bed complement of one hundred and eighty-eight (188) acute care beds at its main campus at 5655 Frist Boulevard in Hermitage (Davidson County), TN.

The project will require major and minor renovation of approximately 9,626 square feet on the hospital's 20,294 square foot third floor, which currently contains a 20-bed inpatient psychiatric unit and its support spaces. The third floor will, then, be converted to a 17,030 square foot inpatient rehabilitation unit

which will house 20 rehabilitation beds. The remaining 3,264 square feet of office space in one wing will remain as offices (*their future use has not yet been determined)*. The completed rehabilitation service will include all private patient bedrooms with handicapped-accessible/ADA-compliant private bathrooms; and ADL (Activities of Daily Living) suite with a kitchen, bedroom, and bath; a Day Room/Dining Room multipurpose room, gym, and other patient and staff support spaces (*See page 8 as well as Attachments B.III and B. IV of the original application*).

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

**COMPREHENSIVE INPATIENT REHABILITATION SERVICES**

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

   *See criterion #2 below.*

2. The need shall be based upon the current year's population and projected four years forward.

   *The applicant has chosen Davidson and Wilson Counties as the service area for its inpatient rehabilitation service. The 2016 population of these two counties is 739,405 residents. Applying the Guidelines for Growth's "ten beds per 100,000 population", the need for inpatient rehabilitation beds in this two county service area is 73.9, or rounded up, 74 beds. There are currently 224 licensed beds certified as inpatient rehabilitation beds within Davidson and Wilson Counties. Southern Hills Medical Center also has an unimplemented Certificate of Need for four (4) additional rehabilitation beds with an expiration date of April 1, 2015. Thus, there currently exists a net surplus of 154 licensed beds (see table on page 7 of this summary). It appears that the application does not meet criteria 1 and 2.*

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

   *The applicant has chosen Davidson and Wilson Counties as the service area for its inpatient rehabilitation service, which has received 85.4% of its admissions from residents of these two counties in 2011. It appears that the application does meet this criterion.*

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

*The SMC application for a Rehab Unit is for 20 beds.*

*It appears that the application meets this criterion.*

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

*This criterion is not applicable.*

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HSDA, unless all existing units or facilities are utilized at the following levels:

| | |
|---|---|
| 20-30 bed unit | ~ 75% |
| 31-50 bed unit/facility | ~ 80% |
| 51 bed plus unit/facility | ~ 85% |

*Currently, there are five inpatient rehabilitation services operating in Davidson and Wilson Counties. Below is a comparison of how the utilization of the current 183 operating and staffed beds compared with the 2000 Edition of the Guidelines for Growth's occupancy standards. Overall, only one inpatient rehabilitation unit per year met the occupancy standards: Baptist Hospital in 2010 and Skyline Medical Center's main campus unit in 2011.*

| Bed Unit Range | G of G* Occupancy Standard | Hospital | Rehab Bed Capacity | 2010 Occupancy | 2011 Occupancy | Meets G of G* Standard |
|---|---|---|---|---|---|---|
| 20-30 beds | ~ 75% | Southern Hills Medical Ctr | 12 beds | Not open | 69.2% | No |
| 20-30 beds | ~ 75% | Baptist Hospital | 24 beds | 75.1% | 69.0% | Only 1st of 2 years |
| 20-30 beds | ~ 75% | McFarland Hospital | 26 beds | 27.8% | 29.4% | No |
| 31-50 bed unit/facility | ~ 80% | Skyline Medical Center | 41 beds | 72.2% | 75.1% | Only 2nd of 2 years |
| 51 beds plus | ~ 85% | Vanderbilt Stallworth | 80 beds | 77.6% | 76% | No |

**G of G = Guidelines for Growth*

*It appears that the application does not meet this criterion.*

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the

proposal. It is preferred that the medical director of a rehabilitation hospital be a board certified physiatrist.

*The applicant intends to staff the 20 bed unit with 26.0 FTE nursing and therapy staff in the first year and plans to add 3.0 FTE nursing staff in the second year of operation. The applicant intends to recruit a physician with Board Certification in Physical Medicine and Rehabilitation (a physiatrist) for the medical director of its inpatient rehabilitation service. It appears that the application intends to meet this criterion.*

SUMMARY:

Summit Medical Center's proposal to establish a 20-bed acute inpatient rehabilitation unit will be certified as a "distinct part unit" by Medicare. The applicant states this will not increase hospital bed complement, because it will be a conversion of an existing 20-bed inpatient adult psychiatric unit on the hospital's third floor. Current psychiatric patients remaining in that unit, or presenting subsequently at Summit's Emergency Department, will be stabilized and transported to Skyline Medical Center's behavioral medicine facility in Madison, which has sufficient capacity to admit them.

The objective of the proposed reassignment of beds is to improve access to acute rehabilitation care in Summit's service area, while concentrating behavioral medicine care at HCA TriStar's Skyline Madison facility. According to the applicant, Summit Medical Center discharges a large number of patients who need rehabilitation, but has no beds approved for that purpose. Because Skyline Madison has the bed capacity to serve adult psychiatric patients now being admitted to Summit, it makes sense to concentrate those psychiatric admissions at Skyline Madison, freeing up Summit's third floor beds for reassignment to an acute rehabilitation program.

The applicant indicates Summit Medical Center has proposed this in-house acute rehabilitation service for several reasons:

1) Acute rehabilitation in an inpatient setting is an important part of the continuum of high quality care for a wide range of conditions. Summit is the only hospital located in the growing eastern sector of the Nashville urban area; and Summit is committed to continuous improvement in the services it provides. Many persons need inpatient rehabilitation after an initial hospital stay, in order to regain acceptable functionality in activities of daily living and working. Patients who have undergone amputation, stroke, burns, major traumas, hip and knee replacements, shoulder and back surgery, or

other events, or who are treated for serious arthritic or neurological issues, and many other conditions, all benefit from having access to acute inpatient rehabilitation immediately upon discharge from their initial hospital stay. Having the option to receive this kind of care on the same campus which they have chosen for their initial hospitalization is efficient, and makes sense when it does not require excessive new bed construction costs.

2) Distribution of rehabilitation services to suburban locations such as Summit's is a trend favored by the consumer. Patients in Nashville have shown a desire to access such services not just in tertiary downtown hospitals, but also in suburbs closer to where they live, and where they often receive their hospital care. The applicant claims that there has been a significant shift of rehabilitation admissions recently, from downtown centers to suburban locations. The applicant uses the table below to show that from 2008 to 2011, downtown rehabilitation admissions declined by 15%, while suburban rehabilitation admissions rose 56%. The applicant states the suburban market share increased from 20% in 2008 to 32% in 2011, while the central Davidson County share decreased from 80% to 68% in that period. And during this, the total days of rehabilitation provided in Davidson County has remained stable. The applicant states there has been an orderly redistribution of resources.

**Applicants Illustration of Movement of Rehabilitation Patient Days**

| Movement of Rehabilitation Patient Days in Davidson County CY2008-CY2011 | | | |
|---|---|---|---|
| Location | CY 2008 | CY 2011 | Change '08-'11 |
| Central County* | 33,199 (80%) | 28,221 (68%) | -15% |
| Suburban County Areas | 8,329 (20%) | 13,071 (32%) | +56% |
| Totals | 41,528 | 41,292 | |

*Central providers were Vanderbilt Stallworth, Baptist, & Nashville Rehabilitation Hospital (which is now closed).

** Suburban providers were Skyline and Southern Hills Medical Centers.

Source: Joint Annual Reports, 2008-2011.

*Note to Agency members: An analysis of the Central County demonstrates that the movement of rehabilitation patient days appears to be an amplification of the shift in numbers of only a few facilities. Baptist's and Vanderbilt Stallworth's patient days have remained relatively stable. The inactivation of Nashville Rehabilitation Hospital's 31 licensed beds accounted for 97% of the drop in patient days for the "Central County" category. The inactivation of Skyline-Madison's rehabilitation unit permitted the redistribution of 22 beds to Skyline Medical Center's main campus' rehabilitation unit (10 beds) in 2009 and Southern Hills Medical Center's*

*rehabilitation unit (12 beds) in 2010, thus permitting growth of these two HCA Tri-Star facilities (see the table and its footnotes on page 10 of this Summary for details).*

3) Distribution of this type of care to Summit Medical Center is especially needed as the hospital increases its healthcare role in the community. In the second half of CY2011, Summit opened a major Emergency Department expansion, and became a Certified Stroke Center. These and other service improvements have dramatically increased the number of its discharged patients who go immediately into an inpatient rehabilitation program elsewhere. With such transfers up 41% this year (on an annualized basis), such a program on Summit's own campus will be financially feasible and efficiently utilized.
4) The applicant's fourth reason for the project is consistency: Summit's large service area on the east side of greater Nashville is the only suburban sector of Nashville whose local hospital does not offer inpatient acute rehabilitation care. Certificates of Need for this program have been granted to the other suburban hospitals north, south, and even west (Dickson) of Nashville. The eastern side of the urban area needs a comparable option.
5) Finally, this project will not have any significant adverse impact on other non-HCA providers of this type of care in either Davidson or Wilson Counties. For the past two years, HCA's own rehabilitation programs at Skyline and Southern Hills have been retaining approximately 81% of HCA discharges into rehabilitation units. Last year, Summit discharged only 47 patients to rehabilitation programs other than those of HCA. Thus, most of the admissions to Summit will be a shift of care within the HCA TriStar network, all of it reflecting patient preferences and convenience. And while there is still some available bed capacity at existing rehabilitation providers in the service area, the programs in Davidson County are operating at approximately 70% utilization, which is financially sound.

*Note to Agency Members: The average occupancy for all licensed rehabilitation beds within the applicant's declared service area is 61.4%. Currently there are 10 licensed rehabilitation beds at Skyline Madison's campus which the applicant indicates are unstaffed, have not been open for years and are not likely to re-open for this type of service. Note the applicant's explanation to retain these unused beds on pages 2-3 of the supplemental response.*

Summit Medical Center is 100 percent owned by HCA Health Services of Tennessee, whose parent organization is (through several corporate entities) HCA, Inc of Nashville, Tennessee. HCA is composed of locally owned facilities

that include approximately 190 hospitals and 82 outpatient surgery centers in 23 states, England and Switzerland. Summit Medical Center is part of the locally managed HCA TriStar Group which operates hospitals in South Central Kentucky, Northern Georgia, and fourteen (14) hospitals in Tennessee. An organizational chart is enclosed in the Attachment A.4. *Note to Agency members: Two other HCA TriStar hospitals located in the applicant's proposed service area (Davidson and Wilson Counties) operate rehabilitation units: Skyline Medical Center (41 beds at its main campus in north Nashville, TN; 10 licensed, but not operating beds at its Madison campus); 12 beds (+4 CON approved beds for a total of 16) at Southern Hills Medical Center in Antioch; totaling 63 licensed inpatient rehabilitation plus 4 CON approved beds in Davidson County for a total of 67 approved inpatient rehabilitation beds. In addition, HCA TriStar's Horizon Medical Center also operates 12 inpatient rehabilitation beds at its Dickson (Dickson County), TN campus, bringing the total of HCA TriStar's licensed rehabilitation capacity to 79 beds serving Middle Tennessee.*

According to the Joint Annual Report, Summit Hospital is licensed for 188 beds and staffs all of its beds. The licensed and staffed hospital bed occupancy at Summit Medical Center was 58% respectively in 2011. The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

*Licensed Beds- The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).*

*Staffed Beds-The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.*

SMC's primary service area is Davidson and Wilson Counties, from which approximately 85.4% of SMC's admissions originated in 2011. Davidson County contributed 56.6% of SMC admissions, while Wilson County added another 28.8% in 2011.The applicant indicates that HCA TriStar's experience is the great majority of its rehabilitation units' admissions are patients discharged from the hospital of which they are a part, and, therefore, they believe Davidson and Wilson Counties will also be the primary service area for the proposed rehabilitation service. Population data from the Tennessee Department of Health's Division of Health Statistics indicates that the general population of the applicant's primary service area in 2012 is estimated to be 716,694 and is expected to grow 3.2% to 739,405 by 2016. This growth rate compares to the State's growth rate of 3.4% for the same time period. The age 65+ population in

the service area is expected to increase by 12.4% from 84,344 to 94,797 individuals during this time period compared to a statewide growth rate of 12.4%. In 2016, individuals age 65+ are expected to account for approximately 12.8% of the two county service area population compared to 15.0% for Tennessee. The number of TennCare enrollees residing in the service area equates to 18.7% of the population, with Davidson County having the largest population proportion of TennCare enrollees (19.8%) and Wilson County having the lowest proportion (12.4%).

In applying the *Guidelines for Growth's* bed need formulas, the following calculations result: the need for rehabilitation beds is 74 beds, while the current supply of licensed beds which are certified and approved as rehabilitation beds is 228, leaving a surplus of 154 beds.

Presented below is the inventory of the acute care licensed beds which currently have been certified by HSDA for use as the inpatient rehabilitation beds:

**Inventory of Inpatient Rehabilitation Beds in Davidson and Wilson Counties**

| Hospital | Licensed Acute Care Beds Certified as Inpatient Rehabilitation Beds | Current Status |
|---|---|---|
| Southern Hills Medical. Center | 12 | Licensed & Operational |
| Baptist | 24 | Licensed & Operational |
| Vanderbilt Stallworth | 80 | Licensed & Operational |
| Skyline Medical Center | 41 | Licensed & Operational |
| McFarland Hospital | 26 | Licensed & Operational |
| **Subtotal - Operational** | **183** | **Currently Licensed & Operational** |
| Skyline Medical Center - Madison | 10 | Licensed, but not operational |
| Nashville Rehabilitation Hosp. | 31 | Licensed, but inactive |
| **Subtotal – Licensed, not operating** | **41** | **Licensed, but not operational** |
| **Total Licensed, Certified Rehab Beds** | **224** | Licensed & Certified Rehab Beds |
| CON Approved, but not operational | 4 at Southern Hills | |
| **Total Approved Rehab Beds** | **228** | **Licensed, Certified & Approved** |

Source: Tennessee Department of Health and Health Services and Development Agency Records

*Note to Agency members: Nashville Rehabilitation Hospital closed in December 2009. The license for the 31 bed facility was placed in an inactive status for 24 months by the Tennessee Department of Health, Board for Licensing Health Care Facilities. The inactive status has been extended until January 2013. Nashville Rehabilitation Hospital and its 31 beds are subject to an option to purchase by Middle Tennessee Rehabilitation Hospital; contingent upon the issuance of a CON for the relocation and replacement of the facility, an application for which has been denied by the Agency and is the subject of a contested case appeal. These beds are included by the Department of Health in the licensed bed complement until surrendered or the inactive status is not renewed. Skyline Medical Center has increased their rehabilitation beds on the main campus to 41 beds, while simultaneously reducing the Skyline Medical Center - Madison satellite campus to 22*

*rehabilitation beds per CN0808-062A. As part of the Southern Hills Medical Center's initial application to initiate a 12 bed inpatient rehabilitation service (CN1003-014A), Skyline-Madison campus agreed to delicense 12 additional inpatient rehabilitation beds, reducing the number to 10 rehab beds. Skyline Medical Center – Madison's 10 licensed rehab beds remain unstaffed at this time. The applicant indicates these beds are not likely to re-open for this type of care on page 18 of the original application. On pages 2-3 of the supplemental response the applicant states it would like to retain licensure for these 10 rehabilitation beds.*

The applicant provides a chart on page 16 of the application of the driving distances and times from Summit Medical Center to the other hospitals with inpatient rehabilitation programs. None of the hospitals are further than 21 miles, nor more than 27 minutes driving time. A summary of the historical utilization of inpatient rehab services is below:

**Service Area Inpatient Rehabilitation Bed Utilization Trends**

| Hospital | County | 2008 | 2009 | 2010 | 2011 | 2008-2011 % Change |
|---|---|---|---|---|---|---|
| Baptist - Beds | Davidson | 24 | 24 | 24 | 24 | 0% |
| -Patient Days | | 6,135 | 6,783 | 6,578 | 6,041 | -1.5% |
| - % Occupancy | | 70% | 77.4% | 75% | 69.0% | -1.4% |
| Nashville Rehab - Beds | Davidson | 34 | 31*** | 31*** | 31*** | |
| -Patient Days | | 4,831 | 0 | 0 | 0 | -100% |
| - % Occupancy | | 39% | 0 | 0 | 0 | -100% |
| Skyline Main - Beds | Davidson | 31 | 41* | 41 | 41 | +32.3%% |
| - Patient Days | | 8,329 | 10,150 | 10,804 | 11,306 | +35.8% |
| - % Occupancy | | 74% | 68.0% | 72.2% | 75.5% | 2.0% |
| Skyline – Madison -Beds** | Davidson | 32 | 22* | 22** | 10** | -54.6% |
| -Patient Days | | 0 | 0 | 0 | 0 | -100% |
| - % Occupancy | | 0 | 0 | 0 | 0 | -100% |
| Vanderbilt Stallworth - Beds | Davidson | 80 | 80 | 80 | 80 | 0% |
| -Patient Days | | 22,233 | 22,393 | 22,671 | 22,180 | -0.2% |
| - % Occupancy | | 76% | 75.9% | 77.6% | 76.0% | 0% |
| Southern Hills – Beds**** | Davidson | 0 | 0 | 0 | 12 | 100% |
| -Patient Days | | - | - | - | 1,765 | 100% |
| - % Occupancy | | - | - | - | 69.2% | 100% |
| McFarland Hospital | Wilson | 26 | 26 | 26 | 26 | 0% |
| -Patient Days | | 2,762 | 2,529 | 2,641 | 2,794 | 1.2% |
| - % Occupancy | | 29.1% | 26.6% | 27.8% | 29.4% | 1.0% |
| **Service Area - Rehab Beds** | | **227** | **224** | **224** | **224** | **-1.3%** |
| **-Patient Days** | | **44,290** | **41,855** | **42,645** | **44,086** | **-0.5%%** |
| **- % Occupancy** | | **53.5%** | **51.2%** | **52.2%** | **53.9%** | **+0.8%** |

** Skyline Medical Center – Madison transferred 10 certified/licensed inpatient rehabilitation beds in 2009 to Skyline Medical Center –Main Campus (CN0808-062A)*

*** Skyline Medical Center – Madison transferred 12inpatient rehabilitation beds to Southern Hills Medical Center (CN1003-014A) granted in 2010, but implemented in 2011(see below)*

**** Licensed Beds, but unused*

***** Southern Hills Medical Center opened 12 rehabilitation beds 6/1/2011*

Source: TN Department of Health, Joint Annual Report, 2008-2011

Of the nine (9) short-term, acute care hospitals within SMC's declared service area, the number of hospitals which have been providing inpatient rehab services during the six year 2004-11 timeframe declined from six to five. In 2004, the six

rehab units provided 51,725 patient days of rehab care in 235 beds. By 2011, the number of operating units had fallen to five, the number of licensed beds fell from 235 to 224 and the number of operating rehab beds had dropped by 22.1% from 235 to 183 beds. The seven year utilization trend shows a 14.8% decline in utilization from 51,725 patient days in 2004 to 44,086 patient days in 2011. The occupancy rate has also declined: 60.3% in 2004 to 53.9% in 2011. None of the five operating units are performing above the percentage occupancy levels as recommended by *Guidelines for Growth.*

*Note to Agency members: During the seven year period, a significant contributing factor to the change in utilization, occupancy and drop in inpatient rehabilitation beds has been the change in Medicare reimbursement implemented by the Centers for Medicare and Medicaid Services (CMS). As a participant in the Medicare program, the inpatient rehabilitation facility is required to show a minimum percentage of the facility's total patient population must meet one of thirteen (13) medical conditions. Initially the compliance threshold was 75% (known as the "75% rule'), but was later modified in 2006 to "60% threshold" of the rehabilitation unit's patient population. The CMS' "threshold Rule" for rehabilitation facilities essentially divided rehab patients into two categories: (1) those who are being treated for one or more of 13 specified conditions, i.e., acute care patients and (2) those not receiving treatment for any of the 13 specified conditions, or non-acute rehab patients. Under the new 60% Rule, Medicare reimbursement is available to an inpatient rehabilitation facility only if, on an annual basis, 60% of its patients are acute rehab patients. The 13 specified conditions include: Stroke; Spinal Cord Injury; Amputation; Major Multiple Trauma; Fracture of the Femur (hip fracture); Brain Injury; Neurological Disorders; Burns; Active Polyarticular Rheumatoid Arthritis; Congenital Deformities; Systemic Vasculidities; Severe or Advanced Osteoarthritis; Hip and Knee Replacements accompanied by extreme obesity with a body mass index of at least 50, or be 85 years of age or older.*

***Source: CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements***
***S.2499 2007 Medicare, Medicaid, and SCHIP Extension Act***

With the opening of the 12 bed Southern Hills rehab unit in June 2011, the number of operating acute care rehabilitation facilities increased to five units with 183 staffed rehabilitation beds: Baptist (24 beds), Skyline (41 beds) and Vanderbilt Stallworth (80 beds), McFarland (26 beds), and then Southern Hills (12 beds). CN1111-048A approved an additional 4 beds for Southern Hills, bringing the total to 187 currently operating and CON approved beds. Should this application for 20 additional rehabilitation beds be approved, the total number of currently operating and CON approved rehabilitation beds would grow to 207. Currently, HCA TriStar's rehabilitation bed capacity is 30.5% of the operating inpatient rehabilitation bed capacity in Davidson and Wilson Counties. Should this application be approved, HCA TriStar's share of the staffed operating inpatient rehabilitation bed capacity would increase to 37.2%. Its share

of the licensed inpatient rehabilitation bed capacity (including non-operational and inactive beds) would be 35.1%

The applicant projects that the project will experience 328 admissions and 4,428 patient days (60.7% occupancy) in the first year and 374 admissions and 5,049 patient days (69.2% occupancy) in the second year.

Summit indicates its average gross charge per day will be $3,259 in year one and $3,408 in the second year. With the average deduction from operating revenue of approximately 60% of charges, SMC anticipates the Average Operating Net Revenue per day will be $1,317 in the first year and $1,357 in year two. Gross inpatient revenues for the 20 beds are estimated to generate $14,432,000 in the first year of the project and $17,205,760 in year two. Contractual adjustments of 60% reduce the net operating revenue projections to $5,832,380 in year one and $6,849,561 in the second year. Expenses reduce the Net Operating Income less Capital Expenditures to a projected $2,757,512 gain in the first year and $3,320,550 profit by the second year.

The applicant indicates it plans to staff the unit with 26.0 FTEs of clinical and rehabilitation staff in year one, adding 3.0 nursing staff to the staffing mix in year two.

The applicant anticipates Medicare will generate $7,504,640 in gross revenues and constitute 52% of its payor mix in year one, while TennCare will contribute gross revenues of $432,960 and comprise 3% of its gross revenues the first year. The applicant indicates they have contracts with all three TennCare MCOs available to its service area population: United HealthCare Community Plan (formerly AmeriChoice), TennCare Select and AmeriGroup.

Review of SMC's Historical Data Chart indicates the hospital has experienced several profitable years during the 3 years reported (2009-11). Net Operating Income less Capital Expenditures has been $12,755,852 in 2009, $10,890,220 for 2010, and $12,414,115 for 2011.

The source of funding for the project is identified as cash reserves of HCA. A 06/12/12 letter from HCA TriStar's Chief Financial Officer attests to HCA's ability to finance the project. Review of the HCA's Holdings financial statement as of 12/31/11 revealed current assets of $7.233 billion and current liabilities $5.554 billion for a favorable current ratio of 1.30:1.

The total estimated project cost is $2,500,000. The majority of the cost (62%) is the renovation cost ($1,550,000). The applicant estimates the cost of the renovation is

$161.02/sq.ft., which is in the second quartile of the HSDA's data base for hospital renovation construction projects approved in 2009-2011. Another $607,388 is budgeted for movable equipment, $150,000 for information technology and telecommunications, $27,000 for interim financing, while the remainder of the project's costs ($165,612) is budgeted for fees.

*The applicant has submitted the required corporate documentation and real estate title. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.*

Should the Agency vote to approve this project, the CON would expire in three years.

**CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:**

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for this applicant.

*HCA has financial interests in this project and the following:*

Denied Applications:

**Spring Hill Hospital, Spring Hill (Maury County), TN, CN0804-031D,** was denied at the July 23, 2008 Agency Meeting. The application was for the acquisition of a linear accelerator and the initiation of linear accelerator services at an unaddressed site on the NE corner of the intersection of Saturn Parkway and Kedron Road in Spring Hill, (Maury County), Tennessee. This project was filed as a simultaneous review of Vanderbilt Maury Radiation Oncology, L.L.C., CN0804-024. The estimated cost was projected to be **$7,500,614.00.** Reason for Denial: *The approval of Vanderbilt Maury Radiation Oncology, LLC has satisfied the need for additional capacity.*

**Stonecrest Medical Center, CN0809-072D,** was denied at the December 17, 2008 Agency meeting. The application was for the construction of a six (6) bed neonatal intensive care unit (NICU) and the initiation of Level II-B NICU services. Stonecrest Medical Center is authorized for one hundred one (101) hospital beds. This project was to add another six (6) licensed NICU beds increasing the hospital's authorized bed complement to one hundred seven (107) beds. Estimated project cost was **$2,774,900.** *Reason for Denial: The application did not meet statutory criteria. Note to Agency members: Since this denial an eight (8) bed NICU was approved, CN1107-026A, which is further described in the "Outstanding Certificate of Need" section below.*

Outstanding Certificates of Need

**Natchez Surgery Center, CN1002-011A,** has an outstanding Certificate of Need which will expire on June 1, 2012. It was approved at the May 26, 2010 Agency meeting for the establishment of an ambulatory surgical treatment center (ASTC) with three (3) operating rooms and three (3) procedure rooms. After approval, CN801-001A was surrendered which is a similar facility for this site at 107 Natchez Park Drive, Dickson (Dickson County), TN. The intent of this application is to change the organizational form to permit physician ownership participation. The estimated cost of the project is **$13,073,892.00.** *Project Status: The applicant requested a modification at the March 2012 Agency meeting to extend the expiration date for three (3) years from July 1, 2012 to July 1, 2015,; reduce the number of operating rooms from three (3) to two (2) and procedure rooms from three (3) to one (1); reduce project costs by $4,201,823 from $13,073,892 to $8,872,069; and reduce square footage by 4,965 from 15,424 to 10,459 square feet. The Agency approved the modifications and extension of the expiration date to July 1, 2015.*

**Centennial Medical Emergency Center Department at Spring Hill, CN1006-023A,** has an outstanding Certificate of Need that will expire on January 1, 2014. The CON was approved at the November 17, 2010 Agency meeting for the establishment of a satellite emergency department facility of Centennial Medical Center in Nashville, a licensed 606-bed general hospital, at an unaddressed site on the NE corner of the intersection of Saturn Parkway and Kedron Road in Spring Hill, (Maury County), Tennessee. This satellite facility will provide emergency diagnostic and treatment services for which all necessary diagnostic services will be available, including laboratory, X-ray, ultrasound, and CT scanning. It will not contain any major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements. The estimated project cost is **$9,095,546.00.** *Project Status: Groundbreaking occurred in April 2012 and construction began in May 2012. Targeted completion date is March 2013.*

**StoneCrest Medical Center, CN1107-026A,** has an outstanding Certificate of Need that will expire on December 1, 2014. The CON was approved at the October 26, 2011 Agency meeting to modify its existing facility and add eight (8) licensed Level IIB Neonatal Intensive Care Unit (NICU) beds to its existing one hundred and one (101) licensed acute care bed complement. Upon completion of this project, the total licensed acute care bed capacity of the hospital will be one hundred and nine (109) beds. Upon licensure of these eight (8) beds, eight (8) beds at other HCA facilities will be delicensed. The estimated project cost is **$2,991,463.00**. *Project Status Update: The project final working drawings are about to be submitted for TDH review and is expected to be implemented within a year.*

**Skyline Medical Center (Madison Campus), CN1110-040A,** has an outstanding Certificate of Need which will expire on March 1, 2015. It was approved at the January 25, 2012 Agency meeting for expansion of an existing inpatient adolescent psychiatric unit by eleven (11) beds through the conversion of eleven (11) existing Medical/Surgical beds at its Madison Campus. The result will be a twenty-one (21) adolescent psychiatric bed unit while the hospital's total licensed bed complement of four hundred forty-six (446) acute care beds will remain unchanged. The estimated cost of the project is **$2,412,504.00.** *Project Status Update: The final plans and specs completed and approved; contractor is selected; awaiting capital release for construction, estimated September start of construction; estimated opening during first quarter 2013.*

**Southern Hills Medical Center, CN1111-048A,** has an outstanding Certificate of Need that will expire on April 1, 2015. The CON was approved at the February 22, 2012 Agency meeting to convert four (4) medical surgical beds to four (4) inpatient rehabilitation beds. The proposed conversion will increase the bed complement of SHMC's inpatient rehabilitation unit from twelve (12) to sixteen (16) beds, but will not change the hospital's total licensed bed complement of one hundred and thirty-two (132) acute care beds at its main campus at 391 Wallace Road in Nashville (Davidson County), TN. The estimated project cost is **$700,105.00.** *Project Status: According to the COO of Southern Hills, the plans for renovation have been approved, and a building permit has been issued. Renovation is expected to begin in September and should take approximately 3 months to complete.*

**Parkridge Medical Center, CN1202-005,** has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the relocation of 16 of 25 currently licensed geriatric psychiatric beds to a new satellite campus, (2) the conversion of the remaining 9 geriatric psychiatric beds to medical/surgical, and (3) the addition of 16 acute medical surgical beds. The licensed bed complement at Parkridge Medical Center will remain at 275 beds. The net result of this application is that this site will operate as a general acute hospital with no psychiatric services on site. Estimated project cost is **$1,010,500.** *Project Status Update: The project was recently approved.*

**Parkridge Valley Hospital, CN1202-006** has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the addition of sixteen (16) additional child and adolescent psychiatric beds to the sixty-eight (68) beds currently located on the satellite campus at 2200 Morris Hill Road, Chattanooga (Hamilton County) and (2) the relocation of all forty-eight (48) of its licensed adult psychiatric beds to a new campus. The current licensed hospital bed complement at Parkridge Valley Hospital, which is a satellite location of Parkridge Medical Center, will decrease

from one hundred sixteen (116) beds to eighty-four (84) beds. The net result of this application is that only child and adolescent psychiatric beds will operate at this location. Estimated project cost is **$143,000.** *Project Status Update: The project was recently approved.*

**Parkridge Valley Adult Services, CN1202-007,** has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the relocation of forty-eight (48) adult psychiatric beds from Parkridge Valley Hospital to a new campus to be called Parkridge Valley Adult Services located at 7351 Standifer Gap Road, Chattanooga (Hamilton County); and (2) the relocation of sixteen (16) geriatric psychiatric beds from Parkridge Medical Center to the new Adult Services campus. Parkridge Valley Adult Services will operate as a sixty-four (64) bed satellite hospital of Parkridge Medical Center. The net result of this application is that all adult (including Geriatric) psychiatric services will operate at this site. Estimated project cost is **$6,762,622.** *Project Status Update: The project was recently approved.*

**Horizon Medical Center Emergency Department, CN1202-008,** has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting to establish a satellite emergency department facility located at its Natchez Medical Park campus located at 109 Natchez Park Drive, Dickson (Dickson County). Estimated project cost is **$7,475,395.** *Project Status Update: The project was recently approved.*

**CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:**

There are no other Letters of Intent, denied or pending applications or outstanding Certificates of Need for other entities proposing this type of service.

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**

PMW/ (08/21/12)

# LETTER OF INTENT

## LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

2012 JUN -7 PM 11:09

The Publication of Intent is to be published in the Nashville Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before June 10th, 2012, 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. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to establish a twenty (20) bed acute inpatient rehabilitation unit and service in its hospital facility at 5655 Frist Boulevard, Hermitage, TN 37076, at a capital cost estimated at $2,500,000. The unit will be created by converting 20 adult psychiatric beds to inpatient rehabilitation beds and reclassifying the adult psychiatric unit as an inpatient rehabilitation unit. The adult psychiatric patients will be transferred to the existing adult inpatient psychiatric program at Skyline Medical Center, Madison, a sister facility.

Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will not change its licensed hospital bed complement or initiate any other health service or include any major medical equipment.

The anticipated date of filing the application is on or before June 15, 2012. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 6-5-12 jwdsg@aol.com

(Signature) (Date) (E-mail Address)

# ORIGINAL APPLICATION

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

Summit Medical Center
Name

5655 Frist Boulevard
Street or Route

Davidson
County

Hermitage
City

TN
State

37076
Zip Code

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

John Wellborn
Name

Title

Development Support Group
Company Name

jwdsg@comcast.net
Email address

4219 Hillsboro Road, Suite 203
Street or Route

Nashville
City

TN
State

37215
Zip Code

CON Consultant
Association with Owner

615-665-2022
Phone Number

615-665-2042
Fax Number

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

HCA Health Services of Tennessee, Inc.
Name

615-441-2357
Phone Number

c/o Summit Medical Center, 5655 Frist Boulevard
Street or Route

Davidson
County

Hermitage
City

TN
State

37076
Zip Code

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

A. Sole Proprietorship
B. Partnership
C. Limited Partnership
D. Corporation (For Profit) ✔
E. Corporation (Not-for-Profit)

F. Government (State of TN or Political Subdivision)
G. Joint Venture
H. Limited Liability Company
I. Other (Specify)_____

**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)***

NA
Name

Street or Route | County

City | State | 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 [✓]
B. Option to Purchase [ ]
C. Lease of _____ Years [ ]
D. Option to Lease [ ]
E. Other (Specify) _____ [ ]

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

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

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

**9. Bed Complement Data**

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

| | | Current Beds Licensed | *CON | Staffed Beds | Beds Proposed | TOTAL Beds at Completion |
|---|---|---|---|---|---|---|
| A. | Medical | | | | | |
| B. | Surgical | 110 | | 110 | 110 | 110 |
| C. | Long-Term Care Hospital | | | | | |
| D. | Obstetrical | 24 | | 20 | | 24 |
| E. | ICU/CCU | 24 | | 18 | | 24 |
| F. | Neonatal | 10 | | 10 | | 10 |
| G. | Pediatric | | | | | |
| H. | Adult Psychiatric | 20 | | 20 | - 20 | 0 |
| I. | Geriatric Psychiatric | | | | | |
| J. | Child/Adolescent Psychiatric | | | | | |
| K. | Rehabilitation | | | | + 20 | 20 |
| 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** | 188 | | 178 | NC | 188 |

*CON-Beds approved but not yet in service

2012 AUG 13 AM 10: 22

**10. Medicare Provider Number** 440150

**Certification Type** general hospital

**11. Medicaid Provider Number** 44-0205

**Certification Type** general hospital

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

**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?** p. 4 **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.***

**A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?**

This is an existing facility already certified for both programs. In CY2011, Summit Medical Center had an overall payor mix of 59.0% Medicare and 9.0% TennCare.

**A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) 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 MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.**

**DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.**

Summit Medical Center is fully contracted with all available TennCare MCO's in the Middle Tennessee Region. They are as follows:

| **Table One: Contractual Relationships with Service Area MCO's** | |
|---|---|
| **Available TennCare MCO's** | **Applicant's Relationship** |
| AmeriGroup | contracted |
| United Community Healthcare Plan (formerly AmeriChoice) | contracted |
| Select | contracted |

## SECTION B: PROJECT DESCRIPTION

**B.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.**

Proposed Services and Equipment

• Summit Medical Center is a busy 188-bed community hospital located beside I-40 in Hermitage, Tennessee, in far eastern Davidson County. It is the only general hospital between downtown Nashville (Davidson County) and Lebanon (Wilson County)--which are respectively, 20 and 27 minutes' drive time away.

• Summit proposes to establish a 20-bed acute inpatient rehabilitation unit, certified as a "distinct part unit" by Medicare. This will not increase hospital or service area bed complements, because it will be a conversion of an existing 20-bed inpatient adult psychiatric unit on the hospital's third floor. Psychiatric patients remaining in that unit, or presenting subsequently at Summit's Emergency Department, will be stabilized and transported to Skyline Medical Center's behavioral medicine facility at Madison in East Nashville, which has sufficient capacity to admit them.

Ownership Structure

• Summit Medical Center is an HCA TriStar facility owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains more details, an organization chart, and information on Tennessee facilities owned by HCA.

Service Area

• The project's primary service area will reflect the hospital's primary service area. That area consists of Davidson and Wilson Counties. Approximately 85% of Summit's admissions come from those counties, with no other county contributing as much as 3%.

Need

• In recent years, HCA TriStar community hospitals on the north and south sides of the Nashville area have been granted CON's to add rehabilitation beds, through conversions of existing hospital beds. These CON's allowed them to improve their continuum of care without constructing costly new beds. This is the third such project. Summit's conversion of its psychiatric beds into acute rehabilitation beds will not increase its bed license. But it will improve patient access to rehabilitation in the eastern part of the urban area.

• The location and timing of the project are appropriate for several reasons:

a. Rehabilitation utilization in Davidson County has been shifting to suburban locations that are closer to many patients' homes. Between 2008 and 2011, the total rehabilitation days provided in the downtown area (at Baptist, Vanderbilt, and NRH) decreased 15%, while the rehabilitation days provided in the Davidson County suburbs (at Skyline and Southern Hills) increased 56%. The share of rehabilitation days that were provided in a suburban location increased from 20% to almost 38%.

b. While northern and southern Davidson County hospitals have been granted CON's for acute rehabilitation beds, eastern Davidson County has not. Summit Medical Center in eastern Davidson County is the only place acute rehabilitation beds can be opened in that sector, because Summit is the only hospital between downtown Nashville and the city of Lebanon, in Wilson County--a thirty-two mile distance.

c. The project will complete HCA TriStar's plan to offer acute inpatient rehabilitation programs to patients of four suburban TriStar hospitals surrounding downtown Nashville. It is already in place at HCA TriStar hospitals to the north (Skyline Medical Center), the west (Horizon) Medical Center, and the south (Southern Hills Medical Center); but not yet at Summit Medical Center in eastern Davidson County.

d. Summit's discharges of rehabilitation-appropriate patients are rapidly increasing, due not only to area population growth, but also to the hospital's CY2011 Emergency Department expansion and its designation as a Certified Stroke Center. Summit's growth will ensure that this refocused 20-bed unit will be reasonably utilized, and will not shift costs of rehabilitation care to other types of hospital patient.

e. The utilization of existing rehabilitation beds in Davidson County is at efficient levels. The beds at the county's four operational acute rehabilitation providers provided 41,292 days of care in 2011. This is equal to 70.5% occupancy on the 161 usable rehabilitation beds that will be open in this county, by the summer of 2012. More rehabilitation beds exist "on paper" but are older and for years have not open.

Existing Resources

• There are seven hospitals in the primary service area with licensed rehabilitation beds. But only five of those services are open for patient care. The five facilities with operational rehabilitation beds will have 161 such beds available in the summer of 2012 (157 are open and 4 are under construction). The two facilities with non-operational rehabilitation units have 41 such beds, which are not likely to be open for admissions in the foreseeable future.

Project Cost, Funding, Financial Feasibility, and Staffing

• The estimated cost of the project is $2,500,000, which will be provided through a cash transfer from Summit's parent company, HCA.

• As shown in the Projected Data Chart, the proposed rehabilitation service will operate with a positive financial margin. The unit will have approximately the same charge structure as the unit operating at Southern Hills Medical Center since 2011.

• The project will require the addition of 29 FTE's (nurses, therapists, social workers, and unit management and clerical support). See Table Eighteen in Section C(III).3.

**B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.**

**B.II.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 AREAS, ROOM CONFIGURATION, ETC.**

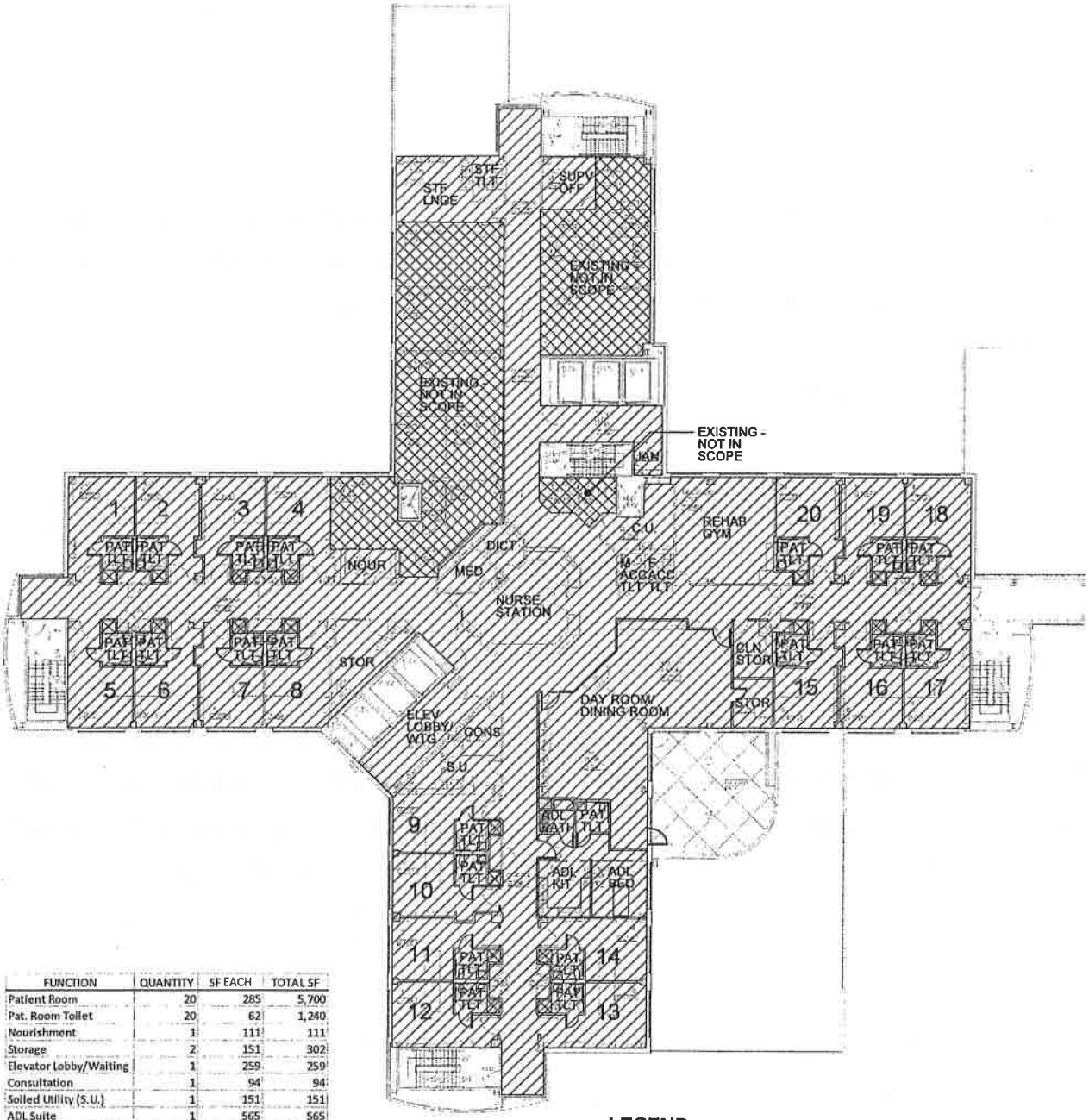
Physical Description

The project will require major and minor renovation on the hospital's third floor, which currently contains a 20-bed inpatient psychiatric unit with support spaces. The project will replace the psychiatric service with an inpatient rehabilitation service of the same bed complement, so it will not change Summit Medical Center's 188-bed license. It will only reassign or reclassify 20 beds. Offices in one wing will remain; their future use has not yet been determined.

The completed rehabilitation service will include 20 private patient bedrooms with handicapped-accessible/ADA-compliant private bathrooms; and ADL (Activities of Daily Living) suite with a kitchen, bedroom, and bath; a Day Room/Dining Room multi-purpose room, gym, and other patient and staff support spaces. The tables below, and the floor plan following this page, identify changes in use and in square footages on the third floor, and provide a detailed space program and preliminary layout for the proposed unit.

| Table Two-A: Summary of Construction and Changes in Size | |
|---|---|
| | **Total Square Feet** |
| Hospital Third Floor Before Project | 20,294 SF (not including elevator, stairs, or mechanical chases |
| Hospital Third Floor After Project | no change |
| | |
| Area of New Construction | none |
| Area of Renovation | 9,626 SF |

| Table Two-B: Proposed Changes in Third Floor Space | | | |
|---|---|---|---|
| | **Existing SF/Area** | **SF To Be Added or Reduced** | **Resulting Total SF/Area** |
| **Nursing Unit and Support Space** | 20,294 SF Psychiatric Unit | (3,264 SF) | 17,030 SF Rehabilitation Unit |
| **Miscellaneous Office Space** | 0 SF | + 3,264 SF | 3,264 SF |




| FUNCTION | QUANTITY | SF EACH | TOTAL SF |
|---|---|---|---|
| Patient Room | 20 | 285 | 5,700 |
| Pat. Room Toilet | 20 | 62 | 1,240 |
| Nourishment | 1 | 111 | 111 |
| Storage | 2 | 151 | 302 |
| Elevator Lobby/Waiting | 1 | 259 | 259 |
| Consultation | 1 | 94 | 94 |
| Soiled Utility (S.U.) | 1 | 151 | 151 |
| ADL Suite | 1 | 565 | 565 |
| Day Room/Dining Room | 1 | 1,328 | 1,328 |
| Clean Storage | 1 | 107 | 107 |
| Male Acc. Toilet | 1 | 43 | 43 |
| Female Acc. Toilet | 1 | 43 | 43 |
| Clean Utility (C.U.) | 1 | 185 | 185 |
| Nurse Station | 1 | 478 | 478 |
| Meds | 1 | 115 | 115 |
| Dictation | 1 | 103 | 103 |
| Janitor Closet | 1 | 47 | 47 |
| Staff Lounge | 1 | 322 | 322 |
| Staff Toilet | 1 | 38 | 38 |
| Supervisor Office | 1 | 146 | 146 |
| Rehab Gym | 1 | 550 | 550 |
| TOTAL NET SQUARE FOOTAGE | | | 11,927 |
| CIRCULATION GROSSING FACTOR | | | 0.43 |
| TOTAL GROSS SQUARE FOOTAGE (Hatched Area) | | | 17,030 |

LEGEND

Rehab Unit

Miscellaneous Office Space

# SUMMIT MEDICAL CENTER
# HERMITAGE, TENNESSEE

Third Floor Rehab Unit

## PROPOSED - ENLARGED THIRD FLOOR PLAN

8

GS&P #28973.00
06.11.2012

G S & P

## Operational Schedule

This is an inpatient acute care unit that will provide medical care and supervision 24 hours daily, throughout the year. The applicant intends to open the unit on or before January 1, 2013. CY2013 will be its first full year of operation.

## Cost and Funding

The project cost is estimated at $2,500,000. This will be entirely funded by HCA, Inc., Summit Medical Center's ultimate parent company, through a cash transfer to TriStar Health System, HCA's regional office in this area.

## Medical Direction and Supervision

To provide medical direction for the rehabilitation program, Summit intends to recruit a Board-certified physical medicine and rehabilitation specialist ("physiatrist"). Both the Medical Directors at HCA TriStar's rehabilitation programs at Skyline Medical Center and Southern Hills Medical Center in Nashville are physiatrists.

**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 COSTS PER SQUARE FOOTAGE CHART...**

Not applicable.

**PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.**

The estimated $1,550,000 renovation construction cost for the project is approximately $161 PSF overall:

| Table Three: Construction Cost PSF | | |
|---|---|---|
| **Construction Cost** | **SF of Renovation** | **Construction Cost PSF** |
| $1,550,000 | 9,626 USF | $161.02 |

The 2009-2011 hospital construction projects approved by the HSDA had the following costs per SF. This project is very consistent with those ranges, being below the median for hospital renovation projects.

**Hospital Construction Cost Per Square Foot**
**Applications Approved by the HSDA**
**Years: 2009 – 2011**

| | Renovated Construction | New Construction | Total Construction |
|---|---|---|---|
| **1st Quartile** | $125.84/sq ft | $235.86/sq ft | $167.99/sq ft |
| **Median** | $177.60/sq ft | $274.63/sq ft | $249.32/sq ft |
| **3rd Quartile** | $273.69/sq ft | $324.00/sq ft | $301.74/sq ft |

*Source: Health Services and Development Agency, 2012*

**IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.**

Not applicable.

**B.II.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 EXISTING SERVICES.**

| **Table Four: Proposed Changes in Assignment of Licensed Hospital Beds Summit Medical Center** | | |
|---|---|---|
| **Bed Assignment** | **Current Assignment** | **Proposed Assignment** |
| General Medical-Surgical, Obstetric, ICU, NICU | 168 | 168 |
| Rehabilitation | 0 | 20 |
| Adult Psychiatric | 20 | 0 |
| *Total Licensed Complement* | *188* | *188* |

The resulting utilization and occupancies for the affected categories of beds are projected in Attachment Four, Section C(II)4 of the application.

The objective of the proposed reassignment of beds is to improve access to acute rehabilitation care in Summit's service area, while concentrating behavioral medicine care at HCA TriStar's Skyline Madison facility. Summit discharges a large number of patients who need rehabilitation, but has no beds approved for that purpose. Because Skyline Madison has the bed capacity to serve adult psychiatric patients now being admitted to Summit, it makes sense to concentrate those psychiatric admissions at Skyline Madison, freeing up Summit's third floor beds for reassignment to an acute rehabilitation program.

**B.II.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 ADOLESCENTS >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. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

Summit Medical Center has proposed this in-house acute rehabilitation service for several reasons.

First, it is good for patients. Acute rehabilitation in an inpatient setting is an important part of the continuum of high quality care for a wide range of conditions. Summit is the only hospital located in the growing eastern sector of the Nashville urban area; and Summit is committed to continuous improvement in the services it provides. Many persons need inpatient rehabilitation after an initial hospital stay, in order to regain acceptable functionality in activities of daily living and working. Patients who have undergone amputation, stroke, burns, major traumas, hip and knee replacements, shoulder and back surgery, or other events, or who are treated for serious arthritic or neurological issues, and many other conditions, all benefit from having access to acute inpatient rehabilitation immediately upon discharge from their initial hospital stay. Having the option to receive this kind of care on the same campus which they have chosen for their initial hospitalization is efficient, and makes sense when it does not require excessive new bed construction costs.

Second, distribution of this service to suburban locations such as Summit's is a trend favored by the consumer. Patients in Nashville have shown a desire to access such services not just in tertiary downtown hospitals, but also in suburbs closer to where they live, and where they often receive their hospital care. Table Five below illustrates that there has been a significant shift of rehabilitation admissions recently, from downtown centers to suburban locations. From 2008 to 2011, downtown rehabilitation admissions shrank by 15% while suburban rehabilitation admissions increased 56%. The suburban market share increased from 20% in 2008 to 32% in 2011, while the central Davidson County share decreased from 80% to 68% in that period. And during this, the total days of rehabilitation provided in Davidson County has remained stable. This has been an orderly redistribution of resources.

**Table Five: Movement of Rehabilitation Patient Days in Davidson County CY2008-CY2011**

| Location | CY 2008 | CY 2011 | Change '08-'11 |
|---|---|---|---|
| Central County | 33,199 (80%) | 28,221 (68%) | -15% |
| Suburban County Areas | 8,329 (20%) | 13,071 (32%) | +56% |
| Totals | 41,528 | 41,292 | |

Source: Joint Annual Reports, 2008-2013. Central providers were Vanderbilt Stallworth, Baptist, and Nashville Rehabilitation Hospital (closed). Suburban providers were Skyline and Southern Hills Medical Centers. See Table Eleven for detailed data.

Third, distribution of this type of care to Summit Medical Center is especially needed as the hospital increases its healthcare role in the community. In the second half of CY2011, Summit opened a major Emergency Department expansion, and became a Certified Stroke Center. These and other service improvements have dramatically increased the number of its discharged patients who go immediately into an inpatient rehabilitation program elsewhere. With such transfers up 41% this year (on an annualized basis), such a program on Summit's own campus will be financially feasible and efficiently utilized.

The fourth reason for the project is consistency: Summit's large service area on the east side of greater Nashville is the only suburban sector of Nashville whose local hospital does not offer inpatient acute rehabilitation care. Certificates of Need for this

program have been granted to the other suburban hospitals north, south, and even west (Dickson) of Nashville. The eastern side of the urban area needs a comparable option.

Finally, this project will not have any significant adverse impact on other non-HCA providers of this type of care in either Davidson or Wilson Counties. For the past two years, HCA's own rehabilitation programs at Skyline and Southern Hills have been retaining approximately 81% of HCA discharges into rehabilitation units. Last year, Summit discharged only 47 patients to rehabilitation programs other than those of HCA. So most of the admissions to Summit will be a shift of care within the HCA TriStar network, all of it reflecting patient preferences and convenience. And while there is still some available bed capacity at existing rehabilitation providers in the service area, the programs in Davidson County are operating at approximately 70% utilization, which is financially sound.

**B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.**

Not applicable. The project does neither of those things.

**B.II.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 SCANNER (MRI), 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 schedule of operations.**
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.**
3. **Indicate applicant's legal interest in equipment (e.g., 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.**

Not applicable. There is no major medical equipment proposed in this project.

**B.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;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS 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.**

See Attachment B.III.A.

**B.III.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.**

Summit Medical Center is located in Hermitage, on the far eastern edge of Davidson County near the Wilson County line. The hospital is on the west side of Old Hickory Boulevard / Highway 45, approximately one mile north of Exit 221 from I-40, and is visible from that exit. Summit serves patients primarily from eastern Davidson County and western Wilson County. Interstate I-40 and U.S. Highway 70, which run east and west between Nashville and Lebanon, are the service area's principal east-west roadways; Old Hickory Boulevard is one of the service area's major roadways running north-south by the Summit campus.

Summit is very accessible to western Wilson County, as well as to eastern Davidson County between Old Hickory Lake (the Cumberland River) and the areas west, north, and east of Percy Priest Lake. The rapidly growing Mt. Juliet community is the fastest growing sector of western Wilson County; and Mt. Juliet is much closer to Summit Medical Center (8.5 miles) than it is to Lebanon (16.9 miles), where Wilson County's only existing acute rehabilitation beds are located (at McFarland Hospital).

**Table Six: Mileage and Drive Times Between Summit Medical Center and Acute Rehabilitation Providers and Communities In the Primary Service Area**

| Acute IP Rehabilitation Provider | County | Distance (Mileage) | Drive Time (Minutes) |
|---|---|---|---|
| 1. Baptist Hospital, Nashville | Davidson (Central) | 14.3 mi. | 22 min. |
| 2. Stallworth Rehabilitation Hospital, Nashville | Davidson (Central) | 14.5 mi. | 23 min. |
| 3. Nashville Rehabilitation Hospital (closed; license in abeyance) | Davidson (Central) | 13.8 mi. | 23 min. |
| 4. Southern Hills Medical Center, Nashville | Davidson (South) | 14.8 mi. | 23 min. |
| 5. Skyline Medical Center, Nashville | Davidson (North) | 15.6 mi. | 21 min. |
| 6. City of Mt. Juliet | Wilson | 8.5 mi. | 14 min. |
| 7. McFarland Hospital, Lebanon, Wilson County | Wilson | 20.6 mi. | 27 min. |

Source: Google Maps, June 14 (10 am), 2012. See Miscellaneous Attachments.

**B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.**

See attachment B.IV.

**IV. FOR A HOME CARE ORGANIZATION, IDENTIFY**

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

**C(I) NEED**

**C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO 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 CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.**

**B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).**

**Project-Specific Review Criteria: Comprehensive IP Rehabilitation Services**

**1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.**

**2. The need shall be based upon the current year's population and projected four years forward.**

Summit's primary service area counties are Davidson and Wilson Counties. Their combined CY2016 population will be 739,405 persons. At 10 beds per 100,000 persons, criteria #1 and #2 above would identify a need for 74 beds for that population--62 for Davidson County and 12 for Wilson County.

However, this review criterion should not be applied against this project, because rehabilitation beds located in tertiary referral areas such as Davidson County are regional, multi-county resources. The THA database indicates that in CY2011, only 47.5% of rehabilitation patients in Davidson and Wilson County programs were residents of Davidson and Wilson Counties. More than half of the beds used in these two counties were used by residents of other counties.

At present, there are 202 approved rehabilitation beds in Davidson and Wilson counties. Of these, 41 are older beds that are not open and are not likely to re-open for this type of care. A total of 161 beds will actually be available by September 2012 (4 are still under construction and 157 are fully operational).

**3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.**

Approximately 85% of Summit's admissions come from Davidson and Wilson counties; and the majority of Summit's rehabilitation unit admissions will come from Summit discharges. So these counties are an appropriate primary service area.

**4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.**

The project complies, having 20 beds.

**5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.**

Not applicable.

**6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:**

**20-30 bed unit 75%**
**31-50 bed unit/facility 80%**
**51+-bed unit/facility 85%**

The term "existing units or facilities" should be interpreted to include only those that are operational or likely to be operational in the foreseeable future. There are seven total acute rehabilitation units licensed for this service; but two are older units that have been closed for several years. In the applicant's opinion neither is likely to re-open. This leaves five providers, whose current occupancies are shown in Table Seven below:

**Table Seven: CY2011 Occupancies of Rehabilitation Providers in the Service Area**

| Provider / December 2011 Beds | CY2011 Occupancy |
|---|---|
| Baptist Hospital / 24 beds | 69.0% |
| VU Stallworth Rehab'n Hospital / 80 beds | 76.0% |
| Skyline Medical Center / 41 beds | 75.5% |
| Southern Hills Medical Center / 12 beds | 69.2% |
| McFarland Hospital / 26 beds (Wilson Co.) | 29.4% |

Source: Joint Annual Report data from Table Eleven, Section C.(I).5 of this application.

Although service area providers are not yet at the target occupancies of the criterion, nonetheless those located in Davidson County are efficiently utilized--at 71.5%, collectively. See Table Eleven in this application, section C.(I).5 below.

HealthSouth's recently approved application to build a Vanderbilt-led rehabilitation hospital in Williamson County stated that Stallworth in central Davidson County can not achieve much higher occupancy than its current level, because of its semiprivate rooms, which require gender separation that often prevents a second admission to a semi-private room. Stallworth has recently declined a number of Summit's requests for admissions to a rehabilitation bed.

Southern Hills' unit has grown in utilization so rapidly that the HSDA recently approved it to add four more rehabilitation beds (by conversion) despite these criteria.

Skyline's rehabilitation program has also grown rapidly, with the growth of their neurosciences programs (stroke; neurosurgery; spinal surgery).

Only the UMC McFarland facility in Lebanon, almost a half-hour drive from Summit, has low occupancy on its rehabilitation beds. Once a general hospital, and now a psychiatric and rehabilitation facility, McFarland long ago was allowed to assign far more licensed rehabilitation beds than its service area can now fill. It is not a reasonable option for Davidson and western Wilson County residents who obtain care in Davidson County, and are not inclined to drive miles into a rural area for their care. Davidson County is not even in McFarland's primary service area: only 3% of McFarland's total admissions (both psychiatric and rehabilitation) come from Davidson County, according to its most recent Joint Annual Report posted on the Department of Health website.

**7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board-certified physiatrist.**

Complies. Staffing requirements and resources for the project are set forth in response C.15 below. The staffing conforms to licensure requirements.

## The Framework for Tennessee's Comprehensive State Health Plan
## Five Principles for Achieving Better Health

**The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.**

### 1. Healthy Lives

***The purpose of the State Health Plan is to improve the health of Tennesseans.***
**Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.**

In this project, the applicant's parent organization (HCA) proposes to use its local TriStar hospital network to better address healthcare needs by coordinating two of its hospitals' scopes of service. Skyline Madison Medical Center will more efficiently and completely utilize its psychiatric beds by absorbing psychiatric patients now at Summit. This will enable Summit Medical Center to broaden its continuum of care by adding a rehabilitation program that is appropriate for the only designated Stroke Center and emergency care resource on the eastern side of the county.

### 2. Access to Care

***Every citizen should have reasonable access to health care.***
**Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.**

This application proposes that the HSDA continue to support the distribution of acute rehabilitation services to suburban communities surrounding Nashville, to improve public access time to acute rehabilitation care.

### 3. Economic Efficiencies

***The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.*** **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

This project is consistent with past CON decisions to distribute acute rehabilitation

programs to suburban sectors of the Nashville area, without increasing total licensed hospital beds. The public's need for this has been demonstrated by the rapid growth in utilization of such units, and by the operational closure of inpatient rehabilitation beds in central Davidson County. This is an improvement in access for suburban patients, accomplished in an efficient manner by re-assignment of existing bed units.

**4. Quality of Care**

***Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.*** **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

TriStar hospitals such as Summit Medical Center pursue and maintain high quality standards in their services, as defined by best practices standards within HCA as well as by standards promulgated by State licensure.

**5. Health Care Workforce**

***The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.*** **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

The project will provide an additional clinical rotation site for students in physical therapy programs of Tennessee educational institutions. Summit already participates in the training of therapists and this will be a major expansion of that role.

**C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.**

As stated, this project continues to implement HCA TriStar's plan to distribute acute rehabilitation services to suburban locations closer to many patients' homes.

**C(I).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 A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).**

Summit Medical Center receives approximately 82% of its admissions from Davidson and Wilson Counties. Under HSDA definitions, they are the hospital's primary service area. On a sub-county level, Summit receives most of its admissions from eastern Davidson County and western Wilson County, for whom it is an important hospital resource. Because HCA TriStar's experience is that the great majority of its rehabilitation units' admissions are patients discharged from the hospital of which they are a part, it is logical to assume that Davidson and Wilson Counties will also be the primary service area for the proposed rehabilitation service. Table Eight below reflects that assumption; its percentages mirror the experience of the hospital in CY2011.

A service area map and a map showing the location of the service within the State of Tennessee are provided as Attachments C, Need--3 at the back of the application.

**Table Eight: Projected Patient Origin**
**Summit Medical Center Acute Inpatient Rehabilitation Unit**

| PSA County | Percent of Total | Yr. 1 Admissions | Yr. 2 Admissions |
|---|---|---|---|
| Davidson | 56.6% | 186 | 212 |
| Wilson | 28.8% | 94 | 108 |
| **PSA Subtotal** | **81.9%** | **280** | **320** |
| Other Counties or States (<3% each) | 14.6% | 48 | 54 |
| **Total** | **100.0%** | **328** | **374** |

Source: Applicant's CY2011 Provisional Joint Annual Report; admissions from Projected Data Chart.

## C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

The county-based primary service area is increasing in population. The State projects that the total population will increase by 3.4% between 2012 and 2016, and that the elderly 65+ population will increase by 12.4%. This is very similar to the projections for the State as a whole. The primary service area's income, poverty and TennCare profiles are not very different from the State average. But within the primary service area, Wilson County has higher median income, a lower poverty rate, and a lower percentage of its residents enrolled in TennCare than does Davidson County.

**Table Nine: Primary Service Area Demographic Data With State of Tennessee Comparison**

| Demographic/ Geographic Area | Davidson County | Wilson County | Primary Service Area Total | State of TN Total |
|---|---|---|---|---|
| Median Age in Years-2010 US Census | 37.4 | 36.3 | 36.9 | 41.3 |
| Total Population-Current Year -2012 | 602,257 | 114,437 | 716,694 | 6,361,070 |
| Total Population-Projected Year -2016 | 618,202 | 121,203 | 739,405 | 6,575,165 |
| Total Population-% change | +2.6% | +5.9% | +3.2% | +3.4% |
| Age 65 & over Population - 2012 | 70,698 | 13,646 | 84,344 | 878,496 |
| Age 65 & over Population - 2016 | 78,799 | 15,998 | 94,797 | 987,074 |
| Age 65 & over Population - % change | +11.5% | +17.2% | +12.4% | +12.4% |
| Age 65 & over Population as % of Total (2012) | 11.7% | 11.9% | 11.8% | 13.8% |
| Age 65 & 0ver Population as % of Total (2016) | 12.7% | 13.2% | 12.8% | 15.0% |
| Median Household Income | $45,668 | $60,678 | $53,173 | $43,314 |
| TennCare Enrollees | 119,539 | 14,174 | 133,713 | 1,211,113 |
| TennCare Enrollees as % of Total | 19.8% | 12.4% | 18.7% | 19.0% |
| Persons Below Poverty Level | 104,190 | 8,697 | 112,888 | 1,049,577 |
| Persons Below Poverty Level as % of Total | 17.3% | 7.6% | 15.8% | 16.5% |

Sources: TDH Population Projections, Feb. 2008; U.S. Census QuickFacts; TennCare Bureau. PSA data is unweighted average, or total, of county data.

**C(I).4.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.**

Like other services of Summit Medical Center, this proposed inpatient acute rehabilitation unit will be accessible to the above groups. It will accept both Medicare and TennCare patients. Like most other such units, the large majority of its services will be for elderly patients.

**C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, 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.**

The table below shows the acute inpatient rehabilitation providers in the two-county service area, and their drive times and distances from the project site (Summit).

**Table Ten: Mileage and Drive Times Between Summit Medical Center and Acute Rehabilitation Providers In the Primary Service Area**

| Acute IP Rehabilitation Provider and City | County | Distance (Mileage) | Drive Time (Minutes) |
|---|---|---|---|
| 1. Baptist Hospital, Nashville | Davidson (Central) | 14.3 mi. | 22min. |
| 2. Stallworth Rehabilitation Hospital, Nashville | Davidson (Central) | 14.5 mi. | 23 min. |
| 3. Nashville Rehabilitation Hospital, Nashville (closed; license in abeyance) | Davidson (Central) | 13.8 mi. | 23 min. |
| 4. Southern Hills Medical Center, Nashville | Davidson (South) | 14.8 mi. | 23 min. |
| 5. Skyline Medical Center, Nashville | Davidson (North) | 15.6 mi. | 21 min. |
| 6. McFarland Hospital, Lebanon | Wilson | 20.6 mi. | 27 min. |

Source: Google Maps, June 10 (10 am), 2012. See Miscellaneous Attachments.

Table Eleven on the following page shows the utilization they reported during the past four years. While all five providers in the two counties averaged 67.8% in CY2011, the four that were open and available in Davidson County averaged 70.5%. And the applicant again points out that the 41 designated rehabilitation beds in Davidson County that were not open and available are very unlikely to become open and available in the foreseeable future, due to licensing issues and other issues.

**Table Eleven: Utilization of Acute Inpatient Rehabilitation Beds (Revised on Supplemental Cycle)**
**Primary Service Area of Summit Medical Center**
**2008-2011**

| ACUTE INPATIENT REHABILITATION PROVIDER | REHAB BEDS IN 2012 | | 2008 | | | | 2009 | | | | 2010 | | | | 2011 (Provisional) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | IN OPERATION | LICENSED OR APPROVED | BEDS | DAYS | ADC | OCC'Y | BEDS | DAYS | ADC | OCC'Y | BEDS | DAYS | ADC | OCC/Y | BEDS | DAYS | ADJUSTED ADC (NOTE 1) | ADJUSTED OCC'Y (NOTE 1) |
| Baptist Hospital | 24 | 24 | 24 | 6,135 | 16.8 | 70.0% | 24 | 6,783 | 18.6 | 77.4% | 24 | 6,578 | 18.0 | 75.1% | 24 | 6,041 | 16.6 | 69.0% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| VU Stallworth Rehabilitation Hospital | 80 | 80 | 80 | 22,233 | 60.9 | 76.1% | 80 | 22,393 | 61.4 | 76.7% | 80 | 22,671 | 62.1 | 77.6% | 80 | 22,180 | 60.8 | 76.0% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| Nashville Rehabilitation Hospital | 0 | 31 | 34 | 4,831 | 13.2 | 38.9% | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| Skyline Madison Medical Center | 0 | 10 | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% |
| Madison / Davidson County | | | | | | | | | | | | | | | | | | |
| Skyline Medical Center | 41 | 41 | 31 | 8,329 | 22.8 | 73.6% | 41 | 10,150 | 27.8 | 67.8% | 41 | 10,804 | 29.6 | 72.2% | 41 | 11,306 | 31.0 | 75.5% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| Southern Hills Medical Center | 12 | 16 | 0 | 0 | 0.0 | 0.0% | 0 | | 0.0 | 0.0% | 0 | 0 | 0.0 | 0.0% | 12 | 1,765 | 8.3 | 69.2% |
| Nashville / Davidson County | | | | | | | | | | | | | | | | | | |
| McFarland Hospital | 26 | 26 | 26 | 2,762 | 7.6 | 29.1% | 26 | 2,529 | 6.9 | 26.6% | 26 | 2,641 | 7.2 | 27.8% | 26 | 2,794 | 7.7 | 29.4% |
| Lebanon / Wilson County | | | | | | | | | | | | | | | | | | |
| **PRIMARY SERVICE AREA TOTALS** | 183 | 228 | 195 | 44,290 | 121.3 | 62.2% | 171 | 41,855 | 114.7 | 67.1% | 171 | 42,694 | 117.0 | 68.4% | 183 | 44,086 | 120.8 | 67.8% |

| OPERATIONAL REHABILITATION PROVIDERS BY COUNTY | Licensed & Approved Beds in Operation By Dec 2012 | CY2011 Days | CY2011 Occ'y |
|---|---|---|---|
| Davidson County Providers (4 open) | 161 | 41,292 | 70.5% |
| Wilson County Provider (1 open) | 26 | 2,794 | 29.4% |

Source: Joint Annual Reports of Hospitals, TDH, HSDA, and TriStar HCA records

Notes:

1. Southern Hills opened 12 beds June 1, 2011. Their ADC during June through December 2011 was 8.3: 1765 rehab days / 214 calendar days =8.3 ADC. Their occupancy during that period was 69.2%: 8.3 / 12 beds = 69.2%. The 2011 Southern Hills utilization data reflects those adjustments. The 2011 PSA Total occupancy has also been adjusted to take Southern Hills into account:
   - Southern Hills Capacity: 12 beds X 214 days = 2,568 days
   - Other Providers Capacity: 171 beds X 365 days = 64,983 days
   - 2011 Total PSA Capacity: 64,983 days
   - 2011 Rehabilitation Days: 44,086 patient days
   - 2011 Occupancy: 44,086 / 64,983 = 67.8%

   Southern Hills will have all 16 approved beds operational in September 2012.
2. Nashville Rehabilitation Hospital's beds are licensed "in abeyance", and have been nonoperational for several years.
3. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational for several years.
4. The lower chart shows the 161 licensed rehabilitation beds that will be operational by the end of 2012: 202 approved beds minus 41 old and nonoperational beds at Skyline Madison (10) and NRH (31).



SUPPLEMENTAL- # 1
June 22, 2012
3:48 pm

**C(I).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.**

Summit Medical Center on Interstate 40 is the only hospital located in the populous and growing communities of eastern Davidson County and western Wilson County. Summit opened a major Emergency Department Expansion in July 2011, and received Accreditation as a Primary Stroke Care Center in November 2011. As a result of these and other service improvements, the hospital's discharges of patients with conditions requiring rehabilitation have soared upward.

Table Twelve-A below shows the annualized increase in Summit's actual discharges to acute rehabilitation programs at all locations, between 2011 and 2012. The 2012 projection is an annualization of the first quarter's actual discharges to rehabilitation programs.

**Table Twelve-A: Annual Discharges to Acute Rehabilitation Programs by Summit Medical Center**

| | CY2011 | CY2012 (Ann'd) | Percent Increase |
|---|---|---|---|
| **Discharges to Acute Rehabilitation Services** | 176 | 248 | +41% |

Source: Hospital records.
Note: At HCA TriStar hospitals, over the past two years Q1 discharges to rehabilitation have averaged 23% of the annual volume. Summit discharged 57 patients to acute rehabilitation programs in Q1 of 2012. (57 / .23 = 248)

Utilization Projection for the Project

Medicare-approved acute rehabilitation units are now required to have 60% of their patient population classified in one of thirteen "Rehabilitation Impairment Categories", or "RIC's". The other 40% of a unit's patients may be other types of conditions that are deemed medically appropriate for rehabilitation. Failure to maintain

the 60% standard will result in decertification by Medicare. Providers work very hard not to violate that objective. Summit's projected unit will be managed to have no less than 62% of its patients in the RIC categories at any time. The RIC group of conditions includes stroke, spinal cord injury, amputation, major multiple trauma, hip fracture, brain injury, neurological disorders, burns, active rheumatoid arthritis, congenital deformity, systemic vasculidities, severe or advanced osteoarthritis, hip and knee replacements with patient obesity and BMI of 50+, and any patient 85 years of age or older.

It should be noted that more than a third of the patients in acute rehabilitation units are there for significant conditions other than the thirteen RIC conditions. An often-cited example is rehabilitation following shoulder surgery. So utilization for this unit was projected considering both RIC and non-RIC patients.

Table Twelve-B below (on the second following page) sets out the projection. It was made by annualizing 2012 data, projecting a hypothetical CY2012 admissions figure for a Summit rehabilitation unit (were it open in 2012), and then projecting annual increases over the next two years.

Step 1: Summit identified in its CY2012 discharge base the number of patients that met RIC criteria, and thus were eligible for an acute rehabilitation admission (256).

Step 2: Assuming that the RIC number would be 62% of total admissions, a non-RIC potential admissions number was calculated: Non-RIC = 38% of the total = 157.

Step 3: The RIC and non-RIC potential patients were added to project 413 potential admissions from Summit's own CY2012 internal discharges.

Steps 4-5: Summit then made an assumption that only 74% of the 413 potential patients would actually be discharged to any hospital rehabilitation program. This was based on HCA experience locally with its own hospitals. It reflects many factors, including patient choice, payor willingness to cover rehabilitative care, the experience of case management personnel, etc. Application of the 74% factor reduced the potential Summit discharges to 306.

Steps 6-7: Using a weighted average of experience at HCA TriStar's Skyline and Southern Hills rehabilitation programs, Summit projected that a Summit program would retain 81% of its 306 internal discharges, or 248 admissions. That is the number of admissions that would be available to a Summit program in CY2012, were the unit open already.

Also at Step 7, Summit projected an annual increase in its available rehabilitation patients over the next two years. Summit projected a 10% increase in available admissions in CY2013 (which is Year One of the proposed unit), and 14.5% increase in CY2014 (Year Two)--as the program's quality becomes increasingly known to the community and to the medical staff. This is a conservative assumption. The increase in the hospital's discharges to all rehabilitation units has been 41% greater this year than last year, on an annualized basis.

Steps 8-9: HCA rehabilitation units in Nashville also receive 20% of their total referrals from non-HCA hospitals. This was assumed to continue in CY2013 and CY2014, resulting in a projection of 328 and 374 admissions those two years. At an average length of stay of 13.5 days (HCA's experience in Nashville), the unit would be approaching 70% occupancy by the end of its second year of operation. This is comparable to today's occupancy on functioning programs at Davidson County's other acute rehabilitation programs.

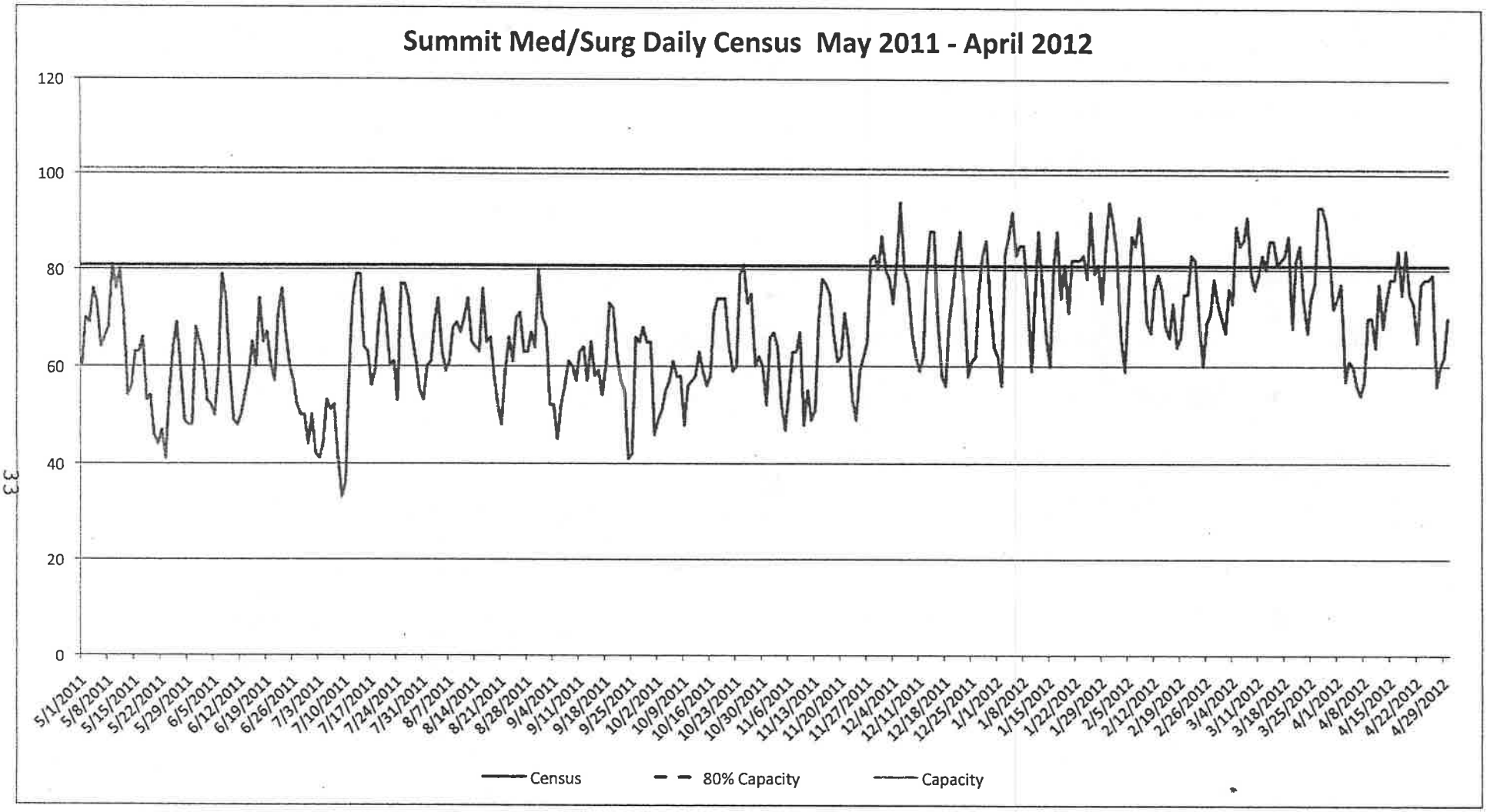
Following Table Twelve-B is Summit's Table Twelve-C, the historical and projected utilization of its beds by service. The project will not affect any bed assignments other than the third floor psychiatric beds, and will not change the hospital's licensed complement. Following Table Twelve-C are graphs of the hospital's recent increases in medical-surgical admissions and Emergency Department Admissions.

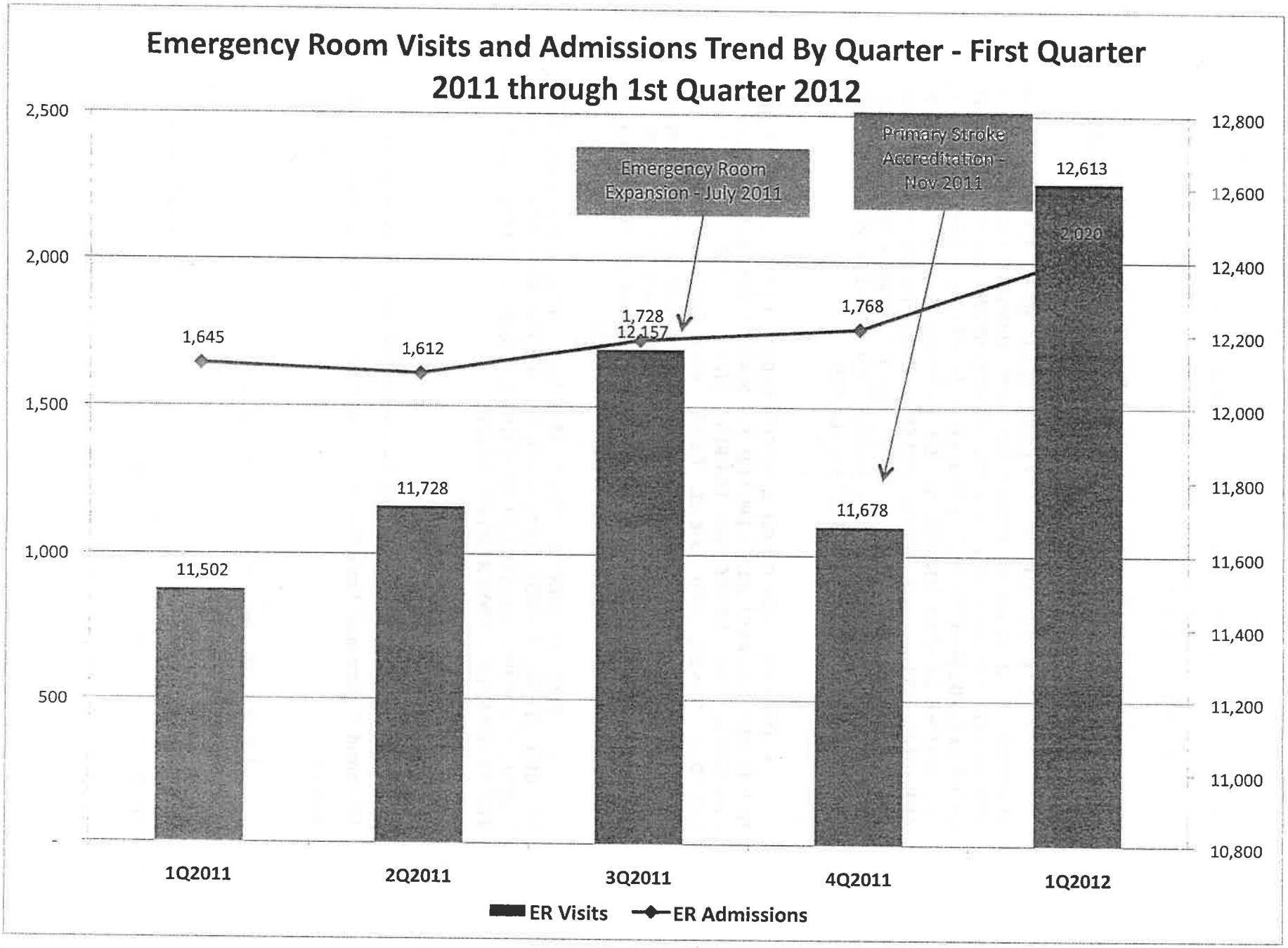
| Table 12-B: Projected Utilization of Rehabilitation Unit<br>Summit Medical Center (SMC)<br>CY2013-CY2014 | | | |
|---|---|---|---|
| | **Annualized CY2012** | **Year 1 CY2013** | **Year 2 CY2014** |
| 1. Summit Medical Center (SMC) Discharges of RIC Patients | 256 | 282 | 294 |
| 2. Other SMC Non-RIC Discharges Appropriate for Rehabilitation | 157 | 173 | 181 |
| 3. Total Potential SMC Discharges of Patients Appropriate for Rehabilitation | 413 | 455 | 475 |
| 4. Percent of Total That Will be Discharged to Rehabilitation | 74% | 74% | 74% |
| 5. Actual SMC Internal Discharges to Rehabilitation at Any Facility | 306 | 337 | 351 |
| 6. Percent of SMC's Discharges to Rehabilitation Retained by SMC | 81% | 81% | 81% |
| 7. SMC Internal Discharges to SMC Rehabilitation (Annual Change) | 248 | 273 (+10%) | 312 (+14.5%) |
| 8. Referrals to SMC Rehabilitation From Other Facilities (20% of Total) | -- | 55 | 62 |
| 9. Total SMC Admissions | -- | 328 | 374 |
| 10. ALOS (Average Length of Stay) | -- | 13.5 days | 13.5 days |
| 11. Patient Days | -- | 4,428 | 5,049 |
| 12. ADC (Average Daily Census) | -- | 12.1 | 13.8 |
| 13. Rehabilitation Bed Occupancy | -- | 60.7% | 69.2% |

**Table Twelve-C: Summit Medical Center**
**Utilization of Licensed Beds, CY 2009 - CY 2011**
**Projected Utilization of Licensed Beds, CY 2012-2014**

| | Actual 2009 | Actual 2010 | Actual 2011 | Projected 2012 | Rehabilitation Year One Projected 2013 | Rehabilitation Year Two Projected 2014 |
|---|---|---|---|---|---|---|
| **Total Beds** | 188 | 188 | 188 | 188 | 188 | 188 |
| Admissions | 9,356 | 9,850 | 9,984 | 10,709 | 10,580 | 10,818 |
| Patient Days | 36,755 | 39,921 | 38,552 | 39,663 | 40,793 | 42,132 |
| ALOS on Admissions | 4 | 4 | 3.9 | 4 | 4 | 4 |
| ADC on Admissions | 100.7 | 109.4 | 105.6 | 108.7 | 111.8 | 115.4 |
| Occupancy on Admissions | 53.6% | 58.2% | 56.2% | 57.8% | 59.4% | 61.4% |
| 23-Hour Observation Days | 5,508 | 5,207 | 4,676 | 5,215 | 5,314 | 5,420 |
| Total Bed Days | 45,651 | 48,710 | 46,367 | 47,829 | 49,087 | 50,562 |
| Total ADC | 125.1 | 133.5 | 127.0 | 131.0 | 134.5 | 138.5 |
| Total Occupancy | 66.5% | 71.0% | 67.6% | 69.7% | 71.5% | 73.7% |
| | | | | | | |
| **Medical-Surgical Beds** | 110 | 110 | 110 | 110 | 110 | 110 |
| Admissions | 6,086 | 6,671 | 6,713 | 7,586 | 7,737 | 7,892 |
| Patient Days | 26,243 | 30,099 | 27,134 | 29,847 | 30,444 | 31,053 |
| ALOS on Admissions | 4.3 | 4.5 | 4.0 | 3.9 | 3.9 | 3.9 |
| ADC on Admissions | 71.9 | 82.5 | 74.3 | 81.8 | 83.4 | 85.1 |
| Occupancy on Admissions | 65.4% | 75.0% | 67.6% | 74.3% | 75.8% | 77.3% |
| 23-Hour Observation Days | 4,562 | 4,670 | 4,427 | 4,735 | 4,830 | 4,926 |
| Total Bed Days | 30,805 | 34,769 | 31,561 | 34,582 | 35,274 | 35,979 |
| Total ADC | 84.4 | 95.3 | 86.5 | 94.7 | 96.6 | 98.6 |
| Total Occupancy | 76.7% | 86.6% | 78.6% | 86.1% | 87.9% | 89.6% |
| | | | | | | |
| **Critical & Intermediate Care Beds** | 24 | 24 | 24 | 24 | 24 | 24 |
| Admissions | 1,011 | 1,082 | 1,163 | 1,233 | 1,257 | 1,283 |
| Patient Days | 5,080 | 5,105 | 5,601 | 4,877 | 4,975 | 5,074 |
| ALOS on Admissions | 5.0 | 4.7 | 4.8 | 4.0 | 4.0 | 4.0 |
| ADC on Admissions | 13.9 | 14.0 | 15.3 | 13.4 | 13.6 | 13.9 |
| Occupancy on Admissions | 58.0% | 58.3% | 63.9% | 55.7% | 56.8% | 57.9% |
| 23-Hour Observation Days | | | | 156 | 159 | 162 |
| Total Bed Days | 5,080 | 5,105 | 5,601 | 5,033 | 5,134 | 5,236 |
| Total ADC | 13.9 | 14.0 | 15.3 | 13.8 | 14.1 | 14.3 |
| Total Occupancy | 58.0% | 58.3% | 63.9% | 57.5% | 58.6% | 59.8% |
| | | | | | | |
| **NICU Beds** | 10 | 10 | 10 | 10 | 10 | 10 |
| Admissions | 69 | 69 | 62 | 62 | 63 | 63 |
| Patient Days | 786 | 825 | 814 | 937 | 946 | 956 |
| ALOS on Admissions | 11.4 | 12.0 | 13.1 | 15.1 | 15.0 | 15.2 |
| ADC on Admissions | 2.2 | 2.3 | 2.2 | 2.6 | 2.6 | 2.6 |
| Occupancy on Admissions | 21.5% | 22.6% | 22.3% | 25.7% | 25.9% | 26.2% |
| 23-Hour Observation Days | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Bed Days | 786 | 825 | 814 | 937 | 946 | 956 |
| Total ADC | 2.2 | 2.3 | 2.2 | 2.6 | 2.6 | 2.6 |
| Total Occupancy | 21.5% | 22.6% | 22.3% | 25.7% | 25.9% | 26.2% |
| | | | | | | |
| **Rehabilitation Beds** | 0 | 0 | 0 | 0 | 20 | 20 |
| Admissions | 0 | 0 | 0 | 0 | 328 | 374 |
| Patient Days | 0 | 0 | 0 | 0 | 4,428 | 5,049 |
| ALOS on Admissions | 0.0 | 0.0 | 0.0 | #DIV/0! | 13.5 | 13.5 |
| ADC on Admissions | 0.0 | 0.0 | 0.0 | 0.0 | 12.1 | 13.8 |
| Occupancy on Admissions | 0.0% | 0.0% | 0.0% | #DIV/0! | 60.7% | 69.2% |
| 23-Hour Observation Days | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Bed Days | 0 | 0 | 0 | 0 | 4,428 | 5,049 |
| Total ADC | 0.0 | 0.0 | 0.0 | 0.0 | 12.1 | 13.8 |
| Total Occupancy | 0.0% | 0.0% | 0.0% | #DIV/0! | 60.7% | 69.2% |
| | | | | | | |
| **Obstetrical Beds** | 24 | 24 | 24 | 24 | 24 | 24 |
| Admissions | 1,435 | 1,395 | 1,232 | 1,183 | 1,195 | 1,206 |
| Patient Days | 3,388 | 3,582 | 3,139 | 2,951 | 2,980 | 3,010 |
| ALOS on Admissions | 2.4 | 2.6 | 2.5 | 2.5 | 2.5 | 2.5 |
| ADC on Admissions | 9.3 | 9.8 | 8.6 | 8.1 | 8.2 | 8.2 |
| Occupancy on Admissions | 38.7% | 40.9% | 35.8% | 33.7% | 34.0% | 34.4% |
| 23-Hour Observation Days | 946 | 537 | 249 | 319 | 325 | 332 |
| Total Bed Days | 4,334 | 4,119 | 3,388 | 3,270 | 3,305 | 3,342 |
| Total ADC | 11.9 | 11.3 | 9.3 | 9.0 | 9.1 | 9.2 |
| Total Occupancy | 49.5% | 47.0% | 38.7% | 37.3% | 37.7% | 38.2% |
| | | | | | | |
| **Pediatric Beds** | 0 | 0 | 0 | 0 | 0 | 0 |
| Admissions | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Days | 0 | 0 | 0 | 0 | 0 | 0 |
| ALOS on Admissions | 0.0 | 0.0 | 0.0 | #DIV/0! | #DIV/0! | #DIV/0! |
| ADC on Admissions | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Occupancy on Admissions | 0.0% | 0.0% | 0.0% | #DIV/0! | #DIV/0! | #DIV/0! |
| 23-Hour Observation Days | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Bed Days | 0 | 0 | 0 | 0 | 0 | 0 |
| Total ADC | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total Occupancy | 0.0% | 0.0% | 0.0% | #DIV/0! | #DIV/0! | #DIV/0! |
| | | | | | | |
| **Psychiatric Beds** | 20 | 20 | 20 | 20 | 0 | 0 |
| Admissions | 755 | 633 | 814 | 645 | 0 | 0 |
| Patient Days | 4,646 | 3,892 | 5,003 | 4,002 | 0 | 0 |
| ALOS on Admissions | 6.2 | 6.1 | 6.1 | 6.2 | #DIV/0! | #DIV/0! |
| ADC on Admissions | 12.7 | 10.7 | 13.7 | 11.0 | 0.0 | 0.0 |
| Occupancy on Admissions | 63.6% | 53.3% | 68.5% | 54.8% | #DIV/0! | #DIV/0! |
| 23-Hour Observation Days | 0 | 0 | 0 | 5 | 0 | 0 |
| Total Bed Days | 4,646 | 3,892 | 5,003 | 4,007 | 0 | 0 |
| Total ADC | 12.7 | 10.7 | 13.7 | 11.0 | 0.0 | 0.0 |
| Total Occupancy | 63.6% | 53.3% | 68.5% | 54.9% | #DIV/0! | #DIV/0! |

Note:
Med Surg: 3,176 admissions Jan-May 2012 annualizes to 7,622 per year, which is 13.5% over CY2011. Table projects 13% increase; then 2% per year.


Summit Med/Surg Daily Census May 2011 - April 2012
120
100
80
60
40
20
0
5/1/2011
5/8/2011
5/15/2011
5/22/2011
5/29/2011
6/5/2011
6/12/2011
6/19/2011
6/26/2011
7/3/2011
7/10/2011
7/17/2011
7/24/2011
7/31/2011
8/7/2011
8/14/2011
8/21/2011
8/28/2011
9/4/2011
9/11/2011
9/18/2011
9/25/2011
10/2/2011
10/9/2011
10/16/2011
10/23/2011
10/30/2011
11/6/2011
11/13/2011
11/20/2011
11/27/2011
12/4/2011
12/11/2011
12/18/2011
12/25/2011
1/1/2012
1/8/2012
1/15/2012
1/22/2012
1/29/2012
2/5/2012
2/12/2012
2/19/2012
2/26/2012
3/4/2012
3/11/2012
3/18/2012
3/25/2012
4/1/2012
4/8/2012
4/15/2012
4/22/2012
4/29/2012
Census
80% Capacity
Capacity


Emergency Room Visits and Admissions Trend By Quarter - First Quarter 2011 through 1st Quarter 2012
2,500
2,000
1,500
1,000
500
-
12,800
12,600
12,400
12,200
12,000
11,800
11,600
11,400
11,200
11,000
10,800
Emergency Room Expansion - July 2011
Primary Stroke Accreditation - Nov 2011
1,645
1,612
1,728
12,157
1,768
2,020
11,502
11,728
11,678
12,613
1Q2011
2Q2011
3Q2011
4Q2011
1Q2012
ER Visits
ER Admissions

**C(II)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 ON LINE D.**

**• 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.**

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1. On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of an administrative appeals hearing.

Line A.5, construction cost, was calculated at approximately $161 PSF overall renovation cost, by HCA Corporate Design and Construction staff. This includes a contingency.

Line A.8 includes both fixed and moveable equipment costs, estimated by HCA Corporate Design and Construction staff.

Line A.9 includes such costs as information systems and telecommunications upgrades and replacements.

## PROJECT COSTS CHART -- SUMMIT MEDICAL CENTER REHABILITATION UNIT

2012 JUN 14 PM 4 28

A. Construction and equipment acquired by purchase:

| | | |
|---|---|---|
| 1. Architectural and Engineering Fees | (8% of A5) | $ 110,000 |
| 2. Legal, Administrative, Consultant Fees (Excl CON Filing) | | 50,000 |
| 3. Acquisition of Site | | 0 |
| 4. Preparation of Site | | 0 |
| 5. Construction Cost | | 1,550,000 |
| 6. Contingency Fund | (included in A.5) | 0 |
| 7. Fixed Equipment (Not included in Construction Contract) | | 0 |
| 8. Moveable Equipment (List all equipment over $50,000) | | 607,388 |
| 9. Other (Specify) | IT, telecommunications, misc. | 150,000 |

B. Acquisition by gift, donation, or lease:

| | |
|---|---|
| 1. Facility (inclusive of building and land) | 0 |
| 2. Building only | 0 |
| 3. Land only | 0 |
| 4. Equipment (Specify) | 0 |
| 5. Other (Specify) | 0 |

C. Financing Costs and Fees:

| | |
|---|---|
| 1. Interim Financing | 27,000 |
| 2. Underwriting Costs | 0 |
| 3. Reserve for One Year's Debt Service | 0 |
| 4. Other (Specify) | 0 |

D. Estimated Project Cost (A+B+C) 2,494,388

E. CON Filing Fee 5,612

F. Total Estimated Project Cost (D+E) TOTAL $ 2,500,000

Actual Capital Cost 2,500,000
Section B FMV 0

**C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.**

**a. 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 ALPHANUMERIC 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 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;**

**__x__E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or**

**_____F. Other--Identify and document funding from all sources.**

The project will be funded by a cash transfer of the required cost, from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System). Documentation of financing is provided in Attachment C, Economic Feasibility--2.

**C(II).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 HSDA.**

The estimated $1,550,000 renovation construction cost for the project is approximately $161 PSF overall:

| Table Three (repeated): Construction Cost PSF | | |
|---|---|---|
| **Construction Cost** | **SF of Renovation** | **Construction Cost PSF** |
| $1,550,000 | 9,626 USF | $161.02 |

The 2009-2011 hospital construction projects approved by the HSDA had the following costs per SF. This project is very consistent with those ranges, being below the median for hospital renovation projects.

**Hospital Construction Cost Per Square Foot**
**Years: 2009 – 2011**

| | Renovated Construction | New Construction | Total Construction |
|---|---|---|---|
| **1st Quartile** | $125.84/sq ft | $235.86/sq ft | $167.99/sq ft |
| **Median** | $177.60/sq ft | $274.63/sq ft | $249.32/sq ft |
| **3rd Quartile** | $273.69/sq ft | $324.00/sq ft | $301.74/sq ft |

*Source: CON approved applications for years 2009 through 2011*

**C(II).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 YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE 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).**

See the following pages for these charts, with notes where applicable.

## HISTORICAL DATA CHART -- SUMMIT MEDICAL CENTER

2012 JUN 14 PM 4 28

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

| | | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|---|
| A. | Utilization Data ( JAR discharge days) | 42,614 | 41,759 | 39,877 |
| B. | Revenue from Services to Patients | | | |
| 1. | Inpatient Services | $ 311,364,654 | 340,144,880 | 371,674,202 |
| 2. | Outpatient Services | 225,484,925 | 240,272,739 | 236,798,113 |
| 3. | Emergency Services | 38,855,183 | 43,587,757 | 46,936,541 |
| 4. | Other Operating Revenue | 1,837,166 | 2,089,089 | 2,369,663 |
| | (Specify) See notes | | | |
| | **Gross Operating Revenue** | $ 577,541,928 | $ 626,094,465 | $ 657,778,519 |
| C. | Deductions for Operating Revenue | | | |
| 1. | Contractual Adjustments | $ 393,868,036 | 424,831,830 | 456,728,007 |
| 2. | Provision for Charity Care | 1,684,364 | 2,281,357 | 3,723,069 |
| 3. | Provisions for Bad Debt | 33,081,202 | 47,854,780 | 44,276,197 |
| | **Total Deductions** | $ 428,633,602 | $ 474,967,967 | $ 504,727,273 |
| **NET OPERATING REVENUE** | | $ 148,908,326 | $ 151,126,498 | $ 153,051,246 |
| D. | Operating Expenses | | | |
| 1. | Salaries and Wages | $ 40,937,360 | 42,362,204 | 42,613,777 |
| 2. | Physicians Salaries and Wages | 0 | 0 | 0 |
| 3. | Supplies | 24,892,000 | 25,195,000 | 29,427,000 |
| 4. | Taxes | 1,322,417 | 1,257,530 | 1,202,224 |
| 5. | Depreciation | 7,080,267 | 7,020,600 | 7,017,441 |
| 6. | Rent | 1,989,000 | 1,826,000 | 1,911,000 |
| 7. | Interest, other than Capital | 269,748 | 251,487 | 243,557 |
| 8. | Management Fees | | | |
| | a. Fees to Affiliates | 10,328,173 | 10,942,208 | 10,588,601 |
| | b. Fees to Non-Affiliates | 0 | 0 | 0 |
| 9. | Other Expenses (Specify) See notes | 49,333,509 | 51,381,249 | 47,633,531 |
| | **Total Operating Expenses** | $ 136,152,474 | 140,236,278 | 140,637,131 |
| E. | Other Revenue (Expenses) -- Net (Specify) | $ | $ | $ |
| **NET OPERATING INCOME (LOSS)** | | $ 12,755,852 | $ 10,890,220 | $ 12,414,115 |
| F. | Capital Expenditures | | | |
| 1. | Retirement of Principal | $ 0 | $ 0 | $ 0 |
| 2. | Interest | 0 | 0 | 0 |
| | **Total Capital Expenditures** | $ 0 | $ 0 | $ 0 |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | | $ 12,755,852 | $ 10,890,220 | $ 12,414,115 |

Notes to historical data

| | Year 2009 | Year 2010 | Year 2011 |
|---|---|---|---|
| Other expenses: | | | |
| Employee Benefits | 10,984,000 | 11,268,000 | 12,925,000 |
| Pro Fees | 1,554,000 | 1,078,000 | 2,400,000 |
| Ancillary Clinical Services | 24,519,509 | 25,782,249 | 18,117,531 |
| Contract Services (all) | 12,276,000 | 13,253,000 | 14,191,000 |
| Total | 49,333,509 | 51,381,249 | 47,633,531 |
| Management Fee | 10,328,000 | 10,942,000 | 11,019,000 |
| | 6.9% | 7.2% | 7.2% |

# PROJECTED DATA CHART -- SUMMMIT REHABILITATION UNIT

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

2012 JUN 14 PM 4 28

| | | Year 2013 | Year 2014 |
|---|---|---|---|
| A. | Utilization Data (discharge days) | 328 / 4,428 | 374 / 5049 |
| B. | Revenue from Services to Patients | | |
| 1. | Inpatient Services | $ 14,432,000 | $ 17,205,760 |
| 2. | Outpatient Services | 0 | 0 |
| 3. | Emergency Services | 0 | |
| 4. | Other Operating Revenue (Specify) | 0 | 0 |
| | **Gross Operating Revenue** | $ 14,432,000 | $ 17,205,760 |
| C. | Deductions for Operating Revenue | | |
| 1. | Contractual Adjustments | $ 8,339,844 | $ 10,046,495 |
| 2. | Provision for Charity Care | 115,456 | 137,646 |
| 3. | Provisions for Bad Debt | 144,320 | 172,058 |
| | **Total Deductions** | $ 8,599,620 | $ 10,356,199 |
| NET OPERATING REVENUE | | $ 5,832,380 | $ 6,849,561 |
| D. | Operating Expenses | | |
| 1. | Salaries and Wages | $ 1,386,168 | $ 1,566,918 |
| 2. | Physicians Salaries and Wages | 0 | 0 |
| 3. | Supplies | 309,964 | 365,821 |
| 4. | Taxes | 0 | 0 |
| 5. | Depreciation | | |
| 6. | Rent | 0 | 0 |
| 7. | Interest, other than Capital | 0 | 0 |
| 8. | Management Fees | 0 | 0 |
| | a. Fees to Affiliates | 404,524 | 482,117 |
| | b. Fees to Non-Affiliates | 0 | 0 |
| 9. | Other Expenses (Specify) See notes | 974,212 | 1,114,155 |
| | **Total Operating Expenses** | $ 3,074,868 | $ 3,529,011 |
| E. | Other Revenue (Expenses) -- Net (Specify) | $ | $ |
| NET OPERATING INCOME (LOSS) | | $ 2,757,512 | $ 3,320,550 |
| F. | Capital Expenditures | | |
| 1. | Retirement of Principal | $ 0 | $ 0 |
| 2. | Interest | 0 | 0 |
| | **Total Capital Expenditures** | $ 0 | $ 0 |
| NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES | | $ 2,757,512 | $ 3,320,550 |

62

Notes to projected data

| | Year 2013 | Year 2014 |
|---|---|---|
| Other expenses: | | |
| Employee Benefits | 375,651 | 424,635 |
| Pro Fees | 85,000 | 85,000 |
| Ancillary Clinical Services | 88,561 | 104,520 |
| Parallon Allocations | 425,000 | 500,000 |
| | 974,212 | 1,114,155 |
| Management Fee (6.9 % of Net Revenue) | 404,524 | 475,074 |
| | 6.9% | 6.9% |

**C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.**

| Table Thirteen: Average Charges, Deductions, Net Charges, Net Operating Income | | |
|---|---|---|
| | **CY2013** | **CY2014** |
| Admissions | 328 | 374 |
| Patient Days | 4,428 | 5,049 |
| Average Gross Charge Per Day | $3,259 | $3,408 |
| Average Gross Charge Per Admission | $44,000 | $46,005 |
| Average Deduction from Operating Revenue Per Day | $1,933 | $2,051 |
| Average Deduction from Operating Revenue Per Admission | $26,218 | $27,690 |
| Average Net Charge (Net Operating Revenue) Per Day | $1,317 | $1,357 |
| Average Net Charge (Net Operating Revenue) Per Admission | $17,782 | $18,314 |
| Average Net Operating Income after Expenses, Per Day | $623 | $658 |
| Average Net Operating Income after Expenses, Per Admission | $8,407 | $8,878 |

**C(II).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.**

The project's most frequent charges are shown in response to C(II).6.B below. The introduction of this unit will not affect any other hospital charges because it will operate with a strong positive revenue margin, making it unnecessary to shift costs to other hospital services.

**C(II).6.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 HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).**

The projected average gross charge for this project will be consistent with the average gross charges for similar area projects approved by the Agency or in operation already. No charge information is publicly available for rehabilitation units in hospitals because the Joint Annual Reports do not contain revenue data specific to inpatient rehabilitation services. It is available for a rehabilitation hospital, however, as shown below. Following is available charge data. (Cases are discharges or admissions.)

**Table Fourteen: Year One Charges of Similar Facilities Compared to CY2013 Charge of This Project**

| Provider | Gross / Net Charges | Cases | Days | Gross/Net Charges Per Case (NOR) | Gross/Net Charges Per Day |
|---|---|---|---|---|---|
| HealthSouth Rehab'n Hospital Williamson County (CN1002-059) | $18,447,324/ **$8,231,016** | 537 | 7,245 | $34,353 / **$15,327** | $2,546 / **$1,136** |
| VU Stallworth Rehabilitation Hospital (2011 JAR) | $56,921,124 / **$25,001,544** | 1,713 | 22,671 | $33,228 / **$14,595** | $2,511 / **$1,103** |
| Southern Hills Medical Center (CN 1111-048) | $19,085,892 / $5,522,620 | 347 | 4,530 | $55,003 / **$15,915** | $4,213 / **$1,220** |
| **THIS PROJECT (2013)** | $14,432,000 / **$5,832,380** | 328 | 4,428 | $44,000 / **$17,782** | $3,259 / **$1,317** |

Source: HSDA Records; Joint Annual Reports; Projected Data Chart

The following page contains a table showing the most frequent procedures to be performed, with their current Medicare reimbursement, and their projected Years One and Two utilization and average gross charges.

| Table Fifteen: Summit Medical Center<br>Charge Data for Most Frequent Admissions to Rehabilitation Unit | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Average Gross Charge | | | Utilization (Admissions) | | |
| Admission Code | Descriptor | Current Medicare Allowable | Current | Year 1 | Year 2 | Current | Year 1 | Year 2 |
| | | | | | | | | |
| 1 | Stroke | $49,091 | N/A | $50,254 | $52,264 | N/A | 86 | 100 |
| 2 | Traumatic Brain Injury | $37,646 | N/A | $38,538 | $40,080 | N/A | 18 | 20 |
| 6 | Neurological | $37,345 | N/A | $38,230 | $39,759 | N/A | 53 | 60 |
| 7 | Fracture of Lower Extremity | $39,152 | N/A | $40,080 | $41,683 | N/A | 31 | 35 |
| 10 | Amputation, Lower Extremity | $42,766 | N/A | $43,779 | $45,530 | N/A | 8 | 9 |
| 17 | Mult Trauma w/o Brain or Sp Cord Inj | $40,658 | N/A | $41,621 | $43,286 | N/A | 7 | 8 |
| | Subtotal, Most Frequent | | | $43,969 | $45,813 | N/A | 203 | 232 |
| | | | | | | | | |
| | All Other | | | $44,000 | $45,600 | N/A | 125 | 142 |
| | Total Admissions | | | | | | 328 | 374 |
| | | | | | | | | |

**C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.**

The Projected Data Chart and charge information in the application demonstrate that the program will be cost-effective, operating with a healthy positive financial margin, while maintaining a competitive charge structure for area payors.

**C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.**

Summit generates a large number of referrals to acute rehabilitation programs each year. An even larger number of discharges have been identified, who are eligible for such transfers. It seems certain that the proposed unit will be sufficiently utilized in its first two years to operate with a strong financial margin, at charges that are comparable to those of other such programs in the area.

**C(II).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.**

Like Summit Medical Center, this proposed unit will serve the groups listed above. Indigent care is projected at approximately .8% of services annually and Medicare and TennCare/Medicaid are projected at a combined 55% of services.

| Table Sixteen: Medicare and TennCare/Medicaid Gross Revenues, Year One | | |
|---|---|---|
| | **Medicare** | **TennCare/Medicaid** |
| Gross Revenue | $7,504,640 | $432,960 |
| Percent of Gross Revenue | 52% | 3% |

**C(II).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 ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.**

These are provided as Attachment C, Economic Feasibility--10.

**C(II)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 DISCUSSSION 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.**
**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.**

With respect to construction, the project requires no new construction. It will be done entirely by renovation. The only major renovation is changing the patient bathrooms on the third floor from psychiatric design bathrooms to ADA-compliant, handicapped-accessible bathrooms as specified by licensing regulations.

With respect to alternatives, there is no alternative way to make acute inpatient rehabilitation more accessible to residents of the eastern urban area of Nashville. Acute rehabilitation is a hospital-based program and Summit is the only hospital between the rehabilitation units at Baptist Hospital in central Davidson County, and UMC McFarland Hospital in central Wilson County--a distance of approximately 32 miles. Deployment of rehabilitation at Summit parallels HSDA decisions for suburban hospitals on the north side of the county (Skyline Medical Center, 41 rehab beds) and the south side of the county (Southern Hills, 16 rehab beds).

Of course, rehabilitation is available in nursing home programs in the service area, but hospital-based acute rehabilitation allows for more intensive therapies and is appropriate for patients who need that. Otherwise, payors and patients would not be using the more expensive hospital-based acute rehabilitation care. The project also permits Summit to offer and control a complete continuum of care for its patients whose discharge from the initial stay needs to proceed seamlessly into acute rehabilitation, with their medical team conveniently close.

**C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.**

Following are the facilities most frequently utilizes in its discharge planning:

Skilled Nursing- McKendree, Mt. Juliet Healthcare, Donelson Place, Lebanon Health and Rehabilitation

Hospice- Alive Hospice, Odyssey, Avalon, Asera Care

Home Health- Suncrest, Gentevia, and Amedysis Home Health Care of Middle

Home Infusion- Walgreens, IV Solutions, Coram

DME- Medical Necessities, At Home Medical, Apria, All-Star

**C(III).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.**

The project will provide easier access to acute inpatient rehabilitation, for residents of eastern Davidson County and western Wilson County who are being discharged from initial acute care stays in Davidson County hospitals--especially Summit Medical Center--and who would prefer the Hermitage location to a downtown or Wilson County location.

The project consolidates HCA TriStar's psychiatric care resources in Nashville, at its two central Davidson County campuses (Skyline Madison and Centennial Pavilion), freeing up beds in its Davidson County suburban hospitals for broader-based healthcare programs.

The project adds rehabilitation beds to the service area without increasing licensed beds--because it merely reassigns existing bed areas on the hospital's third floor.

The impact on non-HCA rehabilitation providers will be minimal. In CY2011, 70% of Summit's discharges to acute rehabilitation programs in Nashville were to sister HCA hospitals. Only 47 patients from Summit were discharged to other service area programs.

**C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, 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.**

Please see the following page for Table Eighteen, showing projected FTE's and salary ranges.

The Department of Labor and Workforce Development website indicates the following Upper Central Tennessee region's annual salary information for clinical employees of this project:

**Table Seventeen: TDOL Surveyed Average Salaries for the Region**

| Position | Entry Level | Mean | Median | Experienced |
|---|---|---|---|---|
| RN | $44,569 | $63,102 | $59,662 | $72,368 |
| Physical Therapist | $57,012 | $74,117 | $73,472 | $82,669 |
| Physical Therapy Assistant | $40,515 | $50,048 | $54,814 | $48,674 |
| Occupational Therapist | $60,560 | $70,045 | $68,908 | $74,787 |
| Certified OT Assistant | $39,499 | $48,716 | $45,335 | $53,325 |
| Social Worker | $26,032 | $46,919 | $45,110 | $57,363 |

## Table Eighteen: Summit Medical Center
## Acute Rehabilitation Service
## Staffing Requirements

| Position Type (RN, etc.) | Current FTE's | Year One FTE's | Year Two FTE's | Salary Range (Hourly) |
|---|---|---|---|---|
| | | | | |
| RN | N/A | 7.0 | 8.5 | 22.74 - 27.00 |
| LPN | N/A | 1.7 | 2.1 | 15.40 - 17.00 |
| Program Director | N/A | 1.0 | 1.0 | 35.00 - 50.00 |
| Nurse Manager | N/A | 1.0 | 1.0 | 25.00 - 40.00 |
| Unit Secretary | N/A | 1.0 | 2.0 | 15.36 - 16.96 |
| Admission Coordinator | N/A | 1.0 | 1.0 | 14.42 - 15.92 |
| Physical Therapists | N/A | 2.0 | 2.0 | 37.11 - 39.00 |
| Physical Therapy Assistant | N/A | 1.0 | 1.0 | 18.00 - 20.00 |
| Occupational Therapy | N/A | 2.0 | 2.0 | 37.11 - 40.00 |
| COTA | N/A | 1.0 | 1.0 | 18.00 - 20.00 |
| Speech Therapy | N/A | 2.0 | 2.0 | 37.11 - 41.00 |
| Case Manager/Social Worker | N/A | 1.5 | 1.5 | 31.48 - 35.00 |
| Outreach Liaisons/PPS Coordinator | N/A | 3.8 | 3.8 | 19.00 - 23.00 |
| | | | | |
| | | | | |
| **Total FTE's** | | 26.0 | 29.0 | |
| | | | | |
| | | | | |
| | | | | |

**C(III).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.**

HCA hospitals nationwide and in Middle Tennessee have established numerous acute inpatient rehabilitation programs and TriStar anticipates no difficulties in attracting the nursing, therapy, support staff, and Medical Director required for an effective program at Summit Medical Center.

**C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.**

The applicant so verifies.

**C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).**

StoneCrest is a clinical rotation site for numerous students in the health professions. The schools with which Summit has student affiliation agreements are:

Absolute Medical
Austin Peay University
Belmont University
Cardiac and Vascular Institute
Cedar Crest College
Columbia State Community College
Cumberland University
ITT Technical
Middle TN School of Anesthesia
Middle Tennessee State University
Southeastern University
South University
Tennessee State University
Tennessee Tech
University of Houston
Trevecca Nazarene
University of Phoenix
University of Tennessee
Vanderbilt University
Weber State University
West Virginia Wesleyan College
Western KY University
Volunteer State Community College

In CY2011, Summit Medical Center served as a training rotation site for 415 students from these schools, in the following disciplines and programs: Nursing (174); EMT/Paramedic (68); Anesthesia Tech (72); Pharmacy Tech (35); Nutrition (3); Respiratory Therapy (25); Medical Imaging (31); Physician's Assistant (2); and Physical Therapy (5).

**C(III).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.**

The applicant so verifies.

**C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION**

| | |
|---|---|
| **LICENSURE:** | Board for Licensure of Healthcare Facilities<br>Tennessee Department of Health |
| **CERTIFICATION:** | Medicare Certification from CMS<br>TennCare Certification from TDH |
| **ACCREDITATION:** | Joint Commission |

**C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.**

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission.

**C(III).7(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.**

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

**C(III)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.**

None.

**C(III)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.**

None.

**C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.**

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

**PROOF OF PUBLICATION**

Attached.

**DEVELOPMENT SCHEDULE**

**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.**

The Project Completion Forecast Chart is provided after this page.

**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.**

Not applicable. The applicant anticipates completing the project within the period of validity.

## PROJECT COMPLETION FORECAST CHART

2012 JUN 14 PM 4 28

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

September 26, 2012

Assuming the CON decision 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.

| PHASE | DAYS REQUIRED | Anticipated Date (MONTH /YEAR) |
|---|---|---|
| 1. Architectural & engineering contract signed | 1 | 9/2012 |
| 2. Construction documents approved by TDH | 26 | 10/2012 |
| 3. Construction contract signed | 30 | 10/2012 |
| 4. Building permit secured | 31 | 10/2012 |
| 5. Site preparation completed | na | na |
| 6. Building construction commenced | 35 | 10/2012 |
| 7. Construction 40% complete | 45 | 11/2012 |
| 8. Construction 80% complete | 75 | 12/2012 |
| 9. Construction 100% complete | 85 | 12/2012 |
| 10. * Issuance of license | 90 | 12/2012 |
| 11. *Initiation of service | 96 | 1/2013 |
| 12. Final architectural certification of payment | 126 | 2/2013 |
| 13. Final Project Report Form (HF0055) | 186 | 4/2013 |

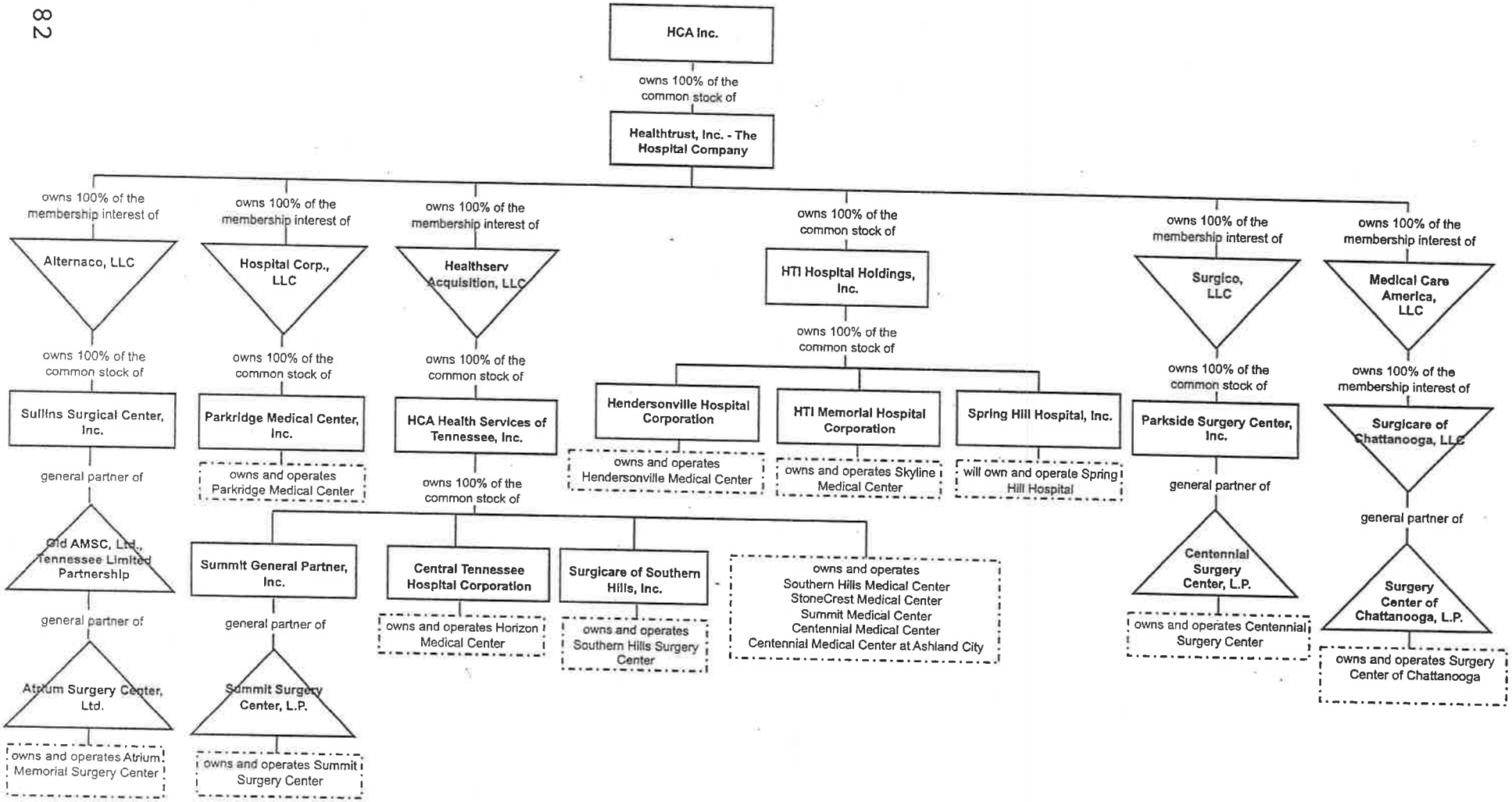
*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

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

# INDEX OF ATTACHMENTS


| | |
|---|---|
| A.4 | Ownership--Legal Entity and Organization Chart (if applicable) |
| A.6 | Site Control |
| B.III. | Plot Plan |
| B.IV. | Floor Plan |
| C, Need--3 | Service Area Maps |
| C, Economic Feasibility--1 | Documentation of Construction Cost Estimate |
| C, Economic Feasibility--2 | Documentation of Availability of Funding |
| C, Economic Feasibility--10 | Financial Statements |
| C, Orderly Development--7(C) | TDH Inspection & Plan of Correction |
| Miscellaneous Information | |
| Support Letters | |

# A.4--Ownership
# Legal Entity and Organization Chart


HCA Inc.
owns 100% of the common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of the membership interest of
Alternaco, LLC
owns 100% of the common stock of
Sullins Surgical Center, Inc.
general partner of
Old AMSC, Ltd., Tennessee Limited Partnership
general partner of
Atrium Surgery Center, Ltd.
owns and operates Atrium Memorial Surgery Center
owns 100% of the membership interest of
Hospital Corp., LLC
owns 100% of the common stock of
Parkridge Medical Center, Inc.
owns and operates Parkridge Medical Center
owns 100% of the membership interest of
Healthserv Acquisition, LLC
owns 100% of the common stock of
HCA Health Services of Tennessee, Inc.
owns 100% of the common stock of
Summit General Partner, Inc.
general partner of
Summit Surgery Center, L.P.
owns and operates Summit Surgery Center
Central Tennessee Hospital Corporation
owns and operates Horizon Medical Center
Surgicare of Southern Hills, Inc.
owns and operates Southern Hills Surgery Center
owns and operates
Southern Hills Medical Center
StoneCrest Medical Center
Summit Medical Center
Centennial Medical Center
Centennial Medical Center at Ashland City
owns 100% of the common stock of
HTI Hospital Holdings, Inc.
owns 100% of the common stock of
Hendersonville Hospital Corporation
owns and operates Hendersonville Medical Center
HTI Memorial Hospital Corporation
owns and operates Skyline Medical Center
Spring Hill Hospital, Inc.
will own and operate Spring Hill Hospital
owns 100% of the membership interest of
Surgico, LLC
owns 100% of the common stock of
Parkside Surgery Center, Inc.
general partner of
Centennial Surgery Center, L.P.
owns and operates Centennial Surgery Center
owns 100% of the membership interest of
Medical Care America, LLC
owns 100% of the membership interest of
Surgicare of Chattanooga, LLC
general partner of
Surgery Center of Chattanooga, L.P.
owns and operates Surgery Center of Chattanooga

## TENNESSEE FACILITIES OWNED BY HCA, INC.

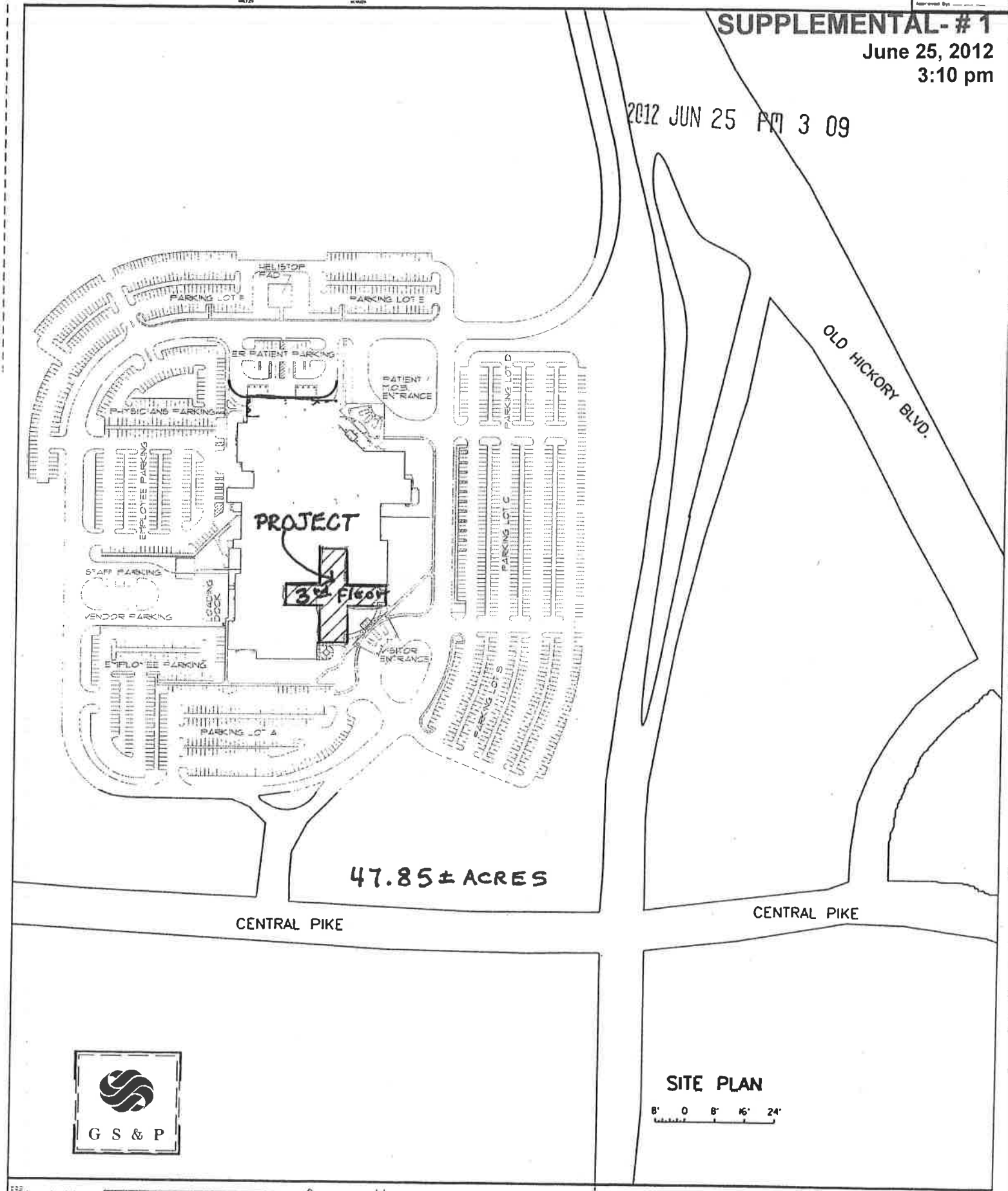
| | | | | | |
|---|---|---|---|---|---|
| Centennial Medical Center | 2300 Patterson Str | | Nashville | TN | 37203 |
| Parthenon Pavilion | 2401 Parman Place | | Nashville | TN | 37203 |
| Sarah Cannon Cancer Center | 250 25th Avenue North | Suite 110 | Nashville | TN | 37203 |
| Sarah Cannon Research Institute | 3322 West End Avenue | Suite 900 | Nashville | TN | 37203 |
| Women's Hospital | 2221 Murphy Avenue | | Nashville | TN | 37203 |
| Centennial Surgery Center | 345 23rd Ave N | Suite 201 | Nashville | TN | 37203-1524 |
| Greenview Regional Hospital | 1801 Ashley Circle | | Bowling Green | KY | 42104-9024 |
| Hendersonville Medical Center | 355 New Shackle Island Road | | Hendersonville | TN | 37075 |
| Horizon Medical Center | 111 Highway 70 East | | Dickson | TN | 37055 |
| Natchez Imaging | 101 Natchez Park Drive | | Dickson | TN | 37055 |
| Radiation Oncology @ SCCC | 105 Natchez Park Drive | | Dickson | TN | 37055 |
| TN Oncology @ SCCC | 103 Natchez Park Drive, | | Dickson | TN | 37055 |
| Parkridge East Hospital | 941 Spring Creek Road | | Chattanooga | TN | 37412 |
| Parkridge Medical Center | 2333 McCallie Avenue | | Chattanooga | TN | 37404 |
| Parkridge Valley Hospital | 2200 Morris Hill Road | | Chattanooga | TN | 37421 |
| Portland Medical Center | 105 Redbud Drive | | Portland | TN | 37148 |
| Skyline Medical Center | 3441 Dickerson Pike | | Nashville | TN | 37207 |
| Skyline Madison Campus | 500 Hospital Drive | | Madison | TN | 37115 |
| Southern Hills Medical Center | 391 Wallace Road | | Nashville | TN | 37211 |
| Southern Hills Surgical Center | 360 Wallace Road | | Nashville | TN | 37212 |
| StoneCrest Medical Center | 200 StoneCrest Boulevard | | Smyrna | TN | 37167 |
| Summit Medical Center | 5655 Frist Boulevard | | Hermitage | TN | 37076 |
| Summit Surgery Center | 3901 Central Pike | Suite 152 | Hermitage | TN | 37076 |

FEB. 27, 2012

# B.III.--Plot Plan

SUPPLEMENTAL- # 1
June 25, 2012
3:10 pm

2012 JUN 25 PM 3 09




G S & P

SITE PLAN

8' 0 8' 16' 24'

| REVISION | | |
|---|---|---|
| No. | Date | Revision |

PRELIMINARY NOT FOR CONSTRUCTION

SUMMIT MEDICAL CENTER

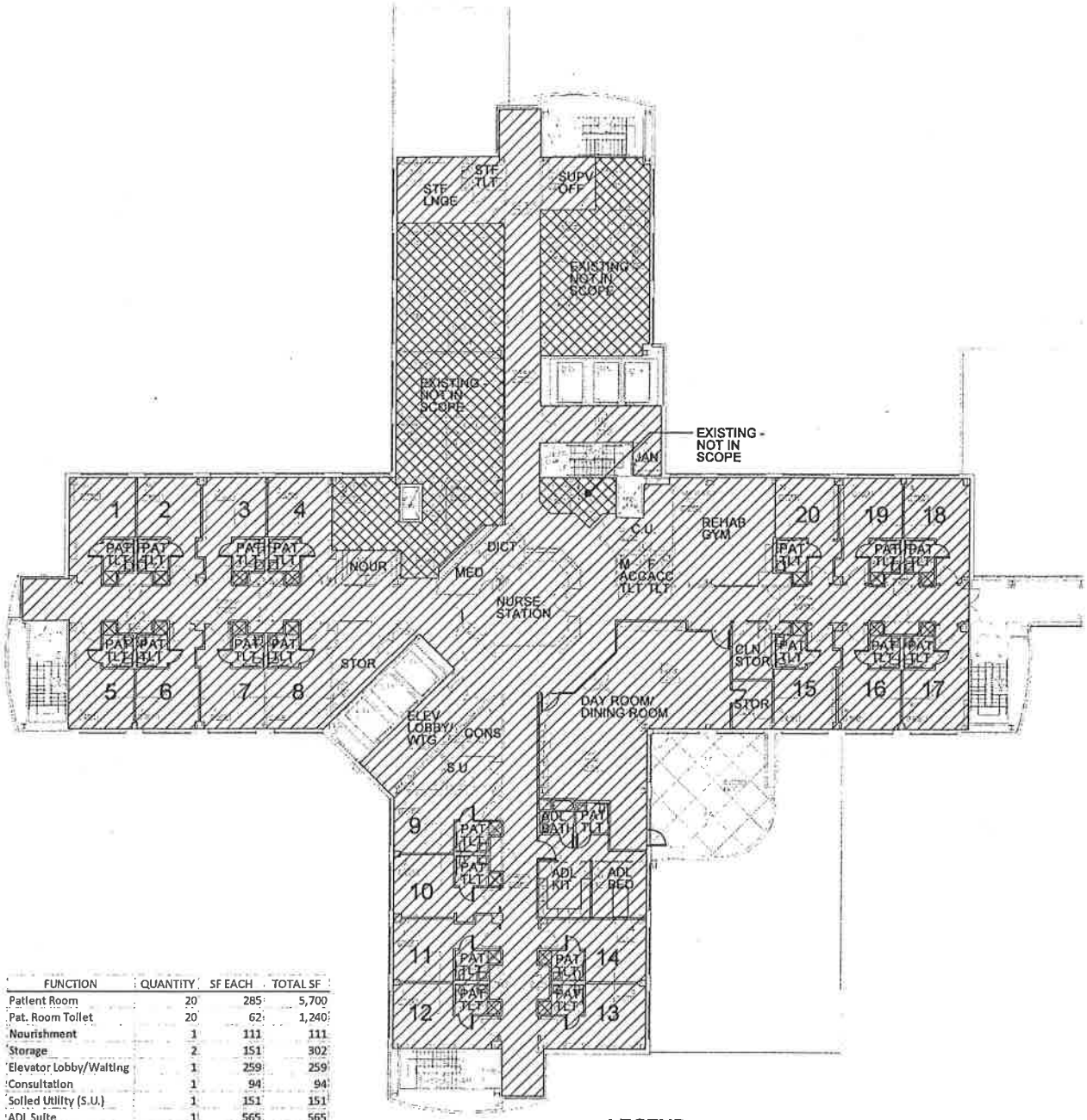
GRESHAM SMITH AND PARTNERS

Design Services For The Built Environment

Atlanta Birmingham Charlotte Cincinnati Columbus Dallas Fort Lauderdale Knoxville Jackson Jacksonville Louisville Memphis Nashville Richmond Tampa

G S & P

# B.IV.--Floor Plan




| FUNCTION | QUANTITY | SF EACH | TOTAL SF |
|---|---|---|---|
| Patient Room | 20 | 285 | 5,700 |
| Pat. Room Toilet | 20 | 62 | 1,240 |
| Nourishment | 1 | 111 | 111 |
| Storage | 2 | 151 | 302 |
| Elevator Lobby/Waiting | 1 | 259 | 259 |
| Consultation | 1 | 94 | 94 |
| Soiled Utility (S.U.) | 1 | 151 | 151 |
| ADL Suite | 1 | 565 | 565 |
| Day Room/Dining Room | 1 | 1,328 | 1,328 |
| Clean Storage | 1 | 107 | 107 |
| Male Acc. Toilet | 1 | 43 | 43 |
| Female Acc. Toilet | 1 | 43 | 43 |
| Clean Utility (C.U.) | 1 | 185 | 185 |
| Nurse Station | 1 | 478 | 478 |
| Meds | 1 | 115 | 115 |
| Dictation | 1 | 103 | 103 |
| Janitor Closet | 1 | 47 | 47 |
| Staff Lounge | 1 | 322 | 322 |
| Staff Toilet | 1 | 38 | 38 |
| Supervisor Office | 1 | 146 | 146 |
| Rehab Gym | 1 | 550 | 550 |
| TOTAL NET SQUARE FOOTAGE | | | 11,927 |
| CIRCULATION GROSSING FACTOR | | | 0.43 |
| TOTAL GROSS SQUARE FOOTAGE (Hatched Area) | | | 17,030 |

## LEGEND

Rehab Unit

Miscellaneous Office Space

# SUMMIT MEDICAL CENTER
# HERMITAGE, TENNESSEE

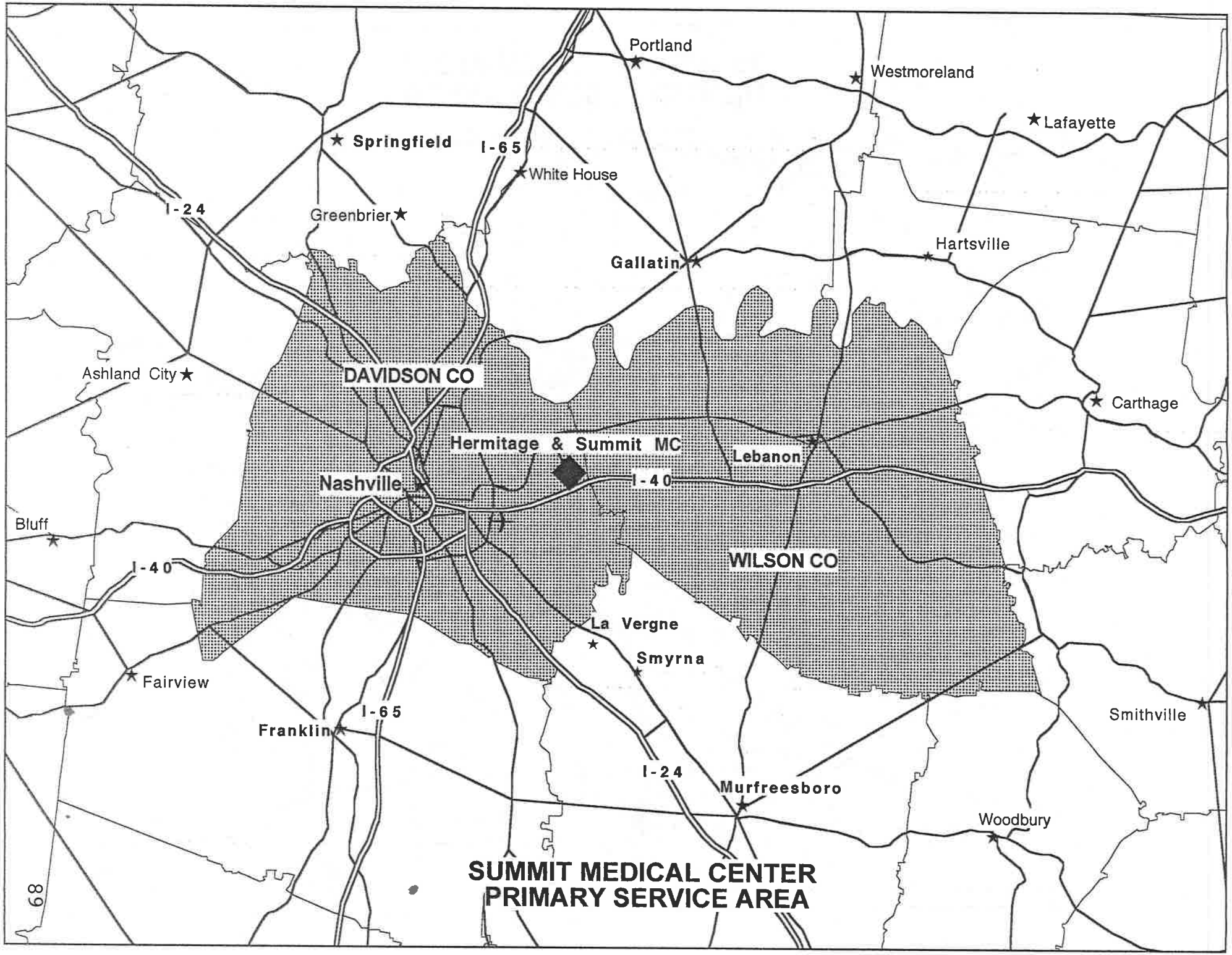
Third Floor Rehab Unit

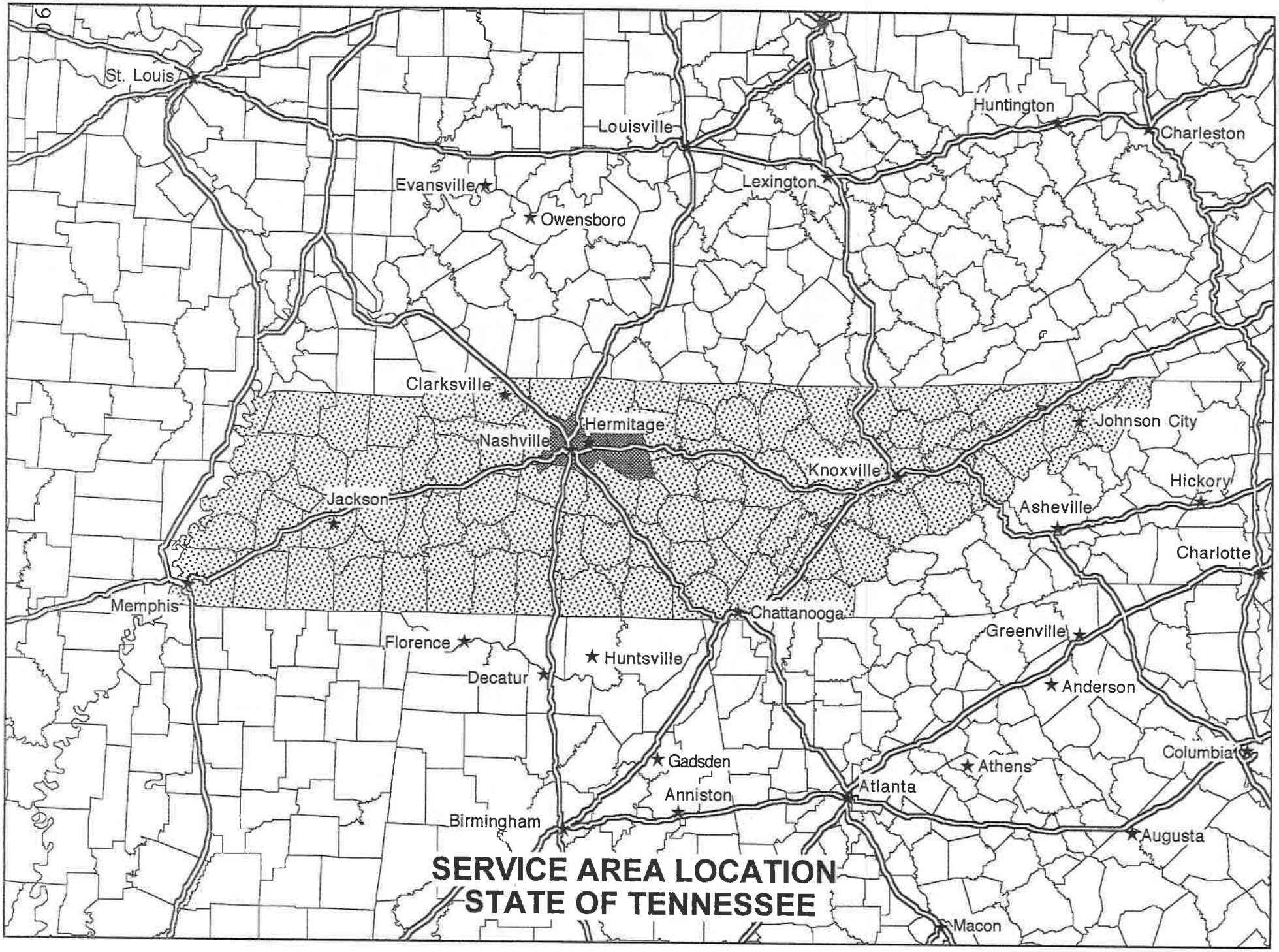
## PROPOSED - ENLARGED THIRD FLOOR PLAN

GS&P #28973.00
06.11.2012

G S & P

# C, Need--3
# Service Area Maps


Portland
Westmoreland
Lafayette
Springfield
I-65
White House
I-24
Greenbrier
Hartsville
Gallatin
Ashland City
DAVIDSON CO
Carthage
Hermitage & Summit MC
Lebanon
Nashville
I-40
Bluff
WILSON CO
I-40
La Vergne
Smyrna
Fairview
I-65
Franklin
Smithville
I-24
Murfreesboro
Woodbury
SUMMIT MEDICAL CENTER
PRIMARY SERVICE AREA




**SERVICE AREA LOCATION**
**STATE OF TENNESSEE**

# C, Economic Feasibility--1
# Documentation of Construction Cost Estimate

GRESHAM
SMITH AND
PARTNERS

June 5, 2012

Mr. Jeff Whitehorn, CHE
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

**Subject:** **Verification of Construction Cost Estimates**
**3rd Floor InPatient Rehabilitation Unit**
**Summit Medical Center**
**Hermitage, Tennessee**
GS&P Project No. 28973.00 / 00.3

Gresham Smith and Partners, Inc., an architectural/engineering firm in Nashville, Tennessee, has reviewed the cost data provided by HCA for the above referenced project, for which this firm has provided a preliminary design. The stated renovated construction cost for this 9,626 SF area is $1,550,000. [In providing opinions of probable construction cost, the Client understands that the Consultant has no control over the cost or availability of labor, equipment or materials, or over market conditions or the Contractor's method of pricing, and that the Consultant's opinions of probable construction costs are made on the basis of the Consultant's professional judgment and experience. The Consultant makes no warranty, express or implied, that the bids or the negotiated cost of the Work will not vary from the Consultant's opinion of probable construction cost.]

It is our opinion that at this time, the projected renovated construction cost is reasonable for this type and size of project and compares appropriately with similar projects in this market.

The building codes applicable to this project will be:

International Building Code, 2006
NFPA 101 Life Safety Code, 2006
FGI Guidelines for Design & Construction of Healthcare Facilities, 2010
ANSIA-117.1, 2003

Sincerely,

Kenneth A. Priest, AIA, NCARB, LEED AP
License No. 16010

bma



Design Services For The Built Environment
1400 Nashville City Center / 511 Union Street / Nashville, Tennessee 37219-1733 / Phone 615.770.8100 / www.greshamsmith.com

# C, Economic Feasibility--2
# Documentation of Availability of Funding

# HCA

TriStar Health System
110 Winners Circle, 1st Floor
Brentwood, TN
37027

Hospital Corporation of America

P 615-886-4900

June 12, 2012

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

RE: CON Application for Acute Rehabilitation Unit
Summit Medical Center

Dear Mrs. Hill:

Summit Medical Center is applying for a Certificate of Need to add the subject service beginning next January.

As Chief Financial Officer of the TriStar Health System, the HCA Division Office to which this facility will belong, I am writing to confirm that HCA Holdings, Inc. will provide through TriStar the approximately $2,500,000 in capital costs required to implement this project. HCA Holdings, Inc.'s financial statements are provided in the application.

Sincerely,

Chris Taylor
CFO
TriStar Division of HCA

# C, Economic Feasibility--10
# Financial Statements

## Financial Statements - Balance Sheet

| Month | | | | Year to Date | | |
|---|---|---|---|---|---|---|
| Begin | Change | Ending | | Begin | Change | Ending |
| | | | **CURRENT ASSETS** | | | |
| 50,410 | -140,390 | -89,980 | Cash & Cash Equivalents | 54,570 | -144,550 | -89,980 |
| | | | Marketable Securities | | | |
| | | | **PATIENT ACCOUNTS RECEIVABLES** | | | |
| 38,783,786 | 3,177,793 | 41,961,579 | Patient Receivables | 40,543,243 | 1,418,336 | 41,961,579 |
| | | | Less Allow for Govt Receivables | | | |
| -20,450,325 | -480,135 | -20,930,460 | Less Allow - Bad Debt | -21,690,707 | 760,247 | -20,930,460 |
| 18,333,461 | 2,697,658 | 21,031,119 | Net Patient Receivables | 18,852,536 | 2,178,583 | 21,031,119 |
| | | | **FINAL SETTLEMENTS** | | | |
| 217,738 | 0 | 217,738 | Due to/from Govt Programs | 113,086 | 104,652 | 217,738 |
| | | | Allowances Due Govt Programs | | | |
| 217,738 | 0 | 217,738 | Net Final Settlements | 113,086 | 104,652 | 217,738 |
| 18,551,199 | 2,697,658 | 21,248,857 | Net Accounts Receivables | 18,965,622 | 2,283,235 | 21,248,857 |
| 5,072,189 | -84,775 | 4,987,414 | Inventories | 5,266,378 | -278,964 | 4,987,414 |
| 640,894 | 340,423 | 981,317 | Prepaid Expenses | 903,792 | 77,525 | 981,317 |
| 75,750 | -38,168 | 37,582 | Other Receivables | 107,158 | -69,576 | 37,582 |
| 24,390,442 | 2,774,748 | 27,165,190 | Total Current Assets | 25,297,520 | 1,867,670 | 27,165,190 |
| | | | **PROPERTY, PLANT & EQUIPMENT** | | | |
| 6,124,510 | 0 | 6,124,510 | Land | 6,124,510 | 0 | 6,124,510 |
| 48,018,314 | 0 | 48,018,314 | Bldgs & Improvements | 46,232,338 | 1,785,976 | 48,018,314 |
| 83,764,594 | 736,608 | 84,501,202 | Equipment - Owned | 76,882,641 | 7,618,561 | 84,501,202 |
| 1,411,670 | 0 | 1,411,670 | Equipment - Capital Leases | | 1,411,670 | 1,411,670 |
| 709,520 | -709,520 | | Construction in Progress | 494,454 | -494,454 | |
| 140,028,608 | 27,088 | 140,055,696 | Gross PP&E | 129,733,943 | 10,321,753 | 140,055,696 |
| -88,409,185 | -584,523 | -88,993,708 | Less Accumulated Depreciation | -83,629,932 | -5,363,776 | -88,993,708 |
| 51,619,423 | -557,435 | 51,061,988 | Net PP&E | 46,104,011 | 4,957,977 | 51,061,988 |
| | | | **OTHER ASSETS** | | | |
| | | | Investments | | | |
| 0 | 0 | 0 | Notes Receivable | 0 | 0 | 0 |
| 10,027,657 | 0 | 10,027,657 | Intangible Assets - Net | 10,027,657 | 0 | 10,027,657 |
| | | | Investments in Subsidiaries | | | |
| | | | Other Assets | | | |
| 10,027,657 | 0 | 10,027,657 | Total Other Assets | 10,027,657 | 0 | 10,027,657 |
| 86,037,522 | 2,217,313 | 88,254,835 | Grand Total Assets | 81,429,188 | 6,825,647 | 88,254,835 |
| | | | **CURRENT LIABILITIES** | | | |
| 3,194,402 | 257,552 | 3,451,954 | Accounts Payable | 3,254,037 | 197,917 | 3,451,954 |
| 3,584,063 | 237,151 | 3,821,214 | Accrued Salaries | 3,972,479 | -151,265 | 3,821,214 |
| 1,330,865 | 54,470 | 1,385,335 | Accrued Expenses | 1,494,224 | -108,889 | 1,385,335 |
| 18,493 | -161 | 18,332 | Accrued Interest | 20,167 | -1,835 | 18,332 |
| | | | Distributions Payable | | | |
| 860,185 | 4,325 | 864,510 | Curr Port - Long Term Debt | 298,465 | 566,045 | 864,510 |
| 20,466 | -8,237 | 12,229 | Other Current Liabilities | 38,311 | -26,082 | 12,229 |
| | | | Income Taxes Payable | | | |
| 9,008,474 | 545,100 | 9,553,574 | Total Current Liabilities | 9,077,683 | 475,891 | 9,553,574 |
| | | | **LONG TERM DEBT** | | | |
| 3,500,250 | -74,047 | 3,426,203 | Capitalized Leases | 2,980,758 | 445,445 | 3,426,203 |
| -213,248,238 | 3,662,582 | -209,585,656 | Inter/Intra Company Debt | -194,483,871 | -15,101,785 | -209,585,656 |
| | | | Other Long Term Debts | | | |
| -209,747,988 | 3,588,535 | -206,159,453 | Total Long Term Debts | -191,503,113 | -14,656,340 | -206,159,453 |
| | | | **DEFFERED CREDITS AND OTHER LIAB** | | | |
| | | | Professional Liab Risk | | | |
| | | | Deferred Incomes Taxes | | | |
| 91,329 | 3,345 | 94,674 | Long-Term Obligations | 101,530 | -6,856 | 94,674 |
| 91,329 | 3,345 | 94,674 | Total Other Liabilities & Def | 101,530 | -6,856 | 94,674 |
| | | | **EQUITY** | | | |
| 1,000 | 0 | 1,000 | Common Stock - par value | 1,000 | 0 | 1,000 |
| 23,562,553 | 0 | 23,562,553 | Capital in Excess of par value | 23,562,553 | 0 | 23,562,553 |
| 223,890,799 | 0 | 223,890,799 | Retained Earnings - current yr | 261,202,489 | 0 | 261,202,489 |
| 39,231,355 | -1,919,667 | 37,311,688 | Net Income Current Year | | | |
| | | | Distributions | | | |
| | | | Other Equity | | | |
| 286,685,707 | -1,919,667 | 284,766,040 | Total Equity | 263,753,088 | 21,012,952 | 284,766,040 |
| 86,037,522 | 2,217,313 | 88,254,835 | Total Liabilities and Equity | 81,429,188 | 6,825,647 | 88,254,835 |

F00025 - SUMMIT MED CTR-TOT HOS OPS - S031

Dec - 2011

6/12/2012 04:45:06 PM

**Financial Statements - Income Statement**

All Entities

Report ID: ALCFS008

| Month | | | | | | | | Year to Date | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Bud Var | Var % | Prior Year | PY Var | Var % | | Actual | Budget | Bud Var | Var % | Prior Year | PY Var | Var % |
| | | | | | | | **REVENUES** | | | | | | | |
| 6,192 | 5,372 | 820 | 15.26% | 5,230 | 962 | 18.39% | Inpatient Revenue Routine Services | 62,552 | 59,281 | 3,272 | 5.52% | 55,645 | 6,907 | 12.41% |
| 30,930 | 28,483 | 2,447 | 8.59% | 29,216 | 1,714 | 5.87% | Inpatient Revenue Ancillary Services | 309,122 | 308,438 | 684 | 0.22% | 284,499 | 24,622 | 8.65% |
| 37,122 | 33,855 | 3,267 | 9.65% | 34,446 | 2,676 | 7.77% | Inpatient Gross Revenue | 371,674 | 367,719 | 3,955 | 1.08% | 340,145 | 31,529 | 9.27% |
| 26,716 | 28,740 | (2,024) | -7.04% | 24,195 | 2,521 | 10.42% | Outpatient Gross Revenue | 283,735 | 315,688 | (31,954) | -10.12% | 283,860 | (126) | -0.04% |
| 63,838 | 62,595 | 1,243 | 1.99% | 58,641 | 5,197 | 8.86% | Total Patient Revenue | 655,409 | 683,407 | (27,998) | -4.10% | 624,005 | 31,403 | 5.03% |
| 86 | 88 | (3) | -2.89% | 100 | (15) | -14.48% | Other Revenue | 1,088 | 1,070 | 19 | 1.77% | 1,144 | (56) | -4.86% |
| 63,924 | 62,684 | 1,240 | 1.98% | 58,741 | 5,183 | 8.82% | Gross Revenue | 656,497 | 684,477 | (27,979) | -4.09% | 625,149 | 31,348 | 5.01% |
| | | | | | | | **DEDUCTIONS** | | | | | | | |
| 14,996 | 15,113 | (117) | -0.77% | 14,088 | 909 | 6.45% | Total CY CA - Medicare (1,2) | 166,932 | 163,201 | 3,731 | 2.29% | 145,773 | 21,159 | 14.52% |
| 85 | 92 | (7) | -7.40% | 53 | 33 | 62.35% | Total CY CA - Medicaid (3) | 1,697 | 1,027 | 670 | 65.25% | 1,199 | 498 | 41.55% |
| 806 | 585 | 221 | 37.73% | 469 | 337 | 71.92% | Total CY CA - Champus (6) | 6,740 | 6,301 | 439 | 6.96% | 5,483 | 1,257 | 22.92% |
| (67) | | (67) | | (138) | 71 | 51.48% | Prior Year Contractuals | (1,281) | (890) | (391) | -43.92% | (945) | (336) | -35.57% |
| 28,237 | 26,841 | 1,396 | 5.20% | 25,692 | 2,544 | 9.90% | Total CY CA - Mgd Care (7,8,9,12,13) | 272,657 | 288,407 | (15,750) | -5.46% | 263,561 | 9,096 | 3.45% |
| 859 | 329 | 530 | 161.20% | 419 | 441 | 105.31% | Charity | 3,824 | 3,573 | 250 | 7.01% | 2,489 | 1,335 | 53.63% |
| 1,695 | 1,942 | (247) | -12.73% | 12 | 1,683 | 14,389.04% | Bad Debt | 13,078 | 21,092 | (8,014) | -37.99% | 15,424 | (2,346) | -15.21% |
| 2,591 | 4,119 | (1,529) | -37.11% | 4,815 | (2,224) | -46.19% | Other Deductions | 39,800 | 44,573 | (4,773) | -10.71% | 41,040 | (1,240) | -3.02% |
| 49,202 | 49,022 | 180 | 0.37% | 45,408 | 3,794 | 8.36% | Total Revenue Deductions (incl Bad Debt) | 503,446 | 527,283 | (23,837) | -4.52% | 474,023 | 29,423 | 6.21% |
| 14,722 | 13,662 | 1,060 | 7.76% | 13,334 | 1,388 | 10.41% | Cash Revenue | 153,051 | 157,194 | (4,143) | -2.64% | 151,126 | 1,925 | 1.27% |
| | | | | | | | **OPERATING EXPENSES** | | | | | | | |
| 3,770 | 3,705 | 65 | 1.77% | 3,677 | 94 | 2.55% | Salaries and Wages | 42,614 | 42,946 | (332) | -0.77% | 42,362 | 252 | 0.59% |
| | | | | | | | Contract Labor | | | | | 6 | (6) | -100.00% |
| 958 | 978 | (20) | -2.01% | 1,061 | (103) | -9.68% | Employee Benefits | 11,539 | 11,337 | 201 | 1.78% | 11,268 | 270 | 2.40% |
| 2,450 | 2,195 | 255 | 11.61% | 2,542 | (92) | -3.62% | Supply Expense | 25,181 | 25,214 | (33) | -0.13% | 25,195 | (14) | -0.06% |
| 241 | 249 | (8) | -3.32% | 152 | 89 | 58.81% | Professional Fees | 2,316 | 2,991 | (675) | -22.57% | 1,554 | 762 | 49.01% |
| 1,204 | 1,200 | 3 | 0.27% | 1,191 | 13 | 1.10% | Contract Services | 13,570 | 14,093 | (524) | -3.72% | 13,253 | 316 | 2.39% |
| 330 | 260 | 70 | 26.82% | 309 | 20 | 6.58% | Repairs and Maintenance | 3,455 | 3,336 | 119 | 3.58% | 3,361 | 95 | 2.82% |
| 137 | 135 | 1 | 0.79% | 151 | (15) | -9.68% | Rents and Leases | 1,911 | 1,649 | 262 | 15.86% | 1,826 | 85 | 4.66% |
| 170 | 147 | 23 | 15.55% | 146 | 25 | 16.85% | Utilities | 2,079 | 2,066 | 13 | 0.65% | 1,977 | 102 | 5.18% |
| (356) | (436) | 81 | 18.53% | (260) | (96) | -36.92% | Insurance | 1,772 | 1,716 | 56 | 3.27% | 1,336 | 437 | 32.68% |
| | | | | | | | Investment Income | | | | | | | |
| 94 | 107 | (13) | -12.14% | (229) | 322 | 141.02% | Non-Income Taxes | 1,041 | 1,282 | (241) | -18.80% | 1,121 | (80) | -7.10% |
| 272 | 220 | 52 | 23.74% | 312 | (40) | -12.73% | Other Operating Expense | 2,564 | 2,653 | (89) | -3.36% | 2,443 | 120 | 4.91% |
| 9,271 | 8,761 | 510 | 5.82% | 9,053 | 218 | 2.41% | Cash Expense | 108,041 | 109,284 | (1,243) | -1.14% | 105,702 | 2,339 | 2.21% |
| 5,451 | 4,901 | 550 | 11.23% | 4,281 | 1,170 | 27.33% | EBITDA | 45,010 | 47,910 | (2,900) | -6.05% | 45,424 | (414) | -0.91% |
| | | | | | | | **CAPITAL AND OTHER COSTS** | | | | | | | |
| 626 | 556 | 70 | 12.67% | 532 | 94 | 17.70% | Depreciation & Amortization | 7,017 | 6,681 | 336 | 5.03% | 7,021 | (3) | -0.04% |
| | | | | | | | Other Non-Operating Expenses | | | | | | | |
| 7,856 | (1,641) | 9,496 | 578.85% | (1,551) | 9,407 | 606.44% | Interest Expense | (9,907) | (18,487) | 8,580 | 46.41% | (16,656) | 6,748 | 40.52% |
| (1,111) | 1,064 | (2,175) | -204.47% | 30 | (1,141) | -3,864.78% | Mgmt Fees and Markup Cost | 10,589 | 12,763 | (2,175) | -17.04% | 10,942 | (354) | -3.23% |
| | | | | | | | Minority Interest | | | | | | | |
| 7,371 | (21) | 7,392 | 14,799.90% | (990) | 8,360 | 844.73% | Total Capital and Others | 7,699 | 958 | 6,741 | 703.76% | 1,307 | 6,391 | 488.93% |
| (1,920) | 4,922 | (6,842) | -139.00% | 5,271 | (7,190) | -136.42% | Pretax Income | 37,312 | 46,952 | (9,640) | -20.53% | 44,117 | (6,805) | -15.43% |
| | | | | | | | **TAXES ON INCOME** | | | | | | | |
| | | | | | | | Federal Income Taxes | | | | | | | |
| | | | | | | | State Income Taxes | | | | | | | |
| | | | | | | | Total Taxes on Income | | | | | | | |
| (1,920) | 4,922 | (6,842) | -139.00% | 5,271 | (7,190) | -136.42% | Net Income | 37,312 | 46,952 | (9,640) | -20.53% | 44,117 | (6,805) | -15.43% |

**HCA Holdings, Inc.**

**Condensed Consolidated Income Statements**

**For the Years Ended December 31, 2011 and 2010**

**(Dollars in millions, except per share amounts)**

2012 JUN 19 PM 4 29

| | 2011 | | 2010 | |
|---|---|---|---|---|
| | **Amount** | **Ratio** | Amount | Ratio |
| Revenues before provision for doubtful accounts | **$32,506** | | $30,683 | |
| Provision for doubtful accounts | **2,824** | | 2,648 | |
| Revenues | **29,682** | **100.0 %** | 28,035 | 100.0 % |
| Salaries and benefits | **13,440** | **45.3** | 12,484 | 44.5 |
| Supplies | **5,179** | **17.4** | 4,961 | 17.7 |
| Other operating expenses | **5,470** | **18.5** | 5,004 | 17.9 |
| Electronic health record incentive income | **(210)** | **(0.7)** | - | - |
| Equity in earnings of affiliates | **(258)** | **(0.9)** | (282) | (1.0) |
| Depreciation and amortization | **1,465** | **4.9** | 1,421 | 5.0 |
| Interest expense | **2,037** | **6.9** | 2,097 | 7.5 |
| Gains on sales of facilities | **(142)** | **(0.5)** | (4) | - |
| Gain on acquisition of controlling interest in equity investment | **(1,522)** | **(5.1)** | - | - |
| Impairments of long-lived assets | **-** | **-** | 123 | 0.4 |
| Losses on retirement of debt | **481** | **1.6** | - | - |
| Termination of management agreement | **181** | **0.6** | - | - |
| | **26,121** | **88.0** | 25,804 | 92.0 |
| Income before income taxes | **3,561** | **12.0** | 2,231 | 8.0 |
| Provision for income taxes | **719** | **2.4** | 658 | 2.4 |
| Net income | **2,842** | **9.6** | 1,573 | 5.6 |
| Net income attributable to noncontrolling interests | **377** | **1.3** | 366 | 1.3 |
| Net income attributable to HCA Holdings, Inc. | **$2,465** | **8.3** | $1,207 | 4.3 |
| Diluted earnings per share | **$4.97** | | $2.76 | |
| Shares used in computing diluted earnings per share (000) | **495,943** | | 437,347 | |

**HCA Holdings, Inc.**
**Supplemental Non-GAAP Disclosures**
**Operating Results Summary**
**(Dollars in millions, except per share amounts)**

| | Fourth Quarter | | For the Years Ended December 31, | |
|---|---|---|---|---|
| | 2011 | 2010 | 2011 | 2010 |
| Revenues | $7,769 | $7,161 | $29,682 | $28,035 |
| Net income attributable to HCA Holdings, Inc. | $1,935 | $283 | $2,465 | $1,207 |
| Gains on sales of facilities (net of tax) | (84) | (3) | (80) | (2) |
| Gain on acquisition of controlling interest in equity investment (net of tax) | (1,424) | - | (1,424) | - |
| Impairments of long-lived assets (net of tax) | - | 2 | - | 77 |
| Losses on retirement of debt (net of tax) | - | - | 303 | - |
| Termination of management agreement (net of tax) | - | - | 149 | - |
| Net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement (a) | 427 | 282 | 1,413 | 1,282 |
| Depreciation and amortization | 387 | 359 | 1,465 | 1,421 |
| Interest expense | 465 | 526 | 2,037 | 2,097 |
| Provision for income taxes | 253 | 169 | 769 | 702 |
| Net income attributable to noncontrolling interests | 107 | 111 | 377 | 366 |
| Adjusted EBITDA (a) | $1,639 | $1,447 | $6,061 | $5,868 |
| Diluted earnings per share: | | | | |
| Net income attributable to HCA Holdings, Inc. | $4.25 | $0.65 | $4.97 | $2.76 |
| Gains on sales of facilities | (0.18) | (0.01) | (0.16) | (0.01) |
| Gain on acquisition of controlling interest in equity investment | (3.13) | - | (2.87) | - |
| Impairments of long-lived assets | - | - | - | 0.18 |
| Losses on retirement of debt | - | - | 0.61 | - |
| Termination of management agreement | - | - | 0.30 | - |
| Net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement (a) | $0.94 | $0.64 | $2.85 | $2.93 |
| Shares used in computing diluted earnings per share (000) | 455,460 | 437,568 | 495,943 | 437,347 |

(a) Net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA should not be considered as measures of financial performance under generally accepted accounting principles ("GAAP"). We believe net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are important measures that supplement discussions and analysis of our results of operations. We believe it is useful to investors to provide disclosures of our results of operations on the same basis used by management. Management relies upon net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA as the primary measures to review and assess operating performance of its hospital facilities and their management teams.

Management and investors review both the overall performance (including; net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and GAAP net income attributable to HCA Holdings, Inc.) and operating performance (Adjusted EBITDA) of our health care facilities. Adjusted EBITDA and the Adjusted EBITDA margin (Adjusted EBITDA divided by revenues) are utilized by management and investors to compare our current operating results with the corresponding periods during the previous year and to compare our operating results with other companies in the health care industry. It is reasonable to expect that gains on sales of facilities, impairments of long-lived assets and losses on retirement of debt will occur in future periods, but the amounts recognized can vary significantly from period to period, do not directly relate to the ongoing operations of our health care facilities and complicate period comparisons of our results of operations and operations comparisons with other health care companies.

Net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are not measures of financial performance under GAAP, and should not be considered as alternatives to net income attributable to HCA Holdings, Inc. as a measure of operating performance or cash flows from operating, investing and financing activities as a measure of liquidity. Because net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are not measurements determined in accordance with GAAP and are susceptible to varying calculations, net income attributable to HCA Holdings, Inc., excluding gains on sales of facilities, gain on acquisition of controlling interest in equity investment, impairments of long-lived assets, losses on retirement of debt and termination of management agreement and Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

**HCA Holdings, Inc.**
**Condensed Consolidated Balance Sheets**
**(Dollars in millions)**

| | December 31, 2011 | September 30, 2011 | December 31, 2010 |
|---|---|---|---|
| **ASSETS** | | | |
| Current assets: | | | |
| Cash and cash equivalents | $373 | $359 | $411 |
| Accounts receivable, net | 4,533 | 3,925 | 3,832 |
| Inventories | 1,054 | 891 | 897 |
| Deferred income taxes | 594 | 643 | 931 |
| Other | 679 | 875 | 848 |
| Total current assets | 7,233 | 6,693 | 6,919 |
| Property and equipment, at cost | 28,075 | 26,647 | 25,641 |
| Accumulated depreciation | (15,241) | (15,002) | (14,289) |
| | 12,834 | 11,645 | 11,352 |
| Investments of insurance subsidiaries | 548 | 545 | 642 |
| Investments in and advances to affiliates | 101 | 837 | 869 |
| Goodwill and other intangible assets | 5,251 | 2,701 | 2,693 |
| Deferred loan costs | 290 | 297 | 374 |
| Other | 641 | 1,038 | 1,003 |
| | $26,898 | $23,756 | $23,852 |
| **LIABILITIES AND STOCKHOLDERS' DEFICIT** | | | |
| Current liabilities: | | | |
| Accounts payable | $1,597 | $1,334 | $1,537 |
| Accrued salaries | 965 | 876 | 895 |
| Other accrued expenses | 1,585 | 1,336 | 1,245 |
| Long-term debt due within one year | 1,407 | 725 | 592 |
| Total current liabilities | 5,554 | 4,271 | 4,269 |
| Long-term debt | 25,645 | 25,871 | 27,633 |
| Professional liability risks | 993 | 993 | 995 |
| Income taxes and other liabilities | 1,720 | 1,683 | 1,608 |
| Total liabilities | 33,912 | 32,818 | 34,505 |
| Equity securities with contingent redemption rights | - | - | 141 |
| **EQUITY (DEFICIT)** | | | |
| HCA Holdings, Inc. stockholders' deficit | (8,258) | (10,194) | (11,926) |
| Noncontrolling interests | 1,244 | 1,132 | 1,132 |
| Total deficit | (7,014) | (9,062) | (10,794) |
| | $26,898 | $23,756 | $23,852 |

# C, Orderly Development--7(C)
# TDH Inspection & Plan of Correction

# Board for Licensing Health Care Facilities

State of Tennessee

0000000033

No. of Beds 0188

## DEPARTMENT OF HEALTH

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

HCA HEALTH SERVICES OF TENNESSEE, INC. *to conduct and maintain a*

*Hospital* SUMMIT MEDICAL CENTER

*Located at* 5655 FRIST BOULEVARD, HERMITAGE

*County of* DAVIDSON *, Tennessee.*

*This license shall expire* APRIL 20 *,* 2013 *, 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* 1ST *day of* JULY *,* 2012 *.*

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

*By* Vincent T. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

*By* [illegible]

COMMISSIONER

# Summit Medical Center

Hermitage, TN

has been Accredited by

## The Joint Commission

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

Hospital Accreditation Program

**April 25, 2009**

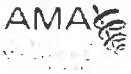
Accreditation is customarily valid for up to 39 months.

David L. Nahrwold, M.D.
Chairman of the Board

Organization ID #7806
Print/Reprint Date: 7/10/09

Mark Chassin, M.D.
President

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



# CERTIFICATE OF DISTINCTION

*has been awarded to*

## Summit Medical Center
## Hermitage, TN

*for Advanced Certification as a*

## Primary Stroke Center

*by*

## The Joint Commission

*based on a review of compliance with national standards, clinical guidelines and outcomes of care*

## November 29, 2011

*Certification is customarily valid for up to 24 months.*

Organization ID#7806

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

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

AMA

# Summit Medical Center

## Hermitage, TN

has been Accredited by

# The Joint Commission

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

Hospital Accreditation Program

## April 25, 2009

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold, M.D.
Chairman of the Board

Organization ID #7806
Print/Reprint Date: 7/10/09

Mark Chassin, M.D.
President

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

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

**Organization Identification Number: 7806**

**Program(s)**
Hospital Accreditation Program

**Surveyor(s) and Survey Date(s)**
John E. Eiland, MSN, RN - (04/21 - 04/23/2009)
(04/24 - 04/24/2009)
William J. Elberson, MD - (04/21 - 04/23/2009)
(04/24 - 04/24/2009)
Thomas M. Messer, CHFM, MBA - (04/21 - 04/21/2009)

**Executive Summary**

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

# The Joint Commission
## Summary of Findings

**DIRECT Impact Standards:**

| | | |
|---|---|---|
| **Program:** | Hospital Accreditation Program | |
| **Standards:** | EC.02.01.01 | EP8 |
| | MM.05.01.01 | EP8 |

**INDIRECT Impact Standards:**

| | | |
|---|---|---|
| **Program:** | Hospital Accreditation Program | |
| **Standards:** | LD.04.01.07 | EP2 |
| | LS.02.01.10 | EP5,EP9 |
| | MM.04.01.01 | EP13 |

# The Joint Commission
# Findings

**Chapter:** Environment of Care

**Program:** Hospital Accreditation Program

**Standard:** EC.02.01.01

**Standard Text:** The hospital manages safety and security risks.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

8. The hospital controls access to and from areas it identifies as security sensitive.

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s)**

EP 8
Observed in Tracer Activity at Summit Imaging site.
It was noted that nuclear material was delivered to the Nuclear Laboratory before the clinic was opened and the delivery personnel had complete and unmonitored access to the entire clinic. The delivery personnel were provided the combination to the lab by clinic personnel. The landlord of the building provided at least one key to the delivery agency. It was unclear if or how many extra keys to the clinic were distributed to nonemployees or what other non-organizational entities had access to the clinic.

Additionally, there were times when the individual opening the clinic at the beginning of the day would unlock a side door to the clinic to allow other staff to enter the clinic. This would permit nonemployees an unmonitored access to the clinic as well.

Permitting nonemployees to have open and unmonitored access to the entire clinic as well as secure areas within the clinic exposes the organization to potential security risks.

---

**Chapter:** Leadership

**Program:** Hospital Accreditation Program

**Standard:** LD.04.01.07

**Standard Text:** The hospital has policies and procedures that guide and support patient care, treatment, and services.

**Primary Priority Focus Area:** Communication

**Element(s) of Performance:**

2. The hospital manages the implementation of policies and procedures. (See also NR.02.03.01, EP 2)

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s)**

EP 2
Observed in Infection Control Session at Summit Medical Center site.
During the document review and Infection Control Session, it was noted that the previous annual summary only addressed seven surveillance activities. Likewise the current annual risk assessment included only those seven points which required no prioritization due to the minimal resources required. This represented only a fraction of the activities conducted by the Infection Control Department; some of which were critical elements to the execution of an effective infection control program. As a result, the annual summaries, the program's general goals and the committee's interventions as evidenced in meeting minutes were not congruent and not interrelated.

---

**Chapter:** Life Safety

**Program:** Hospital Accreditation Program

**Standard:** LS.02.01.10

**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

5. Doors required to be fire-rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)

**Scoring Category :** C
**Score :** Insufficient Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

**Scoring Category :** C
**Score :** Insufficient Compliance

**Observation(s)**

EP 5
Observed in environmental tours at Summit Medical Center site.
The smoke door on 6th floor South had a vertical gap greater than 1/8 inch.

Observed in environmental tours at Summit Medical Center site.
While tracing a patient, it was noted that the fire door leading to the imaging suites was ajar. The door was prevented from closing by a malfunctioning latch. The latch was repaired before the end of the survey.

Observed in environmental tours at Summit Medical Center site.
While tracing a patient, it was noted that a fire door leading to the imaging suite did not latch positively when closed.

EP 9
Observed in the building tour at Summit Medical Center site.
A three inch sleeve used to allow wiring to pass through in the smoke barrier located adjacent to room 710 did not have fire rated material installed to a sufficient quantity to prevent the passage of smoke.

Observed in the building tour at Summit Medical Center site.
A three inch sleeve used to allow wiring to pass through in the smoke barrier located adjacent to room 402 did not have fire rated material installed to a sufficient quantity to prevent the passage of smoke.

Observed in the building tour at Summit Medical Center site.
A one inch sleeve used to allow wiring to pass through in the smoke barrier located adjacent to room 301 did not have fire rated material installed to a sufficient quantity to prevent the passage of smoke.

---

**Chapter:** Medication Management

**Program:** Hospital Accreditation Program

**Standard:** MM.04.01.01

**Standard Text:** Medication orders are clear and accurate.

**Primary Priority Focus Area:** Medication Management

**Element(s) of Performance:**

13. The hospital implements its policies for medication orders.

**Scoring Category :** C
**Score :** Insufficient Compliance

**Observation(s)**

EP 13
Observed in a patient record at Summit Medical Center site.
While tracing a patient, it was noted that an order for medication used to treat airway constriction lacked a dose. The order was filled and the medication administered without clarification.

Observed in tracer activity at Summit Medical Center site.
Organization policy requires medications to be re-ordered when a patient is transferred to a different level of care, A patient was transferred to the MICU and a medication was continued despite the fact that an order to continue the medication was not obtained.

Observed in 5th Floor at Summit Medical Center site.
During an individual patient tracer activity, it was noted that a medication order "continue previous orders" was written 4/14/2009 following a surgical procedure.

Observed in 5th Floor at Summit Medical Center site.
Further, similar orders were rewritten by the surgeon two more times following additional surgical interventions. There was no indication that the orders were clarified by Medical, Nursing nor Pharmacy staff.

---

**Chapter:** Medication Management

**Program:** Hospital Accreditation Program

**Standard:** MM.05.01.01

**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

**Element(s) of Performance:**

8. All medication orders are reviewed for the following: Therapeutic duplication.

**Scoring Category :** C
**Score :** Partial Compliance

**Observation(s)**

EP 8
Observed in 5th Floor at Summit Medical Center site.
During an individual patient tracer activity, it was noted that two oral pain medications, Lortab and Percocet, were both ordered prn pain with no delimiting criteria to aid the nurse in choosing one medication over the other.

Observed in 5th Floor at Summit Medical Center site.
Additionally, besides the initial order for the two oral narcotics, the medications were reordered following three surgical interventions without further clarification by Medical, Pharmacy or Nursing staff.

---

# SUPPORT LETTERS

Continued from last column

see and must be acceptable to the **City of Murfreesboro**.

If a check is offered as guaranty, the check of the successful bidder will be cashable at the discretion of the **City of Murfreesboro**, pending the satisfactory execution and acceptance of the contract and the contract bond.

**ISSUANCE OF BIDDING DOCUMENTS**

This **City of Murfreesboro** and the Tennessee Department of Transportation are on a cash basis for sales of Plans, Proposal Contracts, Standard Specifications, Standard Drawings, Standard Drawing Books and Tabulations of Bids. Requests for documents must be accompanied by cash, check, money order, or they may be mailed to the buyer

month period will be furnished at **$10.00** per sheet. Individual Plan sheets and individual Standard Drawings will be furnished at **$10.00** per sheet. Tabulations of bids will be furnished at **$10.00** per sheet. Tennessee Department of Transportation Standard Drawing Books will be furnished by the Tennessee Department of Transportation at **$100.00** per book plus **9.25%** sales tax, for in-state delivery. Tennessee Department of Transportation Standard Specifications for Road and Bridge Construction, dated March 1, 2006, will be furnished by the Tennessee Department of Transportation at **$12.00** per book plus **9.25%** sales tax, for in-state delivery. There will be a minimum charge of $2.00 on any purchase. All documents will be furnished without refund and transmitted at your risk.

When two or more contractors wish to bid together in a joint venture, each contractor will be required to make a written request for such a proposal to the City of Murfreesboro. This request shall be signed by an authorized signatory of each firm.

Requests for joint venture proposals may be made in person or by telephone. However, the proposal for said joint venture will not be issued until the request in writing, as

Continued to next column

Continued from last column

set forth above, is received by the **City of Murfreesboro**.

**REJECTION OF PROPOSALS**

Proposals will be rejected as irregular if prior to the formal opening of the Proposal all of the following documents have not been signed: (1) the bidder shall sign by written signature the Proposal form, (2) the bidder shall sign by written signature the Proposal Certification form, (3) the bidder shall sign by written signature the Proposal Bond form or the Proposal Guarantee, whichever is applicable, (4) the Agent or Attorney-in-Fact representing a Surety Company shall sign by written signature the Proposal Bond, if applicable. In addition, Proposals will be rejected if any of the above signatures are a repro-

"Proposals shall be completed on the forms as issued. Please review a part of Subsection 102.02 of the Tennessee Department of Transportation Standard Specifications stating: "All of the documents that are bound therein are part of the Proposal and shall not be detached." Proposals shall not be taken apart. Proposals taken apart may be subject to rejection. Also, please review a part of Subsection 102.09 of the Tennessee Department of Transportation Standard Specifications stating: "Proposals will be rejected as being irregular if they are not prepared on the prescribed forms; if they show any omissions, alterations of form, additions, or conditions not called for, unauthorized alternate bids, or ir-

Continued to next column

Continued from last column

regularities of any kind; or if they fail to contain a unit price for each item listed." Proposals shall be completed on the forms as issued. Photostatic or facsimile copies of Proposal sheets may not be attached to the Proposal. Proposals containing forms not issued by the **City of Murfreesboro** may be subject to rejection.

**ADDENDA**

Addenda to the Proposal will be acknowledged by all bidders. Failure to acknowledge receipt of Addendum Letters is grounds for rejection.

**RETAINAGE**

Effective for all contracts, the City of Murfreesboro will not hold retainage. In addition, the Contractor will not be able to hold retainage from the subcontractor.

**SUBCONTRACTS**

**PRE-BID MEETING**

A Mandatory Pre-bid meeting will be held at **10:00 AM on June 19, 2012** at Room 218, City Hall, 111 West Vine Street, Murfreesboro, TN. Representatives of Owner and Engineer shall be present to discuss the project.

**Rob Lyons**
**City of Murfreesboro**
**Officer**

0101560443

**MEETING NOTICE**

"Mid-Cumberland Area Development will have their Annual Meeting and Luncheon on Thursday June 14th at The Palm Restaurant, 140 5th Avenue South, Nashville, TN 37203 from 11:30 to 1:30. The regularly scheduled meetings will resume at Pathway Lending, 201 Venture Circle, Nashville, TN 37228 at 1:30 on the 1st

Continued to next column

Continued from last column

and 3rd Thursday of the month starting in July. Should you have any questions do not hesitate to call."

2012 JUN 14 PM 1 23

cars.com

Also search Tennessean Classifieds at www.tennessean.com, click on Classifieds.

Automotive

0101560258

**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. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to establish a twenty (20) bed acute inpatient rehabilitation unit and service in its hospital facility at 5655 Frist Boulevard, Hermitage, TN 37076, at a capital cost estimated at $2,500,000. The unit will be created by converting 20 adult psychiatric beds to inpatient rehabilitation beds and reclassifying the adult psychiatric unit as an inpatient rehabilitation unit. The adult psychiatric patients will be transferred to the existing adult inpatient psychiatric program at Skyline Medical Center, Madison, a sister facility.

Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will not change its licensed hospital bed complement or initiate any other health service or include any major medical equipment.

The anticipated date of filing the application is on or before June 15, 2012. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

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**
**500 Deaderick Street, Suite 850**
**Nashville, Tennessee 37243**

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection 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.

SUNDT

Sundt Construction, Inc. is soliciting certified Small Disadvantaged, Veteran-Owned, Service Disabled Veteran-Owned, Women-Owned, and HUBZone Small Business Companies, who are interested in proposing on Sundt Construction's UEPH Barracks Project at Fort Campbell, KY

Interested companies must be capable of being certified as a Small Business Enterprise.

For more information regarding this project please contact Casey Sundt via e-mail @ cjsundt@sundt.com

Equal Employment Opportunity Employer

TN-0101560312

## Antique/Classic Vehicles

**CADILLAC ELDORADO '98** 2 door, Black interior, Black exterior, 31,000 mi., V8, Cyl., 2WD AM/FM Stereo, A/C, alloy wheels, bucket seating, cassette, cruise, Side Airbag, leather int., PDL, Power Seats, Power Sliding Doors, PW, rear A/C Classic car in mint condion! $8000.00 Call(615)794-5348 or(615)957-7990

**CHEVROLET CAMARO '92,** 25th Anniv Ed. 5.0 V8. 42,515 1-owner miles. Carport kept. All pwr, T-Tops, $6500. 615-794-7887

**FORD TAURUS SE, '99, 4dr, V6 auto, cold ac, falled Marta, good tires, 166k. $1000 Cash +TTL. TNDL 17049. 615-569-6646**

**MERCURY COUGAR '67 XR7**, restored original automobile. 68K mi, dark metallic green, tan leather inter. 289 cu in V-8 auto trans. New tires. Styled wheels, lots of original rec. $11,000. **615-457-0435**

**TRIUMPH TR6 '74**, 77,450 mi, carmine, tan int, tires almost new, new Weber carb, electronic ingition $12,500. 615-654-4819

## Cars

**123 AUTO RECYCLING**
We buy cars, trucks, vans in any cond. Free pick up. No title needed. We beat any reasonable offer. Cash paid on spot. 615-935-5023

**#1 CASH AUTO BUYER**
Maximum Ca$h Paid
We Beat Competitor $$
Minimum Paid $300-$750
Any Make/Model Condition
615-767-3484
Instant Cash

**ACCURA TL '08,** w/nav. Bronz w/lt gray leather. Nice car w/great gas mileage. Non smoker. $19,500. 615-370-1374

... should be on everyone. $32,500. (615)873-0542

**AUDI S4 CABRIOLET '08** Brilliant Black w/Black, 35K, 6 spd, loaded, warr, **$33,900**+ttl, no doc fee. A3225. 615-300-6001
**cox-motorcars.com**

**BENTLEY ARNAGE '05 R 4 dr, black/black, 15,300 mi. locally owned. Service recs. Pristine! $84,500 615-777-AUTO (2886) www.neatcars.com**

**BMW 335i Sport Convertible '08** Platinum Bronze w/Beige, 17K, nav, loaded, warr. **$33,900**+ttl, no doc fee. B7112. 615-300-6001
**cox-motorcars.com**

**BMW 528i '09** Monaco w/Natural Brown, 56K mi, loaded, warr., **$24,900**+ttl, no doc fee. B4412. 615-300-6001
**cox-motorcars.com**

**BMW 528i SPORT '09** Monaco w/Natural Brown, 26K, loaded, warranty. **$30,900** +ttl, no doc fee. B5661. 615-300-6001
**cox-motorcars.com**

**BMW 535i '09** Black w/Charcoal, 24K, loaded, warr. **$32,900**+ttl, no doc fee. B2311. 615-300-6001
**cox-motorcars.com**

**BMW 535xi '09** Black Sapphire w/Natural Brown, 60K mi., loaded, warr., **$25,900**+ttl, no doc fee. B4212. 615-300-6001
**cox-motorcars.com**

**BMW 535xi SPORT '09** Deep Sea w/Natural Brown, 44K mi., loaded, warr., **$29,900**+ttl, no doc fee. B8136. 615-300-6001
**cox-motorcars.com**

**BMW 750 Li '07,** blue, black leather, sport pkg, premium sound, DVD. Certified pre-owned. 58K mi. $33,000. 615-804-4934.

**BMW X3.3 SI '08 Black, 58k mi, AWD, 4 dr, auto, loaded, clean CarFax, lady driven, garaged, MINT! $25,900. Call 615-423-8989**

**BUICK PARK AVE '00** Ultra, 157K mi, pewter, everything in good working cond, sunroof, good tires, all electric. $3900. Call Mark, 615-556-8878

ADMIT ONE

## Cars

**FORD ESCORT '99, 4 cyl auto gas saver wagon. New ac, tires, roof rack. 129k. $2999 Cash +TTL. TNDL 17049. 615-569-6646**

**FORD FOCUS '06 SES** Auto, PW, PL, remote entry, safety pkg, alloy wheels, sporty & economical $4,780. 615-330-3152

**FORD MUSTANG '06** GT, 2DR, auto, leather, adult owned, low miles, new tires. Excellent cond. $13,500. Call 615-865-7809

**FORD MUSTANG '97 GT** ... roof, exc cond, garage kept, 196k mi, $4500. 615-824-7389 or 615-545-6422

**LEXUS ES330 '06** immaculate, 90k, 2nd owner, gar kept, non-smoker, 100K mi bumper-bumper warr, clean carfax, Sedbos Inc $20,500 obo. 615-838-1843

**LINCOLN TOWN CAR '07** cruise, tilt, power seats, proportional power steering, 615-591-5060 $16,901 plus $299 doc fee plus TTL P5851 TNDL#3955

**MERCEDES-BENZ 450SL '76** 2dr Convertible, cass./am/fm 2 WD, 8 cyl, 109,500 mi., Silver, $7,500, 615-758-3685

**MERCEDES-BENZ C300 AMG SPORT '11** Black w/Light Gray, 22K, loaded, warr. **$27,900**+ttl, no doc fee. M0911. 615-300-6001
**cox-motorcars.com**

**MERCEDES BENZ E350 '06,** 64K mi. Gray w/charcoal int. Excellent condition! $19,950 obo. Call 615-496-6005.

**MERCEDES BENZ E350 AMG SPORT '09** Barolo Red w/Cashmere, 25K mi., NAV, loaded, warr., **$31,900**+ttl, no doc fee. M7243. 615-300-6001
**cox-motorcars.com**

**MERCEDES-BENZ E350 SPORT '08** Iridium Silver w/ Charcoal, 53K, loaded, warr. **$24,900**+ttl, no doc fee. M4412. 615-300-6001
**cox-motorcars.com**

**MERCEDES-BENZ E350 SPORT '11** Arctic White w/Charcoal, 29K, loaded, warr. **$43,900**+ttl, no doc fee. M7782. 615-300-6001
**cox-motorcars.com**

**MERCEDES-BENZ S550 '07** Flint Gray w/Charcoal, 66K mi, loaded, warr. **$33,900**+ttl, no doc fee. M8210. 615-300-6001
**cox-motorcars.com**

**MERCEDES-BENZ S550 AMG SPORT '08** Black w/Savanna, 33K, loaded, warr. **$48,900**+ttl, no doc fee. M3655. 615-300-6001
**cox-motorcars.com**

**MERCURY GRAND MARQUIS 07** LS, Local Trade, 46K Miles, White w/Leather. Call Danny Cotton ...

13

tic... Ticke... TITANS S... 2012. ... 234, ... Level, ... Parking ... $2570 ea...
Your ticke... every Fr...

TOYOTA ... auto, 138... CD/cass. ... New timi... Runs/driv... 559-772-1...

TOYOTA ... Roomy & great! $2... TNDL 1704...

Mot...

IMPOR... Use cauti... to wire mo... In some ca... been tra... no vehicle...

HARLEY HERITAG... 11K+ mi, New Tire... $9300. ...

HARLEY Softail ... Black, 145... rage kept, ... mi, $12,000...

HARLEY DA... '06, Black ... Screaming ... kit, small ... $4900, 6...

HARLEY O... CHOPPER ... 1200 cc. ... $2900.00 C... 5468. Ride ...

HONDA 750 ... '03 5500 m... garage kept ... dle bags, lik... OBO. Call 61...

HONDA GO... MUST ... ited '85 New ... kept 23000 ... sell becaus... health $250... 615-672-168...

KAWASAKI Z... 1 owner, lik... garage kept, ... rear tire, $45... 615-405-4788...

Sport ... Vehi...

IMPORTA... Use caution ... to wire money ... In some case ... been trans... no vehicle w...

BMW X3.3 S... 58k mi, AWD ... loaded, clean ... driven, gara... $25,900. Call 6...

CHEVROLET ... 6-Speed,, T... Green exteri...

# Skyline Medical Center

TRI STAR HEALTH SYSTEM

2012 JUN 14 PM 4 37

June 11, 2012

Greg Caples
Chief Operating Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076-2053

Dear Greg,

Please accept this letter of support for the consolidation of Summit's adult psychiatric patients at Skyline Madison Campus.

Please be assured that we have the capacity at Skyline Madison Campus to absorb your current annual admissions and inpatient days.

I look forward to working with your team during this process.

Respectfully,

Steve Otto
Chief Executive Officer

SAO/th



3441 Dickerson Pike • Nashville, TN 37207 • 615-769-2000
www.tristarhealth.com

**AFFIDAVIT**

2012 JUN 14 PM 4 29

STATE OF TENNESSEE

COUNTY OF DAVIDSON

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

SIGNATURE/TITLE

Sworn to and subscribed before me this 14th day of June (Month), 2012 (Year) a Notary Public in and for the County/State of Davidson Co. Tennessee.

RANDAL P. WALL STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY MY COMMISSION EXPIRES 9-9-2014

NOTARY PUBLIC

My commission expires September 9 (Month/Day), 2014 (Year).

# SUPPLEMENTAL

DSG Development Support Group

2012 JUN 22 PM 3 48

June 22, 2012

Philip M. Wells, FACHE, Health Planner III
Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

RE: CON Application CN1206-029
Summit Medical Center--Initiation of Inpatient Rehabilitation Services & Conversion of 20 Psychiatric Beds to 20 Inpatient Rehabilitation Beds

Dear Mr. Wells:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section B, Project Description, Item III (Plot Plan)**

   **Your response is noted. However the outline of the building's first floor footprint is blacked-in, not allowing for the display of where the project's construction is proposed to occur on the third floor. Please provide a revised drawing displaying the outline of the patient tower where the third floor remodeling is proposed to occur.**

   An improved plot plan with the requested information will be submitted under separate cover.

2. **Section B, Project Description, Item II B.**

   **The applicant indicates the adult inpatient psychiatric patients who would be admitted to the current adult inpatient psychiatric unit will be transferred and referred to TriStar's Skyline Madison's adult behavior unit.**

   **In order to affirm Skyline Madison's capacity to absorb the patient volumes by the closing of Summit's adult psych unit, please provide the following information regarding Summit's and Skyline's adult psychiatric programs.**



4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

The requested table is provided below. We have added two rows to demonstrate that the psychiatric bed complements at Skyline Madison Medical Center are sufficient to absorb the current census at Summit, which is at its highest in three years.

| | 2009 | 2010 | 2011 |
|---|---|---|---|
| Summit's Adult Psych Unit | | | |
| Beds | 20 | 20 | 20 |
| ADC | 12.7 | 10.7 | 13.7 |
| Occupancy (%) | 64% | 53% | 69% |
| Skyline Madison's Adult Psych Unit | | | |
| Beds | 100 | 100 | 100 |
| ADC | 58.5 | 55.4 | 61.5 |
| Occupancy (%) | 59% | 55% | 62% |
| | | | |
| COMBINED SUMMIT/SKYLINE MADISON ADC | -- | -- | 75.2 |
| COMBINED OCCUPANCY (ON 100 BEDS AND 2011 DAYS) | -- | -- | 75% |

**3. Section C, Need, Item 1 (Specific Criteria- Inpatient Rehabilitation Services, Item2) and Item 5 (Existing Facilities Capacities and Utilization)**

**The applicant notes there is currently a surplus of rehabilitation beds in Davidson and Wilson Counties, its declared service area. The applicant also notes in several places on pages 18 and 26 of the application, "there are 41 older beds which are designated as rehabilitation beds that are not open and available and are unlikely to become open and available in the foreseeable future, due to licensing issues and other issues." Ten (10) of these forty-one (41) licensed and designated as rehabilitation beds are located at the Skyline-Madison facility. Since the applicant, Summit Medical Center, and Skyline Medical Center–Madison are both HCA facilities and Skyline – Madison will benefit from Summit's willingness to shift its adult psychiatric patients and programming to Skyline-Madison facility, has HCA and Skyline-Madison considered relinquishing the bed licensing for the 10 Skyline-Madison rehabilitation beds which will not be used in the foreseeable future as a partial relief to the Davidson County rehabilitation bed surplus?**

2012 JUN 22 PM 3 48



The applicant understands and appreciates the Agency's efforts to reduce the number of currently unused beds in the market. In recognition of that concern, TriStar hospitals have agreed to voluntarily relinquish a total of 59 licensed beds since 2007. In addition, Skyline Madison recently received approval to convert 11 unused med/surg beds to much-needed C & A psych beds, rather than ask for new C & A beds at the Madison campus. Similarly, the Summit application does not add to areawide hospital bed complements; instead it converts existing beds.

Skyline prefers to retain the 10 currently unused Rehab beds at its Madison campus to allow it flexibility to meet future needs, and feels this preference for flexibility is reasonable in light of the uncertainty in the larger healthcare industry, and in light of the demonstrated need for the rehabilitation beds requested in the Summit application.

4. **Section C, Need, Item 5 (Existing Facilities Capacities and Utilization) Please check the math summation on the first two columns regarding facility bed capacities on the chart on page 27 of the application.**

Thank you for noting that due to an error in the totaling formula in the chart, the beds at UMC MacFarland in Lebanon were not included in the totals of existing and approved beds in those first two columns. However, the utilization data and percentages in the other columns and totals were correct, so the narrative and analysis are not affected by the error.

A corrected Supplemental Table Eleven, page27R, is attached following this page.

2012 JUN 22 PM 3 48

5. **Section C, Economic Feasibility, Item 4 (Projected Data Chart)**
**Under "other expense", please explain what "Parallon Allocations" are.**

Parallon is a wholly owned subsidiary of HCA that provides support services for the hospitals and allocates the costs of those services back to the hospitals. The services provided by Parallon include:
--All normal Business Office functions (billing, collections, cashiering, etc)
--Central Scheduling
--Revenue Integrity (chart auditing, charge capture, chargemaster maintenance)
--Credentialing Functions
--Supply Chain - Materials Management, Accounts Payable & Warehouse
--Payroll functions
--Health Information Management (Medical Records) functions

6. **Outstanding CON Project Status Reports**
**Please provide a brief two - three sentence update for the following outstanding CON projects, outlining what stage the project currently stands in its implementation schedule, its projected completion date and whether the project is on schedule to be completed by the completion date and/or CON expiration date:**

Centennial Medical Center, CN0710-079A
The last portion of this project was completed and approved by TDOH in May, 2012. The final report to the HSDA is being prepared.

Centennial Med. Cntr. Satellite Emergency Dept. at Spring Hill, CN1006-023A
The project is under construction with a completion target no later than March, 2012, before the CON expiration date.

StoneCrest Medical Center, CN1107-026A
Final working drawings are about to be submitted for TDH review; the project is scheduled to open within a year, long before the CON expiration date.

Southern Hills Medical Center, CN111-048A
This was approved in February 2012, less than 90 days ago. The applicant is completing final architectural plans and expects to open the project well before its CON expiration date.

**SUPPLEMENTAL- # 1**
**June 22, 2012**
**3:48 pm**



Additional Item From Applicant

Attached is a revised cover page for the application changing the description of the project to a 20-bed application consistent with all the other pages of the application.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

MARK PODY
STATE REPRESENTATIVE
46TH LEGISLATIVE DISTRICT
CANNON, TROUSDALE AND WILSON COUNTIES

203 WAR MEMORIAL BUILDING
NASHVILLE, TENNESSEE 37243-0146
(615) 741-7086
FAX (615) 253-0206

Rep.mark.pody@capitol.tn.gov

# House of Representatives
# State of Tennessee

NASHVILLE

2012 SEP 11 AM 10:08

DISTRICT OFFICE:
113 South Cumberland Street
LEBANON, TENNESSEE
37087

Member of Committees

House Commerce

House Consumer and Employee Affairs

August 29, 2012

Ms. Melanie Hill, Executive Director State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building
5400 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Melanie:

As the State Representative of District 46, I am writing to oppose the Certificate of Need application filed by Summit Medical Center for the establishment of an impatient rehabilitation center in Hermitage. We are justifiably proud of the quality care provided by University Medical Center in Lebanon, including the attentive service the hospital provides in its rehabilitation unit, and wish to preserve that service.

I believe that the approval of a new rehabilitation unit in University Medical Center's service area will endanger University Medical Center's rehabilitation unit. Currently, only 30% of its rehabilitation beds are occupied, and the establishment of an additional rehabilitation unit so close to Lebanon could damage University Medical Center. That negative impact could affect the availability of services, and jobs in Wilson County.

Based on State health planning guidelines, the Nashville Metro area has an excess of rehabilitation beds. All of the rehabilitation units in and around Nashville have vacancies. Another rehabilitation unit, especially one that threatens an established provider such as University Medical Center, is simply unnecessary. Please deny Summit Medical Center's Certificate of Need application.

Sincerely,

Mark A Pody

Mark A. Pody
State Representative

MAP:ds

Cc: Mr. John L. Wellborn
Development Support Group
4219 Hillsboro Road, Suite 230
Nashville, TN 37215

# Tennessee Physical Medicine and Pain Management

**T. Scott Baker, M.D.** **Steven A. Urban, M.D.**

Board Certified in Physical Medicine & Rehabilitation, Pain Medicine and Electrodiagnostic Medicine

PO Box 1165 * 1423 Baddour Parkway * Lebanon, Tennessee 370867 * phone 615-257-0900 * fax 615-443-1444


August 22, 2012

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building
5400 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Dear Ms. Hill:

I am a physician in Wilson County, and I wish to express my opposition to the Certificate of Need application filed by HCA on behalf of Summit Medical Center to establish an inpatient rehabilitation center. I have sent, and continue to send, a number of my patients to University Medical Center's ("UMC") rehabilitation unit in Lebanon. That facility is currently underutilized, and I fear that the establishment of a new rehabilitation center within UMC's service area will draw not only patients but also scarce medical recourses away from UMC's facility. A drain on resources from this area could have a negative impact on the quality of care.

I understand that none of the rehabilitation units in or around Davidson County are close to capacity. Because of the large number of available rehabilitation beds in the greater Nashville area, and given the likely detrimental effect additional rehabilitation units would have on UMC's existing rehabilitation unit, I strongly urge the Tennessee Health Services and Development Agency to deny the Certificate of Need application for Summit Medical Center.

Sincerely,

Thomas Scott Baker

Thomas Scott Baker, M.D.

cc: Mr. John L. Wellborn
Development Support Group
4219 Hillsboro Road, Suite 230
Nashville, Tennessee 37215

LAW OFFICES
GKH
GRANT KONVALINKA & HARRISON, P.C.

2012 SEP 11 AM 9:43

Ninth Floor, Republic Centre
633 Chestnut Street
Chattanooga, Tennessee 37450-0900

Telephone 423/756-8400
Facsimile 423/756-6518
www.gkhpc.com

September 10, 2012

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

**BY FEDERAL EXPRESS**

Re: HCA Summit Medical Center Certificate of Need No. CN1206-029

Dear Ms. Hill:

This firm represents University Medical Center ("UMC") in connection with opposing the certificate of need application filed by HCA Summit Medical Center to establish a 20-bed acute inpatient rehabilitation unit. UMC is a 245-bed full service acute care hospital located in Lebanon, Tennessee, about 20 miles from HCA Summit Medical Center. UMC operates a 26-bed inpatient rehabilitation unit which is currently underutilized. HCA Summit's proposed rehabilitation unit, located within UMC's service area, could well damage UMC, to the detriment of Wilson County residents.

The applicant proposes replacing its current complement of 20 inpatient adult psychiatric beds with the rehabilitation beds and shipping its psychiatric patients to HCA Skyline Medical Center at Madison, in East Nashville. UMC opposes HCA Summit's certificate of need application because the application itself demonstrates that the project is not needed and will not contribute to the orderly development of health care in Tennessee.

HCA Summit attempts to articulate a need for its proposed rehabilitation unit in the context of HCA's master plan for its hospitals in the greater Nashville area. The application fails, however, to demonstrate need in the broader context of delivery of health care in metropolitan Nashville and the surrounding vicinity. Specifically, the application fails to address adequately how the proposed rehabilitation unit conforms to Tennessee's standards and criteria for comprehensive rehabilitation services.

The Tennessee Guidelines for Growth provide that rehabilitation beds are to be determined by applying a guideline of ten beds per 100,000 population in the service area of the proposal. Based on the data in HCA Summit's application, the current service area population is 716,694, and the projected population in 2016 is 739,405. Under the Guidelines, therefore, the service area should have 71 to 74 inpatient rehabilitation beds. Currently, 183 beds are in operation in Davidson and Wilson counties, and 228 total beds have been licensed or approved as inpatient rehabilitation beds.

The Guidelines further provide that additional inpatient rehabilitation beds should not be approved unless existing facilities are utilized at the following levels: 20 to 30 bed unit -75%; 31 to 50 bed unit/facility - 80%; 51 bed + unit/facility - 85%. As noted in the HCA Summit certificate of need application, none of the existing inpatient rehabilitation providers meet or exceed the utilization thresholds provided in the Guidelines.

UMC is located approximately 20 to 25 minutes from HCA Summit Medical Center. As noted in HCA Summit's application, UMC's utilization in its rehabilitation unit over the last four years has consistently been under 30%. Approving an additional rehabilitation unit in such close proximity to UMC would not only reduce UMC's rehabilitation unit census, but also threaten the continued existence of the unit. Residents of Wilson County would likely suffer if this application is approved.

HCA Summit Medical Center's certificate of need application for the establishment of a new 20-bed inpatient rehabilitation unit adjacent to the Wilson County line fails to demonstrate need. Further, the potential damage it would inflict upon UMC and Wilson County evidences a failure to contribute to the orderly development of health care in Tennessee. We therefore respectfully request that the Tennessee Health Services and Development Agency deny HCA Summit Medical Center's certificate of need application.

Sincerely,

J. Scott McDearman

P:\Folders I-Z\u163\001\Univ's ltr opposing con.doc

cc: Mr. John Wellborn
Mr. Saad Ehtisham

Saint Thomas Health

2012 SEP 11 PM 1:27

September 11, 2012

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: Summit Medical Center
CN1206-029

Dear Ms. Hill:

On behalf of Saint Thomas Health and Baptist Hospital, a part of the Saint Thomas Health network of providers, this letter is to express opposition to the Certificate of Need application for Summit Medical Center proposing to establish a 20-bed acute inpatient rehabilitation unit by closing its adult psychiatric unit. After a thorough review of the application, it is clear that the need for the proposed service is not justified and the project does not represent orderly development of healthcare for our region.

Based on review of the application and supplemental material, the following observations are offered:

- Residents of the proposed service area currently have good access to existing inpatient rehabilitation services including four providers in Davidson County and one in Wilson County with varying occupancy levels that range from 29% to 76% for these facilities.
- The project proposes to decrease access to psychiatric services for what is typically a very fragile patient population. It is notable that the census on Summit's psychiatric unit increased in 2011 over levels in the prior two years. While the stated intent is to improve inpatient rehabilitation access for suburban patients, it will have the opposite impact on the suburban psychiatric patients being displaced by the proposal.
- Although not explicitly stated, Summit implies in the application that they had 157 referrals discharged in 2011 to acute rehabilitation programs in the area. This number can be calculated from the following statement in the application: "The impact on non-HCA rehabilitation providers will be minimal. In CY2011, 70% of Summit's discharges to acute rehabilitation programs in Nashville were to sister HCA hospitals. Only 47 patients from Summit were discharged to other service area programs." However, they are projecting 328 discharges in year one of the project and 374 in year two, which is more than double the actual number incurred in the last year. The volume projections for the project seen unrealistic given Summit's actual number of referrals in the last year.

- It is not clear why Skyline Madison is not willing to relinquish unused rehabilitation beds (referred to in the application as "nonoperational for several years") as part of this proposal since the application purposefully does not include those beds in the comparison of market utilization of rehabilitation beds in the service area totals. If included, the occupancy would drop approximately 4% for the service area.

In conclusion, this application should not be approved for the following reasons relative to general criteria for CON:

| | |
|---|---|
| Need | Need has not been substantiated in the application. The proposed service area is currently adequately served by existing service area providers and includes unused licensed inpatient rehabilitation beds owned by HCA in the proposed service area. |
| Economic Factors | Since need has not been substantiated, this duplication of available services adds an unnecessary cost burden and increases overall costs of health care for the public. |
| Contribution to the Orderly Development of Health Care Facilities and/or Services | The proposed facility does not contribute toward the orderly development of health care. It is not orderly development to decrease access for psychiatric patients. In addition, the projected volumes are much higher when compared to current referral volumes. |

Based on the considerations set forth in this letter, we respectfully request the Health Services and Development Agency reject this application for Summit Medical Center.

Respectfully,

Barbara Houchin

Barbara Houchin
Executive Director, Planning

cc: John Wellborn
Saad Ehtisham

**CERTIFICATE OF NEED**
**REVIEWED BY THE DEPARTMENT OF HEALTH**
**DIVISION OF HEALTH STATISTICS**
615-741-1954

**DATE:** August 31, 2012

**APPLICANT:** Summit Medical Center
5655 Frist Boulevard
Hermitage, Tennessee 37076

**CONTACT PERSON:** John L. Wellborn
Development Support Group
4219 Hillsboro Road, Suite 203
Nashville, Tennessee 37215

**COST:** $2,500,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

**SUMMARY:**

The applicant, Summit Medical Center, located in Hermitage (Davidson County), Tennessee, seeks Certificate of Need (CON) approval to establish a twenty bed acute care inpatient rehabilitation unit and service in its hospital facility at 5655 Frist Boulevard. The unit will be created by converting 20 adult psychiatric beds to inpatient rehabilitation beds and reclassifying the adult psychiatric unit as an inpatient rehabilitation unit. The adult inpatient psychiatric patients will be transferred to the existing adult inpatient psychiatric program at Skyline Medical Center, Madison, a sister facility.

Summit Medical Center is a general hospital licensed by the Tennessee Department of Health, Board of Licensing Healthcare Facilities, for 188 hospital beds. This project will not change its licensed hospital bed complement or initiate any other health service or include any major medical equipment.

The projected involves the renovation of 9,626 square feet at an estimated cost of $1,500,000, or approximately $161.02 per square foot. The average renovation costs for CON hospital construction for years 2009 - 2011 range from $125.84 to $273.69 per square foot.

The project will require major renovation and minor renovation on the hospital's third floor, which currently contains a 20-bed inpatient psychiatric unit with support spaces. The project will replace the psychiatric services with an inpatient rehabilitation service of the same bed compliment.

The completed rehabilitation service will include 20 private patient bedrooms with handicapped-accessible/ADA compliant private bathrooms; activities daily living suite with a kitchen, bedroom, and bath; a day room/dining room multi-purpose room, gym, and other patient and staff support spaces.

Summit Medical Center is an HCA TriStar facility owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains an organizational chart and information on Tennessee facilities owned by HCA.

The total estimate project cost is $2,500,000 and will be funded by a cash transfer of the required cost, from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System). Documentation of financing is provided in Attachment C, Economic Feasibility-2.

## GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

**NEED:** The applicant's service area includes Davidson and Wilson counties. The following charts illustrate the 2012 and 2016 total population and age 65 and older population projections.

**Service Area Total Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase or (Decrease) |
|---|---|---|---|
| Davidson | 602,257 | 618,202 | 2.6% |
| Wilson | 114,437 | 121,203 | 5.9% |
| **Total** | **716,694** | **739,405** | **3.2%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision*, Tennessee Department of Health, Division of Health Statistics

**Service Area Age 65 and Older Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase or (Decrease) |
|---|---|---|---|
| Davidson | 70,698 | 78,799 | 11.5% |
| Wilson | 13,646 | 15,998 | 17.2% |
| **Total** | **84,344** | **94,797** | **12.4%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision*, Tennessee Department of Health, Division of Health Statistics

**2010 Service Area Rehabilitation Bed Utilization**

| Facility | Rehab Beds | Patient Days | 2010 Occupancy |
|---|---|---|---|
| Baptist Hospital | 24 | 6,578 | 75.1% |
| Nashville Rehabilitation Hospital | 0 | 0 | 0% |
| Skyline Medical Center | 41 | 10,804 | 72.2% |
| Skyline Madison Medical Center | 0 | 0 | 0% |
| Vanderbilt Stallworth | 80 | 22,671 | 77.6% |
| Southern Hills Medical Center | 12 | 0 | 0 |
| McFarland Hospital | 26 | 2,641 | 27.8 |
| **Total** | ***171** | **42,694** | **Average: 68.4%** |

Source: *Joint Annual Report of Hospitals 2010,* Division of Health Statistics, Tennessee Department of Health
*The 171 total beds represent only the operational beds as of the 2010 JAR. See note below.

*Note to Agency Members: The average bed percentage does not include the nonoperational beds. Southern Hills Hospital opened 12 rehabilitation beds on June 1, 2011 and will have 16 beds by September 2012. The applicant reports that from June 1, 2011 through December 31, 2012, Southern Hills Medical Center had 1,765 patient days and occupancy of 69.2%. Nashville Rehabilitation Hospital 31 beds are licensed "in abeyance" and have been nonoperational for several years. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational for several years. There are 228 total licensed or approved beds in the service area in 2012.*

According to the applicant, in recent years, HCA TriStar community hospitals on the north and south sides of the Nashville area have been granted CONs to add rehabilitation beds, through conversions of existing hospital beds. These CONS's allowed the applicant to improve their continuum of care without constructing costly new beds. The applicant states this is the third such project. Summit's conversion of its psychiatric beds to acute rehabilitation beds will not increase its bed licensed complement; but it will improve patient access to rehabilitation in the eastern part of the urban area.

The applicant states the location and timing of the project are appropriate for the following reasons:

- Rehabilitation utilization in Davidson County has been shifting to suburban locations that are closer to patient's homes. Between 2008 and 2011, the applicant reports the total rehabilitation days provided in the downtown area (Baptist, Vanderbilt, and NRH) decreased 15%, while rehabilitation days provided in the Davidson County suburbs (at Skyline and Southern Hills) increased 56%. The share of rehabilitation days that were provided in a suburban location increased from 20% to almost 38%.

- The applicant reports that while northern and southern Davidson County hospitals have been granted CON's for acute care rehabilitation beds, eastern Davidson County is the only place acute care rehabilitation beds can be opened in that sector, because Summit is the only hospital between downtown Nashville and the city of Lebanon, in Wilson County-a distance of 32 miles.

- The project will complete HCA TriStar's plan to offer acute inpatient rehabilitation programs to patients of four suburban hospitals surrounding downtown. It already has in place at HCA TriStar hospitals to the North (Skyline Medical Center), to the West (horizon Medical Center), and the South (Southern Hills Medical Center); but not yet at Summit Medical Center in Eastern Davidson County.

- Summit reports discharges of rehabilitation-appropriate patients are rapidly increasing, due not only to area population growth, but also to the hospital's CY2011 Emergency Department expansion and its designation as a Certified Stroke Center. Summit believes their growth will ensure that this refocused 20-bed unit will be reasonably utilized and will not shift costs of rehabilitation care to other types of hospital patients.

- According to the applicant, the utilization of existing rehabilitation beds in Davidson County is at efficient levels. The beds in the county's four operational acute rehabilitation providers provided 41,292 days of care in 2011. The applicant states this is equal to 70.5% occupancy on the 161 usable beds that will be open in the county by the summer of 2012. The applicant reports there are more rehabilitation beds that exist "on paper" but are older and for years have not been open.

Additionally, the applicant believes this project is good for patients. Acute rehabilitation is an important part of the continuum of high quality care for a wide range of conditions. Summit is the only hospital located in the growing eastern sector of the Nashville urban area; and is committed to continuous improvement in the services they provide. Many persons need inpatient rehabilitation after an initial hospital stay in order to regain acceptable functionality in activities of daily living and working. Having the option to receive this kind of care on the same campus which they have chosen for their initial hospitalization is efficient, and makes sense when it does not require excessive new bed construction costs.

According to the applicant, this project will not have any significant impact on other non-HCA providers of this type of care either in Davidson or Wilson counties. The applicant states for the past two years, HCA's own rehabilitation programs at Skyline and Southern Hills have been retaining approximately 81% of HCA discharges into their rehabilitation units. Last year, the applicant reports Summit discharged 47 patients to rehabilitation programs other that those of HCA. Most of the admissions to Summit will be a shift of care within the HCA TriStar network, all of it reflecting patient preferences and convenience. While there is still available bed capacity at existing rehabilitation providers in the service area, the programs in Davidson County are operating at approximately 70% utilization, which is financially sound.

The applicant states Medicare-approved acute rehabilitation units are now required to have 60% of their patient population classified in one of thirteen "Rehabilitation Impairment Categories", or RICs. The other 40% of patients may be other types of conditions that are deemed medically appropriate for rehabilitation. Failure to maintain the 60% standard will result in decertification by Medicare. Summit's projected unit will be managed to have no less than 62% of its patients in RIC

categories at any time.

The applicant states it should be noted that more than a third of the patients in acute rehabilitation units are there for significant conditions other than the thirteen RIC conditions. Utilization for this unit was projected considering both RIC and non-RIC patients.

The applicant provides Table 12-B on page 31 on the application detailing their projected utilization for year one and two of the project. The applicant's methodology is as follows:

Summit identified in its 2012 discharge base 256 patients that met RIC criteria and projected 256 eligible for an acute rehabilitation admission;

The applicant assumed that the RIC number would be 62% of total admissions, a non-RIC potential admission number was calculated to be 157;

The RIC and Non-RIC were added to project 413 potential admissions from Summit's own 2012 internal discharges;

Summit then assumed that only 74% of the 413 potential patients would actually be discharged to any hospital rehabilitation program. Application of the 74% factor reduced the potential Summit discharges to 306;

Using a weighted average of experience at HCA TriStar's Skyline and Southern Hills rehabilitation programs, Summit projected that they would retain 81% of its 306 internal discharges, or 248 admissions;

Summit projected an annual increase in its available rehabilitation patients over the next two years. Summit projected an increase of 10% in available admission in year one and a 14.5% in year two as the programs quality become known to the community and to medical staff. Additionally, HCA rehabilitation units in Nashville also receive 20% of their total referrals from non-HCA hospitals. This was assumed to continue in years one and two of this project, resulting in a projection of 328 admissions in year one and 374 admission in year two of the project. The applicant estimates an average length of stay of 13.5 days and believes the unit would be approaching 70% occupancy by the end of the second year of operation.

**TENNCARE/MEDICARE ACCESS:**
The applicant is certified in both Medicaid and Medicare programs. Summit has contracts with AmeriGroup, United Community Healthcare Plan, and TennCare Select.

The following chart illustrates the TennCare enrollees in the applicant's service area.

**TennCare Enrollees in the Proposed Service Area**

| County | 2012 Population | TennCare Enrollees | % of Total Population |
|---|---|---|---|
| Davidson | 602,257 | 118,728 | 19.7% |
| Wilson | 114,437 | 14,067 | 12.3% |
| **Total** | **716,694** | **132,795** | **18.5%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics and *Tennessee TennCare Management Information System, Recipient Enrollment,* Bureau of TennCare

The applicant estimates gross Medicare revenues of $7,504,640 or 52% of total gross revenues and TennCare/Medicaid revenues of $432,960 or 3% of total gross revenues.

**ECONOMIC FACTORS/FINANCIAL FEASIBILITY:**
In the Project Costs Chart, the total estimated project cost is $2,500,000, which includes $110,000 for architectural and engineering fees; $50,000 for legal, administrative, and consultant fees;

$1,550,000 for construction costs; $607,388 for moveable equipment; $150,000 for IT, telecommunications, misc.; $27,000 for interim financing; and $5,612 for CON filing fees.

In the Historical Data Chart, the applicant reported 42,614, 41,759, and 39,877 discharge days in 2009, 2010, and 2011 with gross operating revenues of $577,541,928, $626,094,465, and $657,778,519 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $148,908,326, $151,126,498, and $153,051,246 each year. The applicant reported $10,328,173, $10,942,208, and $10,588,601 in management fees to affiliates each year. The applicant reported a net operating income of $12,755,852, $10,890,220, and $12,414,115 each year, respectively.

In the Projected Data Chart, the applicant projects 328 admissions and 4,428 discharge days in year one and 374 admissions and 5,049 discharge days in year two with gross operating revenues of $14,432,000 and $17,205,760 each year respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $5,832,380 and $6,849,561 each year. The applicant projects management fees to affiliates of $404,524 and $482,117 each year. The applicant projects a net operating income of $2,757,512 in year one and $3,320,550 in year two.

The applicant's estimated year one average gross charge per day is $3,259, with an average deduction of $1,933, resulting in an average net charge per day of $1,317. In year two, the applicant's estimated average gross charge per day is $2,051, with an average deduction of $2,051, resulting in an average net charge per day of $1,357. The applicant compares their estimated charges with other area inpatient rehabilitation services on page 46 of the application.

The applicant states there is no alternative way to make acute impatient rehabilitation more accessible to residents of the eastern urban area of Nashville. Acute rehabilitation is a hospital-based program and Summit is the only hospital between the rehabilitation units of Baptist Hospital in Central Davidson County, and McFarland Hospital in central Wilson County, a distance of approximately 32 miles. The applicant states deployment of rehabilitation at Summit parallels HSDA decisions for suburban hospitals on the north side of the county (skyline Medical Center, 41 beds) and the south side of the county (Southern Hills, 16 rehabilitation beds).

The applicant notes rehabilitation is available in nursing home programs in the service area, but hospital-based acute rehabilitation allows for more intensive therapies and is appropriate for patients who are in need of those services. The project also permits Summit to offer and control a complete continuum of care for its patients whose discharge from the initial stay needs to proceed seamlessly into acute rehabilitation with their medical team conveniently close by.

**CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:**
The applicant provides a listing of the facilities they most frequently utilize in discharge planning on page 51 of the application.

According to the applicant, this project will provide easier access to acute inpatient rehabilitation for residents of eastern Davidson County and western Wilson County who are being discharge from initial acute care stays in Davidson County hospitals especially Summit Medical Center and who prefer the Hermitage location to downtown or the Wilson County location.

The project also consolidates HCA TriStar's psychiatric care resources in Nashville at its two central Davidson County campuses (Skyline Madison and Centennial Pavilion), freeing up beds in Davidson County suburban hospitals for broader-based healthcare programs.

The project adds rehabilitation beds to the service area without increasing licensed beds, because it merely reassigns existing bed areas on the hospital's third floor.

The impact on non-HCA rehabilitation providers will be minimal. In CY2011, 70% of Summit's discharges to acute rehabilitation programs in Nashville were to sister HCA hospitals. Only 47 patients from Summit were discharged to other service area programs.

The applicant projects 26 FTE staff in year one and 29 FTE staff in year two of the project. The applicant provides a listing of these positions and salary ranges in Table 18, page 54 of the application.

The applicant provides a listing of schools with which Summit has student affiliation agreements on page 56 of the application. In Cy2011, Summit Medical Center served as a training rotation for 415 students from the listed schools in the areas of nursing, EMT/paramedic, anesthesia tech, pharmacy tech, nutrition, respiratory therapy, medical imaging, physician's assistants, and physical therapy.

Summit Medical Center is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited by the Joint Commission.

## SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

## COMPREHENSIVE INPATIENT REHABILITATION SERVICES

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

2. The need shall be based upon the current year's population and projected four years forward.

   *The Division of Health Statistic calculated the bed need to be 74 beds based on the 2016 service area population.*

   *Southern Hills Hospital opened 12 rehabilitation beds on June 1, 2011 and will have 16 beds by September 2012. The applicant reports that from June 1, 2011 through December 31, 2012, Southern Hills Medical Center had 1,765 patient days and occupancy of 69.2%. Nashville Rehabilitation Hospital 31 beds are licensed "in abeyance" and have been nonoperational for several years. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational for several years. There are 228 total licensed or approved beds in the service area in 2012. Taking into account all licensed or approved beds, there is a surplus of 154 beds in the service area.*

   *According to the applicant, this review criterion should not be applied against this project because rehabilitation beds located in tertiary referral areas such as Davidson County are regional, multi-county resources. The applicant states the THA data base indicates that in CY2011, only 47.5% of rehabilitation patients in Davidson and Wilson County programs were residents of Davidson and Wilson counties. The applicant reports more than half the beds used in these two counties were used by residents of other counties.*

   *The applicant provides a correct Table 11, page 27 in Supplemental 1, which shows a 2012 total of 228 licensed or approved beds. Of these, 41 are older beds that are not open and are not likely to reopen. The number of operational beds in the service area is 183 and 4 more will become operational at Southern Hills Medical Center by September 2012 for a total of 187.*

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

*The applicant states approximately 85% of Summit's admissions come from Davidson and Wilson counties; and the majority of Summit's rehabilitation unit admissions will come from Summit discharges. Therefore, Davidson and Wilson counties are an appropriate primary service area.*

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

   *The project will have 20 beds.*

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

   *This project is not for a freestanding rehabilitation hospital.*

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:

| | |
|---|---|
| 20-30 bed unit | ~ 75% |
| 31-50 bed unit/facility | ~ 80% |
| 51 bed plus unit/facility | ~ 85% |

***2010 Service Area Rehabilitation Bed Utilization***

| Facility | Rehab Beds | Patient Days | 2010 Occupancy |
|---|---|---|---|
| Baptist Hospital | 24 | 6,578 | 75.1% |
| Nashville Rehabilitation Hospital | 0 | 0 | 0% |
| Skyline Medical Center | 41 | 10,804 | 72.2% |
| Skyline Madison Medical Center | 0 | 0 | 0% |
| Vanderbilt Stallworth | 80 | 22,671 | 77.6% |
| Southern Hills Medical Center | 0 | 0 | 0 |
| McFarland Hospital | 26 | 2,641 | 27.8 |
| **Total** | ***171** | **42,694** | **Average: 68.4%** |

*Source: Joint Annual Report of Hospitals 2010, Division of Health Statistics, Tennessee Department of Health*
**The 171 total beds represent only the operational beds as of the 2010 JAR. See note below.*

*Note to Agency Members: The average bed percentage does not include the nonoperational beds. Southern Hills Hospital opened 12 rehabilitation beds on June 1, 2011 and will have 16 beds by September 2012. The applicant reports that from June 1, 2011 through December 31, 2012, Southern Hills Medical Center had 1,765 patient days and occupancy of 69.2%. Nashville Rehabilitation Hospital 31 beds are licensed "in abeyance" and have been nonoperational for several years. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational for several years. There are 228 total licensed or approved beds in the service area in 2012.*

*The applicant reports 2011 occupancy of 69.0% for Baptist Hospital; 76.0% for Vanderbilt Stallworth; 75.5% for Skyline Medical Center; 69.2 for Southern Hills Medical Center; and 29.4% for McFarland Hospital. The applicant states the service providers are not yet at the target occupancies of the criterion, nonetheless those located in Davidson County are efficiently utilized at 71.5% collectively.*

*HealthSouth's recently approved application to build a Vanderbilt-led rehabilitation hospital in Williamson County stated that Vanderbilt Stallworth in central Davidson County can not achieve much higher occupancy than its current level because of its semi-private rooms, which require gender separation that often prevents a second admission to a semi-private room. The applicant reports that Stallworth recently declined a number of Summit's request for admissions to a rehabilitation bed.*

*Southern Hills unit has grown in utilization so rapidly that HSDA recently approved the addition of 4 more rehabilitation beds by conversion despite these criteria.*

*Skyline's rehabilitation program has also grown rapidly with the growth of their neurosciences programs (stroke; neurosurgery; spinal surgery).*

*The applicant reports only UMC McFarland's facility in Lebanon, almost a half-hour drive from Summit, has low occupancy in its rehabilitation beds. Once a general hospital, and now a psychiatric and rehabilitation facility, McFarland long ago was allowed to assign far more licensed rehabilitation beds than its service area can now fill. The applicant states it is not a reasonable option for Davidson and western Wilson County residents who obtain care in Davidson County, and are not inclined to drive miles into a rural are for their care. Davidson County is not even in McFarland's primary service area: only 3% of McFarland's admissions (both psychiatric and rehabilitation) come from Davidson County, according to its most recent Joint Annual Report.*

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board certified physiatrist.

   *The applicant states they comply with licensure staffing requirements and provide the projected staffing in response C.15.*

**HEALTH SERVICES AND DEVELOPMENT AGENCY**
**SEPTEMBER 26, 2012**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | Sycamore Shoals Hospital |
| PROJECT NUMBER: | CN1206--030 |
| ADDRESS: | 1501 West Elk Avenue<br>Elizabethton (Carter County), TN 37683 |
| LEGAL OWNER: | Mountain States Health Alliance<br>303 Med Tech Parkway, Suite 330<br>Johnson City (Washington County), TN 37604 |
| OPERATING ENTITY: | Not Applicable |
| CONTACT PERSON: | Laura Linn<br>(423) 302-3385 |
| DATE FILED: | June 15, 2012 |
| PROJECT COST: | $14,000.00 |
| FINANCING: | Cash Reserves |
| PURPOSE FOR FILING: | Discontinuance of Obstetrical Services |

DESCRIPTION:

Sycamore Shoals Hospital (SSH) is seeking approval to discontinue its obstetrical services and convert seven (7) obstetrical beds to seven (7) medical-surgical beds, with the hospital licensed bed complement remaining the same. The obstetrical unit currently occupies 21,610 square feet. This request would become effective shortly after approval of this application.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

Discontinuance of Obstetrical Services

A. Need
   1. A specific service area should be identified and all existing providers of obstetrical services in that service area should be identified.

*The applicant has identified Carter, Johnson and Washington Counties as the service area and Sycamore Shoals Hospital in Carter County and Johnson City Medical Center and Franklin Woods Community Hospital in Washington as the existing providers of obstetrical services. All are affiliated hospitals of Mountain States Health Alliance, headquartered in Johnson City, Tennessee.*

*It appears the application meets this criterion.*

2. The female population aged 15-44 in the service area should be identified. The current year's population and the population four years hence should be used.

   *Using the Tennessee Department of Health, Division of Health Statistics' population projections, the applicant has identified the female population aged 15-44 in the three county service area as consisting of 39,408 females in 2012. The TDoH's projections show a slight increase (0.2%) in the three county service area's female population ages 15-44 between 2012 and 2016: up to 39,488 in 2016.*

   *It appears the application meets this criterion.*

3. The number of obstetrical patients served by the facility over the past three years should be listed.

   *Sycamore Shoals has identified that there were 479 deliveries at SSH in 2009, 438 in 2010, 466 in 2011, and 408 deliveries in FY 2012.*

   *It appears the application meets this criterion.*

4. The estimated number of obstetrical patients affected by the discontinuance of obstetrical services should be listed. The estimated number of obstetrical patients below the federally established poverty level and affected by the discontinuance of the service should be listed separately.

   *The applicant has identified that there will be approximately 403 obstetrical patients who will be affected by the discontinuance of OB at SSH; approximately 300 (74.5%) are covered by the TennCare/Medicaid program. Approximately 19.55% of the service area population is estimated to have income below the federal poverty level, approximating 79 obstetrical patients.*

*It appears the application meets this criterion.*

B. Accessibility

1. Indicate the distance in miles and approximate travel time that patients in need of obstetrical services would have to travel, should the service be discontinued at the designated site.

   *The applicant has identified the distances in miles and approximate travel times that patients in need of obstetrical services will have to travel to the OB providers continuing OB services to the patients (on page 7 of this Summary and page 8 of the supplemental response.*

   *It appears the application meets this criterion.*

2. Indicate the modes of transportation which will be used by obstetrical patients to travel to alternate sites, should the service be discontinued at the designated site.

   *The primary mode of transportation of the patients diverted by this proposal is personal private vehicle. This is the same mode of transportation used by the OB patients who have utilized SSH in previous years.*

   *It appears the application meets this criterion.*

3. Indicate the facilities that will provide obstetrical services in the service area, should the service be discontinued at the designated site.

   *The applicant has identified the Johnson City Medical Center and Franklin Woods Community Hospital as the two closest obstetrical services providers who, according to the applicant, are already capturing 40% of the patients from Carter and Johnson Counties.*

   *After the application was deemed complete, Johnston Memorial Hospital (a MSHA affiliated facility) in Abingdon, Virginia, was also identified as willing to accept OB patients.*

   *It appears the application meets this criterion.*

4. The charges for obstetrical services at alternate service delivery sites should be compared to those of the facility seeking to discontinue the service.

   *The applicant has provided a comparison of rates with other OB providers which show comparable or lower rates to the applicant's current OB service (see page 14 of the supplemental response).*

   *It appears the application meets this criterion.*

5. The applicant should document that TennCare and/or Medicare patients can receive obstetrical services at the alternate service delivery sites.

   *The applicant has provided letters from the Chief Executive Officers of both Johnson City Medical Center and Franklin Woods Community Hospital documenting their interest and available capacity to absorb the additional volume and increase in TennCare/Medicaid payor mix created by SSH's discontinuance of obstetrics.*

   *Dwayne Taylor, CEO of Sycamore Shoals Hospital, provided a letter affirming that Johnston Memorial Hospital in Abingdon, Virginia would accept TennCare patients.*

   *It appears the application meets this criterion.*

SUMMARY

Sycamore Shoals Hospital (SSH) is a 121-bed not-for-profit acute care hospital located in Elizabethton, Carter County, Tennessee and part of the 1,623 bed Mountain States Health Alliance system (MSHA). SSH is licensed for 109 acute care beds, 12 Geriatric Psychiatric beds, and also provides outpatient and emergency services. The applicant states as an acute care community hospital, SSH is able to provide care for residents of the Elizabethton area, but if more specialized care is needed, patients can be easily transferred by ground or air to Johnson City Medical Center in Johnson City, TN, also part of Mountain States Health Alliance. MSHA is a 13 hospital, integrated healthcare system serving a population of more than 1.1 million people in a 29-county service area.

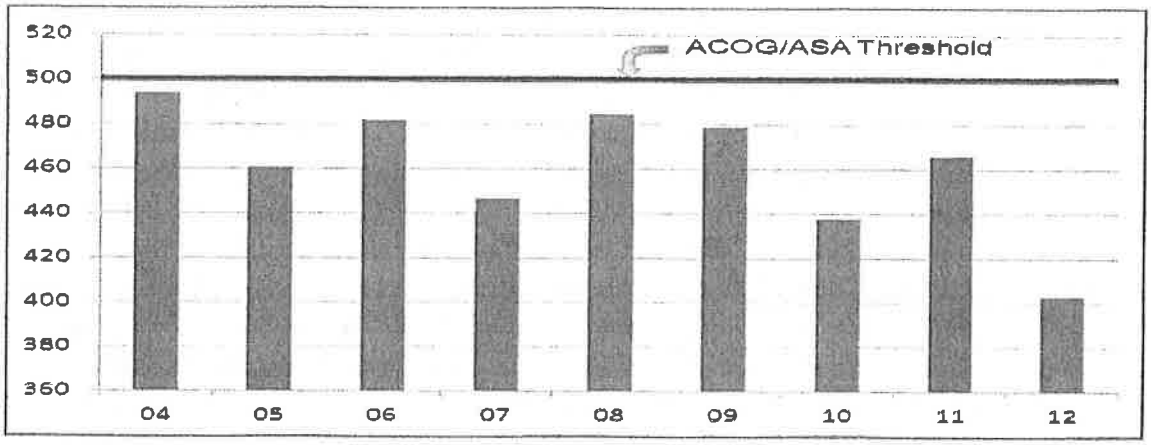
The applicant indicates its seven (7) obstetrical beds at Sycamore Shoals Hospital have historically been underutilized, and despite the best efforts of the hospital, this trend continues. The applicant states low volumes not only cause inefficiency issues for SSH, but also increase the potential for safety and quality of care issues for patients.

For more than six years, Sycamore Shoals sought to recruit an additional OB/GYN to add to the two-physician First Medical OB/GYN group, the only obstetrical group that practices at SSH. (*See page 3 of the supplemental response for further detail of SSH's OB/GYN recruitment efforts*). In 2009, a female OB/GYN joined the First Medical OB/GYN group and its two existing male partners, as well as the Sycamore Shoals' medical staff.. The OB/GYN group and the hospital were hopeful that the addition of a female physician would be attractive to potential patients. Though the recruitment efforts were successful, volumes have not increased as anticipated. *Note to Agency members: The applicant has subsequently learned that the female member of the OB medical staff, who was hired in 2009/2010 by First Medical OB/GYN, has announced that she is leaving the area. The applicant states they were not aware of this before making the determination to discontinue OB services at SSH and her leaving was not a factor in this decision.*

The applicant states the shifting demographics in the service area help to explain why recruitment cannot sustain the obstetrics program at Sycamore Shoals Hospital now and into the future. The female child-bearing age population surrounding the hospital is declining, and will continue to do so. Between 2011 and 2016, the number of females ages 15-44 in Carter, Johnson and Carter Counties is expected to drop 0.8% (38,911 in 2011 to 38,619 in 2016), according to projections provided by The Neilson Group, © 2012 Thomson Reuters (*See Attachment C Need.4.A). Note to Agency members: The Tennessee Department of Health, Division of Health Statistics shows a slight increase* (0.2%) *in the three county service area's female population ages 15-44 between 2012 and 2016: 39,408 in 2012 to 39,488 in 2016 (see chart on the top of page 15 of the original application).* The population of the county is aging as demonstrated by the expected 5.3% growth in the 55 and older age group. The healthcare needs of the community is shifting along with the demographic trends, thus explaining the decreased need for obstetrical services.

The applicant also indicates Sycamore Shoals Hospital has been unable to maintain delivery volumes that meet or exceed the 500 delivery threshold established by the American College of Obstetricians and Gynecologists (ACOG) and the American Society of Anesthesiologists (ASA) in their joint publication "Optimal Care for Anesthesia Care in Obstetrics", published in May 2009. These groups maintain that "Providing comprehensive care for obstetric patients in ... small units [less than 500 deliveries annually] is extremely inefficient, not cost effective and frequently impossible." The graph below demonstrates this shortfall.

**SSH Deliveries**




*Note to Agency members: The ACOG Committee Opinion in its entire context mentions: "good obstetrical care requires the availability of qualified personnel and equipment to administer general or regional anesthesia both effectively and emergently. The extent to which anesthesia services are available varies widely among hospitals. However, for hospitals providing obstetrical care, certain optimal anesthesia goals should be sought.... A survey jointly sponsored by the American Society of Anesthesiologists and The American College of Obstetricians and Gynecologists found that many hospitals in the United States have not yet achieved the goals mentioned previously. Deficiencies were most evident in smaller delivery units. Some smaller units are necessary because of geographical considerations. Currently, approximately 34% of hospitals providing obstetrical care have fewer than 500 deliveries per year. Providing comprehensive care for obstetric patients in these small units is extremely inefficient, not cost effective, and frequently impossible. Thus, the following recommendations are made:*

1. *Whenever possible, small units should consolidate.*
2. *When geographic factors require the existence of smaller units, these units should be part of a well-established regional perinatal system.*

*A copy of ACOG Committee Opinion No. 433 is attached to the end of this Summary.*

*As described in the Tennessee Department of Health's "Tennessee Perinatal Care System, Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities – 6th Edition," the Regional Perinatal Center for Northeast Tennessee is Johnson City Medical Center.*

Sycamore Shoals Hospital indicates the goal of this project is to ensure that area residents receive the highest quality obstetrics care, which can best be provided

at one of two nearby Mountain States Health Alliance facilities. Franklin Woods Community Hospital and Johnson City Medical Center are both less than 20 minutes away from Sycamore Shoals Hospital, and both have OB capacity available with occupancy rates at 48.2% and 63.7%, respectively. By discontinuing OB services at SSH, the hospital can better align its service offerings to meet the needs of the aging residents of their community.

Sycamore Shoals Hospital is licensed by the Tennessee Department of Health and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (The Joint Commission). Within the 121 acute care beds are 94 medical surgical beds, 8 critical care beds, 7 obstetrical beds, and 12 geriatric/psychiatric beds. Sycamore Shoals Hospital is owned and operated by Mountain States Health Alliance (MSHA) of Johnson City. MSHA operates 13 hospitals in 2 states. Besides Sycamore Shoals Hospital, Johnson City Medical Center, and Franklin Woods Community Hospital, Mountain States Health Alliance also operates Niswonger Children's Hospital, Quillen Rehabilitation Hospital, Woodridge Psychiatric Hospital, Indian Path Medical Center, and Johnson County Community Hospital in northeastern Tennessee and five hospitals in southwestern Virginia, including Johnston Memorial Hospital in Abingdon, Virginia.. *(See organization chart in Attachment A.4).*

According to the Final 2011 Joint Annual Report (JAR), SSH staffed 79 of its 121 licensed acute care beds and recorded a licensed occupancy of 34.6% and a staffed occupancy of 53.1%. According to the Department of Health's Joint Annual Report the two bed categories are defined as follows:

*Licensed Beds- The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).*

*Staffed Beds-The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.*

The applicant declares that the primary service area for Sycamore Shoals Hospital's obstetrical services includes Carter, Johnson, and Washington Counties. The applicant indicates this area is reasonable since it accounts for 85% of all the hospital's OB deliveries during FY 2011. The applicant projects the total population of the primary service area to grow 2.1% between 2012 and 2016 (from 198,079 to 202,254), while the child bearing female population (defined as age 15-44) is not growing at the same rate as the total population 0.2% vs. 2.1%. The portion of the service area population enrolled in TennCare is 17.3%.

(Johnson County has the highest proportion of the population enrolled at 32.5%, while Washington County currently has only 15.9% enrolled. Statewide enrollment in the TennCare program represents 19.0% of Tennessee's population.

Since 2009, Sycamore Shoals births have declined from 479 to 466 births in 2011 while OB inpatient utilization has risen slightly from 2.78 average patients per day (ADC) to 3.78 average patients per day. So far year-to-date in 2012, the SSH number of births is projected to decline to 403 and the OB average daily census (ADC) has fallen to 3.23 patients/day.

**Sycamore Shoals Hospital OB Inpatient Utilization 2009-2012**

| | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|
| **Births** | 479 | 438 | 466 | 408 |
| **ADC** | 2.78 | 3.45 | 3.78 | 3.23 |
| **OB Occupancy** | 39.8% | 49.2% | 54.0% | 46.2% |

Source: Joint Annual Report of Hospitals: 2009-2011and SSH internal data for 2012

Internal SSH data indicates the hospital's OB payor mix is 74% TennCare/Medicaid. Thus in 2012, the hospital estimated 300 of its 403 patients were TennCare patients. The applicant maintains these patients will continue to have access to alternative Mountain States Health Alliance OB providers who have the volume and capacity to provide safe OB care regardless of the patients' ability to pay. The applicant indicates Johnson City Medical Center (JCMC) is 10.5 miles and 16 minutes travel time from SSH in neighboring Washington County. Also in neighboring Washington County is Franklin Woods Community Hospital (FWCH), which is 13.3 miles away from SSH and can be reached in 19 minutes. Patients would have a commute of 43-79 minutes from more remote communities in Johnson and Carter Counties to JCMC, and FWCH (See *Page 8 of the supplemental response which contains comparative travel distance and times to SSH, JCMC, and FWCH).* Both the Chief Executive Officers of Johnson City Medical Center and Franklin Woods Community Hospital have provided letters documenting their interest and available capacity to absorb the additional volume and increase in TennCare/Medicaid payor mix created by SSH's discontinuance of obstetrics.

The applicant indicates that five other hospitals in the service area and counties contiguous to the service area provide obstetrical services. All of the five hospitals are within approximately one hour driving distance. Two of the facilities offer Level III Neonatal ICU services (JCMC and Holston Valley). All provide normal and C-Section delivery services at comparable or lower rates (see page 14 of the supplemental response).

**Other Hospitals offering OB Services in (or contiguous to) the 3 County Service Area**

| Hospital (Health System Affiliate) | County | Distance from SSH in miles | Travel Time from SSH in minutes | 2011 No. of OB Beds | 2011 OB % Occupancy | 2011 Deliveries |
|---|---|---|---|---|---|---|
| Johnson City Medical Center (MSHA) | Washington | 10.5 mi | 16 min | 22 | 63.7% | 1,261 |
| Franklin Woods Community Hospital (MSHA) | Washington | 13.3 mi | 19 min | 20 | 48.2% | 839 |
| Indian Path Medical Center (MSHA) | Sullivan | 31.9 mi | 38 min | 21 | 30.1% | 859 |
| Holston Valley Medical Center (Wellmont) | Sullivan | 32.2 mi | 38 min | 17 | 58.0% | 993 |
| Bristol Regional Medical Center (Wellmont) | Sullivan | 26 mi | 33 min | 15 | 34.3% | 844 |

A group of healthcare providers from Johnson County, the Pregnancy Support Center of Johnson County in Mountain City, Tennessee registered their concerns regarding the discontinuance of OB at Sycamore Shoals Hospital in Elizabethton (Carter County), Tennessee and the level of prenatal care in Johnson County, requesting the HSDA hold a public hearing regarding the discontinuance of OB at Sycamore Shoals Hospital. Discussions between the Pregnancy Support Center of Johnson County and Sycamore Shoals Hospital ensued with the hospital pledging to support more prenatal education effort in Johnson County and to work with TennCare to allow for the TennCare MCOs to cover perinatal care with the providers associated with MSHA's affiliated Johnston Memorial Hospital in Abingdon, Virginia, which has a shorter commute from Mountain City than to Johnson City. Copies of the letters from both parties expressing their agreement to work together to improve prenatal care for the mothers of Johnson County are attached, following this Summary. Upon the acceptance of this agreement by both parties, the Pregnancy Support Center of Johnson County withdrew its request for a public hearing.

The Department of Health's Perinatal Advisory Committee also reviewed and commented on Sycamore Shoals' application. Dr. Michael D. Warren, Director of the Division of Family Health & Wellness for the Department of Health, shared the request to discontinue OB services with the Department's Perinatal Advisory Council (PAC). The only concern addressed was the need to provide training for the hospital ER personnel and that equipment and supplies remain in the ER for unexpected deliveries. He also reported that the Northeast Regional Perinatal Center at Johnson City Medical Center is in the process of addressing that concern by training the hospital ER staff, including neonatal resuscitation program (NRP), mock codes and scenarios for preterm labor,

bleeding, etc. A core set of equipment and supplies will be readily available. Their perinatal educators and physicians are involved.

According to the Historical Data Chart, Sycamore Shoals Hospital reported favorable operating margins in each of the three reporting periods: $2,900,289 in 2009, $4,817,761 in 2010, and $2,264,063 in 2011. The Obstetrical Department showed a Net Operating Losses of ($735,109) in FY 2011 and ($989,122) in FY 2012.

Following implementation of the project, the revised Projected Data Chart in the first supplemental response shows SSH exhibiting favorable operating margins in each of the first two years of operation: $1,063,811 in 2013 and $1,998,902 in 2014. The Obstetrical and Newborn Nursery staff members have been reassigned or have left SSH to pursue continuing education or other interests.

The applicant intends to finance the project from cash reserves of Mountain States Health Alliance. A 6/19/12 letter from MSHA's Chief Finance Officer attests to the ability of Mountain States Health Alliance to fund the project.

The total estimated project cost is $14,000.00, primarily in administrative, legal and consultant fees budgeted at $10,000, $1,000 for signage and minor finish changes, and $3,000 for the CON filing fee.

*The applicant has submitted the required corporate and real estate deed documentation. HSDA Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.*

Should the Agency vote to approve this project, the CON would expire in three years.

**CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:**

There are no other Letters of Intent, denied or pending applications or outstanding Certificates of Need for this applicant.

*Sycamore Shoals Hospital is part of Mountain States Health Alliance which has financial interest in this project as well as the following projects:*

Pending Applications

**Franklin Woods Community Hospital, CN1208-042,** has a pending application which is scheduled to be heard on Consent Calendar at the October 24, 2012 Agency meeting. The application is for the initiation of extracorporeal

shockwave lithotripsy (ESWL) by relocating an existing unit from Johnson City Medical Center. The estimated cost of the project is **$13,000.**

Outstanding Certificates of Need

**Johnson City Medical Center, CN1004-020A,** has an outstanding Certificate of Need which will expire on September 1, 2014. It was approved at the July 28, 2010 Agency meeting for the construction of a sixteen (16) operating room surgery suite, supporting Pre/Post/PACU unit and Central Sterile Unit attached to the existing main campus structure of JCMC. There will be no change in the hospital bed complement. The estimated project cost is **$69,007,000.** *Project Status Update: Since work on both this and the following project will be combined, the progress report is the same. Site work and utility relocations as well as the drilling for caissons have commenced. The site work contractor finished hauling off the unsuitable soils and bringing in shale for the building pad. The existing storm line and structures are removed and plugged. Work on the new sanitary sewer and storm drain lines have been completed. The general contractor's subcontractor has mobilized and begun work on the utility tunnel and shear walls.*

**Johnson City Medical Center, CN1106-021A,** has an outstanding Certificate of Need which will expire on November 1, 2014. It was approved at the September 28, 2011 meeting for the renovation and expansion of the current radiation oncology department in the existing main campus structure of JCMC. The estimated project cost is **$14,999,924.** *Project Status Update: See the above update.*

**CERTIFICATE OF NEED INFORMATION FOR OTHER CARTER, JOHNSON & WASHINGTON COUNTY FACILITIES:**

There are no other Letters of Intent, pending or denied applications or outstanding Certificates of Need for other entities within the service area proposing discontinuation of OB services.

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**

PMW

(8/24/12)

ACOG COMMITTEE OPINION

Number 433 • May 2009 (Replaces No. 256, May 2001)

# Optimal Goals for Anesthesia Care in Obstetrics

**Committee on Obstetric Practice**

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

**ABSTRACT:** A joint statement from the American Society of Anesthesiologists and the American College of Obstetricians and Gynecologists was developed to address issues of concern to both specialties. Good obstetric care requires the availability of qualified personnel and equipment to administer general or regional anesthesia both electively and emergently. The extent and degree to which anesthesia services are available varies widely among hospitals. However, for hospitals providing obstetric care, certain optimal anesthesia goals should be sought.

This joint statement from the American Society of Anesthesiologists and the American College of Obstetricians and Gynecologists has been designed to address issues of concern to both specialties. Good obstetric care requires the availability of qualified personnel and equipment to administer general or regional anesthesia both electively and emergently. The extent and degree to which anesthesia services are available varies widely among hospitals. However, for any hospital providing obstetric care, certain optimal anesthesia goals should be sought as follows:

I. Availability of a licensed practitioner who is credentialed to administer an appropriate anesthetic whenever necessary. For many women, regional anesthesia (epidural, spinal, or combined spinal epidural) will be the most appropriate anesthetic.

II. Availability of a licensed practitioner who is credentialed to maintain support of vital functions in any obstetric emergency.

III. Availability of anesthesia and surgical personnel to permit the start of a cesarean delivery within 30 minutes of the decision to perform the procedure.

IV. Immediate availability of appropriate facilities and personnel, including obstetric anesthesia, nursing personnel, and a physician capable of monitoring labor and performing cesarean delivery, including an emergency cesarean delivery in cases of vaginal birth after cesarean delivery (1). The definition of immediately available personnel and facilities remains a local decision based on each institution's available resources and geographic location.

V. Appointment of a qualified anesthesiologist to be responsible for all anesthetics administered. There are many obstetric units where obstetricians or obstetrician-supervised nurse anesthetists administer labor anesthetics. The administration of general or regional anesthesia requires both medical judgment and technical skills. Thus, a physician with privileges in anesthesiology should be readily available.

Persons administering or supervising obstetric anesthesia should be qualified to manage the infrequent but occasional life-threatening complications of major regional anesthesia such as respiratory and cardiovascular failure, toxic local anesthetic convulsions, or vomiting and aspiration. Mastering and retaining the skills and knowledge necessary to manage these complications require adequate training and frequent application.

To ensure the safest and most effective anesthesia for obstetric patients, the director of anesthesia services, with the approval of the medical staff, should develop and enforce

American Society of Anesthesiologists
Physicians providing the lifeline of modern medicine

**The American College of Obstetricians and Gynecologists**
Women's Health Care Physicians
409 12th Street, SW
PO Box 96920
Washington, DC 20090-6920

written policies regarding provision of obstetric anesthesia as follows:

I. A qualified physician with obstetric privileges to perform operative vaginal or cesarean delivery should be readily available during administration of anesthesia. Readily available should be defined by each institution within the context of its resources and geographic location. Regional or general anesthesia or both should not be administered until the patient has been examined and the fetal status and progress of labor evaluated by a qualified individual. A physician with obstetric privileges who concurs with the patient's management and has knowledge of the maternal and fetal status and the progress of labor should be readily available to handle any obstetric complications that may arise. A physician with obstetric privileges should be responsible for midwifery back up in hospital settings that utilize certified nurse–midwives and certified midwives as obstetric providers.

II. Availability of equipment, facilities, and support personnel equal to that provided in the surgical suite. This should include the availability of a properly equipped and staffed recovery room capable of receiving and caring for all patients recovering from major regional or general anesthesia. Birthing facilities, when used for analgesia or anesthesia, must be appropriately equipped to provide safe anesthetic care during labor and delivery or postanesthesia recovery care.

III. Personnel other than the surgical team should be immediately available to assume responsibility for resuscitation of the depressed newborn. The surgeon and anesthesiologist are responsible for the mother and may not be able to leave her to care for the newborn even when a regional anesthetic is functioning adequately. Individuals qualified to perform neonatal resuscitation should demonstrate:

   A. Proficiency in rapid and accurate evaluation of the newborn condition, including Apgar scoring
   B. Knowledge of the pathogenesis of a depressed newborn (acidosis, drugs, hypovolemia, trauma, anomalies, and infection), as well as specific indications for resuscitation
   C. Proficiency in newborn airway management, laryngoscopy, endotracheal intubations, suctioning of airways, artificial ventilation, cardiac massage, and maintenance of thermal stability

In larger maternity units and those functioning as high-risk centers, 24-hour in-house anesthesia, obstetric, and neonatal specialists usually are necessary. Preferably, the obstetric anesthesia services should be directed by an anesthesiologist with special training or experience in obstetric anesthesia. These units also will frequently require the availability of more sophisticated monitoring equipment and specially trained nursing personnel.

A survey jointly sponsored by the American Society of Anesthesiologists and The American College of Obstetricians and Gynecologists found that many hospitals in the United States have not yet achieved the goals mentioned previously. Deficiencies were most evident in smaller delivery units. Some small delivery units are necessary because of geographic considerations. Currently, approximately 34% of hospitals providing obstetric care have fewer than 500 deliveries per year (2). Providing comprehensive care for obstetric patients in these small units is extremely inefficient, not cost-effective, and frequently impossible. Thus, the following recommendations are made:

1. Whenever possible, small units should consolidate.
2. When geographic factors require the existence of smaller units, these units should be part of a well-established regional perinatal system.

The availability of the appropriate personnel to assist in the management of a variety of obstetric problems is a necessary feature of good obstetric care. The presence of a pediatrician or other trained physician at a high-risk cesarean delivery to care for the newborn, or the availability of an anesthesiologist during active labor and delivery when vaginal birth after cesarean delivery is attempted and at a breech or multifetal delivery are examples. Frequently, these physicians spend a considerable amount of time standing by for the possibility that their services may be needed emergently but may ultimately not be required to perform the tasks for which they are present. Reasonable compensation for these standby services is justifiable and necessary.

A variety of other mechanisms have been suggested to increase the availability and quality of anesthesia services in obstetrics. Improved hospital design, which places labor and delivery suites closer to the operating rooms, would allow for more efficient supervision of nurse–anesthetists. Anesthesia equipment in the labor and delivery area must be comparable to that in the operating room.

Finally, good interpersonal relations between obstetricians and anesthesiologists are important. Joint meetings between the two departments should be encouraged. Anesthesiologists should recognize the special needs and concerns of obstetricians and obstetricians should recognize anesthesiologists as consultants in the management of pain and life-support measures. Both should recognize the need to provide high-quality care for all patients.

## References


1. Vaginal birth after previous cesarean delivery. ACOG Practice Bulletin No. 54. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;104:203–12.
2. Bucklin BA, Hawkins JL, Anderson JR, Ullrich FA. Obstetric anesthesia workforce survey: twenty-year update. Anesthesiology 2005;103:645–53.

Copyright © May 2009 by the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, posted on the Internet, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher. Requests for authorization to make photocopies should be directed to: Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400.

ISSN 1074-861X

Optimal goals for anesthesia care in obstetrics. ACOG Committee Opinion No. 433. American College of Obstetricians and Gynecologists and American Society of Anesthesiologists. Obstet Gynecol 2009;113:1197–9.

SYCAMORE SHOALS
HOSPITAL
Mountain States Health Alliance

August 29, 2012

Samanthia Norman
Johnson County Pregnancy Support Center

Re: Prenatal Coverage in Johnson County

Dear Ms. Norman,

We appreciate the time you have spent with us to share your concerns that the level of prenatal care in Johnson County would be compromised as a result of Sycamore Shoals Hospital's request to discontinue obstetrical services. I want to assure you and your organization that MSHA completely recognizes and agrees with the importance of access to prenatal care and we have no intentions to reduce that access. As a healthcare provider, we fully understand the link between consistent prenatal care and positive outcomes for both the mother and the baby and want to acknowledge that a healthy mother and a healthy baby is our goal as well. The decision to close the obstetrical service at Sycamore Shoals Hospital will not impact the level of prenatal care available to your community. The obstetrical practice which has historically delivered at Sycamore Shoals Hospital (Drs. John Green and Brent Laing) will continue to maintain their practice in Elizabethton and therefore will continue to provide prenatal care to Johnson County residents at their location in Elizabethton.

During the course of these discussions, MSHA has investigated opportunities to enhance access to prenatal care in Mountain City. Despite multiple efforts in years past to provide an obstetrical physician presence in Mountain City, this model has proven unsustainable due to very low volumes. As a result, MSHA is committed to evaluating alternative avenues to create a sustainable model that will enable us to attain our shared goal of a healthy mother and a healthy baby. As a result of these recent discussions, MSHA is committed to pursuing the following:

- MSHA will support Dr. Suzanna Shine, a local family practice physician located in Mountain City, who has agreed to see prenatal patients up to 24 weeks of pregnancy at her practice. Dr. Shine welcomes the opportunity to see more prenatal patients and MSHA will explore efforts to educate the community on the services she provides. In addition Dr. Shine does accept TennCare.
- MSHA will work with the Pregnancy Support Center to explore other innovative concepts such as a centering pregnancy program or other program(s) that could improve prenatal compliance.

1501 West Elk Avenue Elizabethton, Tennessee 37643 Telephone 423.542.1300

SYCAMORE SHOALS
HOSPITAL
Mountain States Health Alliance

- Following the 24 week period, Dr. Shine has agreed to coordinate with Drs. Green and Laing as well as any obstetricians from Abingdon whom the patient may choose to see for the remainder of their pregnancy to endure a seamless transition.
- MSHA commits to facilitate discussions with the two obstetric groups in Abingdon to determine if they will consider a physical presence in Johnson County through an outreach clinic. MSHA also commits to hold these same discussions with the obstetric physicians in Elizabethton and Johnson City.
- MSHA has confirmed that Johnston Memorial Hospital in Abingdon will and does accept TennCare patients. Johnson Memorial Hospital will welcome any obstetrical patients from Johnson County.

I think our recent discussions have been very helpful and there are several opportunities for partnership between our organizations. At the end of the day, we share a common vision – to reduce the incidence of low-birth weight babies and infant mortality within Johnson County. Together, I think we can achieve this important goal.

Sincerely,

Dwayne Taylor

1501 West Elk Avenue Elizabethton, Tennessee 37643 Telephone 423.542.1300

# Pregnancy Support Center of Johnson County

P.O. Box 614 (located at 917 Crossroads Drive) Mountain City, TN 37683 (423) 727-8600

August 31, 2012

Melanie M. Hill, Executive Director
Health Services & Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Sycamore Shoals Hospital Request to Discontinue OB Services

Dear Ms. Hill,

On behalf of Women in Johnson County and the Pregnancy Support Center of Johnson County (PSCJC) we will not move forward with a public hearing related to our concerns with MSHA decision to discontinue Obstetrical Deliveries. Our concern was to reasonable access for women of Johnson County to deliver their children.

Two meetings have occurred with Dwayne Taylor CEO Sycamore Hospital, Lisa Heaton AVP Administrator/CNO Johnson County Community Hospital and other representatives. While Mr. Taylor and Ms. Heaton were very willing and supportive of working with us on prenatal care concerns we continued to emphasize that the request for a hearing was related to the withdrawal of OB Beds at Sycamore Shoals Hospital. We proposed that MSHA make Johnston Memorial Family Birthing Center and MSHA obstetrical physicians available to Johnson County Women and in particular the low socioeconomic women who utilize TennCare.

Based on the second meeting with Samanthia Norman and Pastor Ron Drake of the PSCJC Mr. Taylor provided his assurance and the attached document as to MSHA commitment to working with PSCJC to improve prenatal care and access. As related to Hospital delivery location we have been assured TennCare clients can utilize the Family Birthing Center @ Johnston Memorial and accepted by at minimum MSHA obstetricians. I would add that Johnston Memorial is closer and easier to access than Sycamore Shoals.
Thank you for your time and support as we worked to this positive outcome
Sincerely,

Pam Steinke RN Nurse Manager volunteers PSCJC
Samanthia Norman Director, PSCJC

Cc: Ron Drake Executive Chair PSCJC
Mayor Larry Potter Johnson County

Making a difference where life begins

*Deuteronomy 30:19*

615-741-2364-phone

615-741-9884-fax

www.tn.gov/hsda

---

From: Pam Steinke [pamsteinke@yahoo.com]
Sent: Thursday, August 30, 2012 8:51 AM
To: Melanie Hill; Mark Farber
Cc: norman Samanthia
Subject: Johnson County Public Hearing

Ms Hill and Mr Farber

Samanthia Norman had a second meeting with MSHA officials ( I was unable to attend). The leadership of MSHA are assuring us that women in Johnson County can access the closer hospital in Abington Virginia owned by MSHA.
We have one letter from Sycamore Shoals CEO verifying that position. We will not request a public hearing but will send a letter to you Ms Hill ,with what we believe is assurance from MSHA.
We would hope that the availability of Johnston Memorial Hospital and Physicians would be addressed at the September 26th hearing to document MSHA s promise to Johnson County.
How would you like my letter to be sent ? I can mail or attach as an email . I will copy MSHA officials and the pregnancy center Director and Board member.
Thank you both for working with me and supporting concerns of care to Johnson County Women.

Pam Steinke
Sent from my iPad

# LETTER OF INTENT

# LETTER OF INTENT

2012 JUN -8 AM 10: 09

# TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Elizabethton Star (Name of Newspaper) which is a newspaper of general circulation in Carter (County), Tennessee, on or before June 10 (Month / day), 2012 (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: Sycamore Shoals Hospital (Name of Applicant) a Hospital (Facility Type-Existing) owned by: Mountain States Health Alliance with an ownership type of Not-for-Profit Corporation and to be managed by: Mountain States Health Alliance intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

the discontinuance of obstetrical services at Sycamore Shoals Hospital, which is located at 1501 W. Elk Avenue, Elizabethton, Tennessee 37643. This project will not involve any other major medical equipment, will not initiate nor discontinue any other type of health service, and will not change the licensed total bed count of 121 beds at the facility. The estimated project cost is $14,000.

The anticipated date of filing the application is: June 15, 2012

The contact person for this project is Laura Linn (Contact Name) Senior Planning Analyst (Title)

who may be reached at: Mountain States Health Alliance (Company Name) 303 Med Tech Parkway, Suite 330 (Address)

Johnson City (City) TN (State) 37604 (Zip Code) (423) 302-3385 (Area Code / Phone Number)

Laura Y Linn (Signature) 6/7/12 (Date) linnlm@msha.com (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**
**500 Deaderick Street, Suite 850**
**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.

==========

HF0051 (Revised 05/03/04 – all forms prior to this date are obsolete)

# ORIGINAL APPLICATION

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

Sycamore Shoals Hospital
Name

1501 West Elk Avenue — Carter
Street or Route — County

Elizabethton — TN — 37683
City — State — Zip Code

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

Laura Linn — Senior Planning Analyst
Name — Title

Mountain States Health Alliance — LinnLM@msha.com
Company Name — Email address

303 Med Tech Parkway, Suite 330 — Johnson City — TN — 37604
Street or Route — City — State — Zip Code

Employee — 423-302-3385 — 423-302-3448
Association with Owner — Phone Number — Fax Number

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

Mountain States Health Alliance — 423-431-6111
Name — Phone Number

303 Med Tech Parkway, Suite 300 — Washington
Street or Route — County

Johnson City — TN — 37604
City — State — Zip Code

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

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

**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)***

NA
Name

Street or Route County

City State 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 | X | D. | Option to Lease | |
| B. | Option to Purchase | | E. | Other (Specify) _____ | |
| C. | Lease of ____ Years | | | | |

**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 | 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 | | H. | 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 Health Care Service as defined in TCA § 68-11-1607(4) | | | | |
| E. | (Specify)_____ | | I. | Change of Location | |
| F. | Discontinuance of OB Services | X | J. | Other (Specify)_____ | |
| G. | Acquisition of Equipment | | | | |

**9. Bed Complement Data**

***Please indicate current and proposed distribution and certification of facility beds[1].***

| | Current Beds Licensed | *CON | Staffed Beds | Beds Proposed | TOTAL Beds at Completion |
|---|---|---|---|---|---|
| A. Medical | 80 | | 38 | 7 | 87 |
| B. Surgical | 14 | | 14 | | 14 |
| C. Long-Term Care Hospital | | | | | |
| D. Obstetrical | 7 | | 7 | -7 | 0 |
| E. ICU/CCU | 8 | | 8 | | 8 |
| F. Neonatal | | | | | |
| G. Pediatric | | | | | |
| H. Adult Psychiatric | | | | | |
| I. Geriatric Psychiatric | 12 | | 12 | | 12 |
| J. Child/Adolescent Psychiatric | | | | | |
| K. Rehabilitation | | | | | |
| 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** | **121** | | **79** | | **121** |

*CON-Beds approved but not yet in service

**10. Medicare Provider Number** 44-0018
**Certification Type** Acute Care Hospital

**11. Medicaid Provider Number** 0-44-0018
**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 to question # 13:** This project will continue to involve the treatment of TennCare participants. Sycamore Shoals Hospital is a participant in the following MCOs:

**Med/Surg**
BlueCare (Volunteer State Health Plan)
AmeriChoice (United of the River Valley)

**BHOs**
United Behavioral Health
ValueOptions

**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.**

Sycamore Shoals Hospital (SSH) is a 121-bed not-for-profit acute care hospital located in Elizabethton, Carter County, Tennessee and part of the 1,623 bed Mountain States Health Alliance system (MSHA). SSH is licensed for 109 acute care beds, 12 Geriatric Psychiatric beds, and also provides outpatient and emergency services. As an acute care community hospital, Sycamore Shoals Hospital is able to provide care for residents of the Elizabethton area, but if more specialized care is needed, patients can be easily transferred by ground or air to Johnson City Medical Center in Johnson City, TN, also part of Mountain States Health Alliance. MSHA is a 13 hospital, integrated healthcare system serving a population of more than 1.1 million people in a 29-county service area.

This proposal is for the discontinuation of obstetrical services at Sycamore Shoals Hospital. The estimated cost for the project is $14,000, the majority of which is comprised of CON-related expenses. The remaining $1,000 will cover signage changes and other minor changes to finishes, as required, to convert the OB areas to general medical/surgical care. Funding for this project will be through continued operations and the use of existing cash reserves of Mountain States Health Alliance. No additional staff will be required for this project.

The seven obstetrical beds at Sycamore Shoals Hospitals have historically been underutilized, and despite the best efforts of the hospital, this trend continues. Low volumes not only cause inefficiency issues for SSH, but also increase the potential for safety and quality of care issues for patients.

For more than six years, Sycamore Shoals sought to recruit an additional OB/GYN to add to the two-physician First Medical OB/GYN group, the only obstetrical group that practices at SSH. In 2009, a female OB/GYN joined the group, and the existing male partners of the group, as well as the hospital, were hopeful that the addition of a female physician would be attractive to potential patients. Though the recruitment efforts were successful, volumes have not increased as anticipated.

Shifting demographics in the service area help to explain why recruitment cannot sustain the obstetrics program at Sycamore Shoals Hospital now and into the future. The female child-

bearing age population surrounding the hospital is declining, and will continue to do so. By 2016, the number of females ages 15-44 in Carter County is expected to drop 0.8%. The population of the county is aging as demonstrated by the expected 5.3% growth in the 55 and older age group. The healthcare needs of this community is shifting along with the demographic trends, thus explaining the decreased need for obstetrical services.

The goal of this project is to ensure that area residents receive the highest quality obstetrics care, which can best be provided at one of two nearby Mountain States Health Alliance facilities. Franklin Woods Community Hospital and Johnson City Medical Center are both less than 20 minutes away from Sycamore Shoals Hospital, and both have OB capacity available with occupancy rates at 48.2% and 63.7%, respectively. By discontinuing OB services at SSH, the hospital can better align its service offerings to meet the needs of the aging residents of their community.

**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.**

Sycamore Shoals Hospital is requesting a certificate of need to discontinue obstetrical services. In order to develop this proposal, Sycamore Shoals Hospital assessed the future need for obstetrical services and the fit of this service within the broader scope of services offerings at the hospital. The lack of need for this service was then validated through analysis of the facility, other Mountain States Health Alliance facilities, and the local market.

**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.**

No change in the total 121 licensed acute hospital beds is requested with this application. The project proposes to convert 7 obstetrical beds to general medical-surgical use. There will be no impact on other existing services.

## SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

***NOT APPLICABLE***

| A. Unit / Department | Existing Location | Existing SF | Temporary Location | Proposed Final Location | Proposed Final Square Footage | | | Proposed Final Cost/ SF | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Renovated | New | Total | Renovated | New | Total |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

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**

Not Applicable

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

Not Applicable

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:**
      A. **Total cost; (As defined by Agency Rule).**
      B. **Expected useful life;**
      C. **List of clinical applications to be provided; and**
      D. **Documentation of FDA approval.**

   b) **Provide current and proposed schedules of operations.**

   Not Applicable

2. **For major mobile 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.**

Not Applicable

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.**

Not Applicable

**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 all drawings do not need to be drawn to scale. Plot plans are required for all projects.***

Plot plans are included in the attachments.

**(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.**

Sycamore Shoals Hospital is located at 1501 W. Elk Avenue, Elizabethton, Tennessee. NET Trans (Northeast Tennessee Rural Public Transit) provides transportation services to several counties in northeast Tennessee, including Carter County. A NET Trans bus stop is located at Sycamore Shoals Hospital, and the route provides access to locations in both Elizabethton and Johnson City. Once in Johnson City, a rider may transfer to the Johnson City Transit System, which has stops both at Johnson City Medical Center and Franklin Woods Community Hospital.

**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 ½" x 11" sheet of white paper.**
**NOTE: DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.**

Floor plans for the project are attached.

**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.**

Not Applicable

## 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.**

   **Special Criteria for Discontinuance of Obstetrical Services**

   **A. Need**

   1. **A specific service area should be identified and all existing providers of obstetrical services in that service area should be identified.**

      The primary service for this proposal includes Carter, Johnson, and Washington Counties, TN. Residents from these counties consistently represent approximately 85% of the patients utilizing SSH OB services, as detailed in the table below.

**SSH IP OB Cases by Patient County**
FYTD 2012 (July 2011 – April 2012)

| Patient County | OB Cases | % of OB Cases | Service Area |
|---|---|---|---|
| Carter, TN | 188 | 52.96% | Primary |
| Johnson, TN | 59 | 16.62% | Primary |
| Washington, TN | 54 | 15.21% | Primary |
| **Primary Service Area** | **301** | **84.79%** | |
| Unicoi, TN | 32 | 9.01% | Secondary |
| Sullivan, TN | 19 | 5.35% | Secondary |
| **Secondary Service Area** | **51** | **14.37%** | |
| Avery, NC | 1 | 0.28% | |
| Greene, TN | 1 | 0.28% | |
| Knox, TN | 1 | 0.28% | |
| **All Other Areas** | **3** | **0.85%** | |
| **Total** | **355** | **100.00%** | |

Source: Internal Data

There are two other providers of obstetrical services in this service area, Johnson City Medical Center and Franklin Woods Community Hospital. Both of these facilities are located in Johnson City, TN (Washington County) and are also part of the Mountain States Health Alliance health system. The table below demonstrates that roughly 40% of the OB patients in Carter and Johnson Counties are already choosing to deliver at one of these two MSHA facilities in Washington County. Review of 2011 data indicates a similar trend.

**Market Share of OB Patients from Carter and Johnson Counties**
MSDRGs 765-768, 774-775

| | 2008 | 2009 | 2010 |
|---|---|---|---|
| Sycamore Shoals Hospital | 49.3% | 44.8% | 52.1% |
| Johnson City Medical Center | 21.1% | 26.1% | 23.9% |
| Franklin Woods Community Hospital | 18.1% | 19.0% | 17.1% |
| Other TN | 3.1% | 2.6% | 2.4% |
| Other NC | 8.2% | 7.1% | 4.4% |
| Other VA | 0.3% | 0.3% | 0.2% |
| | | | |
| Total Market Cases | 684 | 658 | 620 |

Source: THA, VHHA, Medstat

2. **The female population aged 15-44 in the service area should be identified. The current year's population and the population four years hence should be used.**

The current and projected female population of this project's service is provided below. A decline in the potentially child-bearing population of Carter and Johnson Counties, which account for nearly 70% of the OB volume at Sycamore Shoals Hospital, is expected.

**SSH OB Service Area Population Projections**

Females, Ages 15-44

| | 2012 | 2016 | % Change |
|---|---|---|---|
| Carter | 11,990 | 11,882 | -0.9% |
| Johnson | 3,143 | 3,119 | -0.8% |
| Washington | 24,275 | 24,487 | 0.9% |
| Total | 39,408 | 39,488 | 0.2% |

Source: Office of Health Statistics, Bureau of Health Informatics, TN Department of Health

3. **The number of obstetrical patients served by the facility over the past three years should be listed.**

The number of OB patients served at Sycamore Shoals Hospital from 2009 to 2011 is shown below.

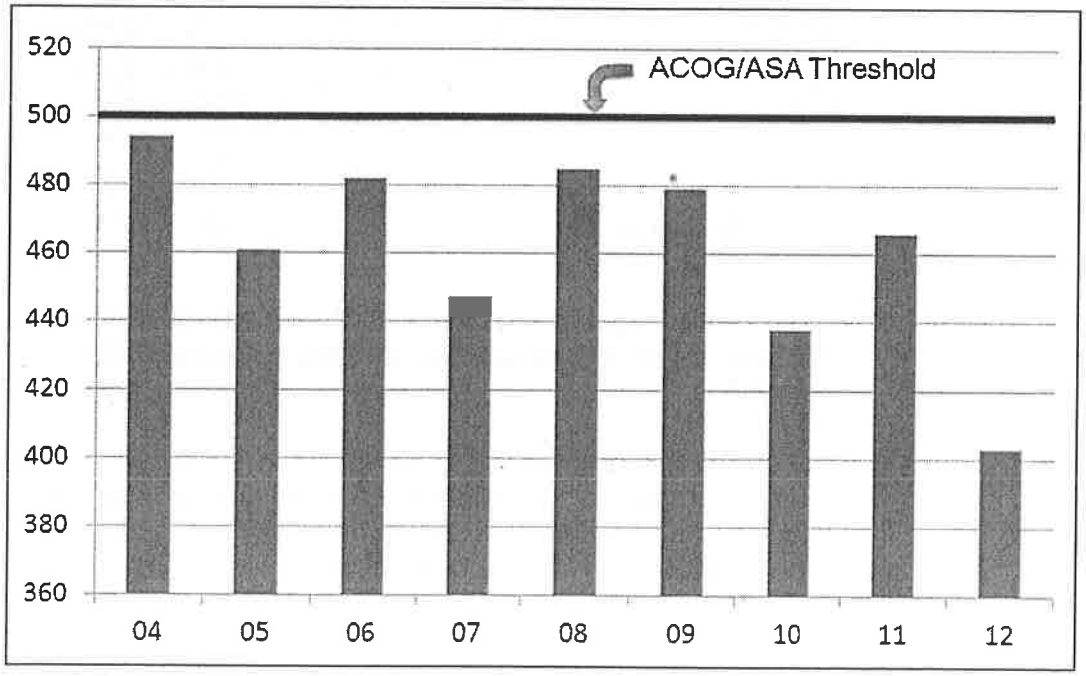
**SSH Deliveries**

| | 2009 | 2010 | 2011 | 2012 Projected |
|---|---|---|---|---|
| Deliveries | 479 | 438 | 466 | 403 |

Source: Joint Annual Report of Hospitals, 2012 estimates annualized from July – April data

Sycamore Shoals Hospital has been unable to maintain delivery volumes that meet or exceed the 500 delivery threshold established by the American College of Obstetricians and Gynecologists (ACOG) and the American Society of Anesthesiologists (ASA) in their joint publication "Optimal Care for Anesthesia Care in Obstetrics." These groups maintain that "Providing comprehensive care for obstetric patients in ... small units [less than 500 deliveries annually] is extremely inefficient, not cost effective and frequently impossible." The graph below demonstrates this shortfall.

**SSH Deliveries**



4. **The estimated number of obstetrical patients affected by the discontinuance of obstetrical services should be listed. The estimated number of obstetrical patients below the federally established poverty level and affected by the discontinuance of the service should be listed separately.**

   Based on utilization in 2012, an estimated 403 patients will be affected by the discontinuance of OB services at Sycamore Shoals Hospital. Internal data indicates 74% of OB patients at SSH are covered under TennCare/Medicaid, amounting to approximately 300 patients annually.

B. **Accessibility**

1. **Indicate the distance in miles and approximate travel time that patients in need of obstetrical services would have to travel, should the service be discontinued at the designated site.**

   Two other providers of obstetrical services are located within this project's service area, Johnson City Medical Center and Franklin Woods Community Hospital. Both of these facilities are also part of Mountain States Health Alliance and are located in Washington County, TN. The distances and approximate travel times to these facilities from Sycamore Shoals Hospital are noted in the table below.

| Facility | Distance from SSH | Travel Time from SSH | County |
|---|---|---|---|
| Johnson City Medical Center | 10.5 miles | 16 minutes | Washington |
| Franklin Woods Community Hospital | 13.3 miles | 19 minutes | Washington |

Source: Google Maps at maps.google.com

2. **Indicate the modes of transportation which will be used by obstetrical patients to travel to alternate sites, should the service be discontinued at the designated site.**

   Transportation to alternate sites is anticipated to be by personal vehicle, as that is the mode most used by patients at Sycamore Shoals Hospital. The sites are accessible using main highways from SSH, and driving times and distances are noted in the response to the previous question.

3. **Indicate the facilities that will provide obstetrical services in the service area, should the service be discontinued at the designated site.**

   Should obstetrical services be discontinued at Sycamore Shoals Hospital, Johnson City Medical Center and Franklin Woods Community Hospital will provide obstetrical services to patients within the service area. These two facilities are already capturing 40% of the patients from Carter and Johnson Counties, TN, and have available capacity to absorb the patients who would have otherwise sought care at SSH. The table below demonstrates the ability of these two hospitals to fully accommodate Carter and Johnson County residents.

| Provider | OB Beds | Days of Capacity | OB Days - MDC 14 | OB Occupancy | Births | Average Daily Census |
|---|---|---|---|---|---|---|
| JCMC | 22 | 8,030 | 5,118 | 63.7% | 1,261 | 14.02 |
| FWCH | 20 | 7,300 | 3,518 | 48.2% | 839 | 9.64 |

Source: FY 2011 Joint Annual Report of Hospitals

Opened in 2010, Franklin Woods is a new facility, and the obstetrical services area at Johnson City Medical Center is currently undergoing a major renovation, which is scheduled to be completed prior to the anticipated approval of this proposal. The new and newly renovated facilities will be attractive to future patients from Carter and Johnson Counties. MSHA anticipates most cases (roughly 70%) from this area going to Franklin Woods as it is a smaller facility with a specialty hospital feel. The remaining 30% of cases are expected to go to JCMC, which is well-equipped to handle high risk OB patients as a regional tertiary referral center with advanced NICU services. With this increased volume, however, neither facility's OB occupancy rates are anticipated to exceed 70%.

4. **The charges for obstetrical services at alternate service delivery sites should be compared to those of the facility seeking to discontinue the service.**

   Mountain States Health Alliance uses the same charge schedule for obstetrical services at each of their facilities; therefore, the charges will remain consistent at the alternate sites (JCMC and FWCH) compared to SSH. A copy of the current change schedule is provided in the attachments (see Attachment C, Economic Feasibility 6.A).

5. **The applicant should document that TennCare and/or Medicare patients can receive obstetrical services at the alternate service delivery sites.**

   Both Johnson City Medical Center and Franklin Woods Community Hospital participate in TennCare and Medicare, and participate in the same MCO's as identified the response to question A.13. TennCare/Medicare comprises 13.0% of patient revenue at JCMC and 13.7% at FWCH.

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

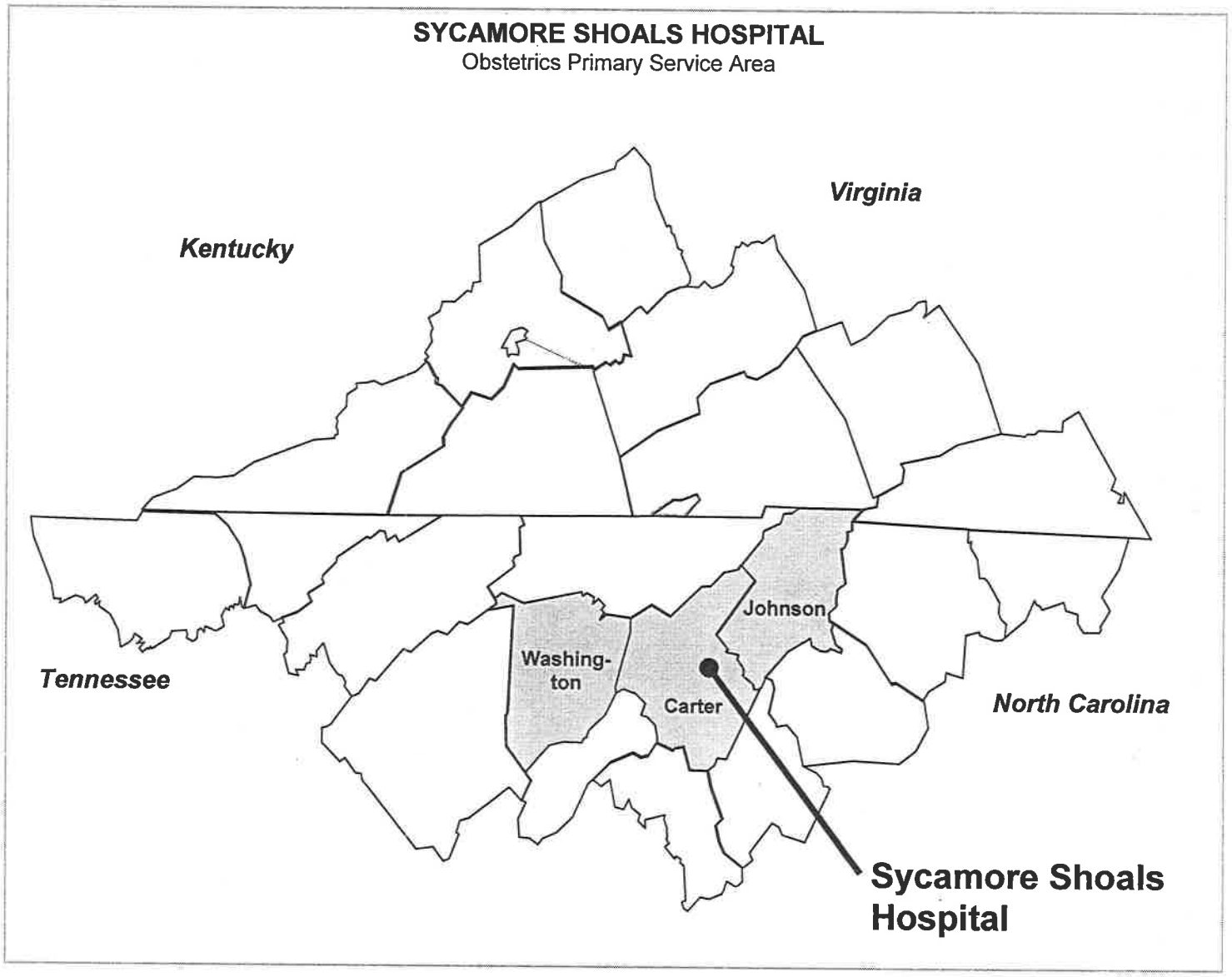
   Not Applicable

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

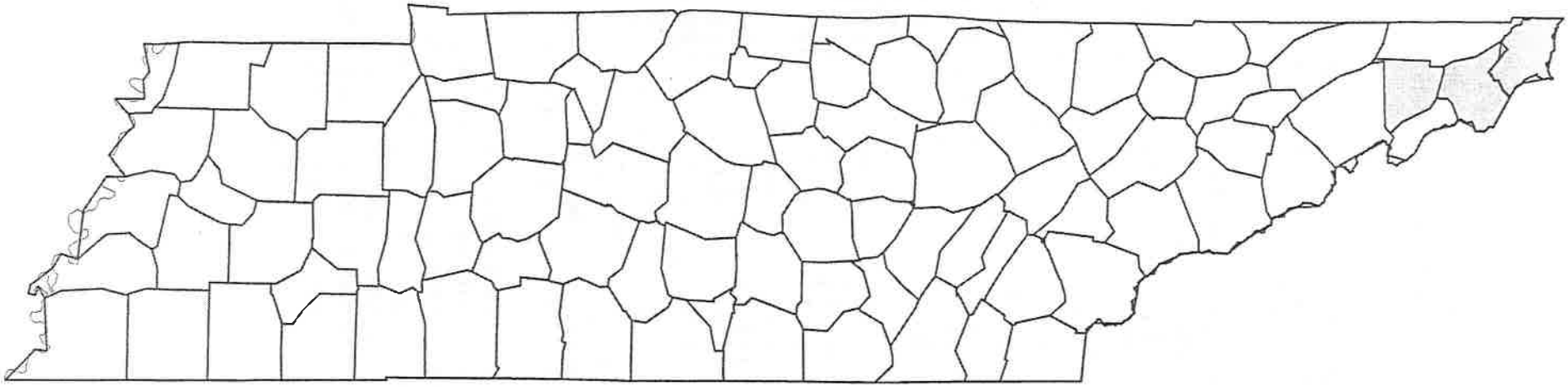
This project is consistent with the long-range plans of Mountain States Health Alliance and Sycamore Shoals Hospital, as well as the Mountain States Health Alliance's Women's Services Strategic Plan. This project supports the organization's long-range planning efforts to develop and maintain a high-quality, patient-centered care environment as seen with other projects approved by the agency such as that with the expansion of the intensive care, cardiovascular units, surgical services, and radiation oncology at Johnson City Medical Center and construction of the Niswonger Children's Hospital.

3. **Identify the proposed service area <u>and</u> 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.).***

   The obstetrics primary service area for Sycamore Shoals Hospital includes Carter, Johnson, and Washington Counties, TN. Residents from these counties represent 85% of the patients utilizing SSH OB services during FY 2011. Maps depicting the service area are provided on the following pages.


SYCAMORE SHOALS HOSPITAL
Obstetrics Primary Service Area
Virginia
Kentucky
Tennessee
North Carolina
Johnson
Washing-
ton
Carter
Sycamore Shoals
Hospital

## SYCAMORE SHOALS HOSPITAL
**Obstetrics Primary Service Area**



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

The following table shows the total population of each of the counties in the project's service area. The Tennessee Department of Health predicts a 2.1 percent growth in the total population of Sycamore Shoals Hospital's service area between 2012 and 2016, with the highest growth outside of Carter and Johnson Counties, residents from which comprise the majority of SSH patients.

The population in the project's service area has a higher concentration of older individuals than national trends. In 2012, 29.2 percent of the project's service area were ages 55 and above, compared to 25.0 percent nationally.

**Service Area Population Projections**

| | Age Cohort | 2012 Population | 2016 Population | % Change |
|---|---|---|---|---|
| **Carter** | 0-14 | 9,699 | 9,925 | 2.3% |
| | 15-44 | 23,946 | 23,562 | -1.6% |
| | 45-54 | 8,495 | 8,304 | -2.2% |
| | 55 and over | 17,825 | 18,773 | 5.3% |
| | **Total** | **59,965** | **60,564** | **1.0%** |
| **Johnson** | 0-14 | 2,702 | 2,785 | 3.1% |
| | 15-44 | 7,315 | 7,223 | -1.3% |
| | 45-54 | 2,684 | 2,663 | -0.8% |
| | 55 and over | 6,052 | 6,501 | 7.4% |
| | **Total** | **18,753** | **19,172** | **2.2%** |
| **Washington** | 0-14 | 20,455 | 20,746 | 1.4% |
| | 15-44 | 48,351 | 48,734 | 0.8% |
| | 45-54 | 16,606 | 16,258 | -2.1% |
| | 55 and over | 33,949 | 36,780 | 8.3% |
| | **Total** | **119,361** | **122,518** | **2.6%** |
| **Total** | 0-14 | 32,856 | 33,456 | 1.8% |
| | 15-44 | 79,612 | 79,519 | -0.1% |
| | 45-54 | 27,785 | 27,225 | -2.0% |
| | 55 and over | 57,826 | 62,054 | 7.3% |
| | **Total** | **198,079** | **202,254** | **2.1%** |

Source: Office of Health Statistics, Bureau of Health Informatics, TN Department of Health

The service area has a considerably lower average household income compared to the national average ($48,035 versus $67,529). The adult educational achievement level of the service area is also much lower than the national average. In Carter County, 53.3 percent of the population has a high school education or below, compared to 44.0 percent nationally. The racial mix in the service area is predominately Caucasian, accounting for more than 92 percent of the population. Please see the "Demographic Snapshot" provided in the attachments for an overview of the service area's demographics, both collectively and for the individual counties.

**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.**

Sycamore Shoals Hospital is committed to meeting the needs of the community and the region, as stated in its mission, "to identify and respond to the health care needs of individuals and communities in our region and to assist them in obtaining their highest level of health". SSH participates in Medicare and TennCare programs as well as the Cover Tennessee program. Mountain States Health Alliance, the parent company of Sycamore Shoals Hospital, provides services to more TennCare patients than any other provider in the region and is a leading provider of charity care. Medicare patients comprise 41.0 percent of SSH's patient revenue, TennCare and Medicaid patients make up 20.8 percent, with another 9.5 percent combined from charity and self-pay.

**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.**

There are no CONs relating to OB services in approved but unimplemented CONs or similar institutions in the service area. The existing services of similar institutions in this proposal's service area are listed below, for fiscal year 2009 through 2011. For Franklin Woods Community Hospital, fiscal year 2009 and 2010 statistics are from the Johnson City Specialty Hospital Joint Annual Report. As detailed in the approved and completed North Side Specialty Replacement Hospital project (CN0609-078A), obstetrical services at Johnson City Specialty Hospital were relocated to Franklin Woods Community Hospital, the replacement hospital for both Johnson City Specialty Hospital and North Side Hospital.

| Provider | OB Beds | Days of Capacity | OB Days - MDC 14 | OB Occupancy | Births | Average Daily Census |
|---|---|---|---|---|---|---|
| Johnson City Medical Center | | | | | | |
| FY 2009 | 20 | 7,300 | 5,067 | 69.4% | 1,217 | 13.88 |
| FY 2010 | 20 | 7,300 | 4,066 | 55.7% | 1,054 | 11.14 |
| FY 2011 | 22 | 8,030 | 5,118 | 63.7% | 1,261 | 14.02 |
| Franklin Woods Community Hospital/Johnson City Specialty Hospital | | | | | | |
| FY 2009 | 10 | 3,650 | 2,107 | 57.7% | 923 | 5.77 |
| FY 2010 | 10 | 3,650 | 1,747 | 47.9% | 892 | 4.79 |
| FY 2011 | 20 | 7,300 | 3,518 | 48.2% | 839 | 9.64 |

Source: FY 2009 - 2011 Joint Annual Report of Hospitals

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.**

The utilization of Sycamore Shoals Hospital Obstetrical Services is shown below, and includes volumes for the past three years. Since this proposal is for the discontinuance of OB services, projected utilization is not applicable.

**Sycamore Shoals Hospital**

Obstetrical Services Utilization FY 2009 - 2011

| Year | OB Beds | Days of Capacity | OB Days - MDC 14 | OB Occupancy | Births | Average Daily Census |
|---|---|---|---|---|---|---|
| FY 2009 | 7 | 2,555 | 1,016 | 39.8% | 479 | 2.78 |
| FY 2010 | 7 | 2,555 | 1,258 | 49.2% | 438 | 3.45 |
| FY 2011 | 7 | 2,555 | 1,380 | 54.0% | 466 | 3.78 |

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 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.**
    - **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.**

The project costs associated with this proposal are identified in the Project Costs Chart below.

## PROJECT COSTS CHART

A. Construction and equipment acquired by purchase:

| | | |
|---|---|---|
| 1. | Architectural and Engineering Fees | $ |
| 2. | Legal, Administrative (Excluding CON Filing Fee), Consultant Fees | $ 10,000 |
| 3. | Acquisition of Site | $ |
| 4. | Preparation of Site | $ |
| 5. | Construction Costs | $ |
| 6. | Contingency Fund | $ |
| 7. | Fixed Equipment (Not included in Construction Contract) | $ |
| 8. | Moveable Equipment (List all equipment over $50,000) | $ |
| 9. | Other (Specify) Signage, Minor Finish Changes, Etc. | $ 1,000 |

2012 JUN 15 AM 10 22

B. Acquisition by gift, donation, or lease:

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

C. Financing Costs and Fees:

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

| | | |
|---|---|---|
| D. | Estimated Project Cost (A+B+C) | **$ 11,000** |
| E. | CON Filing Fee | $ 3,000 |
| F. | Total Estimated Project Cost (D+E) | |
| | **TOTAL** | **$ 14,000** |

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—Appropriate documentation from Chief Financial Officer.**

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

The project will be funded from ongoing operations and existing cash reserves from operations at Mountain States Health Alliance. Documentation of the availability of funds to complete the project is provided in the attachments.

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.**

The total project cost for this proposed project equals $14,000, $13,000 of which is attributable to CON-related expenses. The costs for this project are reasonable in relation to other projects approved by the Health Services and Development Agency. A table comparing this project's costs to other recently submitted applications for the discontinuance of obstetrical services is illustrated in the following table.

| Facility | CON Project # | Total Project Costs |
|---|---|---|
| **Sycamore Shoals Hospital** | | **$14,000** |
| Methodist Healthcare | CN0809-070 | $101,000 |
| Southern Hills Medical Center | CN0809-073 | $50,000 |
| Baptist Memorial Hospital – Huntingdon | CN0412-113 | $5,000 |

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).**

The following two pages contain the Historical Data Chart and the Projected Data Chart.

SUPPLEMENTAL- # 1

June 25, 2012
10:54 am

## HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. Fiscal year begins in July.

2012 JUN 29 AM 10:59

| | FY 2009 | FY 2010 | FY 2011 |
|---|---|---|---|
| A. Utilization Data (patient days) | 14,299 | 15,334 | 15,299 |
| B. Revenue from Services to Patients | | | |
| 1. Inpatient Services | $66,389,792 | $74,499,719 | $81,785,459 |
| 2. Outpatient Services | $79,926,690 | $89,631,381 | $87,438,565 |
| 3. Emergency Services | $17,053,983 | $18,892,626 | $21,248,741 |
| 4. Other Operating Revenue | $1,438,473 | $1,179,319 | $1,040,749 |
| **Gross Operating Revenue** | **$164,808,938** | **$184,203,045** | **$191,513,514** |
| C. Deductions from Gross Operating Revenue | | | |
| 1. Contractual Adjustments | $116,621,850 | $132,577,211 | $140,224,117 |
| 2. Provision for Charity Care | $1,631,372 | $1,881,175 | $2,594,953 |
| 3. Provisions for Bad Debt | $5,581,980 | $5,530,900 | $6,507,082 |
| **Total Deductions** | **$123,835,202** | **$139,989,286** | **$149,326,152** |
| **NET OPERATING REVENUE** | **$40,973,736** | **$44,213,759** | **$42,187,362** |
| D. Operating Expenses | | | |
| 1. Salaries and Wages | $16,593,750 | $17,140,822 | $17,092,280 |
| 2. Physician's Salaries and Wages | $0 | $0 | $0 |
| 3. Supplies | $5,184,881 | $5,474,592 | $5,150,668 |
| 4. Taxes | $0 | $0 | $0 |
| 5. Depreciation | $2,565,402 | $2,598,527 | $2,498,529 |
| 6. Rent | $0 | $0 | $0 |
| 7. Interest, other than Capital | $560,761 | $532,062 | $656,069 |
| 8. Management Fees: | | | |
| a. Fees to Affiliates | $0 | $0 | $0 |
| b. Fees to Non-Affiliates | $0 | $0 | $0 |
| Note: Mgmt fees related to expense allocations for support services have not been included. Shown below. | | | |
| 9. Other Expenses – Specified on separate page | $11,839,523 | $12,373,391 | $12,928,730 |
| **Total Operating Expenses** | **$36,774,317** | **$38,119,394** | **$38,326,276** |
| E. Other Revenue (Expenses) – Net (Specify)_____ | $_____ | $_____ | $_____ |
| **NET OPERATING INCOME (LOSS)** | **$4,229,419** | **$6,094,365** | **$3,861,086** |
| F. Capital Expenditures | | | |
| 1. Retirement of Principal | $_____ | $_____ | $_____ |
| 2. Interest | _____ | _____ | _____ |
| **Total Capital Expenditures** | **$0** | **$0** | **$0** |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | **$4,229,419** | **$6,094,365** | **$3,861,086** |
| Management Fees (Corporate allocation – expense allocations for support services) | $1,329,130 | $1,276,604 | $1,597,023 |
| **NET OPERATING INCOME (LOSS) from SSH Income** | $2,900,289 | $4,817,761 | $2,264,063 |

SUPPLEMENTAL- # 1
June 25, 2012
10:54 am

## PROJECTED DATA CHART

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

2012 JUN 25 AM 10 59

| | FY 2013 | FY 2014 |
|---|---|---|
| A. Utilization Data (patient days) | 13,781 | 13,512 |
| B. Revenue from Services to Patients | | |
| 1. Inpatient Services | $79,862,594 | $82,330,238 |
| 2. Outpatient Services | $96,040,522 | $99,409,696 |
| 3. Emergency Services | $27,986,253 | $28,266,116 |
| 4. Other Operating Revenue (lamaze) | $588,771 | $606,434 |
| **Gross Operating Revenue** | **$204,478,140** | **$210,612,484** |
| C. Deductions from Gross Operating Revenue | | |
| 1. Contractual Adjustments | $152,275,797 | $156,844,071 |
| 2. Provision for Charity Care | $3,690,398 | $3,801,110 |
| 3. Provisions for Bad Debt | $8,604,131 | $8,862,255 |
| **Total Deductions** | **$164,570,326** | **$169,507,436** |
| **NET OPERATING REVENUE** | **$39,907,814** | **$41,105,048** |
| D. Operating Expenses | | |
| 1. Salaries and Wages | $16,400,128 | $16,861,971 |
| 2. Physician's Salaries and Wages | $0 | $0 |
| 3. Supplies | $4,722,674 | $4,729,433 |
| 4. Taxes | $0 | $0 |
| 5. Depreciation | $2,026,303 | $1,678,342 |
| 6. Rent | $0 | $0 |
| 7. Interest, other than Capital | $557,519 | $545,227 |
| 8. Management Fees: | | |
| e. Fees to Affiliates | $0 | $0 |
| f. Fees to Non-Affiliates | $0 | $0 |
| 9. Other Expenses – Specified on separate page | $12,776,750 | $12,899,516 |
| **Total Operating Expenses** | **$36,483,374** | **$36,714,489** |
| E. Other Revenue (Expenses) – Net (Specify)_____ | $_____ | $_____ |
| **NET OPERATING INCOME (LOSS)** | **$3,424,440** | **$4,390,559** |
| F. Capital Expenditures | | |
| 1. Retirement of Principal | $_____ | $_____ |
| 2. Interest | _____ | _____ |
| **Total Capital Expenditures** | **$0** | **$0** |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | **$3,424,440** | **$4,390,559** |
| Management Fees (Corporate allocation – expense allocations for support services) | $2,360,629 | $2,391,657 |
| **NET OPERATING INCOME (LOSS) from SSH Income** | $1,063,811 | $1,998,902 |

## HISTORICAL DATA CHART-OTHER EXPENSES

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

2012 JUN 25 AM 10 59

| OTHER EXPENSES CATEGORIES | YearFY2009 | YearFY2010 | YearFY2011 |
|---|---|---|---|
| 1. Contract Labor | $236,994 | $190,716 | $275,725 |
| 2. Benefits | $3,595,286 | $3,825,910 | $3,847,284 |
| 3. Utilities | $3,509,739 | $3,325,204 | $3,350,941 |
| 4. Fees | $4,226,896 | $4,756,622 | $5,024,593 |
| 5. Bad Debt | $270,608 | $274,939 | $430,187 |
| 6. | | | |
| 7. | | | |
| **Total Other Expenses** | **$11,839,523** | **$12,373,391** | **$12,928,730** |

## HISTORICAL DATA CHART-OTHER EXPENSES

| OTHER EXPENSES CATEGORIES | YearFY2012 |
|---|---|
| 1. Contract Labor | $303,280 |
| 2. Benefits | $4,265,750 |
| 3. Utilities | $3,700,738 |
| 4. Fees | $5,535,711 |
| 5. Bad Debt | $411,963 |
| 6. | |
| 7. | |
| **Total Other Expenses** | **$14,217,443** |

## PROJECTED DATA CHART-OTHER EXPENSES

| OTHER EXPENSES CATEGORIES | YearFY2013 | YearFY2014 |
|---|---|---|
| 1. Contract Labor | $110,350 | $111,497 |
| 2. Benefits | $4,023,277 | $4,065,116 |
| 3. Utilities | $2,997,015 | $3,028,182 |
| 4. Fees | $4,859,198 | $4,909,731 |
| 5. Bad Debt | $428,168 | $432,621 |
| 6. Insurance | $348,742 | $352,369 |
| 7. | | |
| **Total Other Expenses** | **$12,776,750** | **$12,889,516** |

**ATTACHMENT 9**

Question 13 B: Historical Data Chart for SSH OB Services

SUPPLEMENTAL- # 1
June 25, 2012
10:54 am

## HISTORICAL DATA CHART - OB

Give information for the last *two* years for which complete data are available for the facility or agency. The fiscal year begins in July.

Also provided is the facility has a whole for FY2012 for comparison purposes. FY2012 data has been annualized based on 11 months of actual data.

2012 JUN 25 AM 10 59

| | FY 2011 OB Only | FY 2012 OB Only | FY 2012 SSH Total |
|---|---|---|---|
| A. Utilization Data (patient days) | 1,367 | 1,181 | 15,217 |
| B. Revenue from Services to Patients | | | |
| 1. Inpatient Services | $5,141,099 | $4,645,837 | $82,890,529 |
| 2. Outpatient Services | $498,089 | $529,138 | $96,170,615 |
| 3. Emergency Services | $0 | $0 | $24,097,268 |
| 4. Other Operating Revenue (lamaze) | $220 | $87 | $1,005,916 |
| **Gross Operating Revenue** | **$5,639,408** | **$5,175,062** | **$204,164,328** |
| C. Deductions from Gross Operating Revenue | | | |
| 1. Contractual Adjustments | $4,539,159 | $4,165,408 | $149,147,399 |
| 2. Provision for Charity Care | $124,067 | $113,851 | $3,891,363 |
| 3. Provisions for Bad Debt | $236,855 | $217,353 | $8,300,989 |
| **Total Deductions** | **$4,900,082** | **$4,496,612** | **$161,339,751** |
| **NET OPERATING REVENUE** | **$739,326** | **$678,451** | **$42,824,577** |
| D. Operating Expenses | | | |
| 1. Salaries and Wages | $1,272,400 | $1,357,264 | $18,171,140 |
| 2. Physician's Salaries and Wages | $0 | $0 | $0 |
| 3. Supplies | $81,512 | $79,331 | $5,002,349 |
| 4. Taxes | $0 | $0 | $0 |
| 5. Depreciation | $11,545 | $10,017 | $1,917,598 |
| 6. Rent | $0 | $0 | $0 |
| 7. Interest, other than Capital | $0 | $0 | $635,174 |
| 8. Management Fees: | | | |
| c. Fees to Affiliates | $0 | $0 | $0 |
| d. Fees to Non-Affiliates | $0 | $0 | $0 |
| 9. Other Expenses – Specified on separate page | $108,978 | $220,960 | $14,217,443 |
| **Total Operating Expenses** | **$1,474,435** | **$1,667,572** | **$39,943,704** |
| E. Other Revenue (Expenses) – Net (Specify)_____ | $_____ | $_____ | $_____ |
| **NET OPERATING INCOME (LOSS)** | **$(735,109)** | **$(989,122)** | **$2,880,873** |
| F. Capital Expenditures | | | |
| 1. Retirement of Principal | $_____ | $_____ | $_____ |
| 2. Interest | _____ | _____ | _____ |
| **Total Capital Expenditures** | **$0** | **$0** | **$0** |
| **NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES** | **$(735,109)** | **$(989,122)** | **$2,880,873** |
| Management Fees (Corporate allocation – expense allocations for support services) | | | $1,759,837 |
| **NET OPERATING INCOME (LOSS) from SSH Income** | | | $1,212,036 |

1. **During a phone conversation between Phil Wells and Laura Linn on Monday, June 25, 2012, Mr. Wells requested additional information regarding the increase over time to the "Management Fees – Corporate Allocation" line item. The applicant's response is given below.**

   Due to the consolidation of certain departments within MSHA Corporate and changes in reporting responsibilities, certain expenses have been moved from the facility level to corporate and then redistributed through the corporate allocation back out to the facilities. The most prevalent of these items would be Information Systems Maintenance Contracts. Beginning in FY13, all IS Maintenance Contracts will be expensed to the Corporate IS department and then allocated back out to each of the facilities through the Corporate Allocation. This can be seen in the decrease to the "Other Expense" line item from FY12 to FY13.

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

The project's charge information is as follows:

| | |
|---|---|
| Average gross charge per patient day | $11,681 |
| Average deduction from operating revenue | $8,777 |
| Average Net Charge | $2,904 |

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.**

A list of charges related to obstetrical services is provided in the attachments. These charges are consisted to charges at other Mountain States Health Alliance Facilities. There will be no adjustment to charges that will result from implementing this proposal.

**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).**

Sycamore Shoals Hospital's charges have been consistent with those used for obstetrical services by other members of Mountain States Health Alliance. A copy of the current charges is provided in the attachments. Mountain States Health Alliance engages a third-party consulting company to evaluate its current and future charge structure and to evaluate how it compares to the market.

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

The consolidation of Sycamore Shoals Hospital's obstetrical services to the Mountain States Health Alliance facilities in Washington County will reduce loss to Sycamore Shoals Hospital, due to the low and inefficient utilization of the hospital's OB services.

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

Revenue and expense information for this proposal for Years 1 and 2 following project completion is included in the Projected Data Chart. The cash flow as represented is projected to be -$4,805,826 and -$2,764,396 in years 1 and 2, respectively.

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.**

Sycamore Shoals Hospital is committed to meeting the needs of the community and the region, and will continue the provision of medically necessary care, regardless of socioeconomic status, payor source, age, race or gender. SSH participates in both Federal and State programs, including Medicare, TennCare and Medicaid programs. Medicare patients comprise 41.0 percent of SSH's patient revenue, TennCare and Medicaid patients make up 20.8 percent, with another 9.5 percent combined from charity and self-pay.

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.**

The most recent reporting period audited balance sheets and income statements for Mountain States Health Alliance are located in the attachments (audited statements for Fiscal Year 2011 and 2010).

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.**

    Two alternatives were considered: (1) maintain SSH Obstetrical Services, (2) consolidate Obstetrical Services with other MSHA facilities.

    (1) Maintain SSH Obstetrical Services: The first option would be continue obstetrical services at SSH. This option was rejected for a number of reasons, including difficulty in recruiting new obstetricians, consistently low volume compromising patient safety and care quality, and operational inefficiencies resulting in financial losses for the hospital. The current and future demographics of the service area no longer necessitates obstetrical services at SSH, with decline in the child bearing population and the resulting 3.5% decline in area delivery volumes as projected by Thomson Rueters.

    (2) Consolidate Obstetrical Services: Another alternative is the consolidation of OB services to other nearby MSHA facilities. This option was chosen as it continues to provide convenient access for the service area's residents to obstetrical services, while maintaining safety and clinical quality. In addition, this option is more efficient and minimizes financial loss for Mountain States Health Alliance.

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.**

Not Applicable. This proposal does not include new construction.

## (III.) 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.**

   Sycamore Shoals Hospital will continue to work closely with other healthcare providers in the region, including: Mountain States Health Alliance hospitals, hospitals in the Mountain States Healthcare Network, East Tennessee State University and the James H. Quillen College of Medicine, local nursing homes, clinics and other healthcare providers. Sycamore Shoals Hospital has developed extensive working relationships with hospitals in the Northeast Tennessee area as well as many hospitals in Southwest Virginia.

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.**

   Approval of this request to discontinue obstetrical services will contribute to the efficiency of healthcare resources and the orderly development of health care. Positive effects of this proposal include maintaining the goal of providing the highest quality care to area residents. By discontinuing OB services at Sycamore Shoals Hospital, patients will be directed to higher volume Mountain States Health Alliance facilities, where OB departments have no difficulty maintaining high quality services through comprehensive staff coverage around the clock.

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.**

   Not Applicable. This proposal does not add FTE's.

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.**

   Not Applicable.

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.**

   Sycamore Shoals Hospital has reviewed and understands all licensing certification as required by the State of Tennessee. Sycamore Shoals Hospital has policies and procedures in place governing regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

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.).**

   Mountain States Health Alliance works extensively with local colleges and universities and is affiliated with the James H. Quillen College of Medicine, East Tennessee State University, located in Johnson City, Tennessee. MSHA has the largest number of medical residents in the Tri-Cities area, and this affiliation calls for Mountain States Health Alliance to provide clinical training for medical students and residents in the areas of family medicine and psychiatric services.

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.**

   The proposed project will comply with licensure requirements of the Department of Health. The facility will not provide any services that require licensure by the Department of Mental Health and Mental Retardation.

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

   **Licensure:**

   Sycamore Shoals Hospital is licensed to provide services as an acute care provider by the Board for Licensing Health Care Facilities.

   **Accreditation:**

   Sycamore Shoals Hospital is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

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

   Sycamore Shoals Hospital is currently licensed by the Board of Licensing Health Care Facilities and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A copy of the license and the JCAHO accreditation for the SSH is located in the attachments.

(c) **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.**

A copy of the most recent Summary Statement of Deficiencies and the approved Provider's Plan of Correction, is located in the attachments.

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.**

Mountain States Health Alliance, owner and operator of Sycamore Shoals Hospital, has no 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.

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.**

There are no final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

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.**

The applicant will continue to provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as requested.

## 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.**

The full page of the newspaper in which the notice of intent appeared, with mast and dateline intact, is attached.

## 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.**

Form HF0004
Revised 05/03/04
Previous Forms are obsolete

# PROJECT COMPLETION FORECAST CHART

2012 JUN 15 AM 10 22

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): Sept 26, 2012
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.

| Phase | DAYS REQUIRED | Anticipated Date (MONTH/YEAR) |
|---|---|---|
| 1. Architectural and engineering contract signed | | |
| 2. Construction documents approved by the Tennessee Department of Health | | |
| 3. Construction contract signed | | |
| 4. Building permit secured | | |
| 5. Site preparation completed | | |
| 6. Building construction commenced | | |
| 7. Construction 40% complete | | |
| 8. Construction 80% complete | | |
| 9. Construction 100% complete (approved for occupancy | | |
| 10. *Issuance of license | | Sep 27, 2012 |
| 11. *Initiation of service | | Sep 27, 2012 |
| 12. Final Architectural Certification of Payment | | |
| 13. Final Project Report Form (HF0055) | | |

* **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.**

Mountain States Health Alliance
Sycamore Shoals Hospital Discontinuance of Obstetrical Services Project
Certificate of Need Application Attachments

*Attachment A.3:* Corporate Charter and Certificate of Incorporation and Certificate of Existence

*Attachment A.4:* Organizational Structure

*Attachment A.6:* Title / Deed / Legal Interest in Site

*Attachments B.III.(A) & B.IV:* Plot Plan & Floor Plans

*Attachment C, Need 3:* Service Area Map

*Attachment C, Need 4.A:* Demographic Snapshots

*Attachment C, Economic Feasibility 2:* Letter of Available Funds

*Attachment C, Economic Feasibility 6.A:* List of Charges for OB Services

*Attachment C, Economic Feasibility 10:* Balance Sheet and Income Statement for Mountain States Health Alliance: Most Recent Audited Statements – FY2011 and FY2010

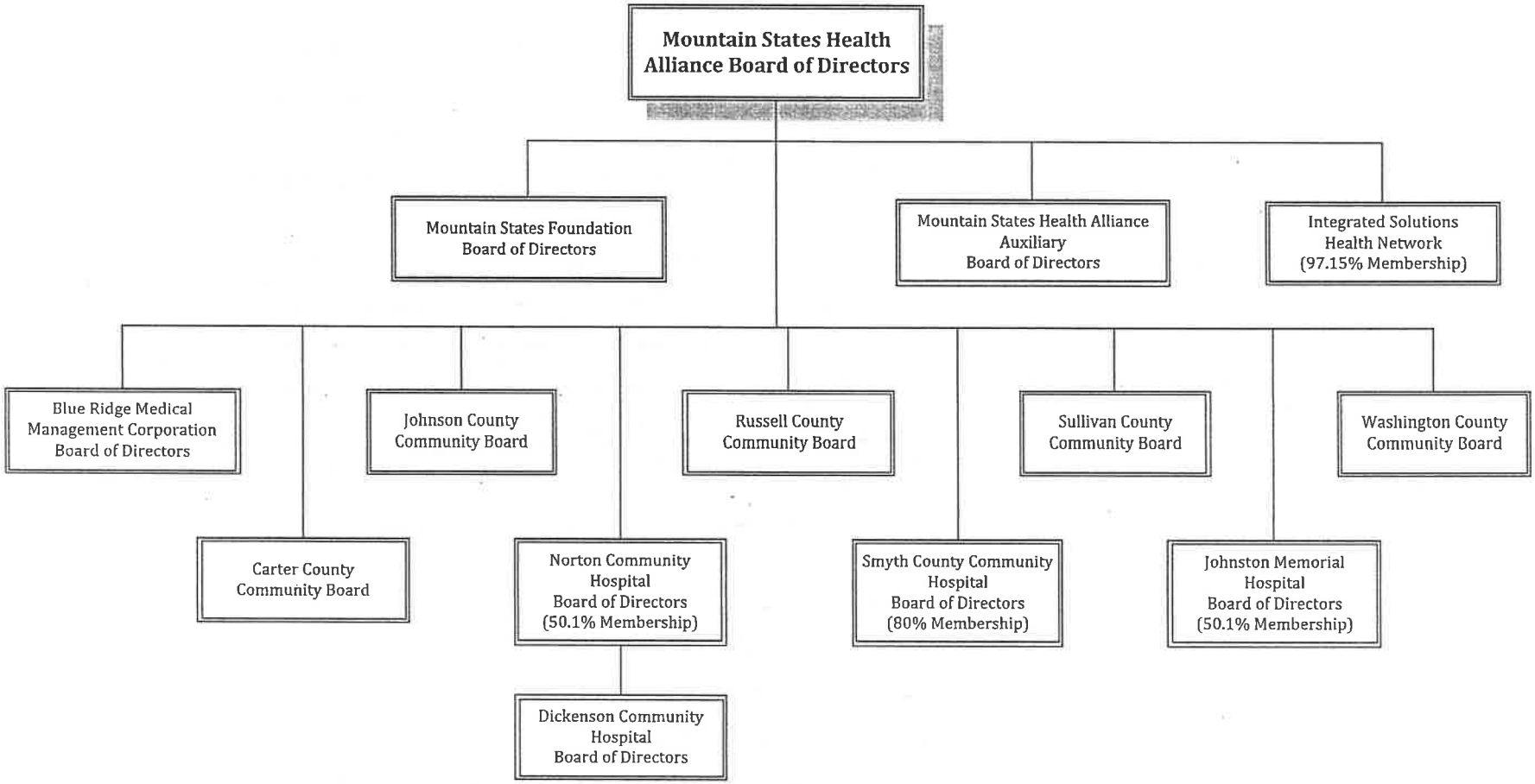
*Attachment C, Contribution to the Orderly Development of Health Care, 7(b):* Current Licensure from Tennessee Department of Health and Joint Commission Accreditation

*Attachment C, Contribution to the Orderly Development of Health Care, 7(c):* Summary Statement of Deficiencies and (Approved) Provider's Plan of Correction

*Attachment C, Proof of Publication:* Publication of Intent, Elizabethton Star

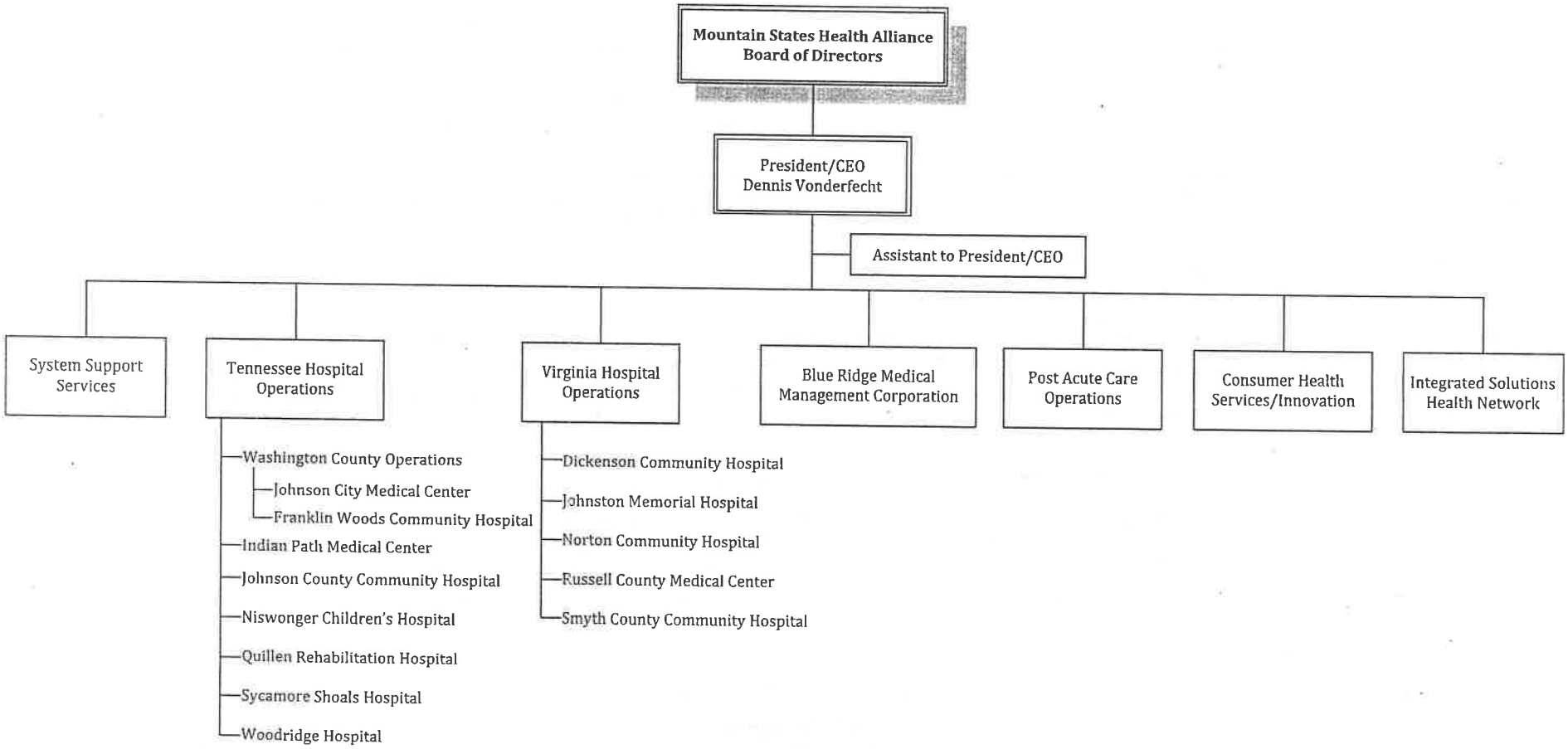
*Attachment:* Affidavit for Application

# Mountain States Health Alliance
# Governance Structure




Dennis Vonderfecht
President and CEO
February 1, 2012

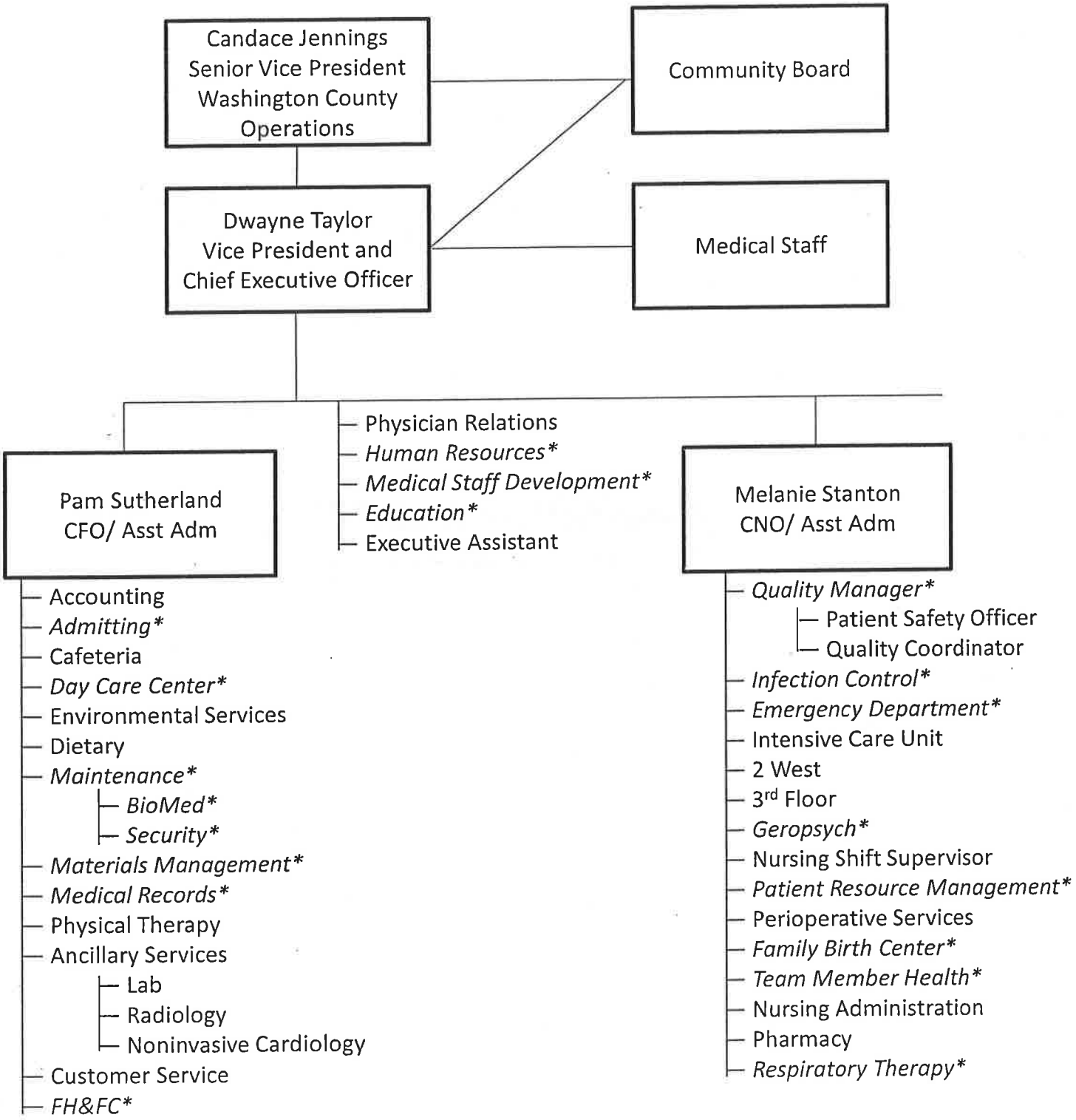
# Mountain States Health Alliance
# Management Structure by Division




Dennis Vonderfecht
President and CEO
February 1, 2012

SYCAMORE SHOALS HOSPITAL
Mountain States Health Alliance

# Organizational Chart

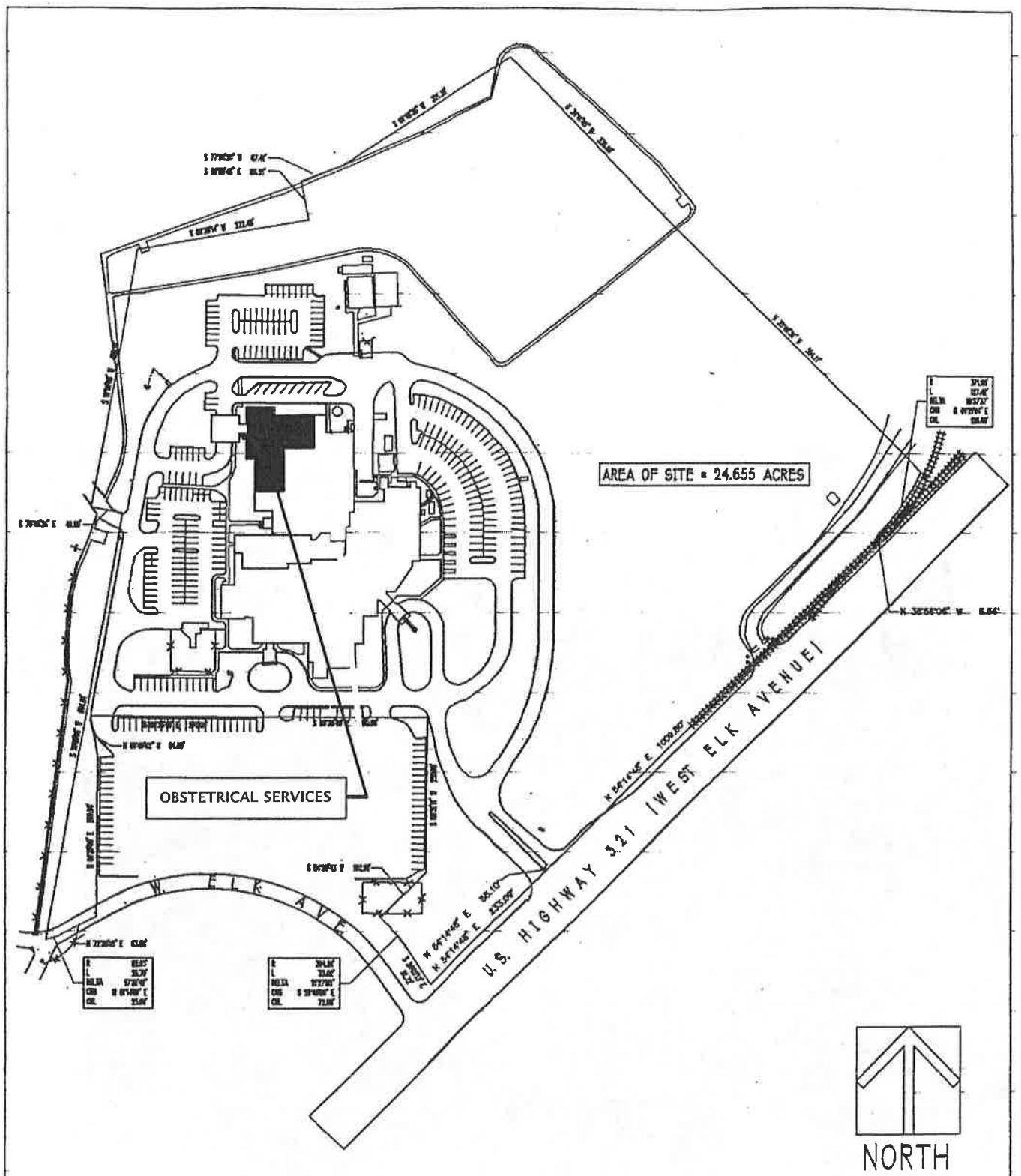



Dwayne Taylor
Sycamore Shoals Hospital
August 11, 2011

* These positions also report to an MSHA manager/director

## ***Attachment B.III.(A) & B.IV:***

Plot Plan & Floor Plans




THOMAS WEEMS ARCHITECT
3203 HANOVER ROAD
JOHNSON CITY, TN 37604
PHONE 423-952-2700
FAX 423-952-2702
TWARCH@PLANETC.COM

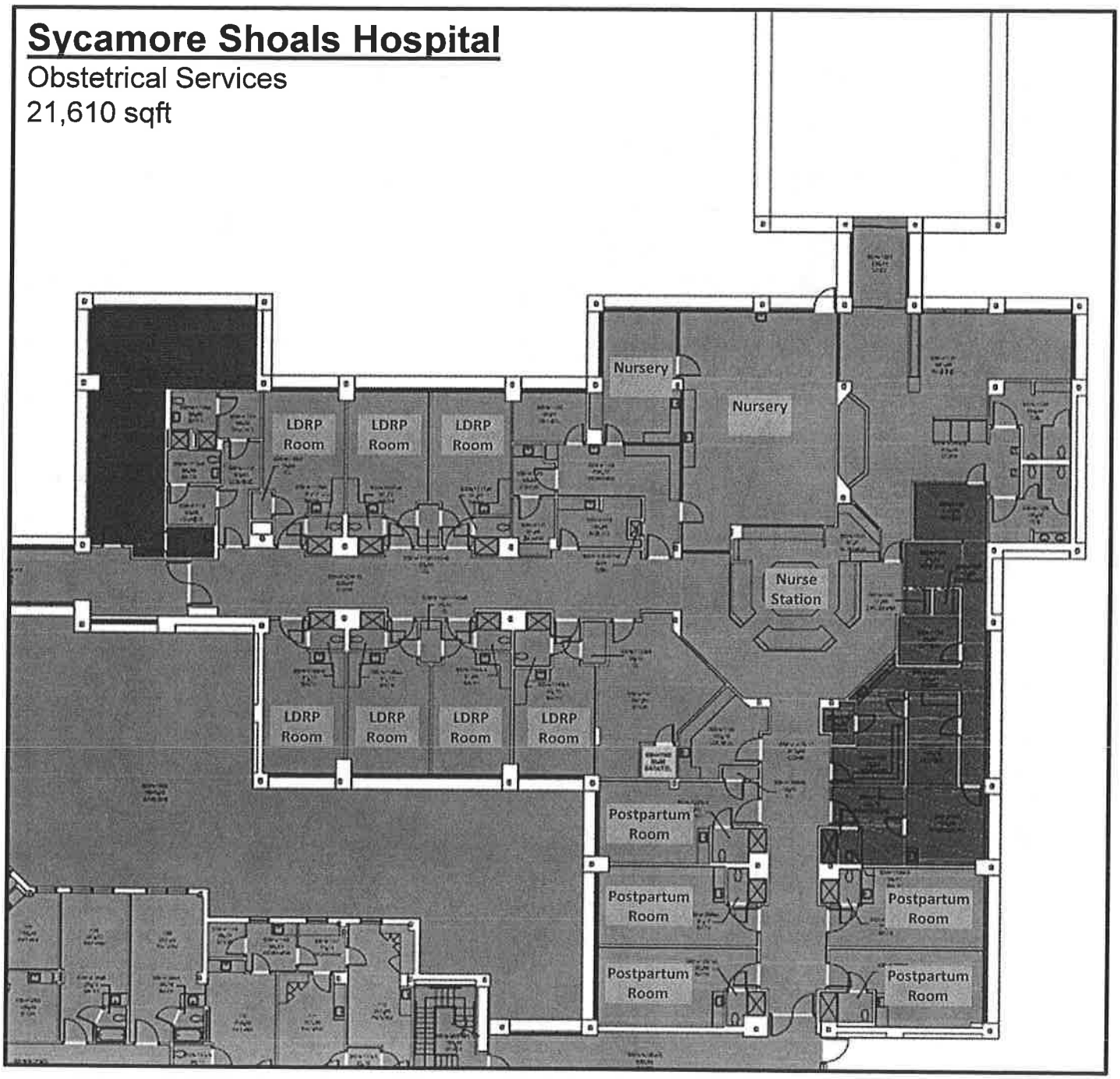
Project Title
SYCAMORE SHOALS HOSPITAL
ELIZABETHTON, TENNESSEE

Drawing Title
SCHEMATIC SITE PLAN

Project Number

Drawn / Date
JANUARY 25, 2001

Drawing Number
1


Sycamore Shoals Hospital
Obstetrical Services
21,610 sqft
Nursery
Nursery
LDRP Room
LDRP Room
LDRP Room
Nurse Station
LDRP Room
LDRP Room
LDRP Room
LDRP Room
Postpartum Room
Postpartum Room
Postpartum Room
Postpartum Room
Postpartum Room

## ***Attachment C, Need 4.A:***

Demographic Snapshots

Demographics Expert 2.7

2011 Demographic Snapshot

Area: Carter, Johnson, & Washington Counties, TN

Level of Geography: ZIP Code

## DEMOGRAPHIC CHARACTERISTICS

| | Selected Area | USA |
|---|---|---|
| 2000 Total Population | 181,783 | 281,421,906 |
| 2011 Total Population | 200,651 | 310,650,750 |
| 2016 Total Population | 208,081 | 323,031,618 |
| % Change 2011 - 2016 | 3.7% | 4.0% |
| Average Household Income | $48,035 | $67,529 |

| | 2011 | 2016 | % Change |
|---|---|---|---|
| Total Male Population | 99,261 | 102,923 | 3.7% |
| Total Female Population | 101,390 | 105,158 | 3.7% |
| Females, Child Bearing Age (15-44) | 38,911 | 38,619 | -0.8% |

## POPULATION DISTRIBUTION

| | Age Distribution | | | | |
|---|---|---|---|---|---|
| Age Group | 2011 | % of Total | 2016 | % of Total | USA 2011 % of Total |
| 0-14 | 32,905 | 16.4% | 33,965 | 16.3% | 20.2% |
| 15-17 | 6,565 | 3.3% | 6,772 | 3.3% | 4.2% |
| 18-24 | 18,279 | 9.1% | 18,196 | 8.7% | 9.7% |
| 25-34 | 27,699 | 13.8% | 26,187 | 12.6% | 13.3% |
| 35-54 | 56,374 | 28.1% | 57,015 | 27.4% | 27.6% |
| 55-64 | 25,796 | 12.9% | 27,675 | 13.3% | 11.7% |
| 65+ | 33,033 | 16.5% | 38,271 | 18.4% | 13.3% |
| Total | 200,651 | 100.0% | 208,081 | 100.0% | 100.0% |

## HOUSEHOLD INCOME DISTRIBUTION

| | Income Distribution | | |
|---|---|---|---|
| 2011 Household Income | HH Count | % of Total | USA % of Total |
| <$15K | 16,867 | 20.2% | 12.9% |
| $15-25K | 12,727 | 15.3% | 10.8% |
| $25-50K | 26,237 | 31.5% | 26.6% |
| $50-75K | 13,833 | 16.6% | 19.5% |
| $75-100K | 6,369 | 7.6% | 11.9% |
| Over $100K | 7,272 | 8.7% | 18.3% |
| Total | 83,305 | 100.0% | 100.0% |

## EDUCATION LEVEL

| | Education Level Distribution | | |
|---|---|---|---|
| 2011 Adult Education Level | Pop Age 25+ | % of Total | USA % of Total |
| Less than High School | 10,465 | 7.3% | 6.3% |
| Some High School | 16,657 | 11.7% | 8.8% |
| High School Degree | 49,007 | 34.3% | 28.9% |
| Some College/Assoc. Degree | 36,710 | 25.7% | 28.3% |
| Bachelor's Degree or Greater | 30,063 | 21.0% | 27.7% |
| Total | 142,902 | 100.0% | 100.0% |

## RACE/ETHNICITY

| | Race/Ethnicity Distribution | | |
|---|---|---|---|
| Race/Ethnicity | 2011 Pop | % of Total | USA % of Total |
| White Non-Hispanic | 185,600 | 92.5% | 64.2% |
| Black Non-Hispanic | 6,624 | 3.3% | 12.1% |
| Hispanic | 4,414 | 2.2% | 16.1% |
| Asian & Pacific Is. Non-Hispanic | 1,169 | 0.6% | 4.6% |
| All Others | 2,844 | 1.4% | 3.0% |
| Total | 200,651 | 100.0% | 100.0% |

© 2011 The Nielsen Company, © 2012 Thomson Reuters. All Rights Reserved

**Demographics Expert 2.7**
**2011 Demographic Snapshot**
**Area: Carter county, TN**
**Level of Geography: Block Group Code**

## DEMOGRAPHIC CHARACTERISTICS

| | Selected Area | USA |
|---|---|---|
| 2000 Total Population | 56,742 | 281,421,906 |
| 2011 Total Population | 59,177 | 310,650,750 |
| 2016 Total Population | 59,776 | 323,031,618 |
| % Change 2011 - 2016 | 1.0% | 4.0% |
| Average Household Income | $40,102 | $67,529 |

| | 2011 | 2016 | % Change |
|---|---|---|---|
| Total Male Population | 29,701 | 29,974 | 0.9% |
| Total Female Population | 29,476 | 29,802 | 1.1% |
| Females, Child Bearing Age (15-44) | 11,121 | 10,782 | -3.0% |

## POPULATION DISTRIBUTION

| | Age Distribution | | | | |
|---|---|---|---|---|---|
| Age Group | 2011 | % of Total | 2016 | % of Total | USA 2011 % of Total |
| 0-14 | 9,073 | 15.3% | 8,980 | 15.0% | 20.2% |
| 15-17 | 1,941 | 3.3% | 1,865 | 3.1% | 4.2% |
| 18-24 | 5,817 | 9.8% | 5,557 | 9.3% | 9.7% |
| 25-34 | 7,837 | 13.2% | 7,616 | 12.7% | 13.3% |
| 35-54 | 16,586 | 28.0% | 16,060 | 26.9% | 27.6% |
| 55-64 | 7,871 | 13.3% | 8,106 | 13.6% | 11.7% |
| 65+ | 10,052 | 17.0% | 11,592 | 19.4% | 13.3% |
| Total | 59,177 | 100.0% | 59,776 | 100.0% | 100.0% |

## HOUSEHOLD INCOME DISTRIBUTION

| | Income Distribution | | |
|---|---|---|---|
| 2011 Household Income | HH Count | % of Total | USA % of Total |
| <$15K | 5,690 | 23.1% | 12.9% |
| $15-25K | 4,147 | 16.8% | 10.8% |
| $25-50K | 8,372 | 33.9% | 26.6% |
| $50-75K | 3,756 | 15.2% | 19.5% |
| $75-100K | 1,410 | 5.7% | 11.9% |
| Over $100K | 1,285 | 5.2% | 18.3% |
| Total | 24,660 | 100.0% | 100.0% |

## EDUCATION LEVEL

| | Education Level Distribution | | |
|---|---|---|---|
| 2011 Adult Education Level | Pop Age 25+ | % of Total | USA % of Total |
| Less than High School | 3,923 | 9.3% | 6.3% |
| Some High School | 5,859 | 13.8% | 8.8% |
| High School Degree | 16,915 | 39.9% | 28.9% |
| Some College/Assoc. Degree | 9,574 | 22.6% | 28.3% |
| Bachelor's Degree or Greater | 6,075 | 14.3% | 27.7% |
| Total | 42,346 | 100.0% | 100.0% |

## RACE/ETHNICITY

| | Race/Ethnicity Distribution | | |
|---|---|---|---|
| Race/Ethnicity | 2011 Pop | % of Total | USA % of Total |
| White Non-Hispanic | 56,091 | 94.8% | 64.2% |
| Black Non-Hispanic | 1,192 | 2.0% | 12.1% |
| Hispanic | 923 | 1.6% | 16.1% |
| Asian & Pacific Is. Non-Hispanic | 219 | 0.4% | 4.6% |
| All Others | 752 | 1.3% | 3.0% |
| Total | 59,177 | 100.0% | 100.0% |

© 2011, Claritas Inc., © 2011 Thomson Reuters. All Rights Reserved

**Demographics Expert 2.7**
**2011 Demographic Snapshot**
**Area: Johnson, TN**
**Level of Geography: Block Group Code**

## DEMOGRAPHIC CHARACTERISTICS

| | Selected Area | USA |
|---|---|---|
| 2000 Total Population | 17,499 | 281,421,906 |
| 2011 Total Population | 18,006 | 310,650,750 |
| 2016 Total Population | 18,081 | 323,031,618 |
| % Change 2011 - 2016 | 0.4% | 4.0% |
| Average Household Income | $37,534 | $67,529 |

| | 2011 | 2016 | % Change |
|---|---|---|---|
| Total Male Population | 9,850 | 9,921 | 0.7% |
| Total Female Population | 8,156 | 8,160 | 0.0% |
| Females, Child Bearing Age (15-44) | 2,695 | 2,525 | -6.3% |

## POPULATION DISTRIBUTION

| | Age Distribution | | | | |
|---|---|---|---|---|---|
| Age Group | 2011 | % of Total | 2016 | % of Total | USA 2011 % of Total |
| 0-14 | 2,583 | 14.3% | 2,587 | 14.3% | 20.2% |
| 15-17 | 558 | 3.1% | 524 | 2.9% | 4.2% |
| 18-24 | 1,291 | 7.2% | 1,333 | 7.4% | 9.7% |
| 25-34 | 2,383 | 13.2% | 2,255 | 12.5% | 13.3% |
| 35-54 | 5,393 | 30.0% | 5,153 | 28.5% | 27.6% |
| 55-64 | 2,587 | 14.4% | 2,645 | 14.6% | 11.7% |
| 65+ | 3,211 | 17.8% | 3,584 | 19.8% | 13.3% |
| Total | 18,006 | 100.0% | 18,081 | 100.0% | 100.0% |

## HOUSEHOLD INCOME DISTRIBUTION

| | Income Distribution | | |
|---|---|---|---|
| 2011 Household Income | HH Count | % of Total | USA % of Total |
| <$15K | 2,071 | 28.6% | 12.9% |
| $15-25K | 1,285 | 17.8% | 10.8% |
| $25-50K | 2,266 | 31.3% | 26.6% |
| $50-75K | 867 | 12.0% | 19.5% |
| $75-100K | 409 | 5.7% | 11.9% |
| Over $100K | 336 | 4.6% | 18.3% |
| Total | 7,234 | 100.0% | 100.0% |

## EDUCATION LEVEL

| | Education Level Distribution | | |
|---|---|---|---|
| 2011 Adult Education Level | Pop Age 25+ | % of Total | USA % of Total |
| Less than High School | 1,711 | 12.6% | 6.3% |
| Some High School | 2,454 | 18.1% | 8.8% |
| High School Degree | 5,443 | 40.1% | 28.9% |
| Some College/Assoc. Degree | 2,557 | 18.8% | 28.3% |
| Bachelor's Degree or Greater | 1,409 | 10.4% | 27.7% |
| Total | 13,574 | 100.0% | 100.0% |

## RACE/ETHNICITY

| | Race/Ethnicity Distribution | | |
|---|---|---|---|
| Race/Ethnicity | 2011 Pop | % of Total | USA % of Total |
| White Non-Hispanic | 17,049 | 94.7% | 64.2% |
| Black Non-Hispanic | 568 | 3.2% | 12.1% |
| Hispanic | 186 | 1.0% | 16.1% |
| Asian & Pacific Is. Non-Hispanic | 25 | 0.1% | 4.6% |
| All Others | 178 | 1.0% | 3.0% |
| Total | 18,006 | 100.0% | 100.0% |

© 2011, Claritas Inc., © 2011 Thomson Reuters. All Rights Reserved

**Demographics Expert 2.7**
**2011 Demographic Snapshot**
**Area: Washington, TN**
**Level of Geography: Block Group Code**

## DEMOGRAPHIC CHARACTERISTICS

| | Selected Area | USA |
|---|---|---|
| 2000 Total Population | 107,198 | 281,421,906 |
| 2011 Total Population | 123,129 | 310,650,750 |
| 2016 Total Population | 129,917 | 323,031,618 |
| % Change 2011 - 2016 | 5.5% | 4.0% |
| Average Household Income | $53,383 | $67,529 |

| | 2011 | 2016 | % Change |
|---|---|---|---|
| Total Male Population | 59,552 | 62,875 | 5.6% |
| Total Female Population | 63,577 | 67,042 | 5.5% |
| Females, Child Bearing Age (15-44) | 25,078 | 25,327 | 1.0% |

## POPULATION DISTRIBUTION

| | Age Distribution | | | | |
|---|---|---|---|---|---|
| Age Group | 2011 | % of Total | 2016 | % of Total | USA 2011 % of Total |
| 0-14 | 21,242 | 17.3% | 22,411 | 17.3% | 20.2% |
| 15-17 | 4,040 | 3.3% | 4,376 | 3.4% | 4.2% |
| 18-24 | 11,139 | 9.0% | 11,250 | 8.7% | 9.7% |
| 25-34 | 17,524 | 14.2% | 16,287 | 12.5% | 13.3% |
| 35-54 | 34,237 | 27.8% | 35,773 | 27.5% | 27.6% |
| 55-64 | 15,259 | 12.4% | 16,821 | 12.9% | 11.7% |
| 65+ | 19,688 | 16.0% | 22,999 | 17.7% | 13.3% |
| Total | 123,129 | 100.0% | 129,917 | 100.0% | 100.0% |

## HOUSEHOLD INCOME DISTRIBUTION

| | Income Distribution | | |
|---|---|---|---|
| 2011 Household Income | HH Count | % of Total | USA % of Total |
| <$15K | 9,076 | 17.7% | 12.9% |
| $15-25K | 7,275 | 14.2% | 10.8% |
| $25-50K | 15,508 | 30.3% | 26.6% |
| $50-75K | 9,181 | 17.9% | 19.5% |
| $75-100K | 4,525 | 8.8% | 11.9% |
| Over $100K | 5,659 | 11.0% | 18.3% |
| Total | 51,224 | 100.0% | 100.0% |

## EDUCATION LEVEL

| | Education Level Distribution | | |
|---|---|---|---|
| 2011 Adult Education Level | Pop Age 25+ | % of Total | USA % of Total |
| Less than High School | 4,818 | 5.6% | 6.3% |
| Some High School | 8,429 | 9.7% | 8.8% |
| High School Degree | 26,354 | 30.4% | 28.9% |
| Some College/Assoc. Degree | 24,523 | 28.3% | 28.3% |
| Bachelor's Degree or Greater | 22,584 | 26.0% | 27.7% |
| Total | 86,708 | 100.0% | 100.0% |

## RACE/ETHNICITY

| | Race/Ethnicity Distribution | | |
|---|---|---|---|
| Race/Ethnicity | 2011 Pop | % of Total | USA % of Total |
| White Non-Hispanic | 112,137 | 91.1% | 64.2% |
| Black Non-Hispanic | 4,878 | 4.0% | 12.1% |
| Hispanic | 3,260 | 2.6% | 16.1% |
| Asian & Pacific Is. Non-Hispanic | 924 | 0.8% | 4.6% |
| All Others | 1,930 | 1.6% | 3.0% |
| Total | 123,129 | 100.0% | 100.0% |

© 2011, Claritas Inc., © 2011 Thomson Reuters. All Rights Reserved

## ***Attachment C, Economic Feasibility 2:***

Letter of Available Funds

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

MOUNTAIN STATES
HEALTH ALLIANCE

2012 JUN 25 AM 10 59

June 19, 2012

Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Agency Members:

This letter is to certify that Mountain States Health Alliance has sufficient cash in the depreciation reserve fund to finance the project cost of $14,000 necessary for the Discontinuance of Obstetric Services Project at Sycamore Shoals Hospital, as described in the certificate of need application.

Sincerely,

Marvin Eichorn
Senior Vice President / Chief Financial Officer

400 North State of Franklin Road Johnson City, Tennessee 37604-6094 Telephone 423.431.6111

## ***Attachment C, Economic Feasibility 6.A:***

List of Charges for OB Services

| ItemNumber | Department | Description | Price | GLKey | CPT/HCPCS |
|---|---|---|---|---|---|
| 6100000 | 610 | PRIVATE ROOM | $898.00 | 610 | |
| 6100005 | 610 | OUTPATIENT BED | $0.00 | 610 | |
| 6100010 | 610 | OBSERVATION | $38.00 | 610 | |
| 6100015 | 610 | ICU/CCU/HIGH RISK ROOM | $2,426.00 | 610 | |
| 6100020 | 610 | INTERMEDIATE NBN CARE | $2,226.00 | 610 | |
| 6100025 | 610 | PROGRESSIVE CARE ROOM | $1,794.00 | 610 | |
| 6100035 | 610 | SEMI-PRIVATE | $653.00 | 610 | |
| 6100050 | 610 | NEWBORN CARE | $776.00 | 610 | |
| 6100107 | 610 | CIRCUMCISION | $430.00 | 610 | |
| 6100118 | 610 | CONTRACTION STRESS TEST | $1,175.00 | 610 | 59020 |
| 6100120 | 610 | TRANS EXCHANGE BLOOD | $1,384.00 | 610 | 36450 |
| 6100122 | 610 | NON STRESS TEST | $657.00 | 610 | 59025 |
| 6100148 | 610 | LEVEL 1 NON COMPLEX | $92.00 | 610 | 99211 |
| 6100163 | 610 | EXTERNAL VERSION PROCED | $3,469.00 | 610 | 59412 |
| 6100166 | 610 | MECHANICAL DILATATION | $600.00 | 610 | |
| 6100183 | 610 | SUTR PK LD | $67.00 | 610 | |
| 6100192 | 610 | LACTATION HIGH COMPLEXITY | $75.00 | 610 | 99213 |
| 6100193 | 610 | LACTATION MOD COMPLEXITY | $60.00 | 610 | 99212 |
| 6100194 | 610 | LACTATION LOW COMPLEXITY | $45.00 | 610 | 99211 |
| 6100195 | 610 | LACTATION CONSULT - NO CHARGE | $0.00 | 610 | 99211 |
| 6100200 | 610 | CS RECOVERY FIRST HR | $481.00 | 610 | |
| 6100205 | 610 | AMNIOCENTESIS PROCED | $2,653.00 | 610 | |
| 6100206 | 610 | AMNIOINFUSION | $183.00 | 610 | |
| 6100300 | 610 | CS RECOV EA ADD 1/2HR | $289.00 | 610 | |
| 6100400 | 610 | TRANS BLOOD/COMPONENTS | $1,225.00 | 610 | 36430 |
| 6108168 | 610 | L&D RECOVERY | $967.00 | 610 | |
| 6108194 | 610 | CERCLAGE REMOVAL | $3,784.00 | 610 | 59871 |
| 6109152 | 610 | DELIVERY | $1,866.00 | 610 | |
| 6109154 | 610 | LABOR FIRST HALF HR | $1,664.00 | 610 | |
| 6109155 | 610 | LABOR EA ADD 15MIN | $92.00 | 610 | |
| 6109156 | 610 | EPIDURAL SERVICE | $778.00 | 610 | |
| 6109158 | 610 | INJ THER PROPHYLAC DIAG SQ/IM | $84.00 | 610 | 96372 |
| 6109164 | 610 | Tamponade Balloon | $1,724.00 | 610 | |

## ***Attachment C, Economic Feasibility 10:***

Balance Sheet and Income Statement for

Mountain States Health Alliance:

Most Recent Audited Statements – FY2011 and FY2010

# MOUNTAIN STATES HEALTH ALLIANCE

*Audited Consolidated Financial Statements*
*(and Supplemental Schedules)*

*Years Ended June 30, 2011 and 2010*

PYA

**MOUNTAIN STATES HEALTH ALLIANCE**

***Audited Consolidated Financial Statements and Supplemental Schedules***

***Years Ended June 30, 2011 and 2010***

Independent Auditor's Report ..... 1

*Audited Consolidated Financial Statements*

Consolidated Balance Sheets ..... 3
Consolidated Statements of Operations ..... 5
Consolidated Statements of Changes in Net Assets ..... 6
Consolidated Statements of Cash Flows ..... 8
Notes to Consolidated Financial Statements ..... 10

*Supplemental Schedules*

Consolidating Balance Sheet ..... 46
Consolidating Statement of Operations ..... 48
Consolidating Statement of Changes in Net Assets ..... 49
Note to Supplemental Schedules ..... 50

PERSHING YOAKLEY & ASSOCIATES, P.C.
Certified Public Accountants
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

## INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited the accompanying consolidated balance sheets of Mountain States Health Alliance and subsidiaries (the Alliance) as of June 30, 2011 and 2010 and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Alliance's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mountain States Health Alliance and subsidiaries as of June 30, 2011 and 2010 and the results of their operations, changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplemental schedules, as listed in the accompanying index, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

As discussed in Note B, the Alliance adopted Financial Accounting Standards Board Accounting Standards Codification 958-10, *Consolidation*, and applicable portions of 958-805, *Not-for-Profit Entities*, during 2011.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
October 26, 2011



**MOUNTAIN STATES HEALTH ALLIANCE**

***Consolidated Balance Sheets***
***(Dollars in Thousands)***

| | June 30, 2011 | June 30, 2010 |
|---|---|---|
| ASSETS | | |
| CURRENT ASSETS | | |
| Cash and cash equivalents | $ 112,768 | $ 234,526 |
| Current portion of investments | 116,175 | 25,092 |
| Patient accounts receivable, less estimated allowances for uncollectible accounts of $53,366 in 2011 and $45,941 in 2010 | 134,611 | 125,580 |
| Other receivables, net | 19,614 | 17,926 |
| Inventories and prepaid expenses | 28,965 | 29,163 |
| TOTAL CURRENT ASSETS | 412,133 | 432,287 |
| INVESTMENTS, less amounts required to meet current obligations | 581,376 | 590,131 |
| PROPERTY, PLANT AND EQUIPMENT, net | 797,418 | 695,598 |
| OTHER ASSETS | | |
| Goodwill - Note B | 148,666 | 151,352 |
| Net deferred financing, acquisition costs and other charges, less current portion | 29,844 | 30,819 |
| Other assets | 28,448 | 29,313 |
| TOTAL OTHER ASSETS | 206,958 | 211,484 |
| | $ 1,997,885 | $ 1,929,500 |

| | June 30, 2011 | June 30, 2010 |
|---|---|---|
| LIABILITIES AND NET ASSETS | | |
| CURRENT LIABILITIES | | |
| Accrued interest payable | $ 20,047 | $ 16,039 |
| Current portion of long-term debt and capital lease obligations | 28,162 | 28,131 |
| Current portion of estimated fair value of derivatives | 102,609 | 10,740 |
| Accounts payable and accrued expenses | 98,819 | 99,227 |
| Accrued salaries, compensated absences and amounts withheld | 57,800 | 47,280 |
| Estimated amounts due to third-party payors, net | 14,813 | 10,155 |
| TOTAL CURRENT LIABILITIES | 322,250 | 211,572 |
| OTHER LIABILITIES | | |
| Long-term debt and capital lease obligations, less current portion | 1,040,923 | 1,054,842 |
| Estimated fair value of derivatives, less current portion | 8,123 | 123,560 |
| Deferred revenue | 19,267 | 20,445 |
| Estimated professional liability self-insurance | 9,692 | 9,541 |
| Other long-term liabilities | 14,352 | 12,628 |
| TOTAL LIABILITIES | 1,414,607 | 1,432,588 |
| COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and N | | |
| NET ASSETS | | |
| Unrestricted net assets | | |
| Mountain States Health Alliance | 400,395 | 317,485 |
| Noncontrolling interests in subsidiaries - Note B | 171,984 | 168,359 |
| TOTAL UNRESTRICTED NET ASSETS | 572,379 | 485,844 |
| Temporarily restricted net assets | | |
| Mountain States Health Alliance | 10,715 | 10,890 |
| Noncontrolling interests in subsidiaries - Note B | 57 | 51 |
| TOTAL TEMPORARILY RESTRICTED NET ASSETS | 10,772 | 10,941 |
| Permanently restricted net assets | 127 | 127 |
| TOTAL NET ASSETS | 583,278 | 496,912 |
| | $ 1,997,885 | $ 1,929,500 |

*See notes to consolidated financial statements.*



**MOUNTAIN STATES HEALTH ALLIANCE**

***Consolidated Statements of Operations***
***(Dollars in Thousands)***

| | Year Ended June 30, 2011 | Year Ended June 30, 2010 |
|---|---|---|
| Revenue, gains and support: | | |
| Net patient service revenue | $ 960,254 | $ 928,270 |
| Other operating revenue | 15,871 | 16,009 |
| TOTAL REVENUE, GAINS AND SUPPORT | 976,125 | 944,279 |
| Expenses: | | |
| Salaries and wages | 342,208 | 325,663 |
| Physician salaries and wages | 59,249 | 54,489 |
| Contract labor | 5,964 | 6,546 |
| Employee benefits | 67,139 | 68,362 |
| Fees | 85,919 | 82,542 |
| Supplies | 169,362 | 175,469 |
| Utilities | 17,300 | 16,193 |
| Other | 69,647 | 69,154 |
| Depreciation | 87,499 | 68,436 |
| Amortization - Note B | 2,559 | 13,123 |
| Estimated provision for bad debts | 6,174 | 7,961 |
| Interest and taxes | 44,153 | 42,264 |
| TOTAL EXPENSES | 957,173 | 930,202 |
| OPERATING INCOME | 18,952 | 14,077 |
| Nonoperating gains (losses): | | |
| Interest and dividend income | 16,224 | 17,298 |
| Net realized gains on the sale of securities | 1,957 | 2,385 |
| Net unrealized gains on securities | 22,168 | 15,018 |
| Derivative related income | 5,072 | 4,394 |
| Loss on early extinguishment of debt - Note F | - | (3,029) |
| Change in estimated fair value of derivatives | 23,049 | (8,607) |
| Other nonoperating gains (losses) | (2,653) | 512 |
| Net assets released from restrictions used for operations | 1,893 | 2,627 |
| NET NONOPERATING GAINS | 67,710 | 30,598 |
| EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES | $ 86,662 | $ 44,675 |

*See notes to consolidated financial statements.*

MOUNTAIN STATES HEALTH ALLIANCE

*Consolidated Statements of Changes in Net Assets*
*(Dollars in Thousands)*

*Year Ended June 30, 2011*

| | *Mountain States Health Alliance* | *Noncontrolling Interests* | *Total* |
|---|---|---|---|
| UNRESTRICTED NET ASSETS: | | | |
| Excess of Revenue, Gains and Support over Expenses and Losses | $ 83,269 | $ 3,393 | $ 86,662 |
| Pension and other defined benefit plan adjustments | 620 | 617 | 1,237 |
| Cumulative effect of a change in accounting principle - Note B | (2,965) | - | (2,965) |
| Net assets released from restrictions used for the purchase of property, plant and equipment | 1,946 | - | 1,946 |
| Distributions to noncontrolling interests | - | (270) | (270) |
| Repurchases of noncontrolling interests and other | 40 | (115) | (75) |
| INCREASE IN UNRESTRICTED NET ASSETS | 82,910 | 3,625 | 86,535 |
| TEMPORARILY RESTRICTED NET ASSETS: | | | |
| Restricted grants and contributions | 3,612 | 58 | 3,670 |
| Net assets released from restrictions | (3,787) | (52) | (3,839) |
| INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS | (175) | 6 | (169) |
| INCREASE IN TOTAL NET ASSETS | 82,735 | 3,631 | 86,366 |
| NET ASSETS, BEGINNING OF YEAR | 328,502 | 168,410 | 496,912 |
| NET ASSETS, END OF YEAR | $ 411,237 | $ 172,041 | $ 583,278 |

*See notes to consolidated financial statements.*



MOUNTAIN STATES HEALTH ALLIANCE

*Consolidated Statements of Changes in Net Assets - Continued*
*(Dollars in Thousands)*

*Year Ended June 30, 2010*

| | *Mountain States Health Alliance* | *Noncontrolling Interests* | *Total* |
|---|---|---|---|
| UNRESTRICTED NET ASSETS: | | | |
| Excess of Revenue, Gains and Support over Expenses and Losses | $ 42,372 | $ 2,303 | $ 44,675 |
| Pension and other defined benefit plan adjustments | 796 | 793 | 1,589 |
| Net assets released from restrictions used for the purchase of property, plant and equipment | 2,283 | - | 2,283 |
| Distributions to noncontrolling interests | - | (151) | (151) |
| Repurchases of noncontrolling interests and other | (63) | (38) | (101) |
| INCREASE IN UNRESTRICTED NET ASSETS | 45,388 | 2,907 | 48,295 |
| TEMPORARILY RESTRICTED NET ASSETS: | | | |
| Restricted grants and contributions | 3,585 | 88 | 3,673 |
| Net assets released from restrictions | (4,825) | (85) | (4,910) |
| INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS | (1,240) | 3 | (1,237) |
| PERMANENTLY RESTRICTED NET ASSETS: | | | |
| Net assets released from restrictions by donor | (50) | - | (50) |
| INCREASE IN TOTAL NET ASSETS | 44,098 | 2,910 | 47,008 |
| NET ASSETS, BEGINNING OF YEAR | 284,404 | 165,500 | 449,904 |
| NET ASSETS, END OF YEAR | $ 328,502 | $ 168,410 | $ 496,912 |

*See notes to consolidated financial statements.*

**MOUNTAIN STATES HEALTH ALLIANCE**

*Consolidated Statements of Cash Flows*
*(Dollars in Thousands)*

| | Year Ended June 30, 2011 | 2010 |
|---|---|---|
| CASH FLOWS FROM OPERATING ACTIVITIES: | | |
| Increase in net assets | $ 86,366 | $ 47,008 |
| Adjustments to reconcile increase in net assets to net cash provided by operating activities: | | |
| Provision for depreciation and amortization | 90,472 | 81,982 |
| Loss on early extinguishment of debt | - | 3,029 |
| Cumulative effect of a change in accounting principle | 2,965 | - |
| Change in estimated fair value of derivatives | (23,049) | 8,607 |
| Equity in net income of joint ventures, net | (898) | (1,117) |
| Gain on sale of assets held for resale and disposal of assets | (367) | (548) |
| Amounts received on interest rate swap settlements | (5,072) | (4,394) |
| Income recognized through forward sale agreements | (864) | (864) |
| Capital Appreciation Bond accretion and other | 2,738 | 2,071 |
| Restricted contributions | (3,670) | (2,159) |
| Pension and other defined benefit plan adjustments | (1,237) | 598 |
| Increase (decrease) in cash due to change in: | | |
| Net patient accounts receivable | (9,031) | 3,232 |
| Other receivables | (2,802) | (1,246) |
| Inventories and prepaid expenses | (643) | (4,640) |
| Trading securities | (123,966) | (13,368) |
| Other assets | (3,632) | (1,159) |
| Accrued interest payable | 4,008 | 3,989 |
| Accounts payable and accrued expenses | 2,741 | (855) |
| Accrued salaries, compensated absences and amounts withheld | 11,361 | (2,289) |
| Estimated amounts due from/to third-party payors, net | 4,658 | 3,757 |
| Other long-term liabilities | 2,961 | (201) |
| Estimated professional liability self-insurance | 151 | (471) |
| Total adjustments | (53,176) | 73,954 |
| NET CASH PROVIDED BY OPERATING ACTIVITIES | 33,190 | 120,962 |
| CASH FLOWS FROM INVESTING ACTIVITIES: | | |
| Purchases of property, plant and equipment, property held for resale and property held for expansion, net | (172,786) | (172,240) |
| Additions to goodwill | (279) | - |
| Net decrease in assets limited as to use | 81,383 | 50,362 |
| Purchases of held-to-maturity securities | (41,060) | (28,175) |
| Net distribution from joint ventures and unconsolidated affiliates | 1,057 | 1,162 |
| Proceeds from sale of property, plant and equipment and property held for resale | 812 | 9,565 |
| NET CASH USED IN INVESTING ACTIVITIES | (130,873) | (139,326) |



| | Year Ended June 30, 2011 | 2010 |
|---|---|---|
| CASH FLOWS FROM FINANCING ACTIVITIES: | | |
| Payments on long-term debt and capital lease obligations, including deposits to escrow | (37,735) | (226,315) |
| Payment of acquisition and financing costs | (1,716) | (3,565) |
| Proceeds from issuance of long-term debt and other financing arrangements | 5,954 | 235,158 |
| Net amounts received on interest rate swap settlements | 5,072 | 4,394 |
| Restricted contributions received | 4,350 | 3,382 |
| NET CASH (USED IN) PROVIDED BY FINANCING ACTIVITIES | (24,075) | 13,054 |
| NET DECREASE IN CASH AND CASH EQUIVALENTS | (121,758) | (5,310) |
| CASH AND CASH EQUIVALENTS, beginning of year | 234,526 | 239,836 |
| CASH AND CASH EQUIVALENTS, end of year | $ 112,768 | $ 234,526 |

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

| | | |
|---|---|---|
| Cash paid for interest | $ 39,507 | $ 38,666 |
| Cash paid for federal and state income taxes | $ 739 | $ 446 |
| Construction related payables in accounts payable and accrued expenses | $ 11,384 | $ 14,847 |
| Property purchased through capital lease arrangement | $ 15,951 | $ - |
| Increase in receivable from sale of property | $ - | $ 1,483 |
| Decrease in land held for expansion related to property exchange transaction | $ - | $ 3,432 |
| Land held for expansion placed in use | $ 4,904 | $ - |

During the year ended June 30, 2010, the Alliance refinanced previously issued debt of $184,050.

*See notes to consolidated financial statements.*

NOTE A–ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions. Membership of the Alliance consists of individuals and institutions who have contributed at least $100 to the capital fund of the Alliance and are entitled to vote at the annual election of the Board of Directors.

The primary operations of the Alliance consist of ten acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 658 beds
- Smyth County Community Hospital (SCCH) - licensed for 279 beds
- Indian Path Medical Center (IPMC) - licensed for 261 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- Johnston Memorial Hospital (JMH) - licensed for 116 beds
- Franklin Woods Community Hospital (FWCH) - licensed for 80 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

FWCH opened in July 2010, replacing operations at North Side Hospital (NSH) and Johnson City Specialty Hospital (JCSH). NSH and JCSH were licensed for 91 beds and 23 beds, respectively, prior to the opening of FWCH and a total of 64 beds were transferred within the Alliance.

The Alliance has a 50.1% interest in JMH. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and; Community Home Care (CHC), a taxable corporation that provides home medical equipment.

The Alliance has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services.

The activities and accounts of JMH, NCH and SCCH are included in the accompanying consolidated financial statements.





NOTE A--ORGANIZATION AND OPERATIONS - Continued

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following organizations:

*Mountain States Physician Group, Inc. (MSPG):* A company that contracts with physicians to provide services to BRMM physician practices.

*Mountain States Properties, Inc. (MSPI):* An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services. In addition, MSPI is a counter-party to various financing transactions, including interest rate swaps.

*Mediserve Medical Equipment of Kingsport, Inc. (Mediserve):* A company that provides durable medical equipment services.

*Synergy Health Group LLC:* An affiliation of member hospitals that work together to maximize cost savings opportunities through aggregated buying power.

*Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery):* A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC at June 30, 2011 and 2010; however, BRMM maintains control over KASC through a management agreement. As such, the accounts and activities of KASC are included in the accompanying consolidated financial statements.

*Piney Flats Urgent Care (PFUC):* A for-profit entity that provides urgent care patient services. BRMM has a 75% ownership of PFUC. The accounts and activities of PFUC are included in the accompanying consolidated financial statements.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of the Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

The Alliance is a majority shareholder of Integrated Solutions Health Network, LLC (ISHN). The primary function of ISHN is to establish, operate and administer a provider-sponsored health care

NOTE A--ORGANIZATION AND OPERATIONS - Continued

delivery network. The accounts and activities of ISHN are included in the accompanying consolidated financial statements.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

*Principles of Consolidation:* The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions. The Alliance classifies those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities.

*Noncontrolling Interests in Subsidiaries:* Noncontrolling interests represent the portion of equity (net assets) in a subsidiary not attributable, directly or indirectly, to a parent organization. Effective July 1, 2010, the Alliance adopted Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-810, *Consolidation*. ASC 958-810 amends the accounting for, and the financial statement presentation of, noncontrolling interests in a subsidiary within consolidated financial statements. ASC 958-810 requires that a noncontrolling interest in the net assets of a subsidiary be accounted for and reported as net assets and provides revised guidance on the treatment of income and losses attributable to the noncontrolling interest and changes in ownership interests in a subsidiary.

The Alliance adopted ASC 958-810 during 2011 and reclassified $168,410 of noncontrolling interests from minority interest to net assets as of June 30, 2010. These amounts are reflected net of distributions and pension and other defined benefit plan adjustments within net assets in the Consolidated Balance Sheets. The Alliance attributed an Excess of Revenue, Gains and Support over Expenses and Losses of $3,393 and $2,303 for the years ending June 30, 2011 and 2010, respectively, to the noncontrolling interests in JMH, NCH, SCCH, KASC, PFUC and ISHN based on the noncontrolling interests' respective ownership percentage. None of the noncontrolling interests include redemption features.

*Use of Estimates:* The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from these estimates.

*Cash and Cash Equivalents:* Cash and cash equivalents include all highly liquid investments with a maturity of three months or less when purchased. Cash and cash equivalents designated as assets





NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents on the Consolidated Balance Sheets.

*Investments:* Investments as reported in the Consolidated Balance Sheets include trading securities, held-to-maturity securities and assets limited as to use (Note C). FASB ASC 958-320, *Investments–Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments (including assets limited as to use) are considered as trading securities. Management annually evaluates the held-to-maturity investment portfolio and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator. Management's evaluation considers the amount of decline in fair value, as well as the time period of any such decline. Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2011.

Within the trading securities portfolio, all debt securities and marketable equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investments without readily determinable fair values are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*. Guaranteed investment contracts are reported at contract value.

Realized gains and losses on trading securities and assets limited as to use are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of $2,367 and $2,418 at June 30, 2011 and 2010, respectively.

*Inventories:* Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

*Property, Plant and Equipment:* Property, plant and equipment is stated on the basis of cost, or if donated, at the fair value at the date of gift. Generally, depreciation is computed by the straight-line method over the estimated useful life of the asset. Equipment held under capital lease obligations is amortized under the straight-line method over the shorter of the lease term or estimated useful life.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Amortization of building and equipment held under capital lease is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

The Alliance reviews capital assets for indications of potential impairment when there are changes in circumstances related to a specific asset. If this review indicates that the carrying value of these assets may not be recoverable, the Alliance estimates future cash flows from operations and the eventual disposition of such assets. If the sum of these undiscounted future cash flows is less than the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2011 and 2010.

Other assets include property held for resale and property held for expansion of $4,230 and $9,135, respectively, at June 30, 2011 and 2010. During 2011, property held for expansion totaling approximately $4,905 was transferred to property, plant and equipment in conjunction with the construction of FWCH. Property held for resale and property held for expansion primarily represent land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Management annually evaluates its investment and records non-temporary declines in value when it is determined the ultimate net realizable value is less than the recorded amount. No such declines were identified in 2011 and 2010.

*Goodwill:* Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. Prior to July 1, 2010, the Alliance amortized goodwill associated with its not-for-profit subsidiaries under the straight-line method over various estimated useful lives ranging from 10 to 25 years. However, effective July 1, 2010, ASC 958-805, *Not-for-Profit Entities*, requires the not-for-profit entities within the Alliance to cease amortization of goodwill, perform a transitional impairment test and perform annual impairment testing in the future.

As a result of its transitional impairment testing as of July 1, 2010, management determined that approximately $2,965 of goodwill associated with one of its reporting units was impaired, and such impairment has been reflected as the Cumulative Effect of a Change in Accounting Principle in the 2011 Consolidated Statement of Changes in Net Assets. Based upon this transitional testing, management does not believe any remaining goodwill acquired by its not-for-profit entities to be





NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

impaired. The reporting unit for evaluation of substantially all such goodwill is the Alliance's aggregate acute-care operations.

For goodwill acquired by its for-profit subsidiaries, the Alliance does not amortize goodwill and annually performs impairment testing. Based upon this annual impairment testing, management has determined that there is no impairment related to goodwill associated with its for-profit subsidiaries.

*Deferred Financing, Acquisition Costs and Other Charges:* Other assets, including deferred financing, acquisition costs and other charges, total $29,844 and $30,819 at June 30, 2011 and 2010, respectively. Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Beginning in 2009, interest rate swap and derivative transaction issuance costs are expensed as incurred.

*Derivative Financial Instruments:* As further described in Note D, the Alliance is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets as either current or long-term liabilities, based upon the remaining term of the instrument. Changes in the estimated fair value of these derivatives are included in the Consolidated Statements of Operations as part of nonoperating gains (losses). Net settlements and other related income of derivatives are also reflected as a part of the Performance Indicator (described below).

These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date. The fair value of various derivatives are netted on the Consolidated Balance Sheets based on management's evaluation of the settlement provisions in the master contract. Gross positions of these derivatives are disclosed in Note D. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

*Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities:* Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) and are recorded at the estimated net present value of such claims. Other long-term liabilities include contributions payable and obligations under deferred compensation arrangements, a defined

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

benefit pension plan, a post-retirement employee benefit plan as well as other liabilities which management estimates are not payable within one year.

*Net Patient Service Revenue/Receivables*: Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The Alliance's revenue recognition policies related to self-pay and other types of payors emphasize revenue recognition only when collections are reasonably assured.

Patient accounts receivable are reported net of both an estimated allowance for uncollectible accounts and an estimated allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, Medicaid, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations estimated based upon the age of the patient accounts receivable, prior experience and any unusual circumstances (such as local, regional or national economic conditions) which affect the collectibility of receivables, including management's assumptions about conditions it expects to exist and courses of action it expects to take.

The Alliance's policy does not require collateral or other security for patient accounts receivable. The Alliance routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

*Charity Care:* The Alliance accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Alliance and various guidelines outlined by the Federal Government. These policies define charity as those services for which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue.

In addition to the charity care services described above, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, Medicaid, TennCare and State indigent programs do not cover the full cost of providing care to beneficiaries of those programs. The Alliance also provides services to the community at large for which it receives little or no payment.

*Excess of Revenue, Gains and Support Over Expenses and Losses:* The Consolidated Statements of Operations and the Consolidated Statements of Changes in Net Assets includes the caption *Excess of*





NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

*Revenue, Gains and Support Over Expenses and Losses* (the Performance Indicator). Changes in unrestricted net assets which are excluded from the Performance Indicator, consistent with industry practice, include contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, pension and related adjustments, and distributions to, or contributions from, owners and transactions with noncontrolling interests.

*Income Taxes:* The Alliance is classified as an organization exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. As such, no provision for income taxes has been made in the accompanying consolidated financial statements for the Alliance and its tax-exempt subsidiaries. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note L). The Alliance has no significant uncertain tax positions at June 30, 2011 and 2010.

*Temporarily and Permanently Restricted Net Assets:* Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. When a donor or time restriction expires; that is, when a stipulated time restriction ends or purpose restriction is fulfilled, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the Consolidated Statements of Operations and Consolidated Statements of Changes in Net Assets as net assets released from restrictions. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

*Fair Value Measurement:* The Alliance had previously adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements.

In January 2010, the FASB issued ASU 2010-06, *Fair Value Measurements and Disclosures (Topic 820) - Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 requires new disclosures regarding significant transfers in and out of Levels 1 and 2, as well as information about activity in Level 3 fair value measurements, including presenting information about purchases, sales, issuances and settlements on a gross versus a net basis in the Level 3 activity roll forward. In addition, ASU 2010-06 clarifies existing disclosures regarding input and valuation techniques, as well as the level of disaggregation for each class of assets and liabilities. The Alliance adopted ASU 2010-06 in 2011, except for the disclosures related to purchases, sales, issuance and settlements, which will be effective for the Alliance beginning July 1, 2012. The adoption of ASU 2010-06 did not, and is not expected to, have an impact on the Alliance's consolidated financial statements.

*Subsequent Events:* The Alliance evaluated all events or transactions that occurred after June 30, 2011, through October 26, 2011, the date the consolidated financial statements were available to be

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2011 consolidated financial statements, other than as discussed in Notes D, F and S.

*New Accounting Pronouncements:* In August 2010, the FASB issued Accounting Standards Update (ASU) 2010-23, *Health Care Entities – Measuring Charity Care for Disclosure.* ASU 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU 2010-23 requires that cost, identified as the direct and indirect costs of providing the charity care, be used as the measurement basis for disclosure purposes. ASU 2010-23 also requires disclosure of the method used to identify or determine such costs. The Hospital will adopt ASU 2010-23 in fiscal year 2012. Management does not expect the adoption of ASU 2010-23 to have a material impact on the consolidated financial statements.

In August 2010, the FASB issued ASU 2010-24, *Health Care Entities – Presentation of Insurance Claims and Related Insurance Recoveries.* The amendments in the ASU clarify that a health care entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. ASU 2010-24 is effective for the Alliance beginning July 1, 2011 and management is currently evaluating the impact of this ASU on the consolidated financial statements.

In July 2011, the FASB issued ASU 2011-07, *Healthcare Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and Allowance for Doubtful Accounts for Certain Healthcare Entities*, which will require certain healthcare entities to reclassify the provision for bad debts associated with providing patient care from an operating expense to a deduction from net patient service revenue in the Consolidated Statements of Operations. Additionally, ASU 2011-07 requires enhanced disclosures about an entity's policies for recognizing revenue and assessing bad debts and qualitative and quantitative information about changes in the allowance for doubtful accounts. The Alliance intends to adopt ASU 2011-07 in fiscal year 2013. Management does not expect the adoption of ASU 2011-07 to have a material impact on the consolidated financial statements.

*Reclassifications:* Certain 2010 amounts have been reclassified to conform with the 2011 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

Assets limited as to use are summarized by designation or restriction as follows at June 30:





NOTE C--INVESTMENTS - Continued

| | *2011* | *2010* |
|---|---|---|
| Designated or restricted: | | |
| Under safekeeping agreements | $ 28,349 | $ 52,050 |
| Under guarantee agreements | 92,720 | 89,486 |
| By Board for capital improvements | 4 | 2,776 |
| Under bond indenture agreements: | | |
| For debt service and interest payments | 67,874 | 78,612 |
| For capital acquisitions | 28,835 | 76,241 |
| | 217,782 | 299,165 |
| Less: amount required to meet current obligations | (116,175) | (25,092) |
| | $ 101,607 | $ 274,073 |

Assets limited as to use consist of the following at June 30:

| | *2011* | *2010* |
|---|---|---|
| Cash, cash equivalents and money market funds | $ 115,579 | $ 170,897 |
| U.S. Government securities | 1,795 | 1,795 |
| U.S. Agency securities | 7,688 | 12,319 |
| Guaranteed investment contracts | 92,720 | 114,154 |
| | $ 217,782 | $ 299,165 |

Trading securities consist of the following at June 30:

| | *2011* | *2010* |
|---|---|---|
| Cash, cash equivalents and money market funds | $ 29,159 | $ 4,799 |
| U.S. Government securities | 9,409 | 3,137 |
| U.S. Agency securities | 31,551 | 13,760 |
| Corporate and foreign bonds | 126,543 | 11,688 |
| Municipal obligations | 451 | 1,461 |
| Preferred and asset backed securities | 8,945 | 7,023 |
| U.S. equity securities | 94,834 | 139,168 |
| Other | 32,718 | 28,608 |
| | $ 333,610 | $ 209,644 |

NOTE C--INVESTMENTS - Continued

Held-to-Maturity securities are carried at amortized cost and consist of the following at June 30:

| | *2011* | *2010* |
|---|---|---|
| Cash, cash equivalents and money market funds | $ 753 | $ 1,131 |
| Corporate and foreign bonds | 135,745 | 103,968 |
| Municipal obligations | 9,661 | 1,315 |
| | $ 146,159 | $ 106,414 |

Held-to-maturity securities had gross unrealized gains and losses of $6,838 and $276, respectively, at June 30, 2011 and $5,525 and $607, respectively at June 30, 2010. At June 30, 2011, the Alliance held nine securities within the held-to-maturity portfolio with a fair value and unrealized loss of $549 and $44, respectively, which had been at an unrealized loss position for over one year. At June 30, 2010, the Alliance held one security within the held-to-maturity portfolio with a fair value and unrealized loss of $591 and $166, respectively, which had been at an unrealized loss position for over one year. At June 30, 2011, the contractual maturities of held-to-maturity securities were $13,816 due in one year or less, $55,563 due from one to five years and $76,780 due after five years. At June 30, 2010, the contractual maturities of held-to-maturity securities were $13,389 due in one year or less, $48,447 due from one to five years and $44,578 due after five years.

At June 30, 2011 and 2010, the Alliance held investments in certain limited partnerships and hedge funds of $32,718 and $28,608, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*.

The Alliance has investments in several joint ventures and corporations which are accounted for under the equity method of accounting.

As a part of the acquisition of membership interests in JMH, SCCH and NCH, the Alliance has committed to invest $132,000, $48,100, and $45,000, respectively. Cumulative amounts expended at June 30, 2011 under these commitments are approximately $150,184.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance.





NOTE D--DERIVATIVE TRANSACTIONS - Continued

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. Such investments are included as assets limited as to use. As of June 30, 2011, management believes the Alliance was fully collateralized with respect to the derivative agreements and management does not believe such collateral is exposed to third-party credit risk. Further, certain of the agreements contain requirements regarding maintenance of financial and liquidity ratios. Management has represented the Alliance is in compliance with all such covenants at June 30, 2011.

*Interest Rate Swaps:* The Alliance is a party to six interest rate swap agreements with Merrill Lynch as the counterparty. The terms of five of these agreements were modified without settlement during 2011 and no gain or loss was realized. However, such modifications did impact the estimated fair value of these interest rate swaps. A liability, representing the estimated net fair value of these swaps, of $8,123 and $33,910 was recognized by the Alliance as of June 30, 2011 and 2010, respectively.

The following is a summary of five of these interest rate swap agreements at June 30, 2011:

| | | | *Payments by:* | | |
|---|---|---|---|---|---|
| *Swap* | *Notional Amount* | *Term* | *Counterparty* | *Alliance* | *Estimated Fair Value* |
| A | $ 170,000 | 4/2008-4/2026 | 1.265% through April 2013; 1.07% through April 2014; then 71.10% of USD-ISDA Swap Rate | 0.00% through April 2014, then USD-SIFMA Municipal Swap Index | $ 3,028 |
| B | 95,000 | 4/2008-4/2026 | 1.265% through April 2013; 1.08% through April 2014; then 71.18% of USD-ISDA Swap Rate | 0.00% through April 2014, then USD-SIFMA Municipal Swap Index | 1,729 |
| C | 173,030 | 4/2008-4/2034 | 1.315% through April 2013; 1.12% through April 2014; then 72.35% of USD-ISDA Swap Rate | 0.00% through April 2014, then USD-SIFMA Municipal Swap Index | 741 |
| D | 82,055 | 12/2007-7/2033 | [1] 3.493% through July 2012; then 0% [2] USD-LIBOR-BBA through July 2012, then 67% USD-LIBOR-BBA | [1] 4.41% through July 2012; then .312% [2] USD-SIFMA | (9,363) |
| E | 50,000 | 2/2008-7/2038 | 67.00% of USD-LIBOR-BBA plus .145% | USD-SIFMA | (3,918) |

Deferred financing and acquisition costs, net of amortization, include $6,480 and $6,823 at June 30, 2011 and 2010, respectively, related to these swaps.

NOTE D--DERIVATIVE TRANSACTIONS - Continued

In addition to the swaps described above, the Alliance and Merrill Lynch are also parties to a total return swap in the notional amount of $23,100 which has an estimated fair value of $(340) and $(252) at June 30, 2011 and 2010, respectively . The agreement consists of the following:

- An agreement that requires the Alliance to pay a variable rate of USD-SIFMA Municipal Swap Index through July 1, 2012 (or termination of the swap) on a notional amount equal to the outstanding 2001A Hospital Revenue and Improvement Bonds (the 2001A Reference Bonds). The Alliance receives a fixed rate of 6.25% of the outstanding 2001A Reference Bonds.

- A "total return provision" under which the Alliance will pay (or receive) an amount equal to the product of the outstanding 2001A Reference Bonds multiplied by the difference between the outstanding 2001A Reference Bonds and the 2001A Reference Bonds' market price at termination, as defined in the agreement. In the event the swap does not terminate prior to July 1, 2012, there would be no settlement of this component as there would be no outstanding 2001A Reference Bonds.

The Alliance is also party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. The Alliance and Lehman Brothers Special Financing, Inc. have been unable to reach a settlement agreement. In September 2010, the Alliance was issued a subpoena to furnish certain documentation related to the transaction. A protocol has been put into place by the bankruptcy court whereby the parties are to undergo alternate dispute resolution, including non-binding arbitration, which management anticipates will occur in 2012.

The fair value of these swaps is undeterminable at January 1, 2009, as prior to the termination date Lehman Brothers liquidated the underlying referenced securities, making a valuation not commercially viable. An estimated liability of $10,565 and $10,740 was recognized by the Alliance as of June 30, 2011 and 2010, respectively. Management believes that the liability as recorded at June 30, 2011 is sufficient to cover any exposure arising from litigation in this matter. However, it is reasonably possible management's estimate may change in the near term, although the amount of any change cannot be estimated. Due to the termination of this agreement, the estimated liability is included as a current liability in the accompanying Consolidated Balance Sheets.

A third party holds collateral with a fair market value of approximately $13,381 and $13,570, respectively, at June 30, 2011 and 2010, with respect to these Lehman derivative agreements. Such collateral is included as current assets limited as to use.





NOTE D--DERIVATIVE TRANSACTIONS - Continued

The arrangement consists of nine agreements each with three separate components (described below) with notional values of $23,600, $8,000, and $8,750 each. The swaps generally consist of the following:

- An arrangement that calls for the Alliance to pay a variable rate (SIFMA Municipal Swap Index) plus certain fixed payment amounts and receive a payment equal to the interest paid by the Alliance on a portion of its early extinguished, but still outstanding, 2000A and 2000B Hospital Mortgage Revenue Refunding Bonds (the Reference Bonds) (whose fixed rates range from 7.50% to 7.75%).

- An arrangement that requires the Alliance to pay a fixed rate of 4.211% through either July 1, 2025, 2029 or 2033 (or termination of the swap) on the outstanding Reference Bonds and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding Reference Bonds; and

- A "total return provision" under which the Alliance will pay (or receive) the difference between the outstanding Reference Bonds, multiplied by 132%, less the fair value of the Reference Bonds on the date of termination and any fixed interest payments made under the arrangements described above. In the event the swaps do not terminate prior to their stated termination dates (2025, 2029 or 2033), there would be no settlement of this component as there would be no outstanding Reference Bonds.

The swap also contains an agreement that consists of two separate components:

- An arrangement that requires the Alliance to pay a fixed rate of 2.98% through July 1, 2016 (or termination of the swap) on the outstanding, but previously defeased, 1991 Hospital Revenue and Improvement Bonds (the 1991 Reference Bonds) and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding 1991 Reference Bonds; and

- A "fixed payor provision" under which the Alliance will pay (or receive) the difference between the outstanding 1991 Reference Bonds multiplied by 100% and any fixed interest payments made as required under the agreement minus the outstanding 1991 Reference Bonds multiplied by the average market price at termination. In the event the swaps do not terminate prior to their stated termination date (2016), there would be no settlement of this component as there would be no outstanding 1991 Reference Bonds.

*Interest Rate Swap Option:* In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns has purchased from the Alliance an option to enter

NOTE D--DERIVATIVE TRANSACTIONS - Continued

into an interest rate swap agreement (swaption) with the Alliance on July 1, 2011, which is an optional redemption date related to the Alliance's early extinguished 2000A and 2000B Bonds (Note F). The purpose of this agreement was to effectively sell the call features related to the early extinguished Series 2000A and 2000B Bonds. As consideration under this agreement, the Alliance received a total of $42,500 in upfront payments as the swaption premium. Such amounts were initially recorded as estimated fair value of derivatives in the Consolidated Balance Sheets. Beginning 30 calendar days prior to July 1, 2011 and terminating 30 calendar days prior to July 1, 2015, the counterparty has the periodic right to exercise the swaption.

The underlying interest rate swap transactions to which the swaption transaction relates have the following terms:

| *Swap* | *Notional Amount* | *Term* | *Payments by:* | |
|---|---|---|---|---|
| | | | *Counterparty* | *Alliance* |
| 2000A | Ranging from $148,170 through July 1, 2018 to $23,000 through July 2033 | 30 days following the exercise date through July 2033 | 64% of USD-LIBOR-BBA | Fixed amounts ranging from 7.13% upon execution to 7.50% through July 2033, based on notional amount |
| 2000B | Ranging from $76,240 through July 1, 2021 to $8,800 through July 2033 | 30 days following the exercise date through July 2033 | 64% of USD-LIBOR-BBA | Fixed amounts ranging from 7.54% upon execution to 8.00% through July 2033, based on notional amount |

The Alliance retained the right to terminate the swaption at any time prior to May 17, 2011 at its fair market value. A liability of $92,044 and $89,650, representing the estimated fair value of the swaption at June 30, 2011 and 2010, respectively, is included in estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. As a derivative financial instrument, this swaption is extremely sensitive to changes in long-term interest rates and other elements in the financial marketplace. As such, estimates of fair value are subject to significant changes in the near term.

Deferred financing and acquisition costs include $0 and $434 at June 30, 2011 and 2010, respectively, related to the costs of this transaction. The change in estimated fair value of derivatives in the accompanying Statements of Operations for 2011 and 2010 includes an unrealized loss of $2,394 and $11,628, respectively, related to this derivative.

The interest rate swap option, described above, was terminated on October 13, 2011. To effectuate this termination, the Alliance transferred a portion of a Guaranteed Investment Contract (GIC), described below, to the third party as a termination payment. A gain of approximately $3,000 was recognized on this termination.





NOTE D--DERIVATIVE TRANSACTIONS - Continued

*Forward Sale Agreements:* In June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. The forward sale agreements originally related to the Debt Service Reserve Fund and to the Debt Service Fund, respectively, (collectively, the "Funds"), as established under provisions of the Master Trust Indenture related to the issuance of the Series 2000 Bonds. In consideration of the future earnings on the Funds, the counterparty paid the Master Trustee a total of $30,000 during 2005, to be held on behalf of the Alliance. In June 2006, one of these agreements was amended to also relate to the Series 2000C, 2000D, 2006A and 2006B Bonds, and to remove the Series 2000A Bonds from consideration under the agreement. As the original intent of these Funds was to secure debt service payments under the above referenced Bonds, the agreement requires these funds to be held under a guaranty agreement as further described below.

In connection with the issuance of the Series 2007 Bonds and the derecognition of a portion of the Series 2000A Bonds, all of the outstanding Series 2000B Bonds, and all of the outstanding 2006B Bonds (Note F), one of these agreements as it relates to the Series 2000A and 2000B Bonds was partially terminated. As such, during 2008 the Alliance reduced its liability with respect to the portion related to the Series 2000A and 2000B Bonds, and paid the counterparty $6,186 under the terms of the agreement. The agreement was amended in fiscal year 2011 to include the Series 2010A Bonds and to remove the Series 2000B and 2006B Bonds.

A liability of $19,001 and $19,864 representing the unamortized payments from the counterparty is included as part of deferred revenue in the accompanying Consolidated Balance Sheets as of June 30, 2011 and 2010, respectively. Amounts are being recognized as investment income over the life of the agreements.

Pursuant to these agreements, the counterparty required that the Alliance's obligations under the swaption and forward sale agreements be collateralized under a guarantee agreement in favor of the counterparty. Due to various requirements of the Master Trust Indenture, the Alliance transferred to MSF a total of $42,500 that was in turn deposited with the counterparty as collateral in a GIC. Amounts received under the forward sale agreements were also deposited into the GIC. All GIC deposits earn interest compounded at 4.14% for the first year, and at 3.5% thereafter through July 1, 2011. The GIC deposits as of June 30, 2011 and 2010 totaled $92,720 and $89,486, respectively. The GIC was substantially utilized on October 13, 2011 to terminate the interest rate swap option agreement discussed above and, as such, is included in the current portion of assets whose use is limited in the Consolidated Balance Sheet at June 30, 2011.

NOTE E--PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consist of the following at June 30:

NOTE E--PROPERTY, PLANT AND EQUIPMENT - Continued

| | 2011 | 2010 |
|---|---|---|
| Land | $ 63,749 | $ 58,037 |
| Buildings and leasehold improvements | 454,852 | 407,104 |
| Property and improvements held for leasing | 80,568 | 84,421 |
| Equipment | 532,767 | 479,523 |
| Buildings and equipment held under capital lease | 42,720 | 22,679 |
| | 1,174,656 | 1,051,764 |
| Less: Allowances for depreciation and amortization | (586,471) | (569,913) |
| | 588,185 | 481,851 |
| Construction in progress (Note N) | 209,233 | 213,747 |
| | $ 797,418 | $ 695,598 |

Accumulated depreciation and amortization on property and improvements held for leasing purposes is $23,348 and $21,543 at June 30, 2011 and 2010, respectively. Net interest capitalized was $10,640 and $11,117 for the years ended June 30, 2011 and 2010, respectively.

The Alliance is constructing replacement facilities for SCCH and JMH and is also performing various renovations on existing hospital facilities. During 2011 and 2010, management of the Alliance assessed the planned current and future use of the existing NSH, SCCH and JMH facilities as well as certain other facilities, and adjusted their estimated useful lives accordingly.

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

Long-term debt and capital lease obligations consist of the following at June 30:

| Description | Maturities | Rates | Outstanding Balance 2011 | Outstanding Balance 2010 |
|---|---|---|---|---|
| 2010A Hospital Revenue Bonds, net of unamortized premium of $1,056 and $1,096 at June 30, 2011 and 2010, respectively | $38,660 uninsured serially, through 2020<br>$14,985 uninsured term bonds, due July 1, 2025<br>$19,385 uninsured term bonds, due July 1, 2030<br>$39,570 uninsured term bonds, due July 1, 2035<br>$55,480 uninsured term bonds, due July 1, 2038 | 3.00% to 5.00%<br>5.38%<br>5.63%<br>6.50%<br>6.00% | $ 169,137 | $ 169,176 |
| 2010B Hospital Revenue Bonds, net of unamortized premium of $711 and $753 at June 30, 2011 and 2010, respectively | $27,330 uninsured serially, through 2020<br>$4,355 uninsured term bonds, due July 1, 2023<br>$4,250 uninsured term bonds, due July 1, 2028 | 2.50% to 5.00%<br>5.00%<br>5.50% | 36,646 | 36,688 |
| 2009A Hospital Revenue Bonds, net of unamortized discount of $121 and $126 at June 30, 2011 and 2010, respectively | $725 uninsured term bonds, due July 1, 2019<br>$1,730 uninsured term bonds, due July 1, 2029<br>$3,105 uninsured term bonds, due July 1, 2038 | 7.25%<br>7.50%<br>7.75% | 5,439 | 5,434 |





NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

| Description | Maturities | Rates | Outstanding Balance 2011 | Outstanding Balance 2010 |
|---|---|---|---|---|
| 2009B Hospital Revenue Bonds | $5,535 uninsured term bonds, due July 1, 2038 | 8.00% | 5,535 | 5,535 |
| 2009C Hospital Revenue Bonds, net of unamortized discount of $2,421 and $2,508 at June 30, 2011 and 2010, respectively | $21,100 uninsured term bonds, due July 1, 2019<br>$20,000 uninsured term bonds, due July 1, 2029<br>$74,855 uninsured term bonds, due July 1, 2038 | 7.25%<br>7.50%<br>7.75% | 113,534 | 113,447 |
| 2008A Hospital Revenue Bonds | $13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender | Variable, 0.07% at June 30, 2011 | 13,245 | 13,245 |
| 2008B Hospital Revenue Bonds | $53,855 uninsured term bonds, due July 1, 2038, subject to early redemption or tender | Variable, 0.07% at June 30, 2011 | 53,855 | 54,050 |
| 2007A Hospital Revenue Bonds | Uninsured term bonds, due July 1, 2038, redeemed in 2011 | NA | - | 4,305 |
| 2007B Taxable Hospital Revenue Bonds, bifurcated into sub-series B-1, B-2 and B-3 during 2011 | $307,900 uninsured term bonds, due July 1, 2033, subject to early redemption or tender | Variable, 0.11% to 0.16% at June 30, 2011 | 307,900 | 314,190 |
| 2007C Hospital Revenue Bonds | Uninsured term bonds, due July 1, 2032, redeemed in 2011 | NA | - | 1,900 |
| 2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of $147 and $153 at June 30, 2011 and 2010, respectively | $6,580 uninsured serially, through 2019<br>$7,375 uninsured term bonds, due July 1, 2026<br>$20,505 uninsured term bonds, due July 1, 2031<br>$135,175 uninsured term bonds, due July 1, 2036 | 5.00%<br>5.25%<br>5.50%<br>5.50% | 169,782 | 170,473 |
| 2001A Hospital First Mortgage Revenue Bonds | $23,100 term bonds, due July 1, 2026, subject to early redemption or tender | 6.85% | 23,100 | 23,900 |
| 2001 Hospital Refunding and Improvement Revenue Bonds (NCH), net of unamortized discount of $34 and $38 at June 30, 2011 and 2010, respectively | $1,465 insured term bonds, due December 1, 2012<br>$1,635 insured term bonds, due December 1, 2014<br>$8,815 insured term bonds, due December 1, 2022 | 5.75%<br>6.00%<br>6.00% | 11,876 | 12,547 |
| 2000A Hospital First Mortgage Revenue Refunding Bonds | $30,358 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030 | 6.63% | 30,358 | 28,417 |
| 2000C Hospital First Mortgage Revenue Bonds | $34,325 insured term bonds, due July 1, 2026 | 8.50% | 34,325 | 35,335 |
| 2000D First Mortgage Taxable Bonds | $14,790 insured term bonds, due July 1, 2026 | 8.50% | 14,790 | 15,225 |
| 1998 Hospital Refunding and Improvement Revenue Bonds (JMH) | $6,495 uninsured term bonds, due July 1, 2016<br>$7,620 uninsured term bonds, due July 1, 2028 | 5.25%<br>5.38% | 14,115 | 15,240 |
| Capitalized lease obligations secured by buildings and equipment | Maturing through 2027 | 3.18% to 13.01% | 16,153 | 16,715 |
| $7,500 promissory note secured by assets of Mediserve Medical Equipment of Kingsport, Inc. | Monthly principal and interest payments of $36 beginning February 2007 maturing December 2011; remaining principal due January 2012 | LIBOR + 1.10% | 5,473 | 6,064 |
| Capitalized lease obligations secured by equipment | Various monthly payments of monthly principal and interest | Various | 587 | 1,325 |
| Master installment payment agreement | Paid-off in 2011 | Unspecified | - | 2,194 |
| $1,409 unsecured promissory note | Monthly principal and interest payments of $23 beginning July 2008 through September 2013; remaining principal and accrued interest due October 2014; note was paid-off in 2011 | LIBOR + 1.25% | - | 920 |
| $10,221 note payable secured by property | Various annual principal and interest payments through April 2013; note was paid-off in 2011 | 6.25% | - | 7,836 |
| $1,065 note payable secured by land | Monthly interest-only payments through October 2011; remaining principal and accrued interest due November 2011 | 5.50% | 572 | 1,065 |
| $6,332 promissory note secured by substantially all assets of the Alliance | Monthly principal payments of $35 plus accrued interest beginning July 2010 maturing June 2015; remaining principal due July 2015 | LIBOR + 2.00% | 5,945 | 6,332 |
| $3,055 note payable secured by property | Monthly principal and interest payments of $27 beginning July 2010 maturing May 2015; remaining principal due June 2015 | 3.00% | 3,743 | 3,955 |

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

| Description | Maturities | Rates | Outstanding Balance 2011 | Outstanding Balance 2010 |
|---|---|---|---|---|
| Note payable under Master Financing Agreement, secured by Equipment | Monthly principal and interest payments of $166 beginning July 2010 maturing June 2017 | 4.62% | 10,431 | 11,900 |
| Note payable under Master Financing Agreement, secured by Equipment | Monthly principal and interest payments of $56 beginning July 2010 maturing June 2017 | 3.75% | 3,580 | 4,100 |
| $4,926 convertible construction loan secured by property and assigned rents | Monthly interest-only payments through January 2011 followed by monthly principal and interest payments of $25 maturing December 2014; remaining principal and accrued interest due January 2015; note was paid-off in 2011 | Prime (stated minimum and maximum interest rates of 3.75% and 6.75%, respectively) | - | 1,195 |
| $1,885 line of credit secured by property | Monthly interest-only payments through March 2011 followed by monthly principal and interest payments of $9 maturing February 2015; remaining principal and accrued interest due March 2015 | Prime - 0.50% (stated minimum and maximum interest rates of 3.50% and 6.25%, respectively) | 1,873 | 265 |
| $1,593 note payable, secured by equipment | Various annual principal payments through July 2014 | Unspecified | 1,593 | - |
| Capitalized lease obligation secured by medical office building (JMH) | Maturing through 2026 | 9.72% | 15,498 | - |
| | | | 1,069,085 | 1,082,973 |
| | Less current portion | | (28,162) | (28,131) |
| | | | $ 1,040,923 | $ 1,054,842 |

In September 2010, in order to reduce credit risk and expenses, the Alliance replaced the existing letters of credit related to the Series 2007B, Series 2008A and Series 2008B Bonds with letters of credit held by several different financial institutions. The substitute letters of credit entitle the Master Trustee to draw amounts equal to the principal amounts of the respective series of Bonds outstanding and up to 37 days interest at a rate of 12%. The substitute letters of credit expire on September 29, 2013 unless renewed or replaced.

*Series 2010 Bonds:* In April 2010, the Alliance issued $168,080 (Series 2010A) and $35,935 Series 2010B fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance. The Alliance recognized a $3,029 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs related to the refinanced Series 2008A and the Series 2007A and 2007C debt issues discussed below.

*Series 2009 Bonds*

In March 2009, the Alliance issued $5,560 (Series 2009A), $5,535 (Series 2009B) and $115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMH, fund a debt service





NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

In connection with its acquisition of a majority ownership in JMH, the Alliance assumed the then outstanding long-term debt of JMH, totaling $33,906, including the JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds as further described in the table above.

*Series 2008 Bonds*

In February 2008, the Alliance issued $72,770 (Series 2008A) and $54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. As discussed above, the payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit. A portion ($59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2008 Bonds is determined weekly by the Remarketing Agent (Merrill Lynch), as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Series 2008 Bonds in the secondary market. In no event shall the variable rate on the Series 2008 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2008A Bonds or the Commonwealth of Virginia for the Series 2008B Bonds. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

The Series 2008 Bonds are subject to optional and mandatory tender for purchase prior to maturity at the option of the holder, upon conversion to a fixed rate, upon conversion to a medium-term rate period, prior to the effective date of any substitute letter of credit, or upon the termination of the letters of credit. The optional and mandatory tender provisions generally call for the Master Trustee to purchase the outstanding Series 2008 Bonds at a purchase price equal to the principal amount thereof plus accrued interest upon a stated date as described in the tender notice delivered to the bond holders.

*Series 2007 Bonds*

In December 2007, the Alliance issued $104,355 (Series 2007A), $327,170 (Series 2007B taxable) and $36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. A portion of the outstanding Series 2007A ($91,685) and Series 2007C ($32,840) Bonds were repaid from proceeds of the Series 2010 Bonds. The remaining outstanding Series 2007A and Series 2007C Bonds were redeemed in 2011.

In 2011 during the letter of credit restructuring, the existing 2007B Bonds were repaid through a remarketing of Sub-Series 2007B-1, 2007B-2 and 2007B-3 (collectively, the Sub-Series 2007B Bonds), created per the mandatory tender and letter of credit substitution provisions. As discussed above, the payment of principal and interest on the Sub-Series 2007B Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit.

The variable rate of interest on the Series 2007 Bonds is determined weekly in the same manner as described above for the Series 2008 Bonds. In no event shall the variable rate on the bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate. Upon such conversion, the bonds become subject to mandatory tender for purchase.

The Sub-Series 2007 Bonds are subject to optional and mandatory tender in the same manner as described above for the Series 2008 Bonds. In addition, the Sub-Series 2007B Bonds are subject to a special mandatory tender with respect to its conversion from taxable debt to tax-exempt debt. As discussed in Note S, certain of the Sub-Series 2007B Bonds were redeemed subsequent to year end.

*Series 2006 Bonds*

During 2006, the Alliance issued $173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and $66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.





NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

*Series 2001 Bonds*

During 2001, the Alliance issued $26,000 Hospital First Mortgage Revenue Bonds (Series 2001A) and $60,175 Hospital First Mortgage Revenue Bonds (Series 2001B). The Series 2001A Bonds were subject to optional tender by Bond holders. Effective July 1, 2007, the Alliance entered into an agreement whereby the beneficial owners of the Series 2001A Bonds have irrevocably waived their rights to tender the Bonds under the provisions of the respective Bond Indenture. The waiver will continue in effect through the maturity of the 2001A Bonds. The Series 2001B Bonds were refunded and redeemed in 2006.

*Series 2000 Bonds*

The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were intended to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date $14,680 of insured Capital Appreciation Bonds. Such bonds bear a 0% coupon rate and have a yield of 6.625% annually. The Alliance recognizes interest expense and increases the amount of outstanding debt each year based upon this yield. Total principal and interest due at maturity (2026 through 2030) is $93,675.

The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. Management, upon advice of legal counsel, believes the amounts deposited in such irrevocable trust accounts have contractually relieved the Alliance of any future obligations with respect to this debt, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized.

Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2011 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately $525,025.

The assets placed in the irrevocable trust accounts are also not recognized as assets of the Alliance. These assets consist primarily of various investments, as permitted by bond indentures and other

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the original amount of $54,300, as well as the Series 2000C and 2000D Bonds which were purchased with the proceeds of the 2000A and 2000B Bonds specifically for the purpose of utilizing the Series 2000C and 2000D Bonds in the irrevocable trust. Therefore, certain of the assets held in the irrevocable trust accounts have future income streams contingent upon payments by the Alliance.

Essentially all of the Alliance's bonds are subject to redemption prior to maturity, including optional, mandatory sinking fund and extraordinary redemption, at various dates and prices as described in the respective Bond indentures and other documents.

*Other Bonds, Notes Payable and Financing Arrangements*

The Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The NCH Series 2001 Hospital Refunding and Improvement Revenue Bonds are secured by revenues and a lien on certain real and personal property of NCH. The JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds are secured by pledged gross receipts of JMH, as defined in the Master Trust indenture.

The scheduled maturities and mandatory sinking fund payments of the long-term debt and capital lease obligations (excluding interest), exclusive of net unamortized original issue discount and premium, at June 30, 2011 are as follows:

| *Year Ending June 30,* | | |
|---|---|---|
| 2012 | $ | 28,162 |
| 2013 | | 32,230 |
| 2014 | | 28,706 |
| 2015 | | 34,504 |
| 2016 | | 33,585 |
| Thereafter | | 912,560 |
| | | 1,069,747 |
| | Net discount | (662) |
| | $ | 1,069,085 |





NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

The Alliance, NCH and JMH are each members of separate Obligated Groups. The bond indentures, master trust indentures, letter of credit agreements and loan agreements related to the various bond issues and notes payable contain covenants with which the respective Obligated Groups must comply. These requirements include maintenance of certain financial and liquidity ratios, deposits to trustee funds, permitted indebtedness, use of facilities and disposals of property. These covenants also require that failure to meet certain debt service coverage tests will require the deposit of all daily cash receipts of the Alliance into a trust fund. Management has represented the Alliance, NCH and JMH are in compliance with all such covenants at June 30, 2011.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2011 or 2010.

NOTE G--SELF-INSURANCE PROGRAMS

The Alliance is substantially self-insured for professional and general liability claims and related expenses. The Alliance maintains a $25,000 umbrella liability policy that attaches over the self-insurance limits of $10,000 per claim and a $15,000 annual aggregate retention. The Alliance's insurance program also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is also substantially self-insured for workers' compensation claims in the State of Tennessee and has established estimated liabilities for both reported and unreported claims. The Alliance maintains a stop-loss policy that attaches over the self-insurance limits of $1,000 per occurrence and $1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2011, the Alliance is involved in litigation relating to medical malpractice and workers' compensation and other claims arising in the ordinary course of business. There are also known incidents occurring through June 30, 2011 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance management has estimated and accrued for the cost of these unreported claims based on historical data and actuarial projections. The estimated net present value of malpractice and workers' compensation claims, both reported and unreported, as of June 30, 2011 and 2010 was $13,531 and $12,601, respectively. The discount rate utilized was 5% at June 30, 2011 and 2010.

NOTE G--SELF-INSURANCE PROGRAMS - Continued

Additionally, the Alliance is self-insured for employee health claims and recognizes expense each year based upon actual claims paid and an estimate of claims incurred but not yet paid, including a catastrophic claims reserve based on historical claims in excess of $75.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations is as follows for the years ended June 30:

| | *2011* | *2010* |
|---|---|---|
| Inpatient service charges | $ 1,983,340 | $ 1,848,590 |
| Outpatient service charges | 1,807,247 | 1,669,705 |
| Gross patient service charges | 3,790,587 | 3,518,295 |
| Less: | | |
| Estimated contractual adjustments and other discounts | 2,647,514 | 2,417,082 |
| Estimated uncollectible self-pay | 110,387 | 111,565 |
| Charity care | 72,432 | 61,378 |
| | 2,830,333 | 2,590,025 |
| Net patient service revenue | $ 960,254 | $ 928,270 |

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare, Blue Cross and various other commercial payors. The Medicare program pays for inpatient services on a prospective basis. Payments are based upon diagnosis related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. The Alliance also receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid and other low income patients. Most Medicare outpatient services are reimbursed on a prospectively determined payment methodology. The Medicare program also reimburses certain other services on the basis of reasonable cost, subject to various prescribed limitations and reductions.

Reimbursement under the State of Tennessee's Medicaid waiver program (TennCare) for inpatient and outpatient services is administered by various managed care organizations (MCOs) and is based on diagnosis related group assignments, a negotiated per diem or fee schedule basis. The Alliance





NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

also receives additional supplemental payments from the State of Tennessee. The amount recognized totaled $11,480 and $7,811 for the years ended June 30, 2011 and 2010, respectively. Such payments are not guaranteed in future periods.

The Virginia Medicaid program reimbursement for inpatient hospital services is based on a prospective payment system using both a per case and per diem methodology. Additional payments are made for the allowable costs of capital. Payments for outpatient services are based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

Amounts earned under the contractual agreements with the Medicare and Medicaid programs are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Activity with respect to audits and reviews of the governmental programs in the healthcare industry has increased and is expected to increase in the future. No additional specific reserves or allowances have been established with regard to these increased audits and reviews as management is not able to estimate such amounts. Management believes that any adjustments from these increased audits and reviews will not have a material adverse impact on the consolidated financial statements. However, due to uncertainties in the estimation, it is at least reasonably possible that management's estimate will change in 2012, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates decreased net patient service revenue by $4,570 in 2011. The impact of final settlements of cost reports or changes in estimates were not significant in 2010.

Participation in the Medicare program subjects the Alliance to significant rules and regulations; failure to adhere to such could result in fines, penalties or expulsion from the program. Management believes that adequate provision has been made for any adjustments, fines or penalties which may result from final settlements or violations of other rules or regulations. Management has represented that the Alliance is in substantial compliance with these rules and regulations as of June 30, 2011.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

NOTE J--EMPLOYEE BENEFIT PLANS

The Alliance sponsors a retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists mainly of employer-funded contributions. During

NOTE J--EMPLOYEE BENEFIT PLANS - Continued

2011 and 2010, the Alliance made contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. In addition, the Alliance sponsors a 403(b) plan which is funded solely by employees' contributions. The Alliance does not make any discretionary or matching contributions into the 403(b) plan. Employees of certain other subsidiaries are covered by other plans, although such plans are not significant. The total expense related to defined contribution plans for the years ended June 30, 2011 and 2010 was $12,682 and $13,311, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was $1,313 and $1,942, and the accrued unfunded post-retirement liability was $3,761 and $3,843 at June 30, 2011 and 2010, respectively.

The Alliance sponsors a secured executive benefit program (SEBP) for certain key executives. Contributions to the plan by the Alliance are based on an annual amount of funding necessary to produce a target benefit for the participants at their retirement date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed $929 and $1,303 to the plan during 2011 and 2010, respectively. Other assets at June 30, 2011 and 2010 include $7,888 and $7,077, respectively, related to the Alliance's portion of the benefits which are recoverable upon the death of the participant. In addition, the Alliance sponsors a Section 457(f) plan for certain key executives. The benefits for substantially all employees previously participating in the SEBP plan have been transferred into the 457(f) plan.

NOTE K--CONCENTRATIONS OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 54% of total net patient service revenue for each of the years 2011 and 2010.

The mix of receivables from patients and third-party payors based on charges at established rates is as follows as of June 30:





NOTE K--CONCENTRATIONS OF RISK - Continued

| | *2011* | *2010* |
|---|---|---|
| Medicare | 40% | 42% |
| Tenncare/Medicaid | 12% | 15% |
| Commercial | 27% | 25% |
| Other third-party payors | 9% | 10% |
| Patients | 12% | 8% |
| | 100% | 100% |

Approximately 98% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2011 and 2010. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements which extend through February 2, 2014.

The Alliance routinely invests in investment vehicles as listed in Note C. The Alliance's investment portfolio is managed by outside investment management companies. Investments in corporate and foreign bonds and notes, municipal obligations, money market funds, equities and other vehicles that are held by safekeeping agents are not insured or guaranteed by the U.S. government. At June 30, 2011, the Alliance also had deposits in financial institutions significantly in excess of the Federal Deposit Insurance Corporation's limits.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2011 and 2010, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of $34,822 and $32,447, respectively, related to operating losses which expire through 2030. At June 30, 2011 and 2010, BRMM had state net operating loss carryforwards of $65,979 and $59,860, respectively, which expire through 2025. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and Tennessee Code Annotated.

At June 30, 2011 and 2010, SWCH had federal and state net operating loss carryforwards of $4,875 and $4,376, respectively, which expire through 2030. CHC files separate federal and state tax returns. At June 30, 2011 and 2010, CHC had a net deferred tax liability of $69 and $58, respectively, due primarily to temporary timing differences related to depreciation. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

NOTE L--INCOME TAXES - Continued

Net deferred tax assets related to these carryforwards and other deferred tax assets have been substantially offset through valuation allowances equal to these amounts. Income taxes paid relate primarily to state taxes for certain subsidiaries and federal alternative minimum tax.

NOTE M--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

*Construction in Progress:* Construction in progress at June 30, 2011 represents costs incurred related to various hospital and medical office building facility renovations and additions. The Alliance has outstanding contracts and other commitments related to the completion of these projects, and the cost to complete these projects is estimated to be approximately $98,721 at June 30, 2011. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

*Physician Contracts:* BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Upon completion of the respective guarantee period, amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician note may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of $1,407 and $1,818 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2011 and 2010, respectively.

*Employee Scholarships:* The Alliance offers scholarships to certain individuals which require that the recipients return to the Alliance to work for a specified period of time after they complete their degree. Amounts due are then forgiven over a specific period of time as provided in the individual contracts. If the recipient does not return and work the required period of time, the funds disbursed on their behalf become due immediately and interest is charged until the funds are repaid. Other receivables June 30, 2011 and 2010 includes $7,250 and $5,571, respectively, related to students in





NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program.

*Promises to Give*: The Alliance has recorded certain unconditional promises to give to unrelated organizations. At June 30, 2011, $1,568 is due within one year, and an additional $180 is due within five years and is included in other long-term liabilities.

*Operating Leases and Maintenance Contracts*: Total lease expense for the years ended June 30, 2011 and 2010 was $9,362 and $10,216, respectively. Future minimum lease payments for each of the next five years and in the aggregate for the Alliance's noncancellable operating leases with remaining lease terms in excess of one year are as follows:

| *Year Ending June 30,* | | |
|---|---|---|
| 2012 | $ | 2,846 |
| 2013 | | 2,631 |
| 2014 | | 2,286 |
| 2015 | | 2,121 |
| 2016 | | 1,285 |
| Thereafter | | 9,914 |
| | $ | 21,083 |

Estimated future minimum payments under various noncancellable maintenance contracts with remaining terms in excess of one year at June 30, 2011 total in the aggregate $1,422 through 2016.

*Asset Retirement Obligation:* The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

*Other:* The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future. In addition, the Alliance has agreed to guarantee a portion of the outstanding indebtedness of a joint venture. Management estimates that the fair value of the guarantee of this debt is immaterial as of June 30, 2011.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

*Healthcare Industry:* Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In March 2010, Congress adopted comprehensive health care insurance legislation, *Patient Care Protection and Affordable Care Act* and *Health Care and Education Reconciliation Act*. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2011:

| *Year Ending June 30,* | | |
|---|---|---|
| 2012 | $ | 1,742 |
| 2013 | | 1,219 |
| 2014 | | 958 |
| 2015 | | 796 |
| 2016 | | 397 |
| Total minimum future rentals | $ | 5,112 |

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2011 and 2010, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Alliance could realize in a current market exchange. The carrying value of substantially all financial instruments approximates fair value due to the nature or term of the instruments, except as described below.





NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

*Investment in Joint Ventures:* It is not practical to estimate the fair market value of the investments in joint ventures.

*Other Long-Term Liabilities:* Estimates of reported and unreported professional liability claims, pension and post-retirement liabilities are discounted to approximate their estimated fair value. It is not practical to estimate the fair market value of other long-term liabilities due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

*Long-Term Debt and Capital Leases:* The fair value of long-term debt is estimated based upon quotes obtained from brokers for bonds and discounted future cash flows using current market rates for other debt. For long-term debt with variable interest rates, the carrying value approximates fair value.

The Alliance's significant capital leases and vendor contracts were negotiated with various entities and are considered unique. It is not practicable to estimate the fair value of these obligations under current conditions. Other capital lease obligations are not significant.

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

| | *2011* | | *2010* | |
|---|---|---|---|---|
| | *Carrying Value* | *Estimated Fair Value* | *Carrying Value* | *Estimated Fair Value* |
| FINANCIAL LIABILITIES: | | | | |
| Long-term debt | $ 1,069,085 | $ 1,046,675 | $ 1,082,973 | $ 1,105,778 |

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 820 establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 - Inputs based on quoted market prices for identical assets or liabilities in active markets at the measurement date.
- Level 2 - Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar

NOTE Q--FAIR VALUE MEASUREMENT - Continued

assets and liabilities in markets that are not active; or other inputs that are observable or can be corroborated by observable market data. The Alliance's Level 2 investments are valued primarily using the market valuation approach.

- Level 3 - Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Alliance's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Alliance'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.

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of June 30, 2011 and 2010:

| | *June 30, 2011* | *Level 1* | *Level 2* | *Level 3* |
|---|---|---|---|---|
| Trading securities | $ 333,610 | $ 164,953 | $ 135,939 | $ 32,718 |
| Assets whose use is limited | 117,170 | 117,170 | - | - |
| Total assets | $ 450,780 | $ 282,123 | $ 135,939 | $ 32,718 |
| Fair value of derivative agreements - Note D | $ (110,732) | $ - | $ - | $ (110,732) |

| | *June 30, 2010* | *Level 1* | *Level 2* | *Level 3* |
|---|---|---|---|---|
| Trading securities | $ 209,644 | $ 164,510 | $ 16,526 | $ 28,608 |
| Assets whose use is limited | 177,180 | 177,180 | - | - |
| Total assets | $ 386,824 | $ 341,690 | $ 16,526 | $ 28,608 |
| Fair value of derivative agreements - Note D | $ (134,300) | $ - | $ - | $ (134,300) |

The valuation of the Alliance's derivative agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses observable market-based inputs, including forward interest rate curves. The fair values of interest rate swap agreements are determined by netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments). The variable cash receipts (or payments) are based on the expectation of future interest rates based on observable





NOTE Q--FAIR VALUE MEASUREMENT - Continued

market forward interest rate curves and the underlying notional amount. The Alliance also incorporates credit valuation adjustments (CVAs) to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. The CVA on the Alliance's interest rate swap agreements at June 30, 2011 and 2010 resulted in a decrease in the fair value of the related liability of $7,940 and $10,085, respectively.

A certain portion of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Alliance's credit risk used in the CVAs, are unobservable inputs available to a market participant. As a result, the Alliance has determined that the interest rate swap valuations are classified in Level 3 of the fair value hierarchy.

The following tables provide a summary of changes in the fair value of the Alliance's Level 3 financial assets and liabilities during the fiscal years ended June 30, 2011 and 2010:

| | *Trading Securities* | *Derivatives, Net* |
|---|---|---|
| July 1, 2009 | $ 30,031 | $ (126,217) |
| Total unrealized/realized losses in the Performance Indicator, net | (1,546) | (8,607) |
| Purchases, issuance and settlements and other, net | 1,446 | 524 |
| Transfers in (out), net | (1,323) | - |
| June 30, 2010 | 28,608 | (134,300) |
| Total unrealized/realized gains in the Performance Indicator, net | 2,847 | 23,049 |
| Purchases, issuance and settlements and other, net | 1,263 | 519 |
| June 30, 2011 | $ 32,718 | $ (110,732) |

There were no changes in valuation techniques in 2011 or 2010. During 2011, as part of the transitional test of goodwill impairment, the Alliance recognized goodwill impairment of $2,965 based primarily on the fair value of the reporting unit, utilizing the income approach. Remaining goodwill determined not to be impaired, for this specific reporting unit, is included in the Consolidated Balance Sheet at $2,900. There were no significant assets or liabilities that were re-measured at fair value on a non-recurring basis during the fiscal year ended June 30, 2010.

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

Direct expenses by functional classification are as follows for the years ended June 30:

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION - Continued

| | *2011* | *2010* |
|---|---|---|
| Healthcare services | $ 817,397 | $ 795,725 |
| Administrative and general | 130,543 | 125,852 |
| Other | 9,233 | 8,625 |
| | $ 957,173 | $ 930,202 |

NOTE S--SUBSEQUENT EVENTS

*Acquisition:* Subsequent to June 30, 2011, the Alliance purchased the stock of a pharmacy provider for approximately $6,700. The Alliance has not completed an allocation of the purchase price although it is anticipated significant intangible assets will be recognized upon such allocation.

*Debt:* In October 2011, the Alliance (along with BRMMC, NCH and SCCH) issued $85,260 of Series 2011 Tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the Tennessee Bonds) and $110,580 through the Industrial Development Authority of Smyth, Virginia (the Virginia Bonds). Such bonds were issued on parity with the outstanding bond indebtedness of the Alliance as of June 30, 2011. The Bonds bear interest at a variable rate determined by a remarketing agent based upon a weekly rate period. Additionally, the Alliance issued $15,960 of Series 2011 Taxable Bonds. NCH and SCCH were also admitted as members of the Alliance Obligated Group.

The proceeds from the Tennessee Bonds will be issued to finance certain capital acquisitions in the State of Tennessee and pay issuance costs related to these Bonds. The proceeds from the Virginia Bonds will be used to refinance $11,200 of 2001 NCH Hospital Refunding and Improvement Revenue Bonds, finance capital acquisitions for NCH, JMH and SCCH and to pay issuance costs associated with these Bonds. The Series 2011 Taxable Bonds proceeds will be used to finance capital acquisitions of SCCH and BRMMC and pay issuance costs. The timely payment of the Tennessee and the Virginia Bonds is secured by a letter of credit which expires October 19, 2014. The Alliance also redeemed $115,135 of the Series 2007B-1 Revenue Bonds and $29,405 of the Series 2007B-3 Revenue Bonds.

Management further anticipates issuance of an additional $25,000 of tax-exempt bonds for the benefit of JMH. JMH is not a member of the Mountain States Health Alliance Obligated Group.

Subsequent to June 30, 2011, JMH exercised their right to purchase a facility previously held under a capital lease for total consideration of $16,051. $2,093 was paid directly to the third party and the remaining $13,958 was by assumption of a promissory note with payments through 2013. The promissory note bears interest at a variable rate of LIBOR plus 1.5%. Additionally, JMH assumed an interest rate swap in the notional amount of $13,940. JMH pays a fixed rate of 7.46%





NOTE S--SUBSEQUENT EVENTS - Continued

and receives a variable rate of LIBOR plus 1.5%. The interest rate swap has a termination date of August 15, 2012.

## MOUNTAIN STATES HEALTH ALLIANCE

***Consolidating Balance Sheet***
***(Dollars in Thousands)***

***June 30, 2011***

| | *Blue Ridge Medical Management ** | *Other Obligated Group Members* | *Eliminations* | *Total Obligated Group* | *Other Entities* | *Mountain States Properties* | *Eliminations* | *Total* |
|---|---|---|---|---|---|---|---|---|
| ASSETS | | | | | | | | |
| CURRENT ASSETS | | | | | | | | |
| Cash and cash equivalents | $ 450 | $ 85,976 | $ - | $ 86,426 | $ 17,023 | $ 9,319 | $ - | $ 112,768 |
| Current portion of investments | - | 7,629 | - | 7,629 | 94,775 | 13,771 | - | 116,175 |
| Patient accounts receivable, less estimated allowances for uncollectible accounts | 4,476 | 96,083 | - | 100,559 | 34,052 | - | - | 134,611 |
| Other receivables, net | 848 | 13,434 | - | 14,282 | 4,552 | 780 | - | 19,614 |
| Inventories and prepaid expenses | 553 | 18,783 | - | 19,336 | 9,477 | 152 | - | 28,965 |
| TOTAL CURRENT ASSETS | 6,327 | 221,905 | - | 228,232 | 159,879 | 24,022 | - | 412,133 |
| INVESTMENTS, less amounts required to meet current obligations | 19,193 | 337,367 | - | 356,560 | 190,937 | 33,879 | - | 581,376 |
| EQUITY IN AFFILIATES | 139,582 | 387,825 | (155,611) | 371,796 | - | - | (371,795) | - |
| PROPERTY, PLANT AND EQUIPMENT, net | 10,696 | 469,613 | - | 480,309 | 258,342 | 58,766 | - | 797,418 |
| OTHER ASSETS | | | | | | | | |
| Goodwill | 3,281 | 143,276 | - | 146,557 | 2,109 | - | - | 148,666 |
| Net deferred financing, acquisition costs and other charges, less current portion | 168 | 27,991 | - | 28,159 | 568 | 1,117 | - | 29,844 |
| Other assets | 8,467 | 10,154 | - | 18,621 | 7,265 | 2,562 | - | 28,448 |
| TOTAL OTHER ASSETS | 11,916 | 181,421 | - | 193,337 | 9,942 | 3,679 | - | 206,958 |
| | $ 187,714 | $ 1,598,131 | $ (155,611) | $ 1,630,234 | $ 619,100 | $ 120,346 | $ (371,795) | $ 1,997,885 |

* Management Services Organization only

MOUNTAIN STATES HEALTH ALLIANCE

*Consolidating Balance Sheet - Continued*
*(Dollars in Thousands)*

*June 30, 2011*

| | Blue Ridge Medical Management * | Other Obligated Group Members | Eliminations | Total Obligated Group | Other Entities | Mountain States Properties | Eliminations | Total |
|---|---|---|---|---|---|---|---|---|
| LIABILITIES AND NET ASSETS | | | | | | | | |
| CURRENT LIABILITIES | | | | | | | | |
| Accrued interest payable | $ - | $ 19,607 | $ - | $ 19,607 | $ 440 | $ - | $ - | $ 20,047 |
| Current portion of long-term debt and capital lease obligations | 550 | 23,724 | - | 24,274 | 3,888 | - | - | 28,162 |
| Current portion of estimated fair value of derivatives | - | 92,044 | - | 92,044 | - | 10,565 | - | 102,609 |
| Accounts payable and accrued expenses | 3,463 | 66,494 | - | 69,957 | 27,645 | 1,217 | - | 98,819 |
| Accrued salaries, compensated absences and amounts withheld | 3,093 | 40,177 | - | 43,270 | 14,530 | - | - | 57,800 |
| Payables to (receivables from) affiliates, net | 11,094 | (81,319) | - | (70,225) | 94,632 | (24,407) | - | - |
| Estimated amounts due to third-party payors, net | - | 12,547 | - | 12,547 | 2,266 | - | - | 14,813 |
| TOTAL CURRENT LIABILITIES | 18,200 | 173,274 | - | 191,474 | 143,401 | (12,625) | - | 322,250 |
| OTHER LIABILITIES | | | | | | | | |
| Long-term debt and capital lease obligations, less current portion | 4,923 | 979,774 | - | 984,697 | 56,226 | - | - | 1,040,923 |
| Estimated fair value of derivatives, less current portion | - | 7,783 | - | 7,783 | - | 340 | - | 8,123 |
| Deferred revenue | - | 19,167 | - | 19,167 | 100 | - | - | 19,267 |
| Estimated professional liability self-insurance | 2,285 | 4,494 | - | 6,779 | 2,913 | - | - | 9,692 |
| Other long-term liabilities | 6,695 | 2,102 | - | 9,097 | 5,255 | - | - | 14,352 |
| TOTAL LIABILITIES | 32,103 | 1,186,894 | - | 1,218,997 | 207,895 | (12,285) | - | 1,414,607 |
| NET ASSETS | | | | | | | | |
| UNRESTRICTED NET ASSETS | | | | | | | | |
| Unrestricted net assets | | | | | | | | |
| Mountain States Health Alliance | 155,478 | 400,395 | (155,478) | 400,395 | 228,554 | 132,631 | (361,185) | 400,395 |
| Noncontrolling interests in subsidiaries | - | - | - | - | 171,984 | - | - | 171,984 |
| TOTAL UNRESTRICTED NET ASSETS | 155,478 | 400,395 | (155,478) | 400,395 | 400,538 | 132,631 | (361,185) | 572,379 |
| Temporarily restricted net assets | | | | | | | | |
| Mountain States Health Alliance | 133 | 10,715 | (133) | 10,715 | 10,483 | - | (10,483) | 10,715 |
| Noncontrolling interests in subsidiaries | - | - | - | - | 57 | - | - | 57 |
| TOTAL TEMPORARILY RESTRICTED NET ASSETS | 133 | 10,715 | (133) | 10,715 | 10,540 | - | (10,483) | 10,772 |
| Permanently restricted net assets | - | 127 | - | 127 | 127 | | (127) | 127 |
| TOTAL NET ASSETS | 155,611 | 411,237 | (155,611) | 411,237 | 411,205 | 132,631 | (371,795) | 583,278 |
| | $ 187,714 | $ 1,598,131 | $ (155,611) | $ 1,630,234 | $ 619,100 | $ 120,346 | $ (371,795) | $ 1,997,885 |

*See note to supplemental schedules.*



MOUNTAIN STATES HEALTH ALLIANCE

*Consolidating Statement of Operations*
*(Dollars in Thousands)*

*Year Ended June 30, 2011*

| | Blue Ridge Medical Management * | Other Obligated Group Members | Eliminations | Total Obligated Group | Other Entities | Mountain States Properties | Eliminations | Total |
|---|---|---|---|---|---|---|---|---|
| Revenue, gains and support: | | | | | | | | |
| Net patient service revenue | $ 35,353 | $ 683,224 | $ (1,702) | $ 716,875 | $ 243,487 | $ - | $ (108) | $ 960,254 |
| Other operating revenue | 26,855 | 3,657 | (20,748) | 9,764 | 39,423 | 7,807 | (41,123) | 15,871 |
| Equity in net gain (loss) of affiliates | 974 | (3,283) | 2,051 | (258) | - | - | 258 | - |
| TOTAL REVENUE, GAINS AND SUPPORT | 63,182 | 683,598 | (20,399) | 726,381 | 282,910 | 7,807 | (40,973) | 976,125 |
| Expenses: | | | | | | | | |
| Salaries and wages | 17,287 | 235,564 | - | 252,851 | 92,108 | 150 | (2,901) | 342,208 |
| Physician salaries and wages | 32,631 | 1,010 | - | 33,641 | 55,417 | - | (29,809) | 59,249 |
| Contract labor | 866 | 3,234 | - | 4,100 | 2,123 | - | (259) | 5,964 |
| Employee benefits | 4,874 | 45,591 | (1,743) | 48,722 | 20,414 | 35 | (2,032) | 67,139 |
| Fees | 3,544 | 81,194 | (20,612) | 64,126 | 22,251 | 713 | (1,171) | 85,919 |
| Supplies | 1,745 | 129,126 | - | 130,871 | 38,594 | 2 | (105) | 169,362 |
| Utilities | 455 | 11,386 | - | 11,841 | 4,452 | 1,007 | - | 17,300 |
| Other | 4,778 | 38,479 | (95) | 43,162 | 28,206 | 3,230 | (4,951) | 69,647 |
| Depreciation | 1,476 | 59,635 | - | 61,111 | 23,666 | 2,722 | - | 87,499 |
| Amortization | 23 | 2,188 | - | 2,211 | 348 | - | - | 2,559 |
| Estimated provision for bad debts | 353 | 4,097 | - | 4,450 | 1,724 | - | - | 6,174 |
| Interest and taxes | (1,228) | 42,204 | - | 40,976 | 3,248 | 1,174 | (1,445) | 44,153 |
| TOTAL EXPENSES | 66,804 | 653,708 | (22,450) | 698,062 | 293,551 | 9,233 | (42,673) | 957,173 |
| OPERATING INCOME (LOSS) | (3,622) | 29,890 | 2,051 | 28,319 | (9,641) | (1,426) | 1,700 | 18,952 |
| Nonoperating gains (losses): | | | | | | | | |
| Interest and dividend income | 662 | 9,810 | - | 10,472 | 6,352 | 645 | (1,445) | 16,224 |
| Net realized gains on the sale of securities | 73 | 1,449 | - | 1,522 | 435 | - | - | 1,957 |
| Net unrealized gains on securities | 1,311 | 13,664 | - | 14,975 | 7,949 | (756) | - | 22,168 |
| Derivative related income | - | 3,512 | - | 3,512 | - | 1,560 | - | 5,072 |
| Change in estimated fair value of derivatives | - | 23,137 | - | 23,137 | - | (88) | - | 23,049 |
| Other nonoperating gains (losses) | (475) | 1,245 | - | 770 | (3,430) | 4 | 3 | (2,653) |
| Net assets released from restrictions used for operations | - | 562 | - | 562 | 1,331 | - | - | 1,893 |
| NET NONOPERATING GAINS | 1,571 | 53,379 | - | 54,950 | 12,837 | 1,365 | (1,442) | 67,710 |
| EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES | $ (2,051) | $ 83,269 | $ 2,051 | $ 83,269 | $ 3,196 | $ (61) | $ 258 | $ 86,662 |

*Management Services Organization only.

*See note to supplemental schedules.*

MOUNTAIN STATES HEALTH ALLIANCE

*Consolidating Statement of Changes in Net Assets*
*(Dollars in Thousands)*

*Year Ended June 30, 2011*

| | Blue Ridge Medical Management* | Other Obligated Group Members | Eliminations | Total Obligated Group | Other Entities: Mountain States Health Alliance | Other Entities: Noncontrolling Interests | Total Other Entities | Mountain States Properties | Eliminations | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| UNRESTRICTED NET ASSETS: | | | | | | | | | | |
| Excess of Revenue, Gains and Support over Expenses and Losses | $ (2,051) | $ 83,269 | $ 2,051 | $ 83,269 | $ (197) | $ 3,393 | $ 3,196 | $ (61) | $ 258 | $ 86,662 |
| Pension and other defined benefit plan adjustments | - | 620 | - | 620 | 620 | 617 | 1,237 | - | (620) | 1,237 |
| Cumulative effect of a change in accounting principle | (2,965) | (2,965) | 2,965 | (2,965) | - | - | - | | | (2,965) |
| Net assets released from restrictions used for the purchase of property, plant and equipment | - | 1,946 | - | 1,946 | 1,946 | - | 1,946 | - | (1,946) | 1,946 |
| Distributions to noncontrolling interests | - | - | - | - | - | (270) | (270) | - | - | (270) |
| Repurchases of noncontrolling interests and other | (63) | 40 | 63 | 40 | (112) | (115) | (227) | - | (62) | (250) |
| INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS | (5,059) | 82,910 | 5,059 | 82,910 | 2,187 | 3,625 | 5,812 | (61) | (2,126) | 86,535 |
| TEMPORARILY RESTRICTED NET ASSETS: | | | | | | | | | | |
| Restricted grants and contributions | - | 3,612 | - | 3,612 | 2,990 | 58 | 3,048 | - | (2,990) | 3,670 |
| Net assets released from restrictions | - | (3,787) | - | (3,787) | (3,225) | (52) | (3,277) | - | 3,225 | (3,839) |
| INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS | - | (175) | - | (175) | (235) | 6 | (229) | - | 235 | (169) |
| INCREASE (DECREASE) IN TOTAL NET ASSETS | (5,059) | 82,735 | 5,059 | 82,735 | 1,952 | 3,631 | 5,583 | (61) | (1,891) | 86,366 |
| NET ASSETS, BEGINNING OF YEAR | 160,670 | 328,502 | (160,670) | 328,502 | 237,212 | 168,410 | 405,622 | 132,692 | (369,904) | 496,912 |
| NET ASSETS, END OF YEAR | $ 155,611 | $ 411,237 | $ (155,611) | $ 411,237 | $ 239,164 | $ 172,041 | $ 411,205 | $ 132,631 | $ (371,795) | $ 583,278 |

*Management Services Organization only.

*See note to supplemental schedules.*



MOUNTAIN STATES HEALTH ALLIANCE

*Note to Supplemental Schedules*

*Year Ended June 30, 2011*

NOTE A—OBLIGATED GROUP MEMBERS

As described in Note F to the consolidated financial statements, the Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. In accordance with Article Six, Section 6.6 of the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Trust Company, NA as Master Trustee, those members pledged include Johnson City Medical Center Hospital, Indian Path Medical Center, Franklin Woods Community Hospital, Sycamore Shoals Hospital, Johnson County Community Hospital, Russell County Medical Center and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), are not pledged to secure the payment of the outstanding bonds as they are not part of the Obligated Group. These affiliates have been accounted for within the Obligated Group based upon the Alliance's original and subsequent investments, as adjusted for the Alliance's pro rata share of income or losses and any distributions, and are included as a part of equity in affiliates in the supplemental consolidating balance sheet.

## ***Attachment C, Contribution to the Orderly Development of Health Care, 7(b):***

Current Licensure from Tennessee Department of Health
and Joint Commission Accreditation

# Board for Licensing Health Care Facilities

State of Tennessee

0000000012

No. of Beds 0121

## DEPARTMENT OF HEALTH

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

MOUNTAIN STATES HEALTH ALLIANCE *to conduct and maintain a*

*Hospital* SYCAMORE SHOALS HOSPITAL

*Located at* 1501 WEST ELK AVENUE, ELIZABETHTON

*County of* CARTER, *Tennessee.*

*This license shall expire* NOVEMBER 03, 2013, *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* 1ST *day of* JULY, 2012.

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

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

*By* John J. Dreyzehner, MD
COMMISSIONER

105

Rec'd 7/9/07

STATE OF TENNESSEE
**DEPARTMENT OF HEALTH**
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

July 2, 2007

Mr. Dwayne Taylor, Administrator
Sycamore Shoals Hospital
1501 West Elk Avenue
Elizabethton TN 37643

Dear Mr. Taylor:

Enclosed is a Statement of Deficiencies which was developed as the result of the state licensure survey conducted at your facility on June 26 and 27, 2007. Corrective action must be achieved prior to August 11, 2007, the forty-fifth (45th) day from the date of survey. A revisit may be conducted to verify compliance.

Please develop a Plan of Correction for the deficiencies cited and return within ten (10) calendar days after receipt of this letter to:

Bureau of Health Licensure and Regulation
Lakeshore Park, Building 1
5904 Lyons View Pike
Knoxville, TN 37919

Your POC must contain the following:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficiency 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 to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

If you have any questions, please contact this office at (865) 588-5656.

Sincerely,

Faye Vance RN

Faye Vance, R.N., B.S., M.S.N.
Public Health Nurse Consultant Manager

FV:aff

Enclosure: 2567

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53112 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/27/2007 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SYCAMORE SHOALS HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1501 WEST ELK AVENUE ELIZABETHTON, TN 37643 | | |

| (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 403 | 1200-8-1-.04 (3) Administration<br><br>(3) When licensure is applicable for a particular job, the number and renewal number of the current license must be maintained in personnel. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Adequate medical screenings to exclude communicable disease shall be required of each employee.<br><br>This Statute is not met as evidenced by: Based on review of personnel files and review of the facility's Team Member Health Program, the facility failed to screen one of fourteen employees reviewed for Tuberculosis.<br><br>The findings included:<br><br>Review of personnel health files revealed an employee in the Radiology Lab was to have an annual PPD skin test for tuberculosis screening completed by January 30, 2007. Review of the health file revealed no documentation the test was completed. Review of the Team Member Health Program - The Annual Team Member Physicals and Special Exams revealed, " ...The Annual Physical at MSHA consists of the following: 1. PPD skin test ... (mandatory) ..." Interview with the Infection Control Practitioner on June 27, 2007, at 9:30 a.m., in the conference room, confirmed the PPD skin test had not been completed. | H 403 | **H403 POC:** The radiology employee completed the PPD skin test on 07-02-07. On June 27, 2007 a report was generated from Net Learning showing those employees whose PPD skin test could be past due or requiring annual retest during the next month. An email was sent to each identified employee and their Department Director or Manager informing them of the need to report to Team Member Health immediately for completion of the annual PPD test.<br><br>Policy in place that states "Team Members are notified on their CBL's in Net Learning the month prior to their actual due date" and that "a monthly notice will be sent to the Department Director/Manager noting team members whose PPD is due in that month". This notice will be sent out by the Team Member Health Nurse on the first day of every month. An additional notice will be sent out by the Team | |
| H 644 | 1200-8-1-.06 (3)(i)1. Basic Hospital Functions<br><br>(3) Infection Control.<br><br>(i) The central sterile supply area(s) shall be | H 644 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Duane Tafa, CEO TITLE 7/16/07 (X6) DATE

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53112 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/27/2007 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: SYCAMORE SHOALS HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE: 1501 WEST ELK AVENUE ELIZABETHTON, TN 37643 | | |

| (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 644 | Continued From page 1<br><br>supervised by an employee, qualified by education and/or experience with a basic knowledge of bacteriology and sterilization principles, who is responsible for developing and implementing written policies and procedures for the daily operation of the central sterile supply area, including:<br><br>1. Receiving, decontaminating, cleaning, preparing, and disinfecting or sterilizing reusable items;<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview and review of personnel files, the facility failed to ensure the central sterile supply area was supervised by an employee who was qualified by education and/or experience.<br><br>The findings included:<br><br>Observation of the central sterile supply area on June 26, 2007, at 10:30 a.m., revealed three employees, including the department supervisor, in the process of sterilizing instrumentation. Interview with the supervisor in the department on June 26, 2007, at 10:30 a.m., revealed the supervisor was "new" in the position, was not certified, and had not attended any training on sterilization procedures. Review of the personnel files confirmed the supervisor had not attended any training on sterilization principles or bacteriology. Interview with the Director of surgical services on June 27, 2007, at 10:15 a.m., in the conference room, revealed the Director of surgical services was not actively overseeing the central sterile supply. Interview with the Director of surgical services confirmed the supervisor had been in the role about a | H 644 | (continued) Member Health Nurse to the Department Director/Manager on the 15th of every month with a listing of employees that have not completed the required PPD test due by months end. Employees that are found to be delinquent on completion of an annual TB skin test/questionnaire will not be allowed work until this requirement is met.<br><br>The Clinical Integration Manager or designee will pull 30 random employee files on a monthly basis for 90 days to monitor compliance.<br><br>**H644 POC**: The Central Sterile Coordinator has enrolled in an online training course entitled "The Sterile Processing Roles and Responsibilities" through www.spdceus.com This consists of 20 modules with quizzes following each. A final exam is to be completed with a passing grade of 70 or better. This course is to be completed by the first of November. Weekly progress will be | |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP53112 | | 06/27/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYCAMORE SHOALS HOSPITAL | 1601 WEST ELK AVENUE<br>ELIZABETHTON, TN 37643 |

| (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 644 | Continued From page 2<br><br>month, and had not attended training in sterilization principles or bacteriology, as needed for the position. | H 644 | H644 POC cont: checked. Completion of this series will be a reqirement for the current employee to remain in the position. Additional online courses will be completed through iceinstitute.com under "Reprocessing/Sterilization/Disinfection". The coordinator will enroll in the next CBSPD offered SPD Technician Certification exam offered in November. Applications can be submitted starting in mid August. | |
| H 678 | 1200-8-1-.06 (4)(g) Basic Hospital Functions<br><br>(4) Nursing Services.<br><br>(g) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. All nursing personnel assigned to special care units shall have specialized training and a program in-service and continuing education commensurate with the duties and responsibilities of the individual. All training shall be documented for each individual so employed, along with documentation of annual competency skills.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview, and review of personnel files, the facility failed to ensure one of fourteen employees reviewed had current BLS (Basic Life Support) certification.<br><br>The findings included:<br><br>Observation of the Intensive Care Unit on June 26, 2007, at 9:40 a.m., revealed patient #7 was receiving nursing care by a Registered Nurse (RN). Review of personnel files revealed the RN's BLS certification had expired March, 2007. Review of the job description for a nurse in the intensive care unit revealed BLS was required. Interview with the Human Resources Representative in the conference room on June 27, 2007, at 10:00 a.m., confirmed the RN had | H 678 | **H678 POC:** Noncompliant employee remained suspended until CPR renewal was obtained. This was successfully completed on 07-02-07.<br><br>CPR expiration dates will be posted on the Intranet Home Page under "HR Reports" that will allow Directors and Managers daily access to CPR expiration dates for their team members. The Directors and Managers will be in-serviced on steps to find and monitor this online information. The Directors and Managers will also be in-serviced on the CPR Training policy which states that "all team members that have | |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP53112 | | 06/27/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYCAMORE SHOALS HOSPITAL | 1501 WEST ELK AVENUE<br>ELIZABETHTON, TN 37643 |

| (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 678 | Continued From page 3<br><br>been working without current BLS certification, and was suspended June 26, 2007, until current certification could be obtained. | H 678 | **H678 POC cont:** direct patient contact will maintain certification in Cardiopulmonary Resuscitation." These employees will not be allowed to work without a valid CPR card. The Clinical Integration Manager or designee will audit 30 random HR files for 90 days to monitor compliance. | |
| H 681 | 1200-8-1-.06 (4)(j) Basic Hospital Functions<br><br>(4) Nursing Services.<br><br>(j) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.<br><br>This Statute is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to obtain a physician's order before administering medications for one patient (#11), and failed to follow physician's orders for IV fluids for one patient (#12) of twenty reviewed.<br><br>Patient #11 was admitted to the facility on June 25, 2007, with diagnoses including Hyperglycemia, Renal Failure, and Diabetes Mellitus Type II Secondary to Steroids. Medical record review revealed on June 25, 2007, at 11:00 p.m., the patient received 8 units of Regular Insulin. Medical record review revealed no physician's order for the medication. Interview with the Charge Nurse on June 26, 2007, at 2:30 p.m., at the nurse's desk, confirmed the patient was given the insulin without a physician's order.<br><br>Patient #12 was admitted to the facility on June 23, 2007, with diagnoses including Non-squamous Cell Lung Carcinoma, Nausea, | H 681 | **H681 POC:** Licensed nursing personnel will complete a self study packet that includes a post test that will cover the below objectives:<br>▪ Identify when physician's orders is needed<br>▪ Elements of a physician order<br>▪ How to correctly transcribe, implement, and sign off orders<br>▪ Procedure for obtaining Co-signatures<br><br>A roster will be maintained to show compliance and the | |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53112 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 06/27/2007 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: SYCAMORE SHOALS HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE: 1501 WEST ELK AVENUE ELIZABETHTON, TN 37643 | | |

| (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 681 | Continued From page 4<br><br>Vomiting, Diarrhea, and Anemia. Observation of the patient in the patient's room on June 26, 2007, at 2:40 p.m., revealed the patient had an IV infusing with 0.9% NaCl (Normal Saline) at 100cc/hr. Medical record review of the physician's orders revealed an order dated June 26, 2007, at 9:30 a.m., for the IV to be changed to 75cc/hr. Interview with the Charge Nurse on June 26, 2007, at 2:40 p.m., in the patient's room, confirmed the physician's order had not been followed. | H 681 | **H681 POC cont:** post test will be returned to the Facility Educator for grading to ensure understanding of in-service content. Licensed staff will undergo remediation as needed. The Clinical Integration Manager or designee will audit 30 random charts per month for 90 days to monitor compliance. | |
| H 682 | 1200-8-1-.06 (4)(k) Basic Hospital Functions<br><br>(4) Nursing Services.<br><br>(k) All orders for drugs, devices and related materials must be in writing and signed by the practitioner or practitioners responsible for the care of the patient. Electronic and computer-generated records and signature entries are acceptable. When telephone or oral orders must be used, they must be:<br><br>1. Accepted only by personnel that are authorized to do so by the medical staff policies and procedures, consistent with federal and state law; and,<br><br>2. Signed or initialed by the prescribing practitioner according to hospital policy.<br><br>This Statute is not met as evidenced by:<br>Based on medical record review, review of the facility's Medical Staff Rules and Regulations, review of federal regulation, and interview, the facility failed to authenticate telephone and verbal orders as soon as possible for two (#7, #15) | H 682 | **H682 POC:** The Physician Administrator of Medical Affairs in coordination with the Chief of Staff will draft a letter and notify by mail all practicing physicians at Sycamore Shoals Hospital reminding them of the responsibility to authenticate telephone and verbal orders during their next rounding or as soon as possible. The letter will also include a reminder that the Medical Staff Rules and Regulations reveal that "all telephone or verbal orders should be placed in the chart and signed by the appropriate authorized personnel to whom they are dictated....Countersignatures | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP53112 | | 06/27/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYCAMORE SHOALS HOSPITAL | 1501 WEST ELK AVENUE<br>ELIZABETHTON, TN 37643 |

| (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 682 | Continued From page 5<br>patient of twenty-two charts reviewed.<br><br>The findings included:<br><br>Patient #7 was admitted to the hospital on June 19, 2007, and transferred to the intensive care unit the following day after a cholecystectomy. Medical record review of the Surgery Orders dated June 20, 2007, revealed the following orders taken off by the nurse and not signed, dated, or timed by the physician:<br>1) Famotidine 20mg IV,<br>2) Piperacillin 3.375 grams IV,<br>3) Place pulse oximeter on admission,<br>4) Administer oxygen at 2 liters per minute if oxygen saturation is less than 92%....., and<br>5) Sequential Compression Device.<br>Patient #15 was admitted to the facility on May 26, 2007, and received several transfusions of plasma. Medical record review of the Physician Order sheet dated May 3, 2007, revealed the following telephone order, "Demerol 25mg-50mg q4 (hrs) prn" transcribed by a nurse and not authenticated by a physician. (Demerol is a schedule II controlled substance). Interview with the Clinical Integration/Risk Manager in the conference room on June 26, 2007, at 2:20 p.m., verified the physician had not signed the order and confirmed the same physician transcribed orders on the same patient the following day without signing the telephone order.<br>Review of the Medical Staff Rules and Regulations reveals, "All telephone or verbal orders should be placed in the chart and signed by the appropriate authorized personnel to whom they are dictated ...Countersignatures are required within 48 hours of giving the verbal order. ...The countersignature for ...schedule II controlled substances...should occur at the time of the next visit or no more than 24 hours later." | H 682 | H682 POC cont: are required within 48 hours of giving the verbal order,...The countersignature for...scheduled II controlled substances....should occur at the time of the next visit or no more than 24 hours later."<br><br>The Clinical Integration Manager or designee will audit 30 random charts monthly for 90 days to monitor compliance and improvement. | |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP53112 | | 06/27/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYCAMORE SHOALS HOSPITAL | 1501 WEST ELK AVENUE ELIZABETHTON, TN 37643 |

| (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 682 | Continued From page 6 | H 682 | | |
| | The Federal Regulation of telephone or verbal orders states, "When telephone or oral orders must be used, they must be ... (ii) Signed or initiated by the prescribing practitioner as soon as possible." Interview with the Clinical Integration/Risk Manager in the conference room on June 26, 2007, at 2:20 p.m., confirmed the telephone order was not authenticated by a physician as soon as possible. | | **H701 POC**: The Registration Staff will notate in the computer if signatures are or are not obtained on the Authorization of Consent to Treat Form at the time of admission and will maintain an automated daily report of patients that are unable to sign. The Registration Staff will f/u each consecutive day to obtain consent **or** work with nursing to obtain telephone consent. Documentation of all attempts will be recorded in the Medical Record. | |
| H 701 | 1200-8-1-.06 (5)(k)5. Basic Hospital Functions | H 701 | | |
| | (5) Medical Records. | | | |
| | (k) All records must document the following: | | | |
| | 5. Properly executed informed consent forms for procedures and treatments specified by hospital policy, or by federal or state law if applicable, as requiring written patient consent; | | | |
| | This Statute is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain consent for treatment for one patient (#15) of twenty-two charts reviewed. | | Registration staff manager will conduct an in-service for registration personnel to inform of process. An attendance roster will be completed and returned to Clinical Integration with a summary of the meeting content. | |
| | The findings included: | | | |
| | Patient #15 was admitted to the facility on May 26, 2007, and received multiple transfusions of plasma. Medical record review of the Treatment Authorization/Financial Agreement dated May 26, 2007, revealed no documentation of authorization for treatment. Interview with the Clinical Integration/Risk Manager in the conference room on June 26, 2007, at 3:00 p.m., verified the policy | | The Clinical Integration Manager or designee will audit 30 charts monthly for 90 days to assess compliance. | |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53112 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 06/27/2007 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SYCAMORE SHOALS HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1501 WEST ELK AVENUE ELIZABETHTON, TN 37643 | | |

| (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 701 | Continued From page 7<br><br>of the hospital is to obtain consent for treatment for all patients and confirmed the facility failed to obtain consent for treatment for patient #15. | H 701 | | |
| H 761 | 1200-8-1-.07 (1)(a) Optional Hospital Services<br><br>(1) Surgical Services.<br><br>(a) 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.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview, and review of facility policy, the facility failed to ensure I.V. (intravenous) fluids were stored in a manner to protect sterility for one of three warming cabinets observed.<br><br>The findings included:<br><br>Observation of a warming cabinet between O.R. rooms #1 and #2 on June 26, 2007, at 10:00 a.m., revealed the lower chamber of the warming cabinet contained approximately twenty 1000cc bags of I.V. Lactated Ringers, manufactured by Baxter, without dates indicating when the fluids were placed in the warmer. Review of the facility's policy Warming I.V. Fluids in Warming Cabinet revealed, "Provision of guidelines for the warming of intravenous fluids in a warming cabinet, in accordance with the manufacturer's (Baxter) guidelines ...I.V. fluids are to be labeled with a sticker at the time they are placed in the warming cabinet. The sticker will have the date | H 761 | **H761 POC**: Copies of the "Perioperative Services" policy titled "Warming I.V. Fluids in Warming Cabinets" and the fax received from Baxter Healthcare Corporation were posted on each of the three warming cabinets in the department. A copy of each was also placed in the department Communication Notebook for staff to review. The team member responsible for placing the fluids in the surgery warmer on June 25th was verbally counseled according to hospital policy. Team members are assigned daily (Monday-Friday) to check the warmers for compliance as well as the temperature. In addition, the Clinical Leader or Charge Nurse will also monitor compliance daily (Monday-Friday) for proper labeling of each fluid, expiration dates, and acceptable temperature range. A formal in-service will be conducted on July 27, 2007 at an upcoming staff meeting. Each employee will be held accountable for placing fluids in the warmers properly and will be counseled according | |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP53112 | | 06/27/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYCAMORE SHOALS HOSPITAL | 1501 WEST ELK AVENUE<br>ELIZABETHTON, TN 37643 |

| (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 761 | Continued From page 8<br>that the fluids are to be removed from the warming cabinet ...I.V. fluids are warmed for a period not to exceed fourteen days ..." Interview with the Registered nurse in charge on June 26, 2007, at 10:00 a.m., in front of the warmer confirmed the fluids were not dated as required by facility and manufacturer policy. | H 761 | **H761 POC cont:** to hospital policy if policy is not followed.<br><br>Compliance of policy will be monitored daily by Clinical Leader or designee Monday-Friday for 90 days. | |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING 77 - MAIN B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP53112 | | 06/26/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYCAMORE SHOALS HOSPITAL | 1501 WEST ELK AVENUE<br>ELIZABETHTON, TN 37643 |

| (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 871 | 1200-8-1-.08 (1) Building Standards<br><br>(1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient.<br><br>This Statute is not met as evidenced by:<br>Based on observation the facility failed to assure fire extinguishers were provided as per NFPA 10.<br><br>The findings included:<br><br>Observation on June 6, 2007 at 9:30 a.m. revealed the fire extinguisher near room 307 was mounted higher than 60 inches from the floor to the top of the handle and at 12:30 p.m. the fire extinguisher in the dietary department near the exit was mounted higher than 60 inches from the floor to the top of the handle.<br><br>Based on observation the facility failed to assure med gas cut off valves were labeled.<br><br>The findings included:<br><br>Observation on June 26, 2007 at 10:00 a.m. revealed the med gas cut off valve at the Endoscopy Area was not labeled.<br><br>Based on observation the facility failed to assure exit egress was not obstructed.<br><br>The findings included:<br><br>Observation on June 26, 2007 at 11:00 a.m. revealed the rear exit from materials management was obstructed by a credenza and a copier.. | H 871 | **H871 POC:**<br>Observation #1<br>Fire Extinguisher more than 60 inches to top outside room 307. The correct fire extinguisher was installed. Safety inspection will be conducted to verify compliance twice monthly for 90 days per Plant Operations personnel.<br><br>Observation #2<br>Med Gas cut off valve at Endo room not labeled. Label installed on top of valve. Safety inspection will be conducted to verify compliance twice monthly for 90 days per Plant Operations personnel.<br><br>Observation #3<br>Rear Exit at Materials Management obstructed by credenza and copier. Items were removed from area. Safety inspection will be conducted to verify compliance twice monthly for 90 days per Plant Operations personnel. | |

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 |
|---|---|---|---|
| | TNP53112 | A. BUILDING TY - MAIN<br>B. WING | 06/26/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYCAMORE SHOALS HOSPITAL | 1501 WEST ELK AVENUE<br>ELIZABETHTON, TN 37643 |

| (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 871 | Continued From page 1<br><br>Based on observation the facility failed to assure corridor doors could resist the passage of smoke.<br><br>The findings included:<br><br>Observation on June 26, 2007 at 11:30 a.m. revealed the surgery nurses lounge door was provided with an inoperable positive latch.<br><br>Based on observation the facility failed to assure corridors were maintained free of all obstruction.<br><br>The findings included:<br><br>Observation on June 26, 2007 at 1:00 p.m. revealed the rear corridor at the MRI was obstructed in clear width by four (4) chairs, one (1) table and a three (3) shelve clean linen cart. | H 871 | **H871 POC cont:**<br>Observation #4<br>Surgery Nurse Lounge door did not have a positive latch. Maintenance adjusted positive latch door and is working properly. Safety inspections will be completed twice a month for 90 days by Plant Operations personnel to monitor compliance.<br><br>Observation #5<br>Rear corridor at MRI was obstructed by linen cart and chairs. Linen cart relocated and chairs rearranged so as not to obstruct corridor. Safety inspections will be conducted twice a month for 90 days by Plant Operations personnel to monitor compliance. | |

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

# Sycamore Shoals Hospital

Elizabethton, TN

has been Accredited by

## The Joint Commission

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

Hospital Accreditation Program

**May 22, 2009**

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold, M.D.
Chairman of the Board

Organization ID #7828
Print/Reprint Date: 10/27/09

Mark Chassin, M.D.
President

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

The Joint Commission

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

Sycamore Shoals Hospital
1501 West Elk Avenue
Elizabethton, TN 37643

## Organization Identification Number: 7828

**Program(s)**
Hospital Accreditation

**Survey Date(s)**
05/08/2012-05/10/2012

### 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.

**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 |
| §482.24(c)(1)(ii) | A-0454 | HAP - RC.01.01.01/EP19 | Standard |
| §482.24(c)(1)(iii) | A-0457 | HAP - RC.01.02.01/EP4 | Standard |

---

**CoP:** §482.41 **Tag:** A-0700 **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

| CoP Standard | Tag | Corresponds to | Deficiency |
|---|---|---|---|
| §482.41(a) | A-0701 | HAP - EM.02.02.13/EP5 | Standard |
| §482.41(b)(1)(i) | A-0710 | HAP - LS.02.01.35/EP4 | Standard |

---

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)

**Scoring Category :** C
**Score :** Partial Compliance

**Observation(s):**

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Sycamore Shoals Hospital (1501 West Elk Avenue, Elizabethton, TN) site for the Hospital deemed service.
Low voltage cable was observed attached to the fire sprinkler pipe inside the mechanical room located on the roof level.

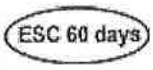
Observed in Building Tour at Sycamore Shoals Hospital (1501 West Elk Avenue, Elizabethton, TN) site for the Hospital deemed service.
Cable was observed on the fire sprinkler pipe above the ceiling at the entrance to the psychiatric unit on Level 2.

---

**Chapter:** Medical Staff

**Program:** Hospital Accreditation

**Standard:** MS.01.01.01




**Standard Text:** Medical staff bylaws address self-governance and accountability to the governing body.

**Primary Priority Focus Area:** Organizational Structure

**Element(s) of Performance:**

10. The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.

**Scoring Category :** A
**Score :** Insufficient Compliance

**Observation(s):**

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

EP 19
§482.24(c)(1)(ii) - (A-0454) - (ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under
§482.12(c) and authorized to write orders by hospital policy in accordance with State law.
This Standard is NOT MET as evidenced by:
Observed in Record Review at Sycamore Shoals Hospital (1501 West Elk Avenue, Elizabethton, TN) site for the Hospital deemed service.
The transfer form for the patient taken to Johnson City Medical Center had the signature of the Registered Nurse but was not dated or timed.

§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 Record Review at Sycamore Shoals Hospital (1501 West Elk Avenue, Elizabethton, TN) site for the Hospital deemed service.
In the chart of newborn who underwent circumcision, it was found that the immediate procedure note was dated but not timed by the physician

Observed in Individual Tracer at Sycamore Shoals Hospital (1501 West Elk Avenue, Elizabethton, TN) site for the Hospital deemed service.
During an individual patient tracer it was noted that several entries in the medical record had not been timed. Hospital policy requires all entries in the medical record be dated and timed.

Observed in Record Review at Sycamore Shoals Hospital (1501 West Elk Avenue, Elizabethton, TN) site for the Hospital deemed service.
During a review of a closed record it was noted that the time was missing on the transfer authorization form.

---

**Chapter:** Record of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** RC.01.02.01

ESC 60 days

**Standard Text:** Entries in the medical record are authenticated.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

4. Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. 4
Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.
Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: For a five-year period following January 26, 2007, all orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient (as specified at 42 CFR 482.12(c)), and who, in accordance with hospital policy and law and regulation, is authorized to write orders.

**Scoring Category :** C
**Score :** Partial Compliance

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

The Joint Commission

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

May 21, 2012

Dwayne Taylor
Chief Executive Officer
Sycamore Shoals Hospital
1501 West Elk Avenue
Elizabethton, TN 37643

Joint Commission ID #: 7828
Program: Hospital Accreditation
Accreditation Activity: Unannounced Full Event
Accreditation Activity Completed: 05/10/2012

Dear Mr. Taylor:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

May 21, 2012

Dwayne Taylor
Chief Executive Officer
Sycamore Shoals Hospital
1501 West Elk Avenue
Elizabethton, Tennessee 37643

HCO ID: # 7828

Dear Mr. Taylor:

We appreciate your patience while we reviewed your clarification request regarding the findings of the May 8-10, 2012 unannounced full survey for the hospital program. Our review is now complete. Careful consideration was given to the original survey findings and the documentation submitted by your organization. Based on our review, below you will find information specific to each clarification submitted and the impact on your organization's final report.

Standard EC.02.05.01 EP 6: The clarifying evidence was accepted because the organization demonstrated compliance with the organization's policy. The 2010 FGI Guidelines apply to new construction only and the organization is maintaining the space as originally designed. As a result, the standard level score has been changed from not compliant to compliant as noted in the final report. EC.02.05.01 no longer appears in your report.

Please feel free to contact me at 630-792-5715 with any questions regarding this review.

Sincerely,
*Jacqueline L. Krishnan*

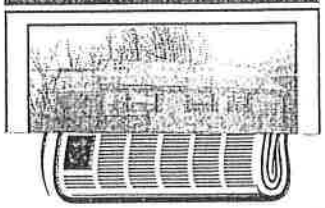
Jacqueline L. Krishnan
Account Executive, Accreditation and Certification Operations

| | |
|---|---|
| **EM.02.02.13 EP 5**<br><br>**No MOS** | During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners. Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions. |
| Who? | Medical Staff |
| What? | Medical Staff Bylaws at the time of survey only required a government issued photo ID. The standard requires that a government-issued picture ID is to be verified in addition to another form of verification. |
| When? | May 23, 2012 – The revision of the bylaws was sent to the voting Medical Staff for approval.<br>June 5, 2012 – Revision to the bylaws was approved by the voting members of the Medical Staff<br>June 20, 2012 – The Medical Executive Committee was updated on the changes to the bylaws to include the second verification of hospital photo identification for disaster privileges. |
| How? | The following statement was added to the current bylaws: "Government-issued photo identification and current hospital photo identification shall also be required to grant disaster privileges." The voting members of the Medical Staff approved the changes on June 5, 2012. Communication of the changes occurred during the Medical Executive Committee on June 20, 2012. |

## ***Attachment C, Proof of Publication:***

Publication of Intent, Elizabethton Star

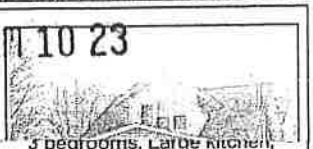
43 HOUSES W/PHOTO



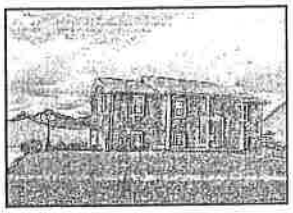
43 HOUSES W/PHOTO

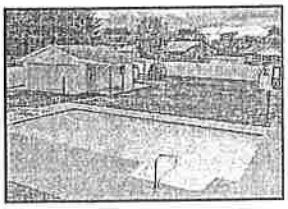
2012 JUN 15 AM 10 23

43 HOUSES W/PHOTO



3 bedrooms, Large kitchen, 1 bath, new roof, original hardwood floors, extra long lot. Great location. $53,000 will consider and offer. (423)543-2184 or (423)474-3666.





**LYNN VALLEY**
**$194,900**

STREET'S REALTY
407 N. MAIN STREET
(423)543-4094 or (423)647-1916

43 HOUSES W/PHOTO

FOR SALE

New Today!

1996 CORVETTE runs great, forest green, (423)773-4416

PAYING UP TO $500.00 FOR JUNK AND RUNNING VEHICLES. 423-297-2626

PAYING cash for junk cars. Will haul for free. (423)647-2408.

THE BONE YARD we buy cars. Free pick-up. 423-791-1384, 423-928-4469.

61 CAMPERS & RV'S

2008 Dutchman Aerolite 24RB-SL Travel Trailer with slide out, sleeps 6, heat & AC, flat screen TV, refrigerator, freezer full equipped. $16,500 O.B.O. 423-957-6451.

63 4X4 VEHICLES FOR SALE

1998 GMC 350 4X4, SWB, 119,000 miles, excellent condition. $4,500 423-470-8746.

# LEGAL NOTICE

## 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 Sycamore Shoals Hospital, a Hospital owned by Mountain States Health Alliance, with an ownership type of Not-for-Profit Corporation and to be managed by: Mountain States Health Alliance intends to file an application for a Certificate of Need for the discontinuance of obstetrical services at Sycamore Shoals Hospital, which is located at 1501 W. Elk Avenue, Elizabethton, Tennessee 37643. This project will not involve any other major medical equipment, will not initiate nor discontinue any other type of health service, and will not change the licensed total bed count of 121 beds at the facility. The estimated project cost is $14,000.

The anticipated date of filing the application is June 15, 2012.

The contact person for this project is Laura Linn, Senior Planning Analyst, who may be reached at: Mountain States Health Alliance, 303 Med Tech Parkway, Suite 330, Johnson City, TN 37604, (423) 302-3385.

**Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted.**

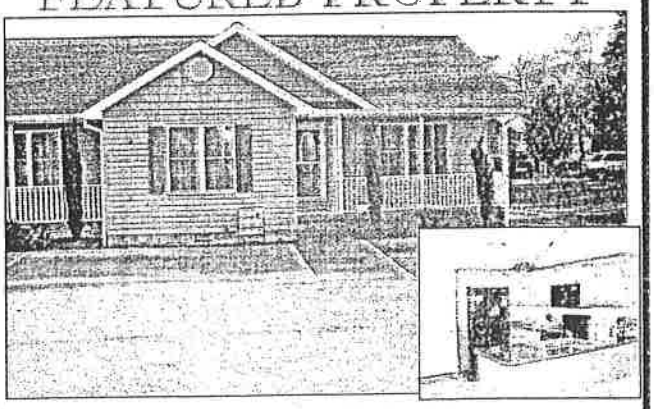
**Written requests for hearing should be sent to:**

**Health Services and Development Agency**
**Andrew Jackson Building**
**500 Deaderick Street, Suite 850**
**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.**

Sunday, June 10, 2012

FEATURED PROPERTY



215 DAWN DRIVE - $199,900

Great Buy!! One level condo in better than new condition. Condo is end unit and has great views and is in great area. Property includes 2 bedrooms and 2 baths. Close to town. *Call Carol for information - 676-4063.*

***Attachment:***

Affidavit for Application

2012 JUN 15 AM 10 23

**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF Carter

Dwayne Taylor, 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 Tennessee Health Services and Development Agency and T.C.A. § 68-11-1601, *et seq.*, and that the responses to questions in this application or any other questions deemed appropriate by the Tennessee Health Services and Development Agency are true and complete.

Dwayne Taylor, CEO

Signature/Title

Sworn to and subscribed before me this the 12th day of June, 2012, a Notary Public in and for the County of Carter State of Tennessee.

Evelyn R. Dugger

NOTARY PUBLIC

My Commission expires May 28, 2014.

EVELEYN R. DUGGER
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF CARTER

HF-0056
Revised 7/02 - All forms prior to this date are obsolete

# SUPPLEMENTAL

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

2012 JUN 25 AM 10 58

June 22, 2012

Laura Linn
Senior Planning Analyst
Mountain States Health Alliance
303 Med Tech Parkway, Suite 330
Johnson City, TN 37604

RE: Certificate of Need Application CN1206-0030
Sycamore Shoals Hospital – Discontinuance of Obstetrics Services

Dear Ms. Linn:

This will acknowledge our June 15, 2012 receipt of your application for a Certificate of Need for the Discontinuance of Obstetrics Services at Sycamore Shoals Hospital, 1501 West Elk Avenue (Carter County), TN 37683. If approved, the seven (7) obstetrical beds will be converted to medical beds and the licensed acute care bed complement at the hospital (TN License no. 0000000012) will remain unchanged at 121 beds.

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 4:00 pm, Monday, June 25, 2012.** 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 4**

   The registration of Mountain States Health Alliance (MSHA) with the Tennessee Secretary of State's office and a copy of the corporate charter of MSHA as requested in the application instructions for this item are noted. Please provide the same for corporate documents for Sycamore Shoals Hospital. If not available, please explain how MSHA's documents should suffice

   Are there any covenants or clauses in the Corporate Charter, Articles of Merger or other corporate documents of the Sycamore Shoals Hospital which address the retention/ disposition of primary care community based programs like obstetrics that have a bearing on the discontinuance of this program?

   A separate corporate charter for Sycamore Shoals Hospital does not exist. The applicant has provided a history of corporate charters in Attachment 1.

The first charter included is for Memorial Hospital, Inc. of Johnson City, Tennessee. In 1983, Memorial Hospital changed its name to Johnson City Medical Center, Inc. In 1998, Johnson City Medical Center purchased the assets and assumed certain liabilities of five hospitals and related assets from Columbia/HCA, including Sycamore Shoals Hospital. In January 1999, the corporation changed its name to Mountain States Health Alliance. Sycamore Shoals Hospital is not a separate corporate entity and is 100 percent owned by Mountain States Health Alliance.

There are no specific covenants or clauses in the Corporate Charter, Articles of Merger or other corporate documents of Mountain States Health Alliance or Sycamore Shoals Hospital which address the retention/disposition of primary care community based programs like obstetrics that have a bearing on the discontinuance of this program.

2. **Section A, Applicant Profile, Item 4**

Please include a description of the type of ownership control, with organizational chart, as requested in the application instructions for this item.

Mountain States Health Alliance is a not-for-profit organization, and as previously noted, Sycamore Shoals Hospital is 100 percent owned by MSHA. An organizational chart is provided in Attachment 2.

3. **Section A, Applicant profile, Item 6**

Please discuss the reason the legal interest in the site is listed in Johnson City Medical Center's name.

As described in the response to question 1, Sycamore Shoals Hospital was purchased by Johnson City Medical Center (JCMC) in 1998, prior to the 1999 name change of Johnson City Medical Center, Inc. to Mountain States Health Alliance. A copy of the bill of sale documenting JCMC's purchase of SSH from Columbia/HCA is included in the Attachment 3. The name on the deed was never changed from Johnson City Medical Center, Inc. to Mountain States Health Alliance.

4. **Section B, Project Description, Item 1**

A) The comprehensive summary is noted. Given the human resource, physician recruitment, and marketing resources available to the hospital from its manager, please briefly summarize the action taken, if any, to recruit and retain delivering physicians (number of recruited, retained and leaving by year) and to sustain and grow the obstetrical program over the past six years.

In 2002, Dr. Brent Laing and Dr. John Green of First Medical OB-GYN began the search for a third partner to their group, which is the only OB-GYN group in Elizabethton and the only obstetrical group on staff at Sycamore Shoals Hospital. The group requested the recruitment help of Mountain States Health Alliance in 2005 since their own recruitment efforts proved unsuccessful. MSHA's recruitment efforts began in 2006, and a list of candidates and resulting outcomes is provided below. In 2009/2010, a female candidate was selected and accepted the position within the group.

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

| Candidate | Date | Recruitment Activities |
|---|---|---|
| 1 | 2006 | Interviewed, rejected by First Medical |
| 2 | 2006 | Interested in the area, but she chose a larger region due to her husband's career |
| 3 | 2006 | Rejected by First Medical |
| 4 | 2006 | Planned to visit the region; however this visit did not occur |
| 5 | 2006 | Reviewed by First Medical |
| 6 | 2006 | Reviewed by First Medical |
| 7 | 2006 | Candidate rejected offer |
| 8 | 2007 | Interviewed by First Medical, but she accepted an offer in New York |
| 9 | 2007 | Rejected by First Medical |
| 10 | 2007 | Rejected by First Medical |
| 11 | 2007 | Phone interview, candidate did not visit |
| 12 | 2008 | Rejected by First Medical |
| 13 | 2008 | Visit, candidate rejected offer |
| 14 | 2009 | Hired by First Medical |

B) The applicant lists the current obstetrical medical staff as three OB-GYN's (2 males and 1 female). Is that correct? Are there any other physicians and/or nurse-midwives on the hospital's medical staff, who are currently delivering babies at Sycamore Shoals? If so, please provide their names and professional qualifications.

The applicant has learned that the female member of the OB medical staff at Sycamore Shoals Hospital who was hired in 2009/2010 by First Medical OB-GYN has announced that she is leaving the area. The applicant was not aware of this before making the determination to discontinue OB services, and her leaving was not a factor in this decision. With her departure, the 2 original OB-GYN's (Dr. Laing and Dr. Green) remain. There are no other physicians and/or nurse-midwives on the hospital's medical staff, who are currently delivering babies at Sycamore Shoals.

C) What are the plans of the three practicing OB-GYN's for continuing to serve the citizens of the service area? Do they intend to remain in Elizabethton, or move elsewhere? If elsewhere, where?

Dr. Brent Laing and Dr. John Green of First Medical OB-GYN plan to remain in Elizabethton, with their offices remaining in a SSH campus medical office building. They will continue to offer primary care to OB patients within this office as they have done in the past. The only change to their patients will be the site at which the deliveries take place as both physicians will be performing those deliveries at one of the two Washington County facilities. Gynecologic cases from these physicians will continue to be treated at Sycamore Shoals Hospital.

D) The applicant indicates the trend in the female populations of childbearing ages (15-44) in the service area is decreasing. However, the chart on page 15 of the

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

application shows only a very light decline (less than a percentage point) in both Johnson and Carter Counties, but an increase in Washington County. As a whole, the female populations of childbearing ages (15-44) in the entire service area is projected to grow. What are the birth rates for the three counties over the past five years?

The requested data is provided below. Birth rates provided by the state of Tennessee do not currently extend beyond 2009.

| County | Year | Crude Birth Rate | Total Births | Total Population |
|---|---|---|---|---|
| **Carter** | | | | |
| | **2005** | 10.3 | 609 | 58,879 |
| | **2006** | 10.7 | 633 | 59,142 |
| | **2007** | 9.5 | 561 | 59,262 |
| | **2008** | 10.4 | 619 | 59,398 |
| | **2009** | 9.8 | 582 | 59,545 |
| **Johnson** | | | | |
| | **2005** | 10.3 | 187 | 18,082 |
| | **2006** | 9.3 | 168 | 18,038 |
| | **2007** | 10.3 | 188 | 18,172 |
| | **2008** | 9.4 | 172 | 18,291 |
| | **2009** | 8.9 | 164 | 18,423 |
| **Washington** | | | | |
| | **2005** | 11.6 | 1,304 | 112,426 |
| | **2006** | 12.0 | 1,368 | 114,275 |
| | **2007** | 12.3 | 1,415 | 115,117 |
| | **2008** | 11.8 | 1,372 | 116,005 |
| | **2009** | 11.6 | 1,356 | 116,936 |
| **Tennessee** | | | | |
| | **2005** | 13.7 | 81,720 | 5,955,935 |
| | **2006** | 14.0 | 84,308 | 6,038,636 |
| | **2007** | 14.2 | 86,661 | 6,090,043 |
| | **2008** | 13.9 | 85,480 | 6,144,738 |
| | **2009** | 13.2 | 82,109 | 6,202,803 |

Source: http://hit.state.tn.us/BirthRateDetail.aspx

The birth rate for Carter, Johnson, and Washington County (TN) is below the Tennessee state averages from 2005 to 2009. Furthermore, all three counties as well as the state, experienced a decline between 2008 and 2009, according to the most recent data available.

In addition, it should be noted the projected growth of female population of childbearing ages (15-44) in the entire service area is not growing at the

same projected growth rate for the total population of the county. Washington County does anticipate a minimal growth of 0.9% in the female population of childbearing age (15-44), but the overall percent this demographic cohort represents of the total population in Washington County will decline from 20.0% in 2012 to 19.6% in 2016.

**5. Section B, Project Description, Item IV (Floor Plan)**

A) Please provide a revised drawing clearly showing the room labels of the current seven (7) maternity beds as well as other portions (L&D, Nursery, etc.) of the obstetrical department physical resources.

A revised floor plan is provided in Attachment 4.

B) To what other uses, does the hospital intend to convert these physical plant resources?

The applicant has not yet made definitive plans for the space vacated by the discontinuance of obstetrical services; however, the decision will be based upon the changing needs of the aging population in the community. Examples of potential uses that would meet the needs of the community would be expanded gynecological surgery options as well as orthopedics.

**6. Section C, Need, Item 1**

Please discuss how the proposed project will relate to the 5 Principals for Achieving Better Health found in the State Health Plan."

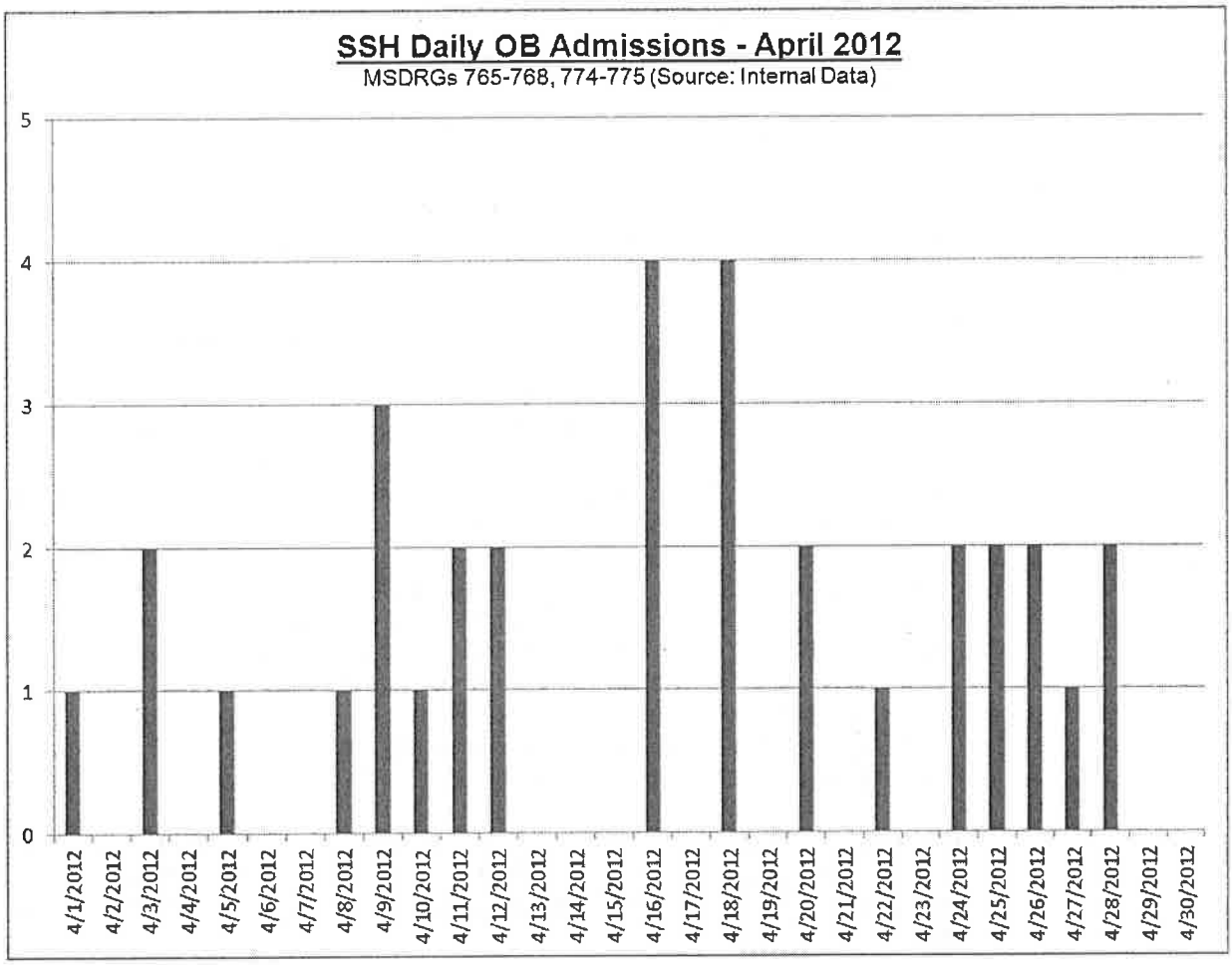
The State Health Plan identifies 5 Principals for Achieving Better Health, which include the following: Healthy Lives, Access to Care, Economic Efficiencies, Quality of Care, and Healthcare Workforce.

1. **Healthy Lives** – According to the State Health Plan, "Many factors contribute to good maternal and infant health, such as ensuring access to prenatal and postnatal care, providing preventive and childcare services, and promoting access to care in vulnerable or at risk populations." Prenatal and postnatal services in Elizabethton will remain intact with the completion of this proposal. This proposal does not seek to eliminate primary Obstetric care for women within this project's service area, only to change the location at which they deliver.

2. **Access to Care** – As noted in the "Health Lives" response, the access for women to primary care services will remain unchanged by this proposal. The staff of the Sycamore Shoals Emergency Department is trained to deliver babies should an emergent situation arise. The drive times to the Johnson City facilities included in the original application and later in these supplemental responses are reasonable and do not pose a threat to appropriate access to care.

The chart below, which shows the daily number of OB admissions to SSH during April 2012, helps demonstrate how the proposed project relates to each of the remaining three principles. Admissions to the unit are not a daily occurrence, and often times, several days can pass between admissions.

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**




3. **Economic Efficiencies** – OB admissions are most often unplanned, which means a hospital that offers obstetrical services must be fully staffed in anticipation of any potential patients presenting in active labor. Maintaining this level of staffing when days go by between deliveries is extremely inefficient. SSH's proposal is to consolidate obstetrical services into the MSHA Washington County facilities, where daily delivery volumes are higher and more consistent. The proposed project will allow MSHA to reallocate valuable nursing resources to other areas of need within the MSHA system.

4. **Quality of Care** – Low volume can compromise safety and quality of care for obstetric patients and newborns. Maintaining staff competencies becomes difficult when few patients are present and already uncommon complications arise even less frequently due to low utilization of the service. The threat to safety and quality is mitigated by consolidating these volumes with appropriate volumes at FWCH and JCMC.

5. **Healthcare Workforce** – Maintaining the current Sycamore Shoals OB program would continue inefficient use of the limited healthcare workforce. These valuable workforce resources will be more productive, more well-trained, and better able to provide a higher level of patient-centered care in an environment where more frequent deliveries occur.

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

**7. Section C, Need, Item 1 (Project Specific Criteria)**

The responses are noted. For additional clarification, please answer the following:

**A). Need, Item 3** (See question 11 below)

1) In addition to the number of births, please provide the average daily census and the licensed bed occupancy for the OB service for the past three years (Can be answered as part of question 11 below).

This question is answered as part of question 11 below

2) The volume of births which the applicant has historically provided as well as projected for 2012, is significantly higher than the volumes experienced at other hospital services which have requested closure of their OB services (typically in the 100-150 range). Please discuss further the applicant's rationale (including the (ACOG/ASA Guidelines) for discontinuing the service at this time.

In the current and future environment of health reform, part of the long-term vision for Mountain States Health Alliance is to pursue the Institute for Healthcare Improvement's "Triple Aim" which includes the following:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of the populations; and
- Reducing the per capita cost of health care.

The regionalization of OB services as described in this proposal is just one part of a larger effort by MSHA to ensure the right services are offered in the right places, in the most patient-centered, effective, and efficient manner possible.

The ACOG/ASA guidelines maintain that "some small delivery units are necessary related to geographic location," provided that no other services are available in a close region. Given that two other facilities providing obstetrical services with available capacity exist a short distance away from SSH, MSHA has chosen to follow ACOG/ASA guidelines that maintain "whenever possible, small units [less than 500 deliveries annually] should consolidate." Additional research from the sources noted below also support Mountain States Health Alliance's decision to discontinue OB services at Sycamore Shoals Hospital.

- Heller et al (2002) – "Birthweight-specific mortality rates were lowest in large delivery units and highest in smaller delivery units...A more than threefold mortality risk was observed in hospitals with < 500 births/year compared with hospitals >1500 births/year"

- Moster, Lie, and Markestad (1999) – "The neonatal death rate was lowest for maternity units with 2001-3000 annual births and steadily increased with decreasing size of the maternity unit to around twice that for units with less than 100 births a year"

- Finnstrom et al (2006) – "Neonatal mortality was significantly higher for infants in families living with the catchment area of the smallest units without a pediatric department"

**A), Need, Item 4:**

1) How does the 74% TennCare/Medicare payor mix of the OB service compare to the hospital's overall TennCare payor mix?

As reported on the FY 2011 Joint Annual Report for SSH, the hospital's overall TennCare/Medicare payor mix is 18.6% (680 discharges). It is expected that OB services would have a higher percentage of TennCare patients since most of the child-bearing population is not Medicare eligible.

**B), Accessibility, Item 1 and Item 3**:

Item 1: Please complete the following table for those hospitals that have expressed an interest in providing OB services to residents of Johnson and Carter Counties:

The table below has been completed as requested.

Location & OB Service Bed Complement of Alternate Hospitals to Applicant

| OB Provider | County (Community) | Distance (in miles) | Travel time (in minutes) |
|---|---|---|---|
| Sycamore Shoals | Johnson – Laurel Bloomery | 42.0 miles | 58 min |
| | Johnson – Mountain City | 34.9 miles | 46 min |
| | Carter – Roan Mountain | 19.1 miles | 27 min |
| Franklin Woods Community Hospital | Johnson – Laurel Bloomery | 55.5 miles | 79 min |
| | Johnson – Mountain City | 48.4 miles | 67 min |
| | Carter – Roan Mountain | 29.9 miles | 47 min |
| Johnson City Medical Center | Johnson – Laurel Bloomery | 52.7 miles | 77 min |
| | Johnson –Mountain City | 45.6 miles | 65 min |
| | Carter – Roan Mountain | 26.9 miles | 43 min |

Item 3: To affirm, please provide documentation from the hospitals located in the contiguous counties identified in the application (Washington Counties) continuing to offer obstetrical services stating they have the interest and capacity to absorb the additional volume and increase in TennCare/Medicaid payor mix created by the applicant's discontinuance of obstetrics.

Letters from Franklin Woods Community Hospital and Johnson City Medical Center documenting their interest and available capacity to absorb the additional volume and increase in TennCare/Medicaid payor mix created by the applicant's discontinuance of obstetrics are provided in Attachment 5.

**8. Section C, Need, Item 2 and Section C, Orderly Development, Item 2**

What services being developed or in the process of being implemented over the next three to five years that will help the hospital reach its goal of making a more effective use of the space dedicated to the OB service?

As noted in the response to question 5.B, the applicant has not yet made definitive plans for the space vacated by the discontinuance of obstetrical services; however, the decision will be based upon the changing needs of the aging population in the community. Examples of potential uses that would meet the needs of the community would be expanded gynecological surgery options as well as orthopedics.

A) Please describe hospital management's discussions with local business and medical community leadership and elected public officials regarding this decision. In your response, please provide letters of support from community leaders and members of the medical staff for the project. What are the expectations of these parties, if any, concerning the applicant's leadership and role in addressing the health care needs of the maternal-fetal population of Carter and Johnson Counties?

The decision has been widely communicated to the community in general and to community leaders and businesses as detailed below.

- Impacted OB/GYN physicians in Elizabethton
- OB/GYN physicians in Johnson City
- Impacted Team members at SSH
- Carter County Mayor
- City of Elizabethton Mayor
- Carter County Sheriff
- Carter County Economic Development
- SSH community board of directors
- JCCH community board of directors
- SSH MEC
- Government Affairs Committee members (SSH and JCCH)
- Nursery physicians
- All Department managers at SSH
- Volunteers at SSH
- Full medical staff at SSH
- Press release general public
- Face to face meeting with Elizabethton Star
- Personal communication at Carter County Tomorrow
- Planned visit to the July Carter County Health and Wellness Committee meeting

A copy of the press release is provided in Attachment 6. The expectations of these parties concerning the applicant's leadership and role in addressing the health care needs of the maternal-fetal population of Carter and Johnson Counties has not changed as a result of this proposal. Sycamore Shoals Hospital, as part of Mountain States Health Alliance, will meet the needs of this

population through its Washington County facilities, which many (roughly 40%) in these communities already utilize for obstetric care.

C) In transitioning the program, please describe the applicant's plans (with timeframes) for informing the general public and women of childbearing ages, the medical community, and the emergency transportation operators regarding the transition.

The consolidation timeline is as follows.

| | |
|---|---|
| MSHA Board Approval | Tuesday, May 15 |
| SSH Board – Informational Session | Wednesday, May 16 |
| Press Release | Thursday, May 17 |
| File LOI | By Sunday, June 10 |
| File application | By Friday, June 15 |
| HSDA Meeting | September 26 |
| Last OB admit | September 26 |
| Remaining patients transferred | September 30 |
| OB Service Closed | October 1 |

As the closure nears, The First Medical OB-GYN and SSH will be communicating the change to all pregnant patients via direct mail and to the general community through print media. Expectant mothers receiving care at First Medical OB-GYN will also be scheduled for an orientation visit at one of the Johnson City hospitals. Emergency transport operators will also be notified that as of September 26, obstetric services will no longer be provided at Sycamore Shoals Hospital.

D) Please provide descriptions of the hospital's plans to coordinate the referral of potential OB patients to other facilities. Please also discuss the plans of active members of the applicant's medical staff to refer to the medical staffs of other hospitals that have the capacity to absorb the additional volumes from the applicant's discontinuance of its OB service.

The applicant anticipates no change to the current referral process. Patients will continue to be referred into the Elizabethton OB group (First Medical OB-GYN).

9. **Section C, Need, Item 4 (Service Area Population Demographics)**

Please complete the following chart.

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

| Demographic Data | Carter County | Johnson County | Washington County | Service Area Total | State of TN Total |
|---|---|---|---|---|---|
| **Total Population – 2012** | 59,965 | 18,753 | 119,361 | 198,079 | 6,361,070 |
| **Total Population – 2016** | 60,564 | 19,172 | 122,518 | 202,254 | 6,575,165 |
| **Total 2016 Population % Change** | 1.0% | 2.2% | 2.6% | 2.1% | 3.4% |
| **Female (ages 15-44). – 2012** | 11,990 | 3,143 | 24,275 | 39,408 | 1,262,870 |
| **Female (ages 15-44). – 2016** | 11,882 | 3,119 | 24,487 | 39,448 | 1,282,051 |
| **Female (ages 15-44). % Change** | -0.9% | -0.8% | 0.9% | 0.2% | 1.5% |
| **Female (ages 15-44) % of Total Population – 2012** | 20.0% | 16.8% | 20.3% | 19.9% | 19.9% |
| **Female (ages 15-44) % of Total Population – 2016** | 19.6% | 16.3% | 20.0% | 19.5% | 19.5% |
| **Median Household Income** | $31,173 | $29,249 | $41,256 | $37,218 | $43,314 |
| **TennCare Enrollees** | 11,359 | 3,880 | 18,964 | 34,203 | 1,206,538 |
| **TennCare Enrollees as % of Total Population** | 18.9% | 20.7% | 15.9% | 17.3% | 19.0% |
| **Persons Below Poverty Level** | 14,092 | 4,463 | 20,172 | 38,727 | 1,049,577 |
| **% of Total Population below Poverty Level** | 23.5% | 23.8% | 16.9% | 19.55% | 16.5% |

**10. Section C, Need, Item 5**

Please identify hospitals located in contiguous counties (Sullivan, Unicoi and Washington) that offer higher volumes of OB services. Using the most recent three years of data available from the provider Joint Annual Report for the OB service of each hospital, please identify the following:

The requested data is provided below. It should be noted that there is not a provider of OB services in Unicoi County.

| Hospital | OB Service Beds | Births | Patient Days | Average Daily Census (ADC) | Percent Occupancy |
|---|---|---|---|---|---|
| **Johnson City Medical Center - Washington County** | | | | | |
| FY 2009 | 20 | 1,217 | 5,067 | 14 | 69.4% |
| FY 2010 | 20 | 1,054 | 4,066 | 11 | 55.7% |
| FY 2011 | 22 | 1,261 | 5,118 | 14 | 63.7% |
| **Franklin Woods Community Hospital - Washington County** | | | | | |
| FY 2009 | 10 | 923 | 2,107 | 6 | 57.7% |
| FY 2010 | 10 | 892 | 1,747 | 5 | 47.9% |
| FY 2011 | 20 | 839 | 3,518 | 10 | 48.2% |
| **Indian Path Medical Center - Sullivan County** | | | | | |
| FY 2009 | 24 | 913 | 2,139 | 6 | 24.4% |
| FY 2010 | 24 | 817 | 2,118 | 6 | 24.2% |
| FY 2011 | 21 | 859 | 2,309 | 6 | 30.1% |
| **Wellmont Holston Valley Medical Center - Sullivan County** | | | | | |
| FY 2009 | 17 | 1,113 | 3,869 | 11 | 62.4% |
| FY 2010 | 17 | 1,109 | 4,045 | 11 | 65.2% |
| FY 2011 | 17 | 993 | 3,599 | 10 | 58.0% |
| **Wellmont Bristol Regional Medical Center - Sullivan County** | | | | | |
| FY 2009 | 15 | 860 | 2,031 | 6 | 37.1% |
| FY 2010 | 15 | 870 | 2,006 | 5 | 36.6% |
| FY 2011 | 15 | 844 | 1,877 | 5 | 34.3% |

SUPPLEMENTAL- # 1
June 25, 2012
10:54 am

2012 JUN 25 AM 10 58

**Section C, Need, Item 6**

Please provide the requested information on the following chart:

| Sycamore Shoals Hospital | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|
| Licensed Medical-Surgical Beds | 94 | 94 | 94 | 94 | 101 | 101 |
| Staffed Medical-Surgical Beds | 88 | 52 | 52 | 52 | 59 | 59 |
| Medical Surgical Average Daily Census (ADC) | 23 | 22 | 24 | 24 | 24 | 24 |
| Med Surg Bed Lic'd % Occupancy | 24.7% | 23.6% | 25.1% | 25.3% | 23.7% | 23.3% |
| Med Surg Bed Staffed % Occupancy | 26.4% | 42.7% | 45.4% | 45.7% | 40.6% | 39.9% |
| | | | | | | |
| Licensed ICU Beds | 8 | 8 | 8 | 8 | 8 | 8 |
| Staffed ICU Beds | 8 | 8 | 8 | 8 | 8 | 8 |
| ICU Average Daily Census (ADC) | 4 | 6 | 6 | 6 | 5 | 5 |
| ICU Bed Lic'd % Occupancy | 50.8% | 68.9% | 70.3% | 68.9% | 60.3% | 58.0% |
| ICU Surg Bed Staffed % Occupancy | 50.8% | 68.9% | 70.3% | 68.9% | 60.3% | 58.0% |
| | | | | | | |
| Licensed OB Beds | 7 | 7 | 7 | 7 | 0 | 0 |
| Staffed OB Beds | 7 | 7 | 7 | 7 | 0 | 0 |
| OB Average Daily Census (ADC) | 4 | 4 | 4 | 3 | 0 | 0 |
| OB Bed Lic'd % Occupancy | 54.6% | 53.3% | 53.5% | 46.2% | 0% | 0% |
| OB Bed Staffed % Occupancy | 54.6% | 53.3% | 53.5% | 46.2% | 0% | 0% |
| | | | | | | |
| Licensed Gero-Psych Beds | 12 | 12 | 12 | 12 | 12 | 12 |
| Staffed Gero-Psych Beds | 12 | 12 | 12 | 12 | 12 | 12 |
| Gero-Psych Average Daily Census (ADC) | 8 | 11 | 9 | 9 | 9 | 9 |
| Gero-Psych Bed Lic'd % Occupancy | 62.6% | 88.2% | 74.6% | 75.7% | 75.0% | 73.5% |
| Gero-Psych Bed Staffed % Occupancy | 62.6% | 88.2% | 74.6% | 75.7% | 75.0% | 73.5% |
| | | | | | | |
| Licensed Total Beds | 121 | 121 | 121 | 121 | 121 | 121 |
| Staffed Total Beds | 115 | 79 | 79 | 79 | 79 | 79 |
| Total Average Daily Census (ADC) | 39 | 42 | 42 | 42 | 38 | 37 |
| Total Bed Lic'd % Occupancy | 31.9% | 34.7% | 34.6% | 34.4% | 31.2% | 30.6% |
| Total Bed Staffed % Occupancy | 33.6% | 53.2% | 53.1% | 52.7% | 47.8% | 46.9% |

**11. Section C, Economic Feasibility, Item 2**

Your response is noted. Please have the CFO resubmit a letter specifically identifying the Project Cost and indicating from what funding source the funds will be drawn.

An updated letter from Marvin Eichorn, CFO is included in Attachment 7. The project cost of $14,000 has been added. The funding source, the depreciation reserve fund, was noted in the original letter, but is also referenced in the updated letter.

**12. Section C, Economic Feasibility, Item 4**

A) The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised information Historical and Projected Data Charts provided at the end of this requests for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a

third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

The requested detailed versions of the Historical and Projected Data Charts are included in Attachments 8 and 9. Please note the applicant has provided revised projections for FY 2013 and 2014 in Attachment 8. When the application was originally submitted, Mountain States Health Alliance was in the process of finalizing the budgeted financials for the upcoming fiscal year, which begins July 1st. Therefore the original projections were in early draft form; the attached reflect the most recent adjustments.

B) Please provide a separate historical data chart or equivalent proforma for the hospital OB service for the hospital's most recent two fiscal year periods.

A separate historical data chart for SSH OB services is provided in Attachment 9.

C) According to the applicant responses on the Historical and Projected Data Charts for the Sycamore Shoals Hospital as a whole, the hospital has experienced profitable years for each of the past three fiscal years (FY2009-FY2011), averaging 1.8% margins. The Projected Data Chart of 2013 and 2014, following the closure of the OB services begins to show significant losses, averaging 1.9% negative margins. The projected loss in patient days is more than the loss of OB patient days alone. Please share with the Agency members what is anticipated to be occurring over the next few years, as the numbers on the surface do not explain the hospital's decision to discontinue OB in financial terms, and in fact, may contradict the wisdom to close the OB program.

As previously noted, the applicant has resubmitted revised projections for FY 2013 and 2014.

Sycamore Shoals Hospital is projected to report a net income of $2,880,873 for FY 2012, as reflected in Attachment 9. This is down significantly from the prior years. A number of challenges have created this downward turn, including increasing inpatient to outpatient shifts; increasing contractual adjustments, bad debt, and charity care; and flattening volumes. These trends are likely to continue, coupled with future additional reimbursement challenges.

Removing the projected loss related to OB services of $989,122 anticipated for FY 2012, the hospital could have realized an estimated net operating income of $3,869,995, which is in line with the adjusted FY 2013 and FY 2014 projections provided.

**13. Section C, Economic Feasibility, Item 6B**

Your response is noted. However, please provide a listing of the applicant's OB charges and a direct comparison to other hospitals' charges for the same OB services.

Charges for a routine vaginal delivery (MSDRG 775) for hospitals in the upper northeast Tennessee region as well as an average for the state are provided in the table below.

**MSDRG 775 Average Charge Per Case**
CY 2010

| Hospital | Avg Charge Per Case | Total Discharges | Total Charges |
|---|---|---|---|
| Franklin Woods Community Hospital | $11,328 | 222 | $2,514,772 |
| Indian Path Medical Center | $12,627 | 437 | $5,518,119 |
| Johnson City Medical Center | $11,956 | 557 | $6,659,425 |
| Johnson City Specialty Hospital | $11,413 | 249 | $2,841,728 |
| Laughlin Memorial Hospital, Inc. | $4,662 | 127 | $592,121 |
| Sycamore Shoals Hospital | $10,311 | 236 | $2,433,334 |
| Takoma Regional Hospital | $3,346 | 145 | $485,101 |
| Wellmont Bristol Regional Medical Center | $6,751 | 523 | $3,530,804 |
| Wellmont Holston Valley Medical Center | $6,314 | 532 | $3,359,055 |
| **TN Hospitals Total** | **$8,344** | **40,093** | **$334,541,549** |

Source: THA Database

It should be noted that the charges indicated do not relate to what is actually paid for services. 75.5% of OB patients at Sycamore Shoals Hospital are Medicaid/TennCare and Medicare, under which reimbursement is fixed. 24.3% of OB patients at SSH are commercially insured, and reimbursement is determined by negotiation. Only 1% of patients are not covered by a government program or commercial insurance.

**14. Section C, Economic Feasibility, Item 7**

Your response is noted. In it you note that the consolidation of OB services to the Mountain States Health Alliance facilities in Washington County will reduce the loss to Sycamore Shoals Hospital. However, an examination of the Historical Data Chart and the Projected Data Chart would indicate that the closure of Sycamore Shoals' OB program contributes to the losses. There is no evidence (in economic and financial terms) presented in the application that would indicate the closure would reduce the losses. The Agency members will appreciate further economic substantiation of the applicant's decision.

Revised FY2013 and FY2014 charts are provided in Attachment 8. The anticipated net income for these years is now projected to be $3,434,440

and $4,390,559, respectively. This difference can be attributed to the fact that more timely and accurate data is available as the FY2013 budget process is now being finalized. Also, the previous projections did not include the benefit of a number of Medicare Break-Even savings initiatives that are not unique to OB services, but are for the facility as a whole. Additionally, the proforma specific to the OB services, demonstrates the impact that department has had on the hospital over the past two years with a loss of $989,122 projected for FY2012.

**15. Section C, Economic Feasibility, Item 9**

Your response is notes. Please provide your response in actual dollars of Medicare and TennCare/Medicaid as well as percentages of Gross Operating Revenue.

The requested payor data is included in the table below, and represents FY 2012 YTD April data (July 2011 – April 2012).

| Payor | Gross Revenue | % of Total Gross Revenue |
|---|---|---|
| TennCare/Medicaid | $35,105,252 | 20.80% |
| Medicare | $67,678,874 | 40.10% |

**16. Section C, Economic Feasibility, Item 11**

Your response is noted. Please provide the actual numbers of area delivery volumes for the past three years along with the projections as provided by Thomson Reuters for the next four years.

Thomson Reuters projects approximately 3.5% decline over 5 years for the SSH service area – Carter County (-4.4%), Johnson County (-5.9%), and Washington County (-3.1%). The requested data is provided in the table below.

**Inpatient OB Delivery Volume**
MSDRGs 765-768, 774-775

| | Actual | | | Projected | | | | |
|---|---|---|---|---|---|---|---|---|
| County | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
| Carter, TN | 506 | 489 | 459 | 455 | 451 | 447 | 443 | 439 |
| Johnson, TN | 178 | 169 | 161 | 159 | 157 | 155 | 154 | 152 |
| Washington, TN | 1,422 | 1,413 | 1,366 | 1,358 | 1,349 | 1,341 | 1,332 | 1,324 |
| Grand Total | 2,106 | 2,071 | 1,986 | 1,972 | 1,958 | 1,943 | 1,929 | 1,916 |
| Source: | THA, VHHA, Medstat | | | Thomson Reuters | | | | |

**17. Section C, Contribution to Orderly Development, Items 3 and 4**

Please provide the current staffing in FTEs by employee classification of the Sycamore Shoals Labor & Delivery, Maternal and Nursery Department. Please indicate whether the employees will be offered positions in other departments of the hospital, other MSHA hospitals, and or laid off.

The current staffing in FTEs by employee classification of the Sycamore Shoals Labor & Delivery, Maternal and Nursery Department is as follows:

| | |
|---|---|
| RN, Manager | 1.0 |
| RN, Staffing | 16.0 |
| LPN | 1.0 |
| Clerical | 1.0 |
| Total | 19.0 |

All of the team members will be assisted with finding other jobs either at Sycamore Shoals Hospital or at other facilities within MSHA. The loss of any jobs should not result from the completion of this proposal.

**18. Section C, Contribution to Orderly Development, Item 7**

The applicant indicates it also is accredited by the Joint Commission. Please provide:

A) Please provide a copy of the applicant's The Joint Commission's accreditation certificate.

B) Please provide a copy of the most recent Joint Commission's survey report and the facility's responses.

Sycamore Shoals Hospital's most recent survey by The Joint Commission was conducted May 8-10, 2012. The applicant has not yet received an updated certificate from this survey, and according to The Joint Commission, the certificate is not expected to arrive until October 2012. A copy of accreditation certificate from the previous survey conducted in May 2009 was provided in the attachments of the original CON application, and this copy remains valid for up to 39 months. An additional copy of the 2009 certificate is provided in Attachment 10 for your convenience.

A copy of the survey report from the May 2012 survey and the Sycamore Shoals Hospital response providing evidence of Direct Impact Standards Compliance is also included in Attachment 10. Reponses to Indirect Standards Compliance are not yet complete, as they are not due to The Joint Commission until July 2012.

**19. Progress Report**

According to HSDA records an affiliated facility has an outstanding CON:

1. CN1004-020A – Johnson City Medical Center – Facility Modification for Surgery
2. CN1106-021A – Johnson City Medical Center – Facility Modification for Radiation Therapy

Please submit a 2-3 sentence update on the progress regarding each of these Outstanding CONs.

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

The update on these two projects will be combined, as the construction currently underway at Johnson City Medical Center relates to both projects due to their physical proximity. Sitework and utility relocations as well as the drilling for caissons have commenced. The sitework contractor finished hauling off unsuitable soils, and bringing in shale for the building pad. The existing storm line and structures were removed and plugged, and work on the new sanitary sewer and storm lines was completed. The concrete subcontractor has mobilized and begun work on the utility tunnel and shear walls.

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, August 17, 2012. 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. Re-submittal 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. ɔ 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.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Philip M. Wells, FACHE
Health Planner III

PMW

Enclosure

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

ATTACHMENTS
Supplemental Information for CN1206-0030

Attachment 1 – Question 1: History of Corporate Charters

Attachment 2 – Question 2: Organizational Chart

Attachment 3 – Question 3: Bill of Sale

Attachment 4 – Question 5 A: Revised Floor Plan

Attachment 5 – Question 7 B Item 3: Letters from FWCH and JCMC

Attachment 6 – Question 8 A: Press Release

Attachment 7 – Question 12: Revised Funding Letter

Attachment 8 – Question 13 A and Question 15: Revised Historical and Projected Data Charts

Attachment 9 – Question 13 B: Historical Data Chart for SSH OB Services

Attachment 10 – Question 19: 2009 Joint Commission Certificate, 2012 Survey Report, and Direct Impact Standards Compliance Response

Attachment 11 – Affidavit

**ATTACHMENT 5**
Question 7 B Item 3: Letters from FWCH and JCMC

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

June 21, 2012

Ms. Melanie Hill
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Sycamore Shoals Hospital Obstetrical Services Discontinuation

Dear Ms. Hill:

As CEO of Franklin Woods Community Hospital, I affirm that Franklin Woods will continue to offer obstetrical services. Our facility has the interest and capacity to absorb the additional volume and increase in TennCare/Medicaid payor mix created by the Sycamore Shoals Hospital's discontinuance of obstetrics.

I am in full support of this project and request the Agency approve this Certificate of Need application.

Sincerely,

Tony Benton
CEO, Franklin Woods Community Hospital


400 North State of Franklin Road Johnson City, Tennessee 37604-6094 Telephone 423.431.6111

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

June 21, 2012

Ms. Melanie Hill
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Sycamore Shoals Hospital Obstetrical Services Discontinuation

Dear Ms. Hill:

As CEO of Johnson City Medical Center, I affirm that JCMC will continue to offer obstetrical services. Our facility has the interest and capacity to absorb the additional volume and increase in TennCare/Medicaid payor mix created by the Sycamore Shoals Hospital's discontinuance of obstetrics.

I am in full support of this project and request the Agency approve this Certificate of Need application.

Sincerely,

David Nicely
CEO, Johnson City Medical Center

400 North State of Franklin Road Johnson City, Tennessee 37604-6094 Telephone 423.431.6111

**ATTACHMENT 6**
Question 8 A: Press Release

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

Contact: Teresa Hicks
Communications Manager
Communications & Marketing
Mountain States Health Alliance
(423) 431-1313
hickste@msha.com

FOR IMMEDIATE RELEASE – 5/17/12

## SSH and local physicians looking to regionalize OB services

ELIZABETHTON, Tenn. – In response to decreased demand and anticipated continued low birth rates in the community, Sycamore Shoals Hospital (SSH) and First Medical OB/GYN are together exploring options for regionalizing obstetric services and enhancing many other aspects of women's services at SSH.

"The populations of Carter and Johnson Counties are experiencing a shift toward a larger number of seniors," said Dwayne Taylor, CEO of SSH. "This is especially relevant to our women's services, as there are fewer women of childbearing age in the service area, but a growing number of women overall needing gynecologic care, as they age."

Pending approval from the State of Tennessee, the physicians of First Medical OB/GYN will begin delivering their patients at Franklin Woods Community Hospital (FWCH) instead of SSH beginning in the fall of 2012.

SSH's delivery volume shows that many Carter County moms have historically preferred to deliver in Johnson City, and that trend has continued at Franklin Woods Community Hospital. By regionalizing obstetrics to FWCH, patients will have better immediate access to more specialized care. Over the past several years, SSH has seen a significant decrease in deliveries. At times the unit can go days without seeing a single patient.

"Nevertheless, we have to keep that unit fully staffed and ready at all times, even when there are no patients," Taylor said. "Those resources could be better used elsewhere in the hospital or within MSHA to serve other patients' needs."

OB services at SSH represent an annual income loss of more than $1.6 million.

Hospital officials will file a proposal with the State of Tennessee in June, with a hearing in September to determine the date of the switch. Until further notice, deliveries will continue at SSH without interruption. As the hospital and physician group continue to work out details of the plan, SSH will keep the community well informed, Taylor said.

"We'll continue to be very transparent with our physicians, patients and the community. The transition isn't going to happen overnight," he said.

According to Dr. John Green, "This is not about Sycamore Shoals or First Medical OB/GYN; this is about patient care, and we all are committed to doing what's best for our patients."

Other women's services, including GYN services, are expected to grow at SSH in the coming years as the community's demographics evolve. Additionally, SSH is busy working on plans to enhance services for seniors, including adding a new oncology clinic on the hospital campus, developing a chest pain center and improving areas of the emergency department to cater to patients 50 years and older.

"We are looking at a number of different options to grow and improve the services that the residents of Carter and Johnson County need most," said Taylor. "Regionalizing OB services will allow us to direct our resources where they matter most to our patients."

###

**SUPPLEMENTAL- # 1**
**June 25, 2012**
**10:54 am**

## AFFIDAVIT

STATE OF TENNESSEE 2012 JUN 25 AM 10 59

COUNTY OF Carter

NAME OF FACILITY: Sycamore Shoals Hospital

I, Dwayne Taylor, 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.

Dwayne Taylor, CEO
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 19th day of June, 2012, witness my hand at office in the County of Carter, State of Tennessee.

Evelyn R Dugger
NOTARY PUBLIC

EVELYN R DUGGER STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF CARTER

My commission expires May 28, 2014

HF-0043

Revised 7/02

**From:** Tina Gregg [tmariegregg@gmail.com]
**Sent:** Wednesday, July 11, 2012 9:07 AM
**To:** Melanie Hill
**Subject:** Sycamore Shoals Birthing Center

Dear Ms. Hill,

I am just writing to express my dismay at the possibility of closing the birthing center at Sycamore Shoals hospital. The birthing center is an excellent facility with a wonderful staff. My husband and I were recently there to give birth to our son. We were extremely impressed with the facility and the staff and could not have asked for a better birthing experience. I know that a lot of people in the area are upset that it might close. There are many people from surrounding areas who depend on the facility so they don't have to drive a long way to meet their needs. I truly hope that a decision will be made to keep the facility open.

Thank you,

Tina Gregg

**KENT WILLIAMS**
STATE REPRESENTATIVE
4TH DISTRICT
CARTER COUNTY

**DISTRICT OFFICE**
126 S. MAIN STREET
ELIZABETHTON, TN 37643

**LEGISLATIVE OFFICE**
G-2 WAR MEMORIAL BUILDING
NASHVILLE, TN 37243
(615) 741-7450
FAX: (615) 253-0310

**House of Representatives**
**State of Tennessee**

**NASHVILLE**

2012 AUG 17 AM 9: 40

**COMMITTEES**

COMMERCE
COMMERCE GENERAL SUBCOMMITTEE

STATE & LOCAL
STATE & LOCAL GENERAL SUBCOMMITTEE

August 15, 2012

Ms. Melanie Hill
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Application by Sycamore Shoals Hospital to Cease Obstetrical Service, CN1206-0030

Dear Ms. Hill:

I am submitting this letter in support of the certificate of need application by Sycamore Shoals Hospital to close its obstetrical service.

Sycamore Shoals is located in my district and I am very familiar with the health care needs of the community. While it is always disappointing for a community to lose a service, in this instance it is understandable why obstetrical service cannot be sustained locally. High quality obstetrical services are easily accessible in Johnson City, and in fact many women from Elizabethton and the surrounding area are already choosing to have their babies at Johnson City hospitals.

The leadership of Sycamore Shoals has done an excellent job of communicating with the community the need to close its obstetrical service and how this will improve the hospitals ability to meet more pressing health care needs. If Sycamore Shoals is relieved of the financial burden of obstetrical service, it will then be in a position to devote more resources to improve the health of the community, such as the development of a designated chest pain center, an enhanced focus on orthopedics, and additional disease-specific certifications (i.e. diabetes).

I hope the Agency will give the application of Sycamore Shoals favorable consideration. I appreciate this opportunity to express my support.

Sincerely,

Kent Williams

Kent Williams
State Representative

KW/bmf

**4th LEGISLATIVE DISTRICT**
**CARTER COUNTY**
**rep.kent.williams@capitol.tn.gov**

**RUSTY CROWE**
3RD SENATORIAL DISTRICT
CARTER & WASHINGTON
COUNTIES

808 E. 8TH AVENUE
JOHNSON CITY, TENNESSEE 37601

SUITE 8, LEGISLATIVE PLAZA
NASHVILLE, TENNESSEE 37243-0203
615-741-2468
1-800-449-8366-1-2468
(Carter & Washington Counties)
FAX 615-741-9349

e-mail: sen.rusty.crowe@capitol.tn.gov

# Senate Chamber
## State of Tennessee

**NASHVILLE**

**CHAIR**
GENERAL WELFARE, HEALTH, & HUMAN RESOURCES
JOINT SELECT COMMITTEE VETERANS AFFAIRS

**MEMBER OF COMMITTEES**
EDUCATION
SELECT OVERSIGHT COMMITTEE ON EDUCATION
GOVERNMENT OPERATIONS

2012 AUG 22 AM 9:51

August 21, 2012

Ms. Melanie Hill
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Application by Sycamore Shoals Hospital to Cease Obstetrical Service, CN1206-0030

Dear Ms. Hill:

It has come to my attention that Sycamore Shoals Hospital has filed a certificate of need application to terminate its obstetrical service. I am submitting this letter in support of request by Sycamore Shoals.

Carter and Washington counties are in my senatorial district, and as chairman of the Senate Health and Welfare Committee, I am very aware of the challenges facing hospitals as they balance the health needs of the community with the necessity that scare resources be allocated efficiently. In this instance, it makes sense for Sycamore Shoals to terminate its obstetrical service. Women who reside in Carter County and the surrounding area have convenient access to high-quality obstetrical services at the hospitals in Johnson City, and many women in the area are already choosing to use these hospitals. If Sycamore Shoals is relieved of the financial burden of maintaining its obstetrical service, the hospital will be better-positioned to devote resources to other services that will benefit the community.

I appreciate this opportunity to comment on the proposal by Sycamore Shoals, and I urge the Agency to approve its application.

Sincerely,

Rusty Crowe

Senator Rusty Crowe
Chair, Senate Health and Welfare Committee
3rd Senatorial District

FIRST MEDICAL
**Obstetrics & Gynecology**
1505 W. Elk Avenue, Suite 1
Elizabethton, TN 37643

(423) 543-7919
Elizabethton

(423) 282-8466
Johnson City

Fax: (423) 543-5323

e-mail: office@fmgmd.com

Brent Laing, MD

John Green, MD

Erika Glas, DO

Rebecca Williams, FNP

Complete gynecology care

Obstetrical care

Birth control

Sterilizations

Infertility

Post-menopausal care

Laparoscopic surgery

Urogynecology

2012 SEP 10 AM 10: 10

August 22, 2012

Ms. Melanie Hill
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

Re: Sycamore Shoals Hospital Obstetrical Services Discontinuation

Dear Ms. Hill:

As a practicing OB/GYN physician at Sycamore Shoals Hospital and a longtime resident of Elizabethton, I would like to update the agency on how obstetrical services will be delivered to the community, should the agency grant this request.

My partner and I have joined a larger multi-specialty group in Johnson City. We will continue to practice out of our Elizabethton office, offering prenatal care to our patients. We will also continue all other facets of women's health at Sycamore Shoals Hospital. Only the delivery event will be moved to Franklin Woods Community Hospital.

We've worked very closely with our new group as well as both hospitals to put together a plan that we believe will meet the community's needs.

Should you have any questions, please feel free to contact me.

Sincerely,

Brent Laing MD FRCS FACOG

**CERTIFICATE OF NEED**
**REVIEWED BY THE DEPARTMENT OF HEALTH**
**DIVISION OF HEALTH STATISTICS**
615-741-1954

**DATE:** August 31, 2012

**APPLICANT:** Sycamore Shoals Hospital
1501 West Elk Avenue
Elizabethton, Tennessee 37643

**CONTACT PERSON:** Laura Linn, Senior Planning Analyst
Mountain States Health Alliance
303 Med Tech Parkway, Suite 330
Johnson City, Tennessee 37604

**COST:** $14,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

**SUMMARY:**
The applicant, Sycamore Shoals Hospital, located in Elizabethton (Carter County), Tennessee, seeks Certificate of Need (CON) approval for the discontinuance of obstetrical services at the hospital located at 1501 West Elk Avenue. This project will not involve any other major medical equipment, will not initiate nor discontinue any other type of health service, and will not change the licensed total bed count of 121 beds at the facility. The hospital is licensed for 109 acute care beds, 12 geriatric psychiatric beds, and also provides outpatient and emergency services.

The project proposes to convert the 7 obstetrical beds to general medical/surgical use. There will be no impact on existing services.

Sycamore Shoals Hospital is 100% owned by Mountain States Health Alliance (MSHA) and is part of the 1,623 bed MSHA system. As an acute care community hospital, Sycamore Shoals Hospital (SSH) is able to provide care for residents of the Elizabethton area, but if more specialized care is needed, patients can easily be transported by ground or air to Johnson City Medical Center, also part of MSHA. MSHA is a 13 hospital, integrated healthcare system serving a population of more than 1.1 million people in a 29-county service area.

The total estimated cost of this project is $14,000, the majority of which is comprised of CON-related expenses. The remaining $1,000 will cover signage changes and other minor changes to finishes as required, to convert the OB areas to general medical/surgical care. Funding for this project will be through continued operations and the use of existing cash reserves of MSHA. The applicant provides a letter from the Senior Vice President /Chief Financial officer of MSHA in Attachment C, Economic Feasibility 2. No additional staff will be required for this project.

## GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

**NEED:**
The applicant's service area consists of Carter, Johnson, Unicoi, Sullivan, and Washington counties.

The following charts illustrate the 2012 and 2016 total population and female age 15-44 population projections for the applicants service area.

**Service Area Total Population Projections for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Carter | 59,965 | 60,564 | 1.0% |
| Johnson | 18,753 | 19,172 | 2.2% |
| Unicoi | 17,882 | 17,973 | 0.5% |
| Sullivan | 154,250 | 154,872 | 0.4% |
| Washington | 119,361 | 122,518 | 2.6% |
| **Total** | **370,211** | **375,099** | **1.3%** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

**Service Area Female Population 15-45 for 2012 and 2016**

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Carter | 11,990 | 11,882 | (0.9%) |
| Johnson | 3,143 | 3,119 | (0.8%) |
| Unicoi | 4,209 | 4,417 | 4.9% |
| Sullivan | 27,413 | 26,845 | (2.1%) |
| Washington | 24,275 | 24,487 | 0.9% |
| **Total** | **71,030** | **70,750** | **(0.4%)** |

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

According to the applicant, the seven obstetrical beds at SSH have historically been underutilized, and despite their best efforts, this trend continues, Low volumes not only cause inefficiency issues for SSH, but also increase the potential for safety and quality of care issues for patients.

The applicant states that for more than six years, SSH has sought to recruit an additional OB/GYN to add to the two physician First Medical OB/GYN group that practices at SSH. In 2009, the applicant reports a female OB/GYN joined the group, and the existing male partners of the group, as well as the hospital, were hopeful that the addition of a female physician would be attractive to potential patients. The applicant reports that although the recruitment efforts were successful, the volumes have not increased as anticipated. In Supplemental 1, the applicant states they have learned that the female member of the OB medical staff who was hired in 2009/2010 has announced that she is leaving the area. The applicant states they were not aware of this before making the determination to discontinue OB services, and her leaving was not a factor in their decision. With the female physician's departure, the original two OB/GYN's remain. There are no other physicians and/or nurse-midwifes on the hospital's medical staff who are currently delivering babies at SSH. The two OB/GYN's plan to remain in Elizabethton, with their offices located in a SSH campus medical office building, and continue to provide primary care to their patients within this office as they have done in the past. The only change to their patients will be the site at which the deliveries take place as both physicians will be performing those deliveries at one of the two Washington County facilities. Gynecologic cases from those physicians will continue to be treated at SSH.

According to the applicant, shifting demographics in the service area help to explain why recruitment cannot sustain the obstetrics program at SSH now and in the future. The female child-bearing age population surrounding the hospital is declining and will continue to do so. The applicant reports that by 2016, the number of females' ages 15-44 in Carter County is expected to drop 0.8%. The population of the county is aging as demonstrated by the expected 5.3% growth in the 55 and older age group. The birth rate for Carter, Johnson, and Washington counties is below the Tennessee State averages from 2005 to 2009. Furthermore, all three counties as well as the State experienced a decline between 2008 and 2009, according to the most recent data. In

addition, the projected growth of the female population of childbearing ages (15-44) in the entire service area is not growing at the same projected growth rate for the total population of the county. Washington County does anticipate a minimal growth of 0.9%, but the overall percent this demographic cohort represents of the total population in Washington County will decline from 20% in 2012 to 19.6% in 2016. The healthcare needs of the community is shifting along with the demographic trends, thus explaining the decreased need for obstetrical services.

SSH states the goal of this project is to ensure that area residents receive the highest quality obstetrics care, which can best be provided at one of two nearby MSHA facilities. Franklin Woods Community Hospital and Johnson City Medical Center are both less than 20 minutes away from SSH, and both have OB capacity available with occupancy rates at 48.2% and 63.7%, respectively. In Supplementa1, the applicant provides a chart of hospitals in the contiguous counties showing the number of OB beds, births, patient days, average daily census, and occupancy percentage.

In Supplemental 1, the applicant states in the current and future environment of health reform, part of the long-term vision for MSHA is to pursue the Institute for HealthCare Improvement's "Triple Aim" which includes the following:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of the populations; and
- Reducing the per capita cost of health care.

According to the applicant, the reorganization of OB services as described in this proposal is just one part of a larger effort by MSHA to ensure the right services are offered in the right places, in the most patient-centered, effective, and efficient manner possible.

The ACOG/ASA guidelines maintain that "some small delivery units are necessary related to geographic location," provided that no other services are available in a close region. Given that two other facilities providing obstetrical services with available capacity exist a short distance away from SSH, MSHA has chosen to follow ACOG/ASA guidelines that maintain "whenever possible, small units (less than 500 deliveries annually) should consolidate". Additional research from sources noted below also support MSHA's decision to discontinue OB services at SSH.

- Heller et al (2002) "Birthweight-specific mortality rates were lowest in large delivery units and highest in smaller delivery units. A more than threefold mortality risk was observed in hospitals with < 500 births/year compared with hospitals > 1,500 births/year.

- Moster, Lie, and Markestad (1999) "The neonatal date rate was lowest for maternity units with 2001-3000 annual births and steadily increased with decreasing size of the maternity unit to around twice that for units with less than 100 births a year".

- Finnstrom et al (2006) "Neonatal mortality was significantly higher for infants in families living with the catchment area of the smallest units without a pediatric department".

By discontinuing OB services at SSH, the hospital can better align its service offerings to meet the needs of the aging residents of their community.

The applicant provides a detailed list of who they communicated their plans to close the OB unit along with a timeline listing the steps involved in the closure of the unit in Supplemental 1.

**TENNCARE/MEDICARE ACCESS:**
The applicant participates in Medicare and TennCare/Medicaid and contracts with BlueCare and AmeriChoice MCOs.

The applicant reports TennCare/Medicaid revenues of $35,105,252 or 20.80% of total gross revenues and Medicare revenues of $67,678,874 or 40.10% of total gross revenues.

The following chart illustrates the TennCare enrollees in the applicant's service area.

**TennCare Enrollees in the Proposed Service Area**

| County | 2012 Population | TennCare Enrollees | % of Total Population |
|---|---|---|---|
| Carter | 59,965 | 11,569 | 19.3% |
| Johnson | 18,753 | 3,986 | 21.3% |
| Unicoi | 17,882 | 3,680 | 20.6% |
| Sullivan | 154,250 | 27,842 | 18.0% |
| Washington | 119,361 | 18,977 | 15.9% |
| **Total** | **370,211** | **66,054** | **17.8%** |

Source: *Tennessee Population Projections 2000-2020,* February 2008 Revision Tennessee Department of Health, Division of Health Statistics and *Tennessee TennCare Management Information System, Recipient Enrollment,* Bureau of TennCare

**ECONOMIC FACTORS/FINANCIAL FEASIBILITY:**

In the Project Costs Chart, the total estimated project cost is $14,000, which includes $10,000 for legal, administrative, and consultant fees; $1,000 for signage, minor finish changes, etc.; and $3,000 for CON filing fees.

In the Historical Data Chart located in Supplemental 1, the applicant reported 14,109, 15,334, and 15,299 patient days in 2009, 2010, and 2011 with gross operating revenues of $164,808,938, $184,203,045, and $191,513,514 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $40,973,736, $44,213,759, and $42,187,362 each year. The applicant identified management fees of $1,329,130, $1,276,604, and $1,597,023 each year. The applicant reported a net operating income of $2,900,289, $4,817,761, and $2,264,063 each year, respectively.

In the Historical Data Chart for OB services only located in Supplemental 1, the applicant reported 1,367 and 1,181 OB patient days in 2011 and 2012 with gross operating revenues of $5,639,408 and $5,175,062 each year, respectively. For SSH total, the applicant reported 15,217 patient days in 2012 with gross operating revenues of $204,164,328. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $739,326 for and $678,451 for OB only and $42,824,577 for SSH total.. For OB services only, the applicant reported a net operating loss of ($735,109) in 2011 and ($989,122) in 2012. For SSH total, the applicant reported management fees of $1,759,837 and a net operating income of $1,212,036 in 2012.

In the Projected Data Chart located in Supplemental 1, the applicant project 13,781 patient days in year one and 13,512 patient days in year two with gross operating revenues of $204,478,140 and $210,612,484 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $39,907,814 and $41,105,048 each year. The applicant projected management fees of $2,360,629 and $2,391,657 each year, respectively. The applicant projects a net operating income of $1,063,811 in year one and $1,998,902 in year two.

The applicant projects and average charge per patient day of $11,681, with and average deduction of $8,777, resulting in an average net charge of $2,904. The applicant reports SSH's charges are consistent with charges at other MSHA facilities.

According to the applicant, two alternatives were considered: maintain SSH Obstetrical Services or consolidate Obstetrical Services. The first option was rejected for a number of reasons, including difficulty in recruiting new obstetricians, consistently low volume compromising patient safety and care quality, and operation inefficiencies resulting in financial losses for the hospital. The current and future demographics of the service area no longer necessitates obstetrical services at SSH, with decline in the child bearing population and the resulting 3.5% decline in area delivery volumes as projected by Thomson Rueters.

The option to consolidate was chosen as it continues to provide services at other nearby MSHA facilities with convenient access for the service area residents to obstetrical services, while maintaining safety and clinical quality. Additionally, this option is more efficient and minimizes financial loss for MSHA.

**CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:**
Sycamore Shoals Hospital will continue to work with Mountain States Health Alliance hospitals, East Tennessee State University and the James H. Quillen College of Medicine, local nursing homes and clinics. They have working relationships with hospitals in Northeast Tennessee and Southwest Virginia.

Approval of this request to discontinue OB services will contribute to the efficiency of healthcare resources and the orderly development of healthcare. Positive effects of this proposal include maintaining the goal of providing the highest quality of care to area residents. By discontinuing OB services at SSH, patients will be directed to higher volume MSHA facilities, where OB departments have no difficulty maintaining high quality services through comprehensive staff coverage around the clock.

This project does not add any staff positions. Current staffing of OB a SSH is 19.0 FTEs. The applicant states all of the team members will be assisted in finding other jobs at either SSH or at other facilities within MSHA. The applicant states the loss of jobs should not result from the completion of this proposal.

MSHA works extensively with local colleges and universities and has an affiliation with East Tennessee State University James H. Quillen College of Medicine to provide clinical training for medical students and residents in the area of family medicine and psychiatric services. MSHA has the largest number of medical residents in the Tri-Cities area.

Sycamore Shoals Hospital is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities. The applicant is accredited by the Joint Commission on Accreditation of HealthCare Organizations (JCAHO) and their last survey occurred on 5/8-10/12.

## SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

## DISCONTINUANCE OF OBSTETRICAL SERVICES

A. Need

1. A specific service area should be identified and all existing providers of obstetrical services in that service area should be identified.

   *The primary service area for this project is Carter, Johnson, and Washington Counties. The secondary service are includes Unicoi and Sullivan counties. Resident from the primary service area consistently represents 85% of the patients utilizing SSH OB services.*

   *There are two other providers of OB services in the service area, Johnson City Medical Center and Franklin Woods Community Hospital. Both of these facilities are located in Johnson City and are part of MSHA.*

2. The female population aged 15-44 in the service area should be identified. The current year's population and the population four years hence should be used.

***Service Area Female Population 15-45 for 2012 and 2016***

| County | 2012 Population | 2016 Population | % Increase/ (Decrease) |
|---|---|---|---|
| Carter | 11,990 | 11,882 | (0.9%) |
| Johnson | 3,143 | 3,119 | (0.8%) |
| Unicoi | 4,209 | 4,417 | 4.9% |
| Sullivan | 27,413 | 26,845 | (2.1%) |
| Washington | 24,275 | 24,487 | 0.9% |
| **Total** | **71,030** | **70,750** | **(0.4%)** |

*Source: Tennessee Population Projections 2000-2020, February 2008 Revision, Tennessee Department of Health, Division of Health Statistics*

3. The number of obstetrical patients served by the facility over the past three years should be listed.

**SSH Deliveries**

| | 2009 | 2010 | 2011 | 2012 Projected |
|---|---|---|---|---|
| Deliveries | 479 | 438 | 466 | 403 |

*Source: Tennessee Department of Health, Division of Health Statistics*

*The applicant states SSH has been unable to maintain delivery volumes that meet or exceed the 500 delivery threshold established by the ACOG/ASA in their joint publication "Optimal Care for Anesthesia Care in Obstetrics". These groups maintain that "Providing comprehensive care for obstetric patients in small units (less than 500 deliveries annually) is extremely inefficient, not cost effective, and frequently impossible".*

4. The estimated number of obstetrical patients affected by the discontinuance of obstetrical services should be listed. The estimated number of obstetrical patients below the federally established poverty level and affected by the discontinuance of the service should be listed separately.

*Based on utilization in 2012, the applicant states an estimated 403 patients will be affected by the discontinuance of OB services at SSH. Internal data indicates 74% of OB patients at SSH are covered under TennCare, amounting to approximately 300 patients annually.*

B. Accessibility

1. Indicate the distance in miles and approximate travel time that patients in need of obstetrical services would have to travel, should the service be discontinued at the designated site.

*There are two other providers of OB services in the service area, Johnson City Medical Center and Franklin Woods Community Hospital. Both of these facilities are located in Johnson City and are part of MSHA.*

| Facility | Distance from SSH | Travel Time from SSH | County |
|---|---|---|---|
| Johnson City Medical Center | 10.5 Miles | 16 minutes | Washington |
| Franklin Woods Community Hospital | 13.3 Miles | 19 Minutes | Washington |

2. Indicate the modes of transportation which will be used by obstetrical patients to travel to alternate sites, should the service be discontinued at the designated site.

*Transportation to alternative sites is anticipated to be by personal vehicle, as that is the mode used by patients at SSH. The sites are accessible using main highways from SSH, and driving times and distances are noted above.*

3. Indicate the facilities that will provide obstetrical services in the service area, should the service be discontinued at the designated site.

   *Johnson City Medical Center and Franklin Woods Community Hospital will provide OB services to patients within the service area. These two facilities are capturing 40% of the patients from Carter and Johnson counties and have available capacity to absorb the patients who would otherwise sought care at SSH.*

| Facility | OB Beds | Days of Capacity | OB Days MDC 14 | OB Occupancy | Births | ADC |
|---|---|---|---|---|---|---|
| Johnson City Medical Center | 22 | 8,030 | 5,118 | 63.7% | 1,261 | 14.2 |
| Franklin Woods Community Hospital | 20 | 7,300 | 3,518 | 48.2% | 839 | 9.64 |

*Source: 2011 Joint Annual Report of Hospitals (Provisional)*

   *Opened in 2010, Franklin Woods Community Hospital is a new facility, and the OB services area at Johnson City Medical Center is currently undergoing a major renovation, which is scheduled to be completed prior to the anticipated approval of this proposal. The new and newly renovated facilities will be attractive to future patients from Carter and Johnson counties. MSHA anticipates most cases (roughly 70%) from this area going to Franklin Woods as it is a smaller facility with a specialty hospital feel. The remaining 30% of cases are expected to go to Johnson City Medical Center, which is well-equipped to handle high risk OB patients as a regional tertiary referral center with advanced NICU services. With this increased volume, neither facility's OB occupancy rates are anticipated to exceed 70%.*

4. The charges for obstetrical services at alternate service delivery sites should be compared to those of the facility seeking to discontinue the service.

   *MSHA uses the same charge schedule for OB services at each of their facilities; therefore, the charges will remain consistent at the alternative sites. A copy of the charge schedule is provided in Attachment C, Economic Feasibility 6.A.*

5. The applicant should document that TennCare and/or Medicare patients can receive obstetrical services at the alternate service delivery sites.

   *Both Johnson City Medical Center and Franklin Woods Community Hospital participate in TennCare and Medicare, and participate in the same MCO's as SSH. TennCare/Medicaid comprises 13.0% of patient revenues at Johnson City Medical Center and 13.7% at Franklin Woods Community Hospital.*

# GENERAL COUNSEL'S REPORT

## September 26, 2012

A. **Memphis Long Term Care Specialty Hospital, Memphis (Shelby County), TN — CN0908-046A**
The project was unanimously approved on November 18, 2009 for the relocation and replacement of a previously approved but unimplemented certificate of need, CN0603-019A, for the establishment of a twenty-four (24) bed long term acute care hospital. The expiration date is January 1, 2013. CN0603-019A could not be implemented because the property was the subject of condemnation by BNSF Railway

Request for change of control of an approved but unimplemented certificate of need: Shelby County Health Care Corporation d/b/a The MED proposes to acquire all of the issued and outstanding equity in Memphis Long Term Care Specialty Hospital, LLC which owns the referenced certificate of need.

The request has been deferred, pending the parties' resolution of site-control issues.

B. **Erlanger East, Chattanooga (Hamilton County), TN — CN0405-047A**
This project was approved on October 27, 2004 for the construction of a new four (4) story patient tower and other ancillary space; transfer of seventy-nine (79) beds from the main campus to the east campus; initiation of cardiac catheterization and the acquisition of a magnetic resonance imaging (MRI) scanner. This project decreased the total number of licensed beds at the main campus from 703 to 624 licensed beds and increased the total number of licensed beds at the east campus from 28 to 107. The project cost was $68,725,321.

Request for extension of expiration date for twenty-four (24) months from December 1, 2012 to December 1, 2014: The Agency approved requests for extensions on June 25, 2008 (twenty-four (24) month extension) and June 23, 2010 (twenty-four (24) month extension).

C. **Vanderbilt University Hospital, Nashville (Davidson County), TN — CN0606-037**
This project was approved unanimously by the Agency on September 27, 2006 for the renovation and expansion of the current hospital, to include: the addition of a third bed tower, the addition of one hundred forty-one (141) acute care beds, including six (6) neonatal intensive care unit (NICU) beds, the renovation and expansion of cardiac catheterization labs and hybrid operating rooms (ORs), and the addition of fourteen (14) newly constructed OR suites. The approved project cost is $234,421, 471.00. A six (6) year expiration date was granted: November 12, 2012.

The project is being implemented gradually due to its many pieces, and the challenges of building up and out of a busy existing urban hospital. Attached documents, including a portion of the 2006 staff summary, provide a more detailed explanation of the project and its progress.

VUMC requests a thirty-two (32) month extension of the expiration date from November 1, 2012 to July 1, 2015.

# GENERAL COUNSEL'S REPORT

## September 26, 2012

**B. Erlanger East, Chattanooga (Hamilton County), TN – CN0405-047A**

This project was approved on October 27, 2004 for the construction of a new four (4) story patient tower and other ancillary space; transfer of seventy-nine (79) beds from the main campus to the east campus; initiation of cardiac catheterization and the acquisition of a magnetic resonance imaging (MRI) scanner. This project decreased the total number of licensed beds at the main campus from 703 to 624 licensed beds and increased the total number of licensed beds at the east campus from 28 to 107. The project cost was $68,725,321.

Request for extension of expiration date for twenty-four (24) months from December 1, 2012 to December 1, 2014: The Agency approved requests for extensions on June 25, 2008 (twenty-four (24) month extension) and June 23, 2010 (twenty-four (24) month extension).

erlanger

2012 AUG 14 AM 8 10

August 13, 2012,

Ms. Melanie M. Hill
Executive Director
State of Tennessee
Health Services & Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: Request for Extension/CN 0405-047AE

Dear Ms. Hill:

In October 2004, the Chattanooga Hamilton County Hospital Authority d/b/a Erlanger Health System received approval from the Tennessee Health Services & Development Agency (HSDA) to expand services at Erlanger East (located at 1755 Gunbarrel Rd, Chattanooga, TN 37421). See CN 0405-047AE (a copy of which is enclosed with this letter for your convenience). Despite Erlanger's diligent and good faith efforts to implement the CON prior to the expiration date of December 1, 2012, significant delays have been experienced as a result of the recession, the deteriorating state of credit markets in the United States and a significant increase in the amount of uncompensated care provided by Erlanger over the last few years.

In spite of these challenges, Erlanger has continued with its efforts to implement the CON using a phased project approach. Erlanger will not have completed full implementation of the approved project by the current expiration date and requests that the CON be extended for an additional 24 months, until December, 2014 so that project can be completed. In support of this request, Erlanger offers the following:

- Erlanger proceeded to implement the approved CON immediately following receipt of CN 0405-047A; however, bids for construction exceeded the authorized budget. Erlanger engaged a construction manager to conduct a value engineering assessment of plans and bids to determine how best to reduce projected cost. The Adams Group was engaged thru December, 2004. Erlanger then revised its plans to implement the project in a phased format. Erlanger advised HSDA that such an approach would likely require more time to implement the entire project, but the approach would afford Erlanger more opportunity to control costs. (See attached Project Status Report September 15, 2006).



975 East Third Street, Chattanooga, TN 37403 (423)778-7000 www.erlanger.org

- Erlanger received occupancy approval from the Bureau of Health Licensure & Regulation for Phase I of the project in May 2007.
- Erlanger filed a request with HSDA in February, 2007 to add authorized imaging services via the acquisition of an imaging center located contiguous to the campus and received approval to do so in April, 2007. Erlanger completed the transaction and integrated the imaging center into its operations effective July 1, 2007.
- Erlanger proceeded with plans to secure financing to implement the next phases of work including the emergency department, bed addition and operating room expansion; however, implementation was delayed as a result of turmoil in the municipal bond market, particularly in relation to auction rate bonds. Auction rate bonds allowed Erlanger and others to issue long term bonds at short term rates; however, since mid-2007, the credit worthiness of bond insurers that guaranteed the debt has significantly deteriorated because of losses in securities tied to sub-prime mortgages.
- The delay in project implementation resulting from turmoil in the auction rate bond market has impacted hospital financing nationwide and was beyond Erlanger's control. Erlanger's efforts to finance the project were further complicated by the collapse and bankruptcy of Lehman Brothers and its subsequent acquisition by Barclays and further tightening of credit markets. These events and circumstances were also beyond Erlanger's control.
- Despite the condition of financial markets in the United States and the associated delays in arranging financing, Erlanger continued with its efforts to obtain financing. In late October, 2009, Moody's Investor Services affirmed Erlanger's bond rating and upgraded its future outlook. This affirmation allowed Erlanger to issue new bonds in late 2009.
- Erlanger also indicated in its CON application that a combination of cash and bond financing would be used to implement the project. Erlanger has been engaged in an effort to monetize certain assets on the Erlanger East campus in an effort to raise cash to finance the Erlanger East expansion project. This transaction, which was delayed by continuing issues in financial and credit markets in the United States, was completed in April, 2012.
- Erlanger engaged Gresham and Smith Architects from Nashville to complete remaining phases of the project for implementation.
- Erlanger has begun the next phase of work on the project, the emergency department, and expects to complete this work at or near to the expiration of the current CON in December, 2012; however, remaining phases of the project, such as the bed tower addition and surgery expansion, will not be completed by this time. For this reason, Erlanger is requesting an extension of the CON until December, 2014.
- Erlanger does not anticipate that its cost to fully implement the CON will increase as a result of the phased approach that Erlanger has utilized to implement the project.

We appreciate your understanding of the circumstances involved with delays in project implementation; however, much of the delay was due to market conditions

beyond our control. We have proceeded diligently and request your approval to extend the current CON until December, 2014. Photos of current construction work are attached.

2012 AUG 14 AM 8 10

Please let us know if you should have questions concerning the above or attached or if additional information is needed. Thank you for your attention to this matter.

Sincerely,

Joseph M. Winick
Senior Vice President, Planning & Business Development
Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System

cc: Charlesetta Woodward-Thompson, President & Chief Executive Officer

STATE OF TENNESSEE
**Health Services and Development Agency**

Certificate of Need No. **CN0405-047AE** is hereby granted under the provisions of T.C.A. § 68-11-1601, *et seq.*, and rules and regulations issued thereunder by this Agency.

To: Erlanger Health System
Whitehall Building, Suite 515, 975 East 3rd Street
Chattanooga, TN 37403

For: Erlanger East

This Certificate is issued for: The construction of a new four (4) story patient tower and other ancillary space totaling approximately 178,500 square feet; renovation of approximately 22,500 square feet of space, transfer of seventy-nine (79) beds from the Erlanger Medical Center main campus to the Erlanger East campus; initiation of cardiac catheterization and the acquisition of MRI scanner. The urgent care center will be upgraded to a full-service emergency department. The additional seventy-nine (79) beds will increase the licensed bed capacity from twenty-eight (28) beds to one hundred seven (107) beds. The main campus licensed bed capacity will decrease from 703 to 624 licensed beds.

* This Certificate is a replacement of the originally issued Certificate of Need pursuant to Agency Rule 0720–3–06(9). Modification and/or addendums to issued certificates. In the event a certificate holder wishes to make substantive changes relating to the scope, cost, or duration of the project, written request must be made to, and formally approved by the Agency. If approved, such changes may be reflected in either the issuance of a modified Certificate of Need, or the issuance of an addendum to the original Certificate... This project was approved at the October 27, 2004 Agency meeting with an expiration date of December 1, 2008. Agency approved a twenty-four (24) month extension at the June 25, 2008 meeting, extending the expiration date to December 1, 2010. On June 23, 2010 a twenty-four (24) month extension of the expiration date was granted, extending the expiration date to December 1, 2012.

On the premises located at: 1755 Gunbarrel Road
Chattanooga (Hamilton), TN 37421

For an estimated project cost of: $68,725,321.00

The Expiration Date for this Certificate of Need is

December 1, 2012

or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the expiration date, this Certificate of Need is null and void.

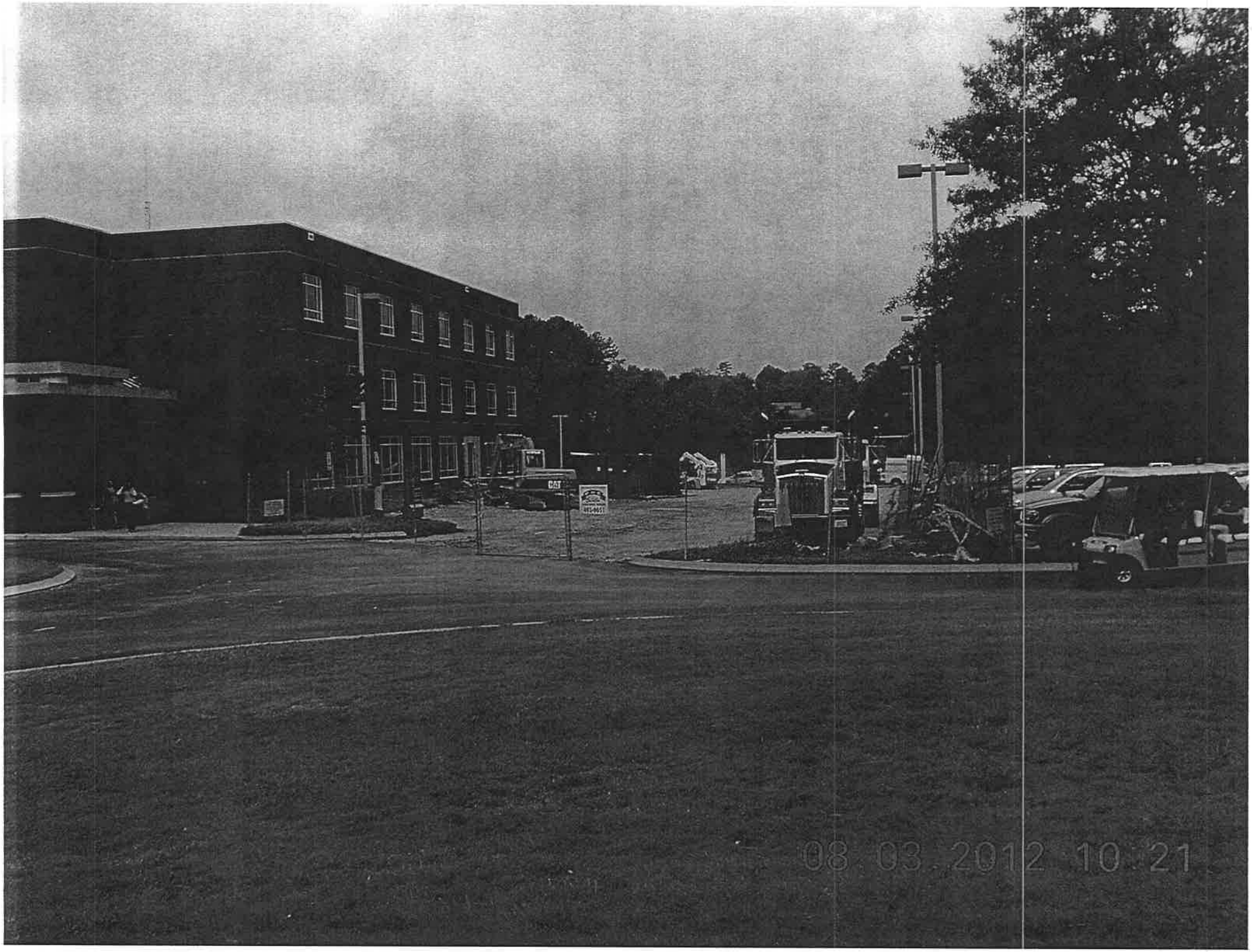
Date Approved: June 23, 2010

Chairman

Date Issued: August 1, 2010

Executive Director

HF-0022 (Rev 1/04)


CAT
08 03 2012 10:21

08.03.2012 10:16

# GENERAL COUNSEL'S REPORT

## September 26, 2012

C. **Vanderbilt University Hospital, Nashville (Davidson County), TN – CN0606-037A**

This project was approved unanimously by the Agency on September 27, 2006 for the renovation and expansion of the current hospital, to include: the addition of a third bed tower, the addition of one hundred forty-one (141) acute care beds, including six (6) neonatal intensive care unit (NICU) beds, the renovation and expansion of cardiac catheterization labs and hybrid operating rooms (ORs), and the addition of fourteen (14) newly constructed OR suites. The approved project cost is $234,421, 471.00. A six (6) year expiration date was granted: November 12, 2012.

The project is being implemented gradually due to its many pieces, and the challenges of building up and out of a busy existing urban hospital. Attached documents, including a portion of the 2006 staff summary, provide a more detailed explanation of the project and its progress.

VUMC requests a thirty-two (32) month extension of the expiration date from November 1, 2012 to July 1, 2015.

VANDERBILT UNIVERSITY MEDICAL CENTER

*Business Development*

2012 AUG 29 PM 3 31

August 29, 2012

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243

Dear Melanie,

The Certificate of Need issued October 24, 2006 for the Third Bed Tower addition to Vanderbilt University Hospital (CN0606-037A) is scheduled to expire on November 1, 2012. This letter is to request an extension of the project timeline, and we are hopeful that the request can be heard during the General Counsel's portion of the September, 2012 agency meeting.

The Third Bed Tower addition has progressed steadily and is substantially complete with the exception of the build-out of the fifth floor shell space to accommodate relocation of cardiac cath labs and hybrid operating rooms. Of the original estimated project cost of $234,421,471, approximately $168,200,000 has been spent toward completing the project. Due to the complexity of this equipment-intensive build-out, and the need to keep services that will ultimately reside on the fifth floor in operation during the construction phase, the project is expected to be completed in the first quarter of 2015. However, out of an abundance of caution we seek an extension until June, 2015. This extension of the project timeline will allow the fifth floor to be complete before relocation of services occur- thus avoiding incremental relocation of services and resulting operational and staffing difficulties.

There are a number of reasons why the project has proceeded more slowly than anticipated. After the project commenced, the nation slipped into a major economic decline, and the board and leadership of the medical center chose a cautious approach to implementation of the project. Construction also was slowed somewhat based on the impact of major flooding in Nashville-- an event that consumed construction resources otherwise available to the project. These complications and the overall complexity of a project that required multiple structural interfaces with the existing south tower of the hospital contributed to the slowing of the project.

3319 West End Avenue
Suite 920 Crystal Terrace
Nashville, TN 37203

www.mc.vanderbilt.edu

Should the extension be granted, we understand the need for an incremental application fee of $20,000, and a check in this amount is enclosed.

Sincerely,

Ron

Ronald W. Hill, MPH

Cc: Jim Christoffersen, General Counsel

Enclosure

Vanderbilt University

Check Date: 08-28-2012 Contact Number: 615-322-2381 Check No. 0001390917

| Invoice Number | Invoice Date | Reference | Voucher ID | Gross Amount | Discount Available | Paid Amount |
|---|---|---|---|---|---|---|
| | 08-28-2012 | CR1652071 | 07578248 | 20,000.00 | 0.00 | 20,000.00 |

Filing Fee
PU Jennifer Hygrell/CT

2012 AUG 29 PM 3 32

| Vendor Number | Vendor Name | | | Discounts Available | |
|---|---|---|---|---|---|
| 0XXXXX2918 | Tennessee Health Services & | | | 0.00 | |
| **Check Number** | **Date** | **TN Tax Exempt ID** | **Total Gross Amount** | **Discounts Taken** | **Total Paid Amount** |
| 0001390917 | 08-28-2012 | 100142007 | 20,000.00 | 0.00 | 20,000.00 |

THIS IS WATERMARKED PAPER - DO NOT ACCEPT WITHOUT NOTING WATERMARK - HOLD TO LIGHT TO VERIFY WATERMARK

**Vanderbilt University**
Nashville, Tennessee 37232

SunTrust Bank, Nashville or
SunTrust Bank, NorthWest Georgia

**0001390917**

64-79 611

**Date** 08-28-2012 **Pay Amount** $20,000.00 ******

**Pay** ****TWENTY THOUSAND AND 00/100 US DOLLARS****

**To The Order Of**
**Tennessee Health Services & Development Agency**
500 Deaderick Street
Suite 850
Nashville TN 37243

Brett Sweet

STATE OF TENNESSEE
**Health Services and Development Agency**

Certificate of Need No. **CN0606-037A** is hereby granted under the provisions of T.C.A. § 68-11-1601, *et seq.*, and rules and regulations issued thereunder by this Agency.

To: Vanderbilty University Hospital
1211 22nd Avnue South
Nashville, TN 37232

For: Vanderbilt University Hospital

This Certificate is issued for: Construction and renovation including the following: addition of a third bed tower; the addition of 141 acute care beds, including six (6) neonatal intensive care unit (NICU) beds; and the renovation and expansion of cardiac cath labs and hybrid operating rooms (ORs); and the addition of fourteen (14) newly constructed OR suites.

On the premises located at: 1211 22nd Avenue South
Nashville (Davidson County), TN 37232

For an estimated project cost of: $234,421,471.00

The Expiration Date for this Certificate of Need is

November 1, 2012

or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the expiration date, this Certificate of Need is null and void.

Date Approved: September 27, 2006

Chairman

Date Issued: October 24, 2006

Secretary

HF-0022 (Rev.1/04)

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

October 25, 2006

Ronald W. Hill, Vice President, Strategic Development
Vanderbilt University Medical Center
3319 West End Avenue, Suite 400
Nashville, TN 37203

RE: Vanderbilt University Hospital - CN0606-037A

Dear Mr. Hill:

As referenced in our recent letter, please find enclosed your Certificate of Need for the above-referenced application that was approved at the September 27, 2006 meeting of the Tennessee Health Services and Development Agency.

The Health Services and Development Agency Rules require that an Annual Progress Report be submitted each year and a Final Project Report form is to be submitted within ninety (90) days after completion of a project which shall include completion date, final costs, and other relevant information in regards to the project, pursuant to Public Acts 2002, Chapter No. 780, § 16-11-1609(d). Also required is the registration of certain medical equipment pursuant to Tennessee Code Annotated § 68-11-1607(i), which states "*The owners of the following types of equipment shall register such equipment with the health services and development agency: computerized axial tomographers, lithotripters, magnetic resonance imagers, linear accelerators and positron emission tomography.*" ....."*The survey shall include but not limited to the identification of the equipment and utilization data according to source of payment.*"

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

Sincerely,

Melanie M. Hill
Executive Director

MMH/MAB

cc: Marguerite Lewis, Division of Health Statistics, Office of Policy, Planning & Assessment
Ann R. Thompson, Health Care Facilities - Licensure
Bill Harmon, Director of Engineering, Health Care Facilities

**HEALTH SERVICES AND DEVELOPMENT AGENCY**
**SEPTEMBER 27, 2006**
**APPLICATION SUMMARY**

| | |
|---|---|
| NAME OF PROJECT: | Vanderbilt University Hospital |
| PROJECT NUMBER: | CN0606-037 |
| ADDRESS: | 1211 22nd Avenue South<br>Nashville (Davidson County), TN 37232 |
| LEGAL OWNER: | Vanderbilt University Hospital<br>1211 22nd Avenue South<br>Nashville (Davidson County), TN 37232 |
| OPERATING ENTITY: | Not Applicable |
| CONTACT PERSON: | Ronald W. Hill<br>(615) 936-6012 |
| DATE FILED: | June 12, 2006 |
| PROJECT COST: | $234,421,471.00 |
| FINANCING: | Tax-Exempt Debt, Cash Reserves, and/or Philanthropy |
| PURPOSE FOR FILING: | Renovation and expansion of the current hospital requiring a capital expenditure greater than $5 million, the addition of one hundred forty-one (141) acute care beds, and the acquisition of additional cardiac catheterization equipment. |

DESCRIPTION:

Vanderbilt University Hospital (VUH) is seeking approval to renovate 77,120 square feet of existing space and to construct 307,470 square feet of new space, the centerpiece of which is a ten story bed tower, which will be placed between the existing VUH building and The Vanderbilt Clinic (TVC). The existing VUH building essentially consists of two towers, VUH-North (N) and VUH-South (S). The New Tower will be attached to VUH-S. The proposed project includes the addition of one hundred forty-one (141) acute care beds including the conversion of an existing skilled nursing unit to acute care beds, the relocation and

expansion of cardiac catheterization services, the relocation of a clinical research unit, and the net increase of twelve operating suites. The applicant stated that elevator additions and renovations, waiting area, and patient amenity renovations are also included. The following chart highlights the major changes made to the Vanderbilt University Hospital building resulting from the construction of the bed tower that affect clinical services.

| Floor | Existing Building Use | Proposed Use of Existing Building | Proposed Use of New Tower |
|---|---|---|---|
| 1st Floor | 4 Cardiac Cath Labs and 1 Hybrid OR | Relocate Cardiac Cath Labs to 5th Floor and replace with Ancillary Support space | NA |
| 2nd Floor | Mechanical Space | Mechanical Space and New Elevators | Patient Amenities Space |
| 3rd Floor | 23 Surgical ICU beds and 19 ORs | Relocate ICU beds to New Tower. 2 ORs decommissioned and replaced by surgery support functions | Add 12 ORs for net increase of 10 ORs |
| 4th Floor | 12 Med/Surg Beds, 10 NICU Beds, and 5 Ors | Add 6 NICU beds | Mechanical and staff support space. New Blood Bank in addition adjacent to TVC. |
| 5th Floor | 48 ICU Beds | 48 ICU Beds (22 in VUH-S and 26 in VUH-N) designated as Cardiology Critical Care | Relocation of 4 Cardiac Cath Labs and 1 Hybrid OR; Add 2 Hybrid ORs and 2 EP Labs |
| 6th Floor | 45 Med/Surg Beds | 43 Med/Surg beds (15 in VUH-S and 28 in VUH-N) remain | 34 ICU beds |
| 7th Floor | 30 Med/Surg Beds and 26 ICU Beds | 26 ICU beds converted to 21 Med/Surg beds for a total of 51 Med/Surg Beds. (21 in VUH-S and 30 in VUH-N) | 34 ICU Beds |

| Floor | Existing Building Use | Proposed Use of Existing Building | Proposed Use of New Tower |
|---|---|---|---|
| 8th Floor | 56 Med/Surg Beds | 51 Med/Surg Beds (23 in VUH-S and 28 in VUH-N) remain. | 34 ICU Beds |
| 9th Floor | 55 Med/Surg Beds | 50 Med/Surg Beds (23 in VUH-S and 27 in VUH-N) remain. | 34 ICU Beds |
| 10th Floor | 17 Med/Surg Beds and 31 ICU Beds | 31 ICU beds converted to Med/Surg, 17 Med/Surg beds reduced to 11, for a total of 42 M/S Beds. (11 in VUH-S and 31 in VUH-N) | 34 ICU Beds |
| 11th Floor | 42 Med/Surg Beds and 9 ICU beds (Burn Unit) | Med/Surg Beds increased by 2 for a total of 44. 9 ICU beds remain. (17 M/S and 9 ICU in VUH-S {Burn Unit} and 27 M/S in VUH-N | Mechanical space |

The following chart highlights the changes proposed to be made to other buildings on the Vanderbilt University Medical Center campus as a result of the proposed project. The applicant provides a chart in the first supplemental response that displays the buildings affected by the proposed project.

| Building | Current Use | Proposed Use |
|---|---|---|
| Medical Center North (MCN) 3rd Floor | 14 Med/Surg Beds-General Clinical Research Center (GCRC) | Relocate GCRC to VUH existing tower and convert this space to research for Department of Pediatric Infectious Disease |
| MCN Round Wing 4th Floor | 11 Med/Surg Beds | 14 Med/Surg Beds |
| MCN Round Wing 7th Floor | 27 SNF Beds | Close SNF Unit and convert to 20 Med/Surg Bed Unit |
| **Building** | **Current Use** | **Proposed Use** |

| | | |
|---|---|---|
| Medical Center East (MCE) 2nd Floor | Patient Support Area | Renovated Patient Support Area |
| MCE 3rd Floor | 9 ORs | 11 ORs |
| Free Electron Laser (FEL) Center | 2 ORs | 2 ORs (No Changes) |

The applicant also states that to accommodate growth in cardiac catheterization during project construction up to two mobile cardiac catheterization lab units will be acquired and utilized until cath labs on the fifth floor are completed.

...

Vanderbilt University Medical Center (VUMC) is owned and operated by Vanderbilt University. VUMC is not separately incorporated. VUMC is composed of four hospitals: Vanderbilt University Hospital (VUH), Vanderbilt Children's Hospital (VCH), Psychiatric Hospital at Vanderbilt, (VPH) and Stallworth Rehabilitation Hospital (Stallworth). The beds at VCH and VPH are included in the license for VUH, currently licensed for 805 acute hospital beds and 27 skilled nursing beds. Stallworth, a joint venture between Vanderbilt and HealthSouth, is licensed for 80 beds.

...

Of the 141 beds to be added, 107 of those beds are to be intensive care unit/cardiac care unit (ICU/CCU) beds.

...

The applicant is requesting a net increase of 21 Medical/Surgical Beds.

...

The applicant will also increase Obstetrical beds from 30 to 36.

...

The applicant currently has 4 adult cardiac catheterization laboratories and 1 hybrid cardiac cath/OR room for a total of five cardiac cath labs on the first floor of VUH. There are also 2 cardiac cath labs in the children's hospital, which is not part of this project. The applicant proposes to relocate adult cardiac cath services from the first floor of VUH to the fifth floor which will contain 4 cardiac cath labs, 3 hybrid cardiac cath/OR rooms, and two electrophysiology (EP) labs.

...

VUH Currently has 19 operating rooms (ORs) on the third floor of the hospital. The applicant proposes to build 12 new ORs in the new tower and decommission 2 of the existing 19 ORs for a net gain of 10 ORs. In addition to the existing 19 ORs, there are 9 existing adult ORs in the Medical Center East (MCE) building, 5 ORs on the fourth floor of VUH, 4 ORs in The Vanderbilt Clinic, and 2 ORs in the Free Electron Laser (FEL) Center. This project also includes adding 2 ORs in the MCE Building.

...

MAF/ (9/11/06)

# GENERAL COUNSEL'S REPORT

## September 26, 2012

A. **Memphis Long Term Care Specialty Hospital, Memphis (Shelby County), TN — CN0908-046A**
The project was unanimously approved on November 18, 2009 for the relocation and replacement of a previously approved but unimplemented certificate of need, CN0603-019A, for the establishment of a twenty-four (24) bed long term acute care hospital. The expiration date is January 1, 2013. CN0603-019A could not be implemented because the property was the subject of condemnation by BNSF Railway

Request for change of control of an approved but unimplemented certificate of need: Shelby County Health Care Corporation d/b/a The MED proposes to acquire all of the issued and outstanding equity in Memphis Long Term Care Specialty Hospital, LLC which owns the referenced certificate of need.

The request has been deferred, pending the parties' resolution of site-control issues.

WEEKS & ANDERSON
*An Association of Attorneys*

**2021 RICHARD JONES ROAD, SUITE 350**
**NASHVILLE, TENNESSEE 37215-2874**
TELEPHONE 615/383-2232
FACSIMILE 615/383-3480

2012 JUL 31 PM 3: 11

KENT M. WEEKS
ROBERT A. ANDERSON

F. B. MURPHY, JR.
E. GRAHAM BAKER, JR.

DIRECT TELEPHONE NUMBER: 615/370-3380

July 31, 2012

Jim Christoffersen, General Counsel
Tennessee Health Services & Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Re: Memphis Long Term Care Specialty Hospital, CN0908-046A, owned by Memphis Long Term Care Specialty Hospital, LLC

Dear Jim:

I represent Shelby County Health Care Corporation d/b/a Regional Medical Center at Memphis ("The Med"), which proposes to acquire all of the issued and outstanding equity (the "Ownership") in Memphis Long Term Care Specialty Hospital, LLC, owner of an approved Certificate of Need for the relocation of a 24 bed Long Term Acute Care Hospital (CN0908-046A, approved November 18, 2009).

As we understand that an Ownership transfer such as this (involving a CON that has not yet been fully implemented) The Med requires approval by the HSDA, we ask that you place this matter on the General Counsel's Agenda for the August 22, 2012 meeting. Please let me know what documentation and information you need for this proposed transfer.

Please call me if you should have any questions or comments. Your assistance in this matter is appreciated.

Sincerely,

E. Graham Baker, Jr.
/np

c: Reginald W. Coopwood, M.D., President/CEO
J. Richard Wagers, Jr., Executive VP/CFO
Monica N. Wharton, Esq., Sr. VP/Chief Legal Officer/General Counsel
Bret L. Perisho, CPA, VP
Mike Hampton

# RE: Hampton-Memphis

Brent, Michael D [MBRENT@babc.com]
**Sent:** Tuesday, September 11, 2012 3:07 PM
**To:** Jim Christoffersen; Melanie Hill
**Cc:** E. Graham Baker Jr. [graham@grahambaker.net]; Mr. Byron R. Trauger [btrauger@tntlaw.net]; Mr. Jerry W. Taylor [jtaylor@farrismathews.com]

understood, and I think Mike H hopes to send that soon.

thanks
Mike

---

From: Jim Christoffersen [Jim.Christoffersen@tn.gov]
Sent: Tuesday, September 11, 2012 3:05 PM
To: Brent, Michael D; Melanie Hill
Cc: E. Graham Baker Jr.; Mr. Byron R. Trauger; Mr. Jerry W. Taylor
Subject: RE: Hampton-Memphis

Mike,

We look forward to receipt of documentation confirming site control at the approved location for the LTACH. It would not be appropriate for the matter to proceed on the General Counsel's report until such time.

Jim Christoffersen

General Counsel

Tennessee Health Services and Development Agency

Andrew Jackson Bldg., Suite 850

500 Deaderick St.

Nashville, TN 37243

(615) 741-2364

---

From: Brent, Michael D [MBRENT@babc.com]
Sent: Tuesday, September 11, 2012 1:12 PM
To: Melanie Hill; Jim Christoffersen
Cc: E. Graham Baker Jr.; Mr. Byron R. Trauger; Mr. Jerry W. Taylor
Subject: Hampton-Memphis

Attached is a letter which Mike H asked me to forward to you, with his apologies for the delay in sending this. Hopefully this clears up the confusion about the parcels at the Kirby campus, but if we still need to meet or have a conference call, please let me know.

Thanks
Mike

---

Confidentiality Notice: This e-mail is from a law firm and may be protected by the attorney-client or work product privileges. If you have received this message in error, please notify the sender by replying to this e-mail and then delete it from your computer.

**MEMPHIS SPECIALTY HOSPITAL, LLC**
**3391 OLD GETWELL ROAD**
**MEMPHIS, TENNESSEE 38118**

September 8, 2012

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
500 Deaderick Street
Suite 850
Nashville, TN 37243

Dear Ms. Hill;

Please accept this communique as a formal one clarifying the site issue for the Kirby tract located in Memphis, Tennessee. The original tract size for the total development was approximately 10(+/-) acres and was to host a 90-bed nursing home, a 24-bed specialty hospital, and an out-patient clinic and medical office building. Several changes were made to the large site because of soil issues and flood plan issues, prior to the transfer of the membership interest in Oaktree Health and Rehabilitation Center, LLC, the developer of the 90 bed nursing home. The site was reduced to approximately 8 (+/-) acres to move out the area that had bad soil challenges, and as many as 10 site plans were done on for the development period. While at a job site in Mississippi on August 17, I received a call to clarify the lay out the development. Rushing to meet the hurried time line, we referred to one of the earlier site plans that had the nursing home and hospital connected, sharing support services. What was also confusing to me was the payment we made in February of $50,000 towards the land contract, which went to cover the nursing home tract only. Please forgive my memory about which plan was which without reviewing the file. Given all that is on my plate, I sometimes do know what day it is. In summarizing this transaction it is important to point out that the site never changed, but just the size and layout of the sub-parcels within the larger site. Secondly, the sub-parcel of the site that is controlled by Oaktree for the nursing home is totally separate from the LTACH site.

As for the LTACH site, I recently meet with Walter Wills , and we are working with the real estate agent that we have been working with since this project started to extend the option on the hospital site for a period long enough to allow the MED to request a change of site.

In closing, please allow me to point out the MED did a study that supported that they had 368 discharges that would be candidates for an LTACH, which would have keep the 24-bed LTACH full and saved the MED a lot of money. Also, this proposed transfer of the membership interest in Memphis Long Term Care Specialty Hospital, LLC, to the MED allows the mission of providing LTACH services to the underserved urban Memphis market to be realized, and is not being done at a profit, but the sale does cover some of my pre-development expenses.

Thank you very much for your time and consideration.

Sincerely

Michael B. Hampton

STATE OF TENNESSEE
**Health Services and Development Agency**

Certificate of Need No. **CN0908-046A** is hereby granted under the provisions of T.C.A. § 68-11-1601, *et seq.*, and rules and regulations issued thereunder by this Agency.

To: Memphis Long Term Care Specialty Hospital
3391 Old Getwell Road
Memphis, TN 38118

For: Memphis Long Term Care Specialty Hospital

This Certificate is issued for: The relocation and replacement of a health care facility, originally approved under CN0603-019A in 2006. The relocation of its twenty-four (24) bed long term acute care hospital to a new facility to be constructed on an approximately 3.08 acre parcel of land at the northwest corner of Kirby Parkway and Kirby Gate Boulevard, Memphis (Shelby County), TN. The real property where the current facility is located is owned by AmeriCare Health Properties, LLC, but leased to Memphis Long Term Care Specialty Hospital, LLC. The new facility will be owned, operated by Memphis Long Term Care Specialty Hospital, LLC and will contain approximately 30,000 square feet of space.

On the premises located at: Corner of Kirby Pkwy. and Kirby Gate Blvd.
Memphis (Shelby County), TN 38118

For an estimated project cost of: $7,617,100.00

The Expiration Date for this Certificate of Need is

January 1, 2013

or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the expiration date, this Certificate of Need is null and void.

Date Approved: November 18, 2009

Chairman

Date Issued: December 16, 2009

Executive Director

HF-0022 (Rev.1/04)

# HEALTH SERVICES AND DEVELOPMENT AGENCY

# * MINUTES

# AUGUST 22, 2012

**AGENCY MEMBERS PRESENT**

Johnson, D. Lynn, Chair
Burns, Charlotte, Vice-Chair
Mills, Thom
Southwick, William
Gaither, Keith, designee for the TennCare Director
Jordan, Lisa, designee for the Commissioner of Commerce and Insurance
Weaver, Faye, designee for the Comptroller of the Treasury

**AGENCY MEMBERS ABSENT**

Byrd, Claudia
Doolittle, Robert S.
Haik, Barrett, M.D.
Wright, James

**AGENCY STAFF PRESENT**

Hill, Melanie, Executive Director
Bobbitt, Melissa, Administrative Services Assistant III
Christoffersen, Jim, General Counsel
Craighead, Alecia, Statistical Analyst III
Farber, Mark, Assistant Executive Director
Finchum, Rhonda, Director of Administrative Services
Wells, Phil, Health Planner III

**COURT REPORTER**

Deen, Meschelle Manley

**GUESTS PRESENT**

Adams, Anca, Esq., Waller Lansden & Dortch
Brent, Michael D., Esq., Bradley Arant Boult Cummings, LLP
Brierly, John R., M.D.
Brotherton, Matthew, Esq., Kramer Rayson, LLC
Chabrew, Jaysan, Analyst, Outpatient Imaging Affiliates, LLC
Crowley, Cheri, Interim Executive Director, HighPoint Hospice
Cutshall, Alyson, Vice President, Caris Healthcare
Dreyfuss, Mike, Esq., Waller Lansden & Dortch
Duncan, Bruce, Vice President, National HealthCare Corporation
Elrod, Dan H., Esq., Butler, Snow
Gibbs, Matt, Trauger & Tuke
Haberman, Ralf, Medical Director, Odyssey Hospice
Harris, Vickie, Consultant, Continuum Connexions
Herman, Michael, COO, HighPoint Health System
Houchin, Barbara, Executive Director, Planning, Saint Thomas Health Services

Huggins, Mike, Senior Executive Consultant, Tennessee Hospital Association
Looney, Kim Harvey, Esq., Waller Lansden Dortch & Davis
Mann, Daryl F., O.D.
Martin, Rachel, R.N., Odyssey Hospice
McDaniel, Lee, M.D.
Merville, LaDonna, Vice President, Hospital Alliance of Tennessee
Moore, Carl
Moreland, Michael, CEO, Middle Tennessee Imaging
Ockerman, Jeff, Director, Division of Health Planning, Tennessee Department of Health
Reed, Ann, R., RN, BSN, MBA, Director of Licensure, Div. of Health Care Facilities, Tenn. Dept. of Health
Smith, Gordon, DPh., Area Vice-President, Gentiva Health Services
Tally, Sarah Lodge, Esq., Butler, Snow
Taylor, Jerry W., Esq., Farris, Mathews, Bobango, PLC
Trauger, Byron R., Esq., Trauger & Tuke
Wellborn, John L., Consultant, Development Support Group
West, William H., Esq., Baker, Donelson, Bearman, Caldwell & Berkowitz

**Chairman Johnson called the meeting to order at 8:30 a.m. in Meeting Room 12, of The Legislative Plaza, Nashville, Tennessee.**

## DIRECTOR'S ANNOUNCEMENTS

Melanie Hill, Executive Director, made the following general announcements:

1) Instructions were provided for those providing testimony on the scheduled agenda items;

2) Status of Agenda items:

   Withdrawn applications—Reeves Eye Surgery Center and Satellite Med;

   Deferred applications—Baptist Memorial Hospital-Huntingdon (deferred to September) and Baptist Center for Cancer Care (deferred to November);

   Southeast Eye Surgery Center-Opposition withdrawn

   General Counsel's Report– Item C, Memphis Long Term Care Specialty Hospital deferred to the September meeting.

3) Audit Committee members and the Audit Committee Chair will be chosen by Agency members at the conclusion of the meeting.

4) Number of applications scheduled for upcoming meetings -- seven (7) for September; four (4) for October; and possibly ten (10) for November

5) Meeting location - October through December meetings will be held in Room 12 at the Legislative Plaza; Staff has been advised that the September meeting will not be at Legislative Plaza due to renovations. Location will be announced as soon as a new site is secured.

6) The Joint Government Operations Sub-Committee for Education, Health, and Welfare met Tuesday, August 21, 2012 to review the Agency's Sunset Performance. The Sub-Committee recommended that the Agency be renewed for four (4) years. The recommendation will now go to the full Committee;

7) Recognition and thanks were extended to:

   Jim Christoffersen, General Counsel and Legislative Liaison, for the excellent job he did both in preparation for and for his performance at the Sub-Committee meeting.

   Chairman Johnson, Vice-Chair Burns, Ms. Jordan and Ms. Weaver for being present at the Sub-Committee meeting.

## STATE HEALTH PLAN UPDATE

Jeff Ockerman, Director, Division of Health Planning, Department of Health reported the following:

The Hospice Questionnaire was released for comments on August 21, 2012 with responses due by September 13, 2012. After receipt, suggested changes will be made and a Public Hearing will be scheduled for mid-October.

The ASTC proposed revisions will be released by the end of August with the Public Hearing to be held mid-September.

A meeting had been held with the Department of Mental Health and Substance Abuse Services to discuss the non-residential substitute narcotic clinics (f/k/a methadone clinics). Work on a questionnaire will begin soon.

Effective August 1st, the Division of Health Planning was moved from the Department of Finance & Administration to the Department of Health.

## CERTIFICATE OF NEED APPLICATIONS

*Mark Farber summarized the following CON applications:*

**Reeves Eye Surgery Center - (Johnson City, Washington County) - Project No. CN1204-018**

The establishment of a single-specialty ambulatory surgical treatment center (ASTC) limited to ophthalmology. It will have one (1) operating room and one (1) laser procedure room. The project does not contain major medical equipment or initiate or discontinue any other health service; and will not affect any licensed bed complements. Project Cost $1,266,514.00.

**DEFERRED FROM THE JULY MEETING**
**WITHDRAWN**

**Baptist Memorial Hospital - Huntingdon - (Huntingdon, Carroll County) - Project No. CN1205-021**

The conversion of twelve (12) acute care beds currently used as medical-surgical beds to twelve (12) geriatric psychiatric beds. The hospital proposes to initiate a geriatric psychiatric service to be managed by Psychiatric Resource Partners. The project involves the renovation of approximately 4,600 square feet. There are no additional services, major medical equipment, or additional beds involved. There will be no change in the hospital licensed total bed count of 70 beds. Project Cost $727,000.00.

**DEFERRED TO THE SEPTEMBER MEETING**

**Satellite Med, LLC - (Cookeville, Putnam County) - Project No. CN1205-022**

The establishment of an outpatient diagnostic center (ODC) and initiation of magnetic resonance imaging (MRI) services. The ODC site will be at 1300 Bunker Hill Road, Cookeville (Putnam County), TN 38506. The only service to be provided by the ODC will be MRI services. The ODC will be licensed by the Tennessee Department of Health. Project Cost $695,000.00.

**WITHDRAWN**

*Mr. Southwick recused.*

**Southeast Eye Surgery Center - (Knoxville, Knox County) - Project No. CN1205-023**

The establishment of a specialty ambulatory surgical treatment center (ASTC) for eye and related procedures. The facility will seek licensure by the Tennessee Department of Health as an ASTC limited to ophthalmology, including eye and oculoplastics procedures. It will have one (1) operating room and one (1) laser procedure room. Project Cost $3,183,836.00.

Byron R. Trauger, Esq., representing the applicant, addressed the Agency and Lee McDaniel, M.D. spoke on behalf of the project. Present were: John R. Brierly, M.D.; Daryl F. Mann, O.D.; and John L. Wellborn, Consultant.

Ms. Jordan moved for approval of the specialty ambulatory surgical treatment center (ASTC) limited to eye and related procedures based on: 1) Need – The application meets the Guidelines for Growth for an additional ASTC, and the need also exists because there are problems in obtaining sufficient OR time which limits productivity; 2) Economic Feasibility – The application is financially feasible. The applicant has access to a commercial loan, and it is projected it will realize positive income in the first two years of operation; and 3) The project does contribute to the orderly development of adequate and effective health care as the other ASTCs in the area will not be significantly adversely affected, and by increasing the productivity they can continue to serve patients in rural areas. **CONDITION: Limited to patients of Southeast Eye Specialists, LLC.** Ms. Burns seconded the motion. The motion CARRIED [6-0-0]. **APPROVED**

AYE: Jordan, Mills, Gaither, Burns, Weaver, Johnson
NAY: None

*Mr. Gaither recused.*

**Odyssey Hospice - (Nashville, Davidson County) - Project No. CN1205-024**

The addition of Sumner and Trousdale counties to the existing licensed service area of Odyssey Hospice which currently consists of: Cannon, Davidson, Robertson, Rutherford, Williamson and Wilson counties. Project Cost $43,000.00.

William H. West, Esq., representing the applicant, addressed the Agency. Speaking in support of the project were: Gordon Smith, DPh., Area Vice-President, Gentiva Health Services; and Ralf Haberman, Medical Director. Rachel Martin, R.N. was present in support.

Speaking in opposition were: Dan H. Elrod, Esq., representing HighPoint Hospice; and Alyson Cutshall, Vice President, Caris Healthcare. Responding to questions by members were: Micheal Herman, COO, HighPoint Hospice; and Cheri Crowley, Intermediate Director, HighPoint Hospice. Present was: Sarah Lodge Tally, Esq.

Mr. West rebutted.

Mr. Elrod provided summation for opposition.

Mr. West provided summation for the applicant.

Ms. Burns moved for denial of the project for the addition of Sumner and Trousdale counties to the hospice service area based on: 1) Need – Guidelines show there is actually a surplus. The applicant has not demonstrated that there is a need. Most importantly, there is no evidence that care is being delayed or denied based upon the current providers; 2) Economic Feasibility – The project is not economically feasible due to there not being a need for this service; and 3) The project does not contribute to the orderly development of adequate and effective health care because it will negatively impact the other providers. Ms. Jordan seconded the motion. The motion CARRIED [6-0-0]. **DENIED**

AYE: Jordan, Mills, Burns, Weaver, Southwick, Johnson
NAY: None

**Baptist Center for Cancer Care - (Germantown, Shelby County) - Project No. CN1205-026**

Modification of CN1105-018A, which authorized the establishment of a comprehensive cancer center known as Baptist Center for Cancer Care (BCCC). The original projects and proposed modifications are as follows:

1) CN1105-018A, which approved new construction of approximately 105,291 square feet. The proposed modification increases the size of the facility by 52,688 square feet to a total of 157,979 square feet;

2) CN1105-018A, approved the relocation of a PET/CT from Baptist Memorial Hospital-Memphis (BMHM) and initiation of PET/CT services at BCCC. The proposed modification will be to relocate the PET/CT scanner acquired by Baptist Memorial Hospital-Tipton (BMHT) under CN1111-050A and currently located at 5945 Wolf River Blvd., Germantown (Shelby County), TN 38138 to BCCC. The PET/CT at BMHM will remain in place;

3) CN1105-018A approved the relocation of two (2) linear accelerators and other radiation oncology equipment along with the cyberknife linear accelerator from BMHM and initiation of linear accelerator services at BCCC. The proposed modification is to replace one (1) of the existing linear accelerators when installed at BCCC. The replaced unit will be taken out of service; and

4) CN1105-018A approved for a project cost of $64,925,225. The proposed modification will increase the project cost by $29,117,691 to a total of $94,042,916.

The location of BCCC continues to be at 1238 and 1280 South Germantown Parkway, Germantown (Shelby County), TN 38138. The project does not involve change in any service previously approved, the addition of beds or any other service for which a certificate of need is required; and 4) One of the exiting linear accelerators to be relocated from BMHM will be replaced when installed at BCCC. The project does not involve change in any service previously approved, the addition of beds or any other service for which a certificate of need is required. Project Cost $94,042,916.00.

**DEFERRED TO THE NOVEMBER MEETING**

**GENERAL COUNSEL'S REPORT**

*Jim Christoffersen summarized the following CON modification requests:*

**Saint Francis Hospital - (Memphis, Shelby County) - Project No. CN0803-023A**

Request for a two (2) month extension of the expiration date from September 1, 2012 to November 1, 2012: The project was approved at the July 23, 2008 Agency meeting for the acquisition of a Cyberknife Stereotactic Radiosurgery System to be installed at the hospital's main campus as an alternative to, but not a replacement of the linear accelerator radiation oncology services already provided at the hospital. The project cost was $6,651,513.

Kim H. Looney, Esq., representing the applicant, addressed the Agency.

Ms. Jordan moved for approval of the request for a two (2) month extension of the expiration date from September 1, 2012 to November 1, 2012. Mr. Southwick and Ms. Burns seconded the motion. The motion CARRIED [7-0-0]. **APPROVED**

AYE: Jordan, Mills, Gaither, Burns, Weaver, Southwick, Johnson
NAY: None

**St. Thomas Outpatient Imaging - Baptist - (Nashville, Davidson County) - Project No. CN1108-031A**

Request for modification: Increase the number of magnetic resonance imaging (MRI) units in the approved but unimplemented outpatient diagnostic center (ODC) from one (1) to two (2) by relocating a 3.0T MRI which will be donated from Baptist Hospital. The modification would also include building out an additional room to house the second MRI. The project cost will increase by $395,000. This project was approved at the November 16, 2011 Agency meeting for the establishment of an ODC and the initiation of MRI services in space leased from Baptist Hospital. Baptist Hospital committed to deactivate an existing MRI when the original project was completed so there would not be no additional MRI capacity in the market. The total project cost would increase from $3,608,100 to $4,003,100.

Dan H. Elrod, Esq., representing the applicant, addressed the Agency.

Ms. Jordan moved for approval of the request for modification to increase the number of MRI units in the approved but unimplemented outpatient diagnostic center from one (1) to two (2) by relocating the unit from Baptist Hospital. Ms. Weaver and Mr. Mills seconded the motion. The motion CARRIED [6-0-1]. **APPROVED**

AYE: Jordan, Mills, Gaither, Burns, Weaver, Johnson
NAY: None
ABSTAINED: Southwick

**Memphis Long Term Care Specialty Hospital - (Memphis, Shelby County) - Project No. CN0908-046A**

Request for change of control of an approved but unimplemented certificate of need: Shelby County Health Care Corporation d/b/a The MED proposes to acquire all of the issued and outstanding equity in Memphis Long Term Care Specialty Hospital, LLC which owns the referenced certificate of need. This project was approved at the November 18, 2009 Agency meeting for the relocation and replacement of the twenty-four (24) bed long term acute care hospital to a new facility to be constructed. The project cost was $7,617,100.

**DEFERRED TO THE SEPTEMBER MEETING**

**CONTESTED CASE**

Mr. Christoffersen provided an update on contested cases.

**OTHER BUSINESS**

Ms. Hill noted that Audit Committee members and chair will serve a one (1) year term and can be re-appointed. Board members that served last year were: Ms. Burns, Chair; Mr. Lammert: Mr. Southwick; Ms. Jordan; and Mr. Johnson.

Ms. Hill opened the floor for nominations.

Mr. Johnson nominated Mr. Southwick, Ms. Burns and Ms. Jordan.

Mr. Southwick nominated Mr. Doolittle.

Ms. Jordan nominated Mr. Gaither.

Ms. Burns nominated Mr. Southwick as Chair of the Audit Committee.

Mr. Johnson ceased nominations.

The motion CARRIED by unanimous voice vote [7-0-0]. **APPROVED**

AYE: Jordan, Mills, Gaither, Burns, Weaver, Southwick, Johnson
NAY: None

**MINUTES**

Mr. Southwick motioned to accept the minutes of the July 25, 2012, meeting. Ms. Burns seconded the motion. The motion CARRIED by unanimous voice vote [7-0-0]. **APPROVED**

AYE: Jordan, Mills, Gaither, Burns, Weaver, Southwick, Johnson
NAY: None

**ADJOURNMENT**

There being no further business, the meeting adjourned.

_____

Melanie M. Hill, Executive Director

MMH/mab

* Minutes provide only a brief staff summary of the meeting and are not intended to be an all-inclusive report. The HSDA maintains a detailed record of each meeting (recording and transcript) that is available upon request by contacting the HSDA office at 615-741-2364.