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CN1211-056

2012 NOV 14 AM 9 59

CERTIFICATE OF NEED APPLICATION

For the

INITIATION OF DIAGNOSTIC CARDIAC CATHETERIZATION SERVICES
FOR
TENNOVA HEALTHCARE – NORTH KNOXVILLE MEDICAL CENTER

November 14, 2012

Contact:
Jeffrey D. Potter
Senior Vice President
Tennova Healthcare
200 E. Blount Avenue, Suite 600
Knoxville, TN 37920

SECTION A:

APPLICANT PROFILE

2012 NOV 14 AM 9 59

1. ***Name of Facility, Agency, or Institution***			
Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – North Knoxville Medical Center			
Name			
7565 Dannaher Drive		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, 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) **Diagnostic Cardiac Catheterization**	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.

		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. A chart showing the total licensed bed complement for Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare is attached as Attachment A.9.**

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.

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 ("North Knoxville"), 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 ("Turkey Creek"). 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., an investor owned hospital management company based in Naples, Florida.

Tennova Healthcare proposes to initiate diagnostic cardiac catheterization services at North Knoxville Medical Center. The project involves building-out shell space within the hospital and equipping the space to serve as a dual cardiac catheterization/ vascular lab with a control room, support areas for the lab, an expanded waiting room for the comfort of patients' family members, and additional pre-operative and post-operative space. North Knoxville is a growing hospital serving north Knox County and ten other rural counties, which include eight medically underserved counties. The purpose of this project is to enhance patient convenience and patient safety by providing diagnostic cardiac catheterization and vascular surgery in a location that is easily accessed by patients in the service area.

Services and Equipment

Within the lab and control room itself, Philips Allura Xper FD20 equipment will be utilized. The Allura FD20 system provides the flexibility to serve the needs of both Cardiologists and Vascular Surgeons through a state of the art monoplane X-ray imaging system conducive to producing high quality outcomes while gaining the efficiency benefits inherent in a dual lab versus single-specialty space. For a more in-depth description of the Philips equipment, Attachment B.I.Project Description.1.

In addition to the lab and control room equipment, IT equipment, monitors, headwalls and beds for the pre-and post-operative areas, furniture and miscellaneous equipment will be installed. For a complete listing of moveable equipment, see Attachment B.I.Project Description.2.

Ownership Structure

The site of service for this project is North Knoxville Medical Center ("North Knoxville"), which is a satellite location of Metro Knoxville HMA, LLC, d/b/a Tennova

Healthcare. North Knoxville Medical Center 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 ("Turkey Creek"). 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, with its home office in Naples, Florida, as shown on the attached organizational chart, Attachment B.I.Project Description.3.

Service Area

While Tennova Healthcare's overall service area encompasses 16 counties, the service area for North Knoxville Medical Center and 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 inpatient services at North Knoxville. A map of the service area is included as Attachment B.I.Project Description.4.

Need

Population in the service area is projected to grow 2.9% from 2012-2016, but during that same period, the population growth for those over 65 years old is expected to increase by 12.2%. By 2016, the population in the service area over 65 years of age is projected to be 15.8% of the total population, supporting a continued need for expanding health care services to support the aging population.

According to the most recent Standards and Criteria for Cardiac Catheterization Services, a need likely exists for new or additional cardiac catheterization services in a proposed service area if the average current utilization for all existing and approved providers is equal to or greater than 70% of capacity (i.e. 70% of 2000 cases) for the proposed service area. In North Knoxville's service area, there are eight existing providers, with a total average utilization of 86% of capacity. To see the utilization by each provider, see the chart in Attachment B.I.Project Description.5.

Project Cost

The estimated project cost is $4,377,421, including the application fee. This reflects the cost of construction and equipment. The room will be equipped with Phillips Allura Xpwe FD20 technology designed for both cardiac catheterization and peripheral vascular procedures. For the equipment quote, see Attachment B.I.Project Description.6.

Construction is required for the project in order to build out shell space that will house the dual cardiac catheterization/vascular lab and control room, as well as support areas, expanded waiting room, and additional pre-and post-operative space. The cost of construction has been estimated at $1,302,289. See Attachment B.I.Project Description.7 for a copy of the contractor's quote.

Funding and Financial Feasibility

No outside financing will be required to fund the project. The 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

The dual cardiac catheterization/vascular lab will be staffed as follows, in addition to general staffing such as Admitting, Pre-Op Nursing, Post-Op Nursing, and the staff on the nursing unit:

Physician	1.0 FTE
First Assist/Cardiovascular OR Technician	1.0 FTE
Cardiovascular Technician	2.0 FTE

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.

Construction will include finishing out shell space on the second floor of the existing hospital, near the operating room suites, to add one dual cardiac catheterization / vascular lab with a control room. Space for a second lab is available but will remain shelled until such time as demand indicates a need for a second lab. Support space will also be finished out, including two holding/recovery bays, as work area, supply room, viewing room for the Physicians, soiled holding area, and on-call rooms for the physicians. The existing family waiting area for the operating room suites will also be expanded in order to accommodate the dual lab patients' family members. Because this space is shell space and is not currently being utilized, no existing services will be relocated or disturbed during the construction process.

		The total cost of construction is $1,302,289. For supporting detail, see the architect's drawing and quote from Johnson and Galyon Construction, 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
Additional Waiting Area					2,636		2,636	$60.28		$60.28
Dual Lab					3,263		3,263	$300.31		$300.31
Prep/Recovery Expansion					1,855		1,855	$88.13		$88.13
B. Unit/Depart. GSF Sub-Total					7,754		7,754			
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF					7,754		7,754	$167.95		$167.95

	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** **<u>5. Cardiac Catheterization Services</u>** **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** Cardiac catheterization services were approved as part of the original Certificate of Need to build the hospital and provide inpatient services on the campus of what was then known as St. Mary's Medical Center North. Although approved by the Agency, St. Mary's and Mercy Health Partners elected not to initiate cardiac catheterization services while the hospital was still new and developing its service offerings. Over the past five years, the hospital has been growing in the volume and the complexity of services it offers to patients as well as building an expanded medical staff. Diagnostic cardiac catheterization and vascular surgery are logical next steps in terms of expanding the hospital's capabilities. Since Health Management purchased Mercy Health Partners and launched Tennova Healthcare, there has been an orderly, deliberate process of evaluating how each hospital can best serve the population in its service area, through the investment of capital and expansion of its service offerings to the local community. Tennova Healthcare is committed to offering as many services as possible close to home, only utilizing transfers to its tertiary medical hospital, Physicians Regional Medical Center, for services that are unsupportable in a smaller hospital.
	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.** The major medical equipment being proposed is the Philips Allura Xper LD20 system for cardiac catheterization/vascular surgery, for a total cost of $1,600,000 plus sales tax. The expected useful life of the equipment is ten (10) years. Because the lab will be a dual lab for both cardiac catheterization and vascular procedures, it will be equipped to handle the following clinical applications: • Left and/or right heart catheterization • Intravascular ultrasound • Endomyocardial biopsy • Abdominal angioplasty with runoff • Carotid, renal, and bilateral extremity studies The FDA has certified the equipment for the clinical uses proposed above. A copy of the FDA letter certifiying the equipment is attached as Attachment B.II.E.1.a.
			b.	**Provide current and proposed schedules of operations.** The proposed schedule of operations is to schedule vascular surgery one day per week and diagnostic cardiac catheterizations two days per week, starting at 7:00 a.m. each day of surgery. The schedule will be expanded as volumes increase with overall growth of the program.
		2.	**For mobile major medical equipment:**	
			a.	**List all sites that will be served;** Not applicable.
			b.	**Provide current and/or proposed schedule of operations;** Not applicable.
			c.	**Provide the lease or contract cost**

				Not applicable.
			d.	**Provide the fair market value of the equipment; and** Not applicable.
			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.** The equipment will be purchased. A quote from the equipment vendor is attached as Attachment B.II.3.
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.*** 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.** North Knoxville Medical Center 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 North Knoxville 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: *DO NOT SUBMIT BLUEPRINTS*. Simple line drawings should be**

	submitted and need not be drawn to scale. A floor plan of the proposed construction areas 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.** 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.** The Five Principles to Achieving Better Health in the State Health Plan are: • Healthy Lives • Access to Care • Economic Efficiencies • Quality of Care • Healthcare Workforce This application contributes to the Five Principles, most notably: • *Access to Care.* Two of the key areas identified in the State Health Plan as impacting access to care are economic access and

geographical access. Through both its broad charity care policy as well as full participation in all TennCare and Medicare programs, Tennova and North Knoxville Medical Center strive to ensure care is provided to patients regardless of income.

This application also addresses geographical access to care, or as the Health Plan says, "the distance one has to travel to receive comprehensive care." 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.

- *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 cardiac catheterization and vascular surgery services utilizing equipment that has been certified as clinically safe and effective for its intended uses. The project is patient-centered by ensuring convenient access for those who need more acute services closer to home. Care will be provided more timely to those patients who must now be transferred for cardiac care. 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. At North Knoxville Medical Center there is a strong commitment to providing services that are accessible to those patients living in rural, underserved areas.

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 Cardiac Catheterization Services, as outlined in the State Health Plan.

Standards and Criteria Regarding Certificate of Need Applications for All Cardiac Catheterization Services:

Applicants proposing to provide any type of cardiac catheterization services must meet the following minimum standards:

1. Compliance with Standards: The Division of Health Planning is working with stakeholders to develop a framework for greater accountability to these Standards and Criteria. Applicants should indicate

whether they intend to collaborate with the Division and other stakeholders on this matter.

The Applicant intends to fully cooperate with the Division and other stakeholders regarding compliance with standards.

2. Facility Accreditation: If the applicant is not required by law to be licensed by the Department of Health, the applicant should provide documentation that the facility is fully accredited or will pursue accreditation by the Joint Commission or another appropriate accrediting authority authority recognized by the Centers for Medicare and Medicaid Services (CMS).

The applicant is licensed by the Department of Health and the Joint Commission.

3. Emergency Transfer Plan: Applicants for cardiac catheterization services located in a facility without open heart surgery capability should provide a formalized written protocol for immediate and efficient transfer of patients to a nearby open heart surgical facility (within 60 minutes) that is reviewed/tested on a regular (quarterly) basis.

North Knoxville Medical Center does not have open heart surgery capabilities, but does have a transfer protocol to Physicians Regional Medical Center. Physicians Regional has one of the most experienced and respected open heart surgery programs in the region and is located eight (8) miles south of North Knoxville Medical Center, straight down I-75. The protocol for transfers from North Knoxville to Physicians Regional is attached as Attachment C.Need.A.3.

4. Quality Control and Monitoring: Applicants should document a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiency. In addition, the applicant should agree to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, which may be developed per Policy Recommendation 2.

Tennova Healthcare has a documented quality program that is comprehensive and includes constant monitoring of patient outcomes and patient safety, performance against national and regional benchmarks, and efficiency. A copy of Tennova's comprehensive quality program is attached, as Attachment C.Need.A.4.

The applicant will cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee.

5. Data Requirements: Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed

information.

The applicant will provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services. Tennova Healthcare already provides this data on its two other hospitals that offer cardiac catheterization services, and the data is provided from existing data reporting systems and processes.

6. Clinical and Physical Environment Guidelines: Applicants should agree to document ongoing compliance with the latest clinical guidelines of the American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards (ACC Guidelines). Where providers are not in compliance, they should maintain appropriate documentation stating the reasons for noncompliance and the steps the provider is taking to ensure quality. These guidelines include, but are not limited to, physical facility requirements, staffing, training, quality assurance, patient safety, screening patients for appropriate settings, and linkages with supporting emergency services.

The applicant will document ongoing compliance with the latest clinical guidelines outlined by the ACC. Tennova Healthcare's two other cardiac catheterization programs are in compliance with these standards, and the expertise of personnel already in the healthcare system will be utilized to ensure that this new program is compliant.

7. Staffing Recruitment and Retention: The applicant should generally describe how it intends to maintain an adequate staff to operate the proposed service, including, but not limited to, any plans to partner with an existing provider for training and staff sharing.

Tennova Healthcare's two other hospitals in metro Knoxville already provide cardiac catheterization services. Experienced staff from those two programs will be utilized to provide training and leadership for any newer staff hired for the cardiac catheterization/vascular lab. Knoxville has adequate resources of trained, qualified staff to support the services, and Tennova Healthcare has a robust and long-standing recruiting process with a demonstrated track record of hiring and retaining staff.

8. Definition of Need for New Services: A need likely exists for new or additional cardiac catheterization services in a proposed service area if the average current utilization for all existing and approved providers is equal to or greater than 70% of capacity (i.e. 70% of 2000 cases) for the proposed service area.

Within North Knoxville Medical Center's 11 county service area, there are eight hospitals providing cardiac catheterization services to adults; two of those hospitals are part of the Tennova system. The average utilization in 2011 by those eight hospitals is 86%. See the chart below:

Facility	# of Cath Labs	Total	Proc. Per Lab	% of Capacity
Tennova - Physicians Reg.	4	6,535	1,634	82%
Tennova - Turkey Creek	2	3,074	1,537	77%
Ft. Sanders Regional	4	4,572	1,143	57%
Parkwest	5	13,201	2,640	132%
Methodist of Oak Ridge	2	3,286	1,643	82%
Morristown Hamblen	2	3,687	1,844	92%
LeConte	1	484	484	24%
UTMC	4	6,669	1,667	83%
Totals with Ave. Utilization	**24**	**41,508**	**1,730**	**86%**

*Note - Adult patients only; no pediatric patients included.
Source - 2012 JAR

9. Proposed Service Areas with No Existing Services: In proposed service areas where no existing cardiac catheterization service exists, the applicant must show the data and methodology used to estimate the need and demand for the service. Projected need and demand will be measured for applicants proposing to provide services to residents of those areas as follows:

Need. The projected need for a service will be demonstrated through need-based epidemiological evidence of the incidence and prevalence of conditions for which diagnostic and/or therapeutic catheterization is appropriate within the proposed service area.

Demand. The projected demand for the service shall be determined by the following formula:

A. Multiply the age group-specific historical state utilization rate by the number of residents in each age category for each county included in the proposed service area to produce the projected demand for cardiac catheterization procedures for the entire proposed service area.

B. Add each age group's projected demand to determine the total

projected demand for cardiac catheterization procedures for the entire proposed service area.

Not applicable; the proposed service is in an area with existing service providers.

10. Access: 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;

North Knoxville Medical Center's service area encompasses designated medically underserved areas by the United States Health Resources and Services Administration, including areas of Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Scott and Union counties.

b. Who documents that the service area population experiences a prevalence, incidence and/or mortality from heart and cardiovascular diseases and other clinical conditions applicable to cardiac catheterization services that is substantially higher than the State of Tennessee average;

According to the Tennessee Department of Health Statistics, the average age-adjusted mortality rate from diseases of the heart was 317 deaths per 100,000 across Tennessee. The counties in North Knoxville's service area with higher average age-adjusted mortality rates from diseases of the heart are Claiborne, Cocke, Scott, Campbell, Union, and Sevier counties.

c. Who is a "safety net hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program; or

North Knoxville Medical Center is not designated as a safety net 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.

North Knoxville Medical Center already contracts with all TennCare MCO's and fully participates in the Medicare program.

Specific Standards and Criteria for the Provision of Diagnostic Cardiac Catheterization Services Only

If an applicant does not intend to provide therapeutic cardiac catheterization services, the HSDA should place a condition on the

resulting CON limiting the applicant to providing diagnostic cardiac catheterization services only. Applicants proposing to provide only diagnostic cardiac catheterization services should meet the following minimum standards:

11. Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 300 diagnostic cardiac catheterization cases per year by its third year of operation. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. If the applicant is proposing services in a rural area where the HSDA determines that access to diagnostic cardiac catheterization services has been limited, and if the applicant is pursuing a partnership with a tertiary facility to share and train staff, the Agency may determine that a minimum volume of 200 cases per year is acceptable. Only cases including diagnostic cardiac catheterization procedures as defined by these Standards and Criteria may count towards meeting this minimum volume standard.

Utilizing the age cohort-specific, population-based demand calculation outlined in standard number 9 above, the projected demand in 2013 from North Knoxville Medical Center's service area is 10,571 diagnostic cardiac catheterizations. To see the details of this calculation, see Attachment C.Need.A.11. North Knoxville's overall inpatient market share in the service area is 7.4%. If North Knoxville Medical Center simply handles its "share" of diagnostic cardiac catheterization volume, it should expect to perform 782 cardiac catheterizations in 2013, as well as the vascular cases that are expected (approximately 100 in the first year). If North Knoxville performed every diagnostic cardiac catheterization in the market for patients for whom it is the closest hospital offering the service, it would perform approximately 2,250 procedures (based on projected volumes from the Clinton side of Anderson county, Campbell, Claiborne, Scott and Union counties, and 10% of Knox county).

However, because cardiac catheterization will be a new service for the hospital, and referral patterns will take some time to develop, the applicant does not anticipate capturing its full market share of diagnostic cardiac catheterizations in the first and second years as the program is developing. In the first year, it is projected that about 35% of the standard market share will be performed, for an estimated 275 diagnostic cardiac catheterizations. By offering a quality service led by highly skilled and reputable physicians in a location that is easily accessible from those portions of the service area, North Knoxville Medical Center expects steady growth of the program over the first three years, until volumes are equivalent with the hospital's overall market share, or approximately 782 cardiac catheterizations per year. With the high quality of Cardiology support provided by East Tennessee Heart Consultants and the convenient location of North Knoxville Medical Center, the minimum standards are expected to be met in the second year of operation of the service.

12. High Risk/Unstable Patients: Such applicants should (a) delineate the steps, based on the ACC Guidelines, that will be taken to ensure that high-risk or unstable patients are not catheterized in the facility, and (b) certify

		that therapeutic cardiac catheterization services will not be performed in the facility unless and until the applicant has received the Certificate of Need approval to provide therapeutic cardiac catheterization services. Appropriate steps will be taken to ensure that high-risk or unstable patients are not catheterized in the facility, but rather are transferred to Physicians Regional Medical Center or Turkey Creek Medical Center for cardiac catheterization. The Applicant certifies that therapeutic cardiac catheterization services will not be performed unless and until Certificate of Need approval to provide therapeutic services is granted. ***13. Minimum Physician Requirements to Initiate a New Service: The initiation of a new diagnostic cardiac catheterization program should require at least one cardiologist who performed an average of 75 diagnostic cardiac catheterization procedures over the most recent five year period. All participating cardiologists in the proposed program should be board certified or board eligible in cardiology and any relevant cardiac subspecialties.*** Cardiology services at Tennova Healthcare's metro Knoxville facilities are provided by members of East Tennessee Heart Consultants, the region's most experienced and longest-standing cardiology practice. Each of the physicians who will be performing diagnostic cardiac catheterizations in the proposed lab is board certified in cardiology and has a fellowship in Invasive Cardiology. The credentialing requirements for cardiac catheterization privileges with Tennova Healthcare are attached as Attachment C.Need.A.13.

	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 North Knoxville Medical Center campus has been the growth of the campus as a comprehensive, full-service hospital. North Knoxville has been gradually expanding its service offering since opening the hospital in 2007. One of the key goals for expanding the hospital's services is to reduce transfers of more acute patients to other medical centers, thereby improving the quality of care as well as patient satisfaction and convenience. North Knoxville Medical Center is very easily accessible for any patients travelling south on I-75 from the most rural and underserved communities in the service area. Part of Tennova Healthcare's long-range plans for the hospital is for North Knoxville to provide more	

acute services for those patients for whom it is the closest and most accessible Knoxville hospital.

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 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 North Knoxville Medical Center draws approximately 94% of its inpatients.

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.

Between 2012 and 2016, the total service area population is expected to grow from 888,532 to 914,251. This is an increase of 2.9%. 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 12.4%. The increase in the number of people in the 65+ group exceeds the increase in all other age groups.

Demographic Variable/Geographic Area	Service Area Statistics
Total Population-2012	888,532
Total Population-2016	914,251
Total Population-% change	2.9%
Age 65+ Population-2012	128,686
Age 65+ Population-2016	144,647
Age 65+ Population-% change	12.4%
Age 65+ Population as % of Total (2012)	14.5%

Source: Tennessee Department of Health Statistics

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

						2010	2015
Race-Ethnicity	**2010**	**2015**	**Change**	**% Change**		**% of Total**	**% 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: US Census Bureau, 2010 Census

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

Unemployment Rate, June, 2012 (11 County)

	Unemployed Civilians	Unemployment Rate
Project Service Area	38,550	8.4%
State of Tennessee	275,600	8.8%
United States	13,400,000	8.6%

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 tables 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

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 eight providers of adult cardiac catheterization services in the service area. When all types of procedures are considered, those providers have a combined utilization of 86%. See table below:

Facility	# of Cath Labs	Total	Proc. Per Lab	% of Capacity
Tennova - Physicians Reg.	4	6,535	1,634	82%
Tennova - Turkey Creek	2	3,074	1,537	77%
Ft. Sanders Regional	4	4,572	1,143	57%
Parkwest	5	13,201	2,640	132%
Methodist of Oak Ridge	2	3,286	1,643	82%
Morristown Hamblen	2	3,687	1,844	92%
LeConte	1	484	484	24%
UTMC	4	6,669	1,667	83%
Totals with Ave. Utilization	**24**	**41,508**	**1,730**	**86%**

*Note - Adult patients only; no pediatric patients included.
Source - 2012 JAR

There are no approved, unimplemented projects initiating cardiac catheterization services in the service area.

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 North Knoxville Medical Center, there is no historical utilization data available, other than the number of patients being treated at North Knoxville who present to North Knoxville Medical Center's Emergency Department with cardiac symptoms who must be transferred for further care. Annually for the past two years 200-225 patients with cardiac symptoms who presented to North Knoxville Medical Center's ED had to be transferred, with 68% of those patients eventually requiring cardiac catheterization services. While some percentage of those patients would still need to be transferred for therapeutic services, records from Physicians Regional

	Medical Center indicate that approximately 50% of the original 200-225 patients could have been treated at North Knoxville if diagnostic cardiac catheterization services were available. In addition, when age cohort-specific population-based demand is calculated, the projected demand in 2013 from North Knoxville Medical Center's service area is 10,571 diagnostic cardiac catheterizations. To see the details of this calculation, see Attachment C.Need.6. North Knoxville's overall inpatient market share in the service area is 7.4%. If North Knoxville simply handles its "share" of diagnostic cardiac catheterization volume, it should expect to perform 782 cardiac catheterizations in 2013, as well as the vascular cases that are expected (approximately 100 in the first year). If North Knoxville Medical Center performed every diagnostic cardiac catheterization in the market for patients for whom it is the closest hospital offering the service, it would perform approximately 2,250 procedures (based on projected volumes from the Clinton side of Anderson county, Campbell, Claiborne, Scott and Union counties, and 10% of Knox county). However, because cardiac catheterization will be a new service for the hospital, and referral patterns will take some time to develop, the applicant does not anticipate capturing its full market share of diagnostic cardiac catheterizations for the first and second years as the program is developing. In the first year, it is projected that about 35% of the standard market share will be performed, for an estimated 275 diagnostic cardiac catheterizations. By offering a quality service led by highly skilled and reputable physicians in a location that is easily accessible from those portions of the service area, North Knoxville Medical Center expects steady growth of the program over the first three years, until volumes are equivalent with the hospital's overall market share, or approximately 782 cardiac catheterizations per year. With the high quality of Cardiology support provided by East Tennessee Heart Consultants and the convenient location of North Knoxville Medical Center, the minimum standards are expected to be met in the second year of operation of the service.

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 has been calculated and is included on the Project Costs Chart.
	•	**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. Not applicable.
	•	**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 equipment cost calculation. Construction costs include all costs to build out the dual lab, support areas, and additional waiting room space.
	•	**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.** Architectural drawings and the contractor's quote is attached as Attachment C.Economic Feasibility.I.

PROJECT COSTS CHART

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A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$35,000
	3.	Acquisition of Site	$0
	4.	Preparation of Site	$0
	5.	Construction Costs	$1,302,289
	6.	Contingency Fund	$50,000
	7.	Fixed Equipment (Not included in Construction Contract)	$1,728,000
	8.	Moveable Equipment (List all equipment over $50,000)	$1,252,305
	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)	$4,367,594

E.	CON Filing Fee	$9,827

F.	Total Estimated Project Cost (D+E)	$4,377,421

	TOTAL	$4,377,421

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. A letter from the CFO is attached as Attachment C.Economic Feasibility.2.
__	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 cost per square foot of construction for Hospital renovation projects, as provided by the Health Services and Development Agency is: 1st Quartile $125.84/sf Median $177.60/sf 3rd Quartile $273.69/sf This project's average cost per square foot is $167.95/sf, placing it between 1st Quartile and Median.	
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 procedure: $14,985 Average deduction from operating revenue: $12,260 Average net charge: $2,725

HISTORICAL DATA CHART

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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 (Admissions)	3,407	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

2012 NOV 14 PM 10 02

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

		Year 1	Year 2
A.	Utilization Data (Procedures – Cardiac Catheterizations)	285	306
B.	Revenue from Services to Patients		
	1. Inpatient Services	$1,157,064	$1,388,477
	2. Outpatient Services	$3,471,192	$4,165,430
	3. Emergency Services	0	0
	4. Other Operating Revenue (Specify)_____	0	0
	Gross Operating Revenue	**$4,628,256**	**$5,553,907**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$3,494,333	$4,193,200
	2. Provision for Charity Care	41,275	45,220
	3. Provisions for Bad Debt	61,912	67,830
	Total Deductions	**$3,597,520**	**$4,306,250**
NET OPERATING REVENUE		**$1,030,736**	**$1,247,657**
D.	Operating Expenses		
	1. Salaries and Wages	$ 55,012	$66,014
	2. Physician's Salaries and Wages	0	0
	3. Supplies	111,000	133,200
	4. Taxes	8,918	10,702
	5. Depreciation	432,742	432,742
	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	0	0
	Total Operating Expenses	**$607,672**	**$642,658**
E.	Other Revenue (Expenses) -- Net (Specify)_____	$0	$0
NET OPERATING INCOME (LOSS)		**$423,064**	**$604,999**
F.	Capital Expenditures		
	1. Retirement of Principal	$4,337,421	$0
	2. Interest	0	0

Total Capital Expenditures	**$4,337,421**	**$0**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**($3,914,357)**	**$604,999**

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**

*** Due to lack of accessibility with the former accounting system, comparable detail for the Other Expense category is not available for 2009 and 2010.**

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**Year 1**	**Year 2**
1.	$0	$0
2.		
3.		
4.		
5.		
6.		
7.		
Total Other Expenses	**$0**	**$0**

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 proposed charge schedule follows below. The same charge schedule will be used for North Knoxville Medical Center that is currently in place at Physicians Regional and Turkey Creek Medical Centers. There are no anticipated changes to the charge schedule as a result of implementing this project.

Charge Schedule - Diagnostic Cardiac Catheterization

CPT Code	DESCRIPTION	CHARGE
85347	ACT	$ 201.00
75625	AORTOGRAM ABDOMINAL	$ 5,202.35
75630	AORTOGRAM ABDOMINAL W/ RUNOFF	$ 5,202.35
75605	AORTOGRAM THORACIC SERIAL S&I	$ 5,202.35
92960	CARDIOVERSION ELECTIVE EXT T	$ 932.15
93455	CORONARY ART/GRFT ANGIO S&I	$ 9,174.25
93454	CORONARY ARTERY ANGIO S&I	$ 8,516.75
93463	DRUG ADMIN & HEMODYNAMIC MEAS	$ 803.75
93005	EKG	$ 242.25
G0278	ILIAC ANGIO W/ CARDIAC CATH	$ 1,714.00
93568	INJECT PULM ART HRT CATH	$ 1,714.00
36013	INTRO CATH MAIN PULMON ARTERY	$ 2,021.00
36010	INTRO CATH SUP/INF VENA CAVA	$ 1,950.00
96374	IV PUSH ONE/FIRST DRUG	$ 290.00
93459	L HRT ART/GRFT ANGIO	$ 11,112.75
93458	L HRT ARTERY/VENTRICLE ANGIO	$ 10,455.00
93622	LEFT VENTRICULAR RECORDING 02	$ 10,632.00
33010	PERICARDIOCENTESIS; INITIAL	$ 2,625.00
93457	R HRT AR/GRFT ANGIO	$ 16,099.25
93456	R HRT CORONARY ARTERY ANGIO	$ 15,441.75
93461	R&L HRT ART/VENT GRFT ANGIO	$ 11,950.00
93460	R&L HRT ART/VENTRICLE ANGIO	$ 11,249.50
93453	R&L HRT CATH W/ VENTRICLGRPHY	$ 9,638.25
75724	RENAL ANGIO BILAT	$ 2,937.75
G0275	RENAL ANGIO W/ CARDIAC CATH	$ 1,447.00
93451	RIGHT HEART CATH	$ 7,248.50
93503	SWAN GANZ INSERT	$ 2,680.00

The anticipated gross revenue in the first year of this project is $4,628,256. Net revenue is projected to be $1,030,736.

	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 $14,985, which is in keeping with Tennova's current charges for diagnostic cardiac catheterizations at Physicians Regional Medical Center and Turkey Creek Medical Center. Average net charges are projected to be $2,725. Charge information from other providers is not available.
7.	**Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.** Because volumes will start out slowly, regular hours for the dual lab will be focused on performing procedures 3 days per week in order to maximize cost-effectiveness. In addition, staff will be shared between Physicians Regional Medical Center's cardiac catheterization labs and the new lab at North Knoxville Medical Center.	
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 realize operating and cash flow profitability by the end of the first year of service and to achieve full payback of the capital invested in the fourth year. 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 and bad debt is projected at a combined 9% 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.** The alternatives to this proposal are to continue transferring patients who need cardiac services to other hospitals, thereby continuing to inconvenience patients and their families, particularly those travelling from the more rural portions of the service area. In partnership with East Tennessee Heart Consultants, Tennova is committed to providing the highest quality cardiac care in locations that are easily accessible to patients. For those patients who are patients of East Tennessee Heart Consultants who live in North Knoxville or north along the I-75 corridor, their only alternative at this point is to receive cardiac catheterization at Physicians Regional Medical Center. With its cardiac catheterization labs at 82% of capacity and the population in the service area both growing and aging, Tennova Healthcare and East Tennessee Heart Consultants believe it is necessary to provide a convenient 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 proposed construction utilizes shell space already under roof inside North Knoxville Medical Center, keeping the overall costs of construction relatively low. The plan to finish out the shelled space for a future second cardiac catheterization lab is the most cost-effective approach for that space, reducing the cost of future expansions.

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 Baptist Convalescent Center Brakebill Nursing Home East Tennessee Children's Hospital Claiborne County Nursing Home Hillcrest Medical Nursing Institute Holston Health and Rehabilitation Center Knoxville Convalescent Center Maynardville Community Medical Center Northhaven Health Care Center Regency Health Care Center Rockwood Health Care Center Serene Manor Medical Center Parkwest Surgery Center Vanderbilt University TN Division of Rehabilitation Services Knoxville Surgery Center Lafollette Medical Center Tennessee Nursing Services, Inc. Wellington Place of Kingston Athens Community Hospital Baptist Health Care Center Blount Memorial Hospital Briarcliff Health Care Center Claiborne County Hospital Farragut Healthcare Hillhaven Health Care Jellico Community Hospital LifeCare Center Morgan County Center for Health Care Peninsula Hospital Ridgeview Terrace of LifeCare Shannondale Nursing Home UT Medical Center – Knoxville Rural/Metro Ambulance Services Laughlin Memorial Hospital Takoma Adventist Hospital NHC, Fort Sanders of Knoxville Physicians Surgery Center 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 in North Knoxville's service area, particularly for patients from the more rural counties.

	The project should have little impact on the utilization rates of other providers in the service area of the project. Because North Knoxville Medical Center is a smaller suburban hospital, its market share of inpatients in the area is lower than the other hospitals in the area providing cardiac catheterization services. Minimum volumes required to approve the service can be achieved simply by North Knoxville beginning the service and then having incremental growth until it essentially maintains its current market share. The purpose of the project is to provide an alternative and convenient location for patients in the northern portion of the service center who are patients of East Tennessee Heart Consultants to receive cardiac catheterization services.
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 dual cardiac catheterization/vascular lab will be staffed as follows, in addition to general staffing such as Admitting, Pre-Op Nursing, Post-Op Nursing, and the staff on the nursing unit: Physician 1.0 FTE First Assist/Cardiovascular OR Technician 1.0 FTE Cardiovascular Technician 2.0 FTE Wage rates as compared to the prevailing wage as published by the Tennessee Department of Labor & Workforce Development are listed below: NKMC Rate / Prevailing Wage First Assist/OR Technician $20.95-31.95/hour $13.35-23.30/hour Cardiovascular Technicians $17.20-25.80/hour $15.50-18.10/hour There is not a corresponding role for the OR Technicians who will be working in the cardiac catheterization / vascular lab on the Tennessee Department of Labor & Workforce Development survey. The wage comparisons shown above are the closest match available.
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.** There are ample resources within Knox County for adequate professional staff, including experienced staff who will be shared with Tennova's other two metro Knoxville facilities.
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) Knox County Schools 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
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.

Copy of Advertisement

To TENNOVA HEALTH CARE

Advertising } NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

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 came HOLLY ROACH, who, being first duly sworn, according to law, says that he/she is a duly authorized representative of the Knoxville News-Sentinel, a Daily newspaper published at Knoxville, in said county and state, and that the advertisement of NOTICE (described above),

of which the annexed is a copy, was published in said paper on the following dates:

NOVEMBER 9, 2012,

and that the statement of account herewith is correct to the best of his/her knowledge and belief.

Subscribed and sworn to before me this 13th day of November, 2012

Karan Dixon

Notary Public. My Commission expires My Commission Expires: August 27, 2013

KARAN DIXON
STATE OF TENNESSEE NOTARY PUBLIC
BLOUNT COUNTY

2012 NOV 14 AM 10 02

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: Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – North Knoxville Medical Center, Hospital owned by: Metro Knoxville HMA Holdings, LLC, d/b/a Tennova Healthcare with an ownership type of Limited Liability Corporation and to be managed by: Metro Knoxville HMA Holdings, LLC, d/b/a Tennova Healthcare intends to file an application for a Certificate of Need for the initiation of diagnostic cardiac catheterization services, to be located on the Tennova Healthcare – North Knoxville Medical Center campus, 7565 Dannaher Drive, Powell, TN 37849. The project involves construction and equipping of shell space within the hospital to serve as a dual cardiac catheterization / vascular lab, support areas for the lab, expanded waiting room, and additional pre-operative and post-operative space. No inpatient beds are involved in this project. The anticipated total cost of the project is $4,377,421.

The anticipated date of filing the application is November 14, 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, Tennessee 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, 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.

PROJECT COMPLETION FORECAST CHART

2012 NOV 14 AM 10 03

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	15	03/2013
2. Construction documents approved by the Tennessee Department of Health	45	4/2013
3. Construction contract signed	60	5/2013
4. Building permit secured	75	5/2013
5. Site preparation completed	N/A	
6. Building construction commenced	90	6/2013
7. Construction 40% complete	160	8/2013
8. Construction 80% complete	230	10/2013
9. Construction 100% complete (approved for occupancy	250	11/2013
10. *Issuance of license		
11. *Initiation of service	280	12/2013
12. Final Architectural Certification of Payment	310	1/2014
13. Final Project Report Form (HF0055)	370	3/2014

*** 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.

AFFIDAVIT

2012 NOV 14 AM 10 03

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.

SVP Planning

SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of November (Month) 2012 (Year) a Notary Public in and for the County/State of Knox/Tennessee.

Susan E. England

NOTARY PUBLIC

My commission expires July 7 (Month/Day), 2015 (Year).

SUSAN E. ENGLAND
STATE TENNESSEE NOTARY PUBLIC
KNOX COUNTY

List of Attachments

2012 NOV 14 AM 10:03

Attachment A.4.a	Tennova Healthcare Organizational documents
Attachment A.4.b	Tennova Healthcare – North Knoxville Medical Center Approval (formerly St. Mary's Medical Center- North)
Attachment A.4.c	Corporate Organizational Chart
Attachment A.6	Tennova Healthcare – North Knoxville Medical Center Property Deed (formerly St. Mary's Medical Center – North)
Attachment A.9	Bed Complement Chart – Tennova Healthcare
Attachment B.I.Project Description.1	Equipment Profile
Attachment B.I.Project Description.2	Moveable Equipment List
Attachment B.I.Project Description.3	Corporate Organizational Chart
Attachment B.I.Project Description.4	Service Area Map
Attachment B.I.Project Description.5	2011 Cardiac Catheterization Utilization
Attachment B.I.Project Description.6	Equipment Quote
Attachment B.I.Project Description.7	Contractor's Quote
Attachment B.II.A	Contractor's Quote
Attachment B.II.E.1.a	FDA Certification
Attachment B.II.3	Equipment Quote
Attachment B.III.(A)	Plot Plan of Site
Attachment B.IV	Floor Plan
Attachment C.Need.A.3	Emergency Transfer Protocol
Attachment C.Need.A.4	Quality Plan
Attachment C.Need.A.11	Population-Based Demand Calculation
Attachment C.Need.A.13	Cardiology Credentialing Requirements
Attachment C.Need.3	Service Area Map
Attachment C.Need.6	Population-Based Demand Calculation
Attachment C.Economic Feasibility.1	Contractors' Quotes and Architect's Drawing
Attachment C.Economic Feasibility.2	CFO Letter
Attachment C.Economic Feasibility.10	Audited Financial Statements
Attachment C.Orderly Development.7.c	Hospital License
Attachment C.Orderly Development.7.d	Most Recent Survey Inspection Report

Attachment A.4.a

RECEIVED
STATE OF TENNESSEE
2011 JUN 10 PM 2:52
TRE HARGETT
SECRETARY OF STATE

40

5983.0364

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

ARTICLES OF ORGANIZATION
(LIMITED LIABILITY COMPANY)

(For use on or after 7/1/2006)

FILED

For Office Use Only

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

1. The name of the Limited Liability Company is: Metro Knoxville HMA, LLC

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

2. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is:
C T Corporation System
(Name)
800 S. Gay Street, Suite 2021 — Knoxville — TN 37929
(Street address) *(City)* *(State/Zip Code)*
Knox
(County)

3. The Limited Liability Company will be: *(NOTE: PLEASE MARK APPLICABLE BOX)*
☐ Member Managed ☒ Manager Managed ☐ Director Managed

4. Number of Members at the date of filing, if more than six (6): _____.

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

6. The complete address of the Limited Liability Company's principal executive office is:
5811 Pelican Bay Blvd, Suite 500 — Naples — FL 34108
(Street Address) *(City)* *(State/County/Zip Code)*

7. Period of Duration if not perpetual: _____

8. Other Provisions:

9. THIS COMPANY IS A NONPROFIT LIMITED LIABILITY COMPANY (Check if applicable) ☐

June 8, 2011
Signature Date

Timothy R. Parry
Signature

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

Timothy R. Parry
Name (printed or typed)

SS-4270 (Rev. 05/06) Filing Fee: $50 per member (minimum fee = $300, maximum fee = $3,000 RDA 2458

TN043 - 02/01/2000 C T System Online

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 06-15-2011

Employer Identification Number:
45-2535623

Form: SS-4

Number of this notice: CP 575 G

METRO KNOXVILLE HMA LLC
% KNOXVILLE HMA HOLDINGS LLC SOLE M
5811 PELICAN BAY BLVD STE 500
NAPLES, FL 34108

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 45-2535623. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

A limited liability company (LLC) may file Form 8832, *Entity Classification Election*, and elect to be classified as an association taxable as a corporation. If the LLC is eligible to be treated as a corporation that meets certain tests and it will be electing S corporation status, it must timely file Form 2553, *Election by a Small Business Corporation*. The LLC will be treated as a corporation as of the effective date of the S corporation election and does not need to file Form 8832.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.**

* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.

* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub. Thank you for your cooperation.

(IRS USE ONLY) 575G 06-15-2011 METR O 9999999999 SS-4

Keep this part for your records. CP 575 G (Rev. 7-2007)

Return this part with any correspondence so we may identify your account. Please correct any errors in your name or address.

CP 575 G

9999999999

Your Telephone Number
( ) -

Best Time to Call

DATE OF THIS NOTICE: 06-15-2011
EMPLOYER IDENTIFICATION NUMBER: 45-2535623
FORM: SS-4 NOBOD

INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

METRO KNOXVILLE HMA LLC
% KNOXVILLE HMA HOLDINGS LLC SOLE M
5811 PELICAN BAY BLVD STE 500
NAPLES, FL 34108

Attachment A.4.b

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 601
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
TELEPHONE (615) 741-7221
FAX 615-741-7051
www.tennessee.gov/health

July 19, 2007

DEBRA K. LONDON, PRESIDENT
ST. MARY'S MEDICAL CENTER
900 EAST OAK HILL AVENUE
KNOXVILLE, TN 37917

Facility Type: Hospital
License Number: 45

Dear MS. LONDON:

Occupancy approval is granted for ST. MARY'S MEDICAL CENTER-NORTH, A NEW FREESTANDING, 5 STORY, 225,523 SQ. FT., 72-BED-ACUTE CARE SATELLITE HOSPITAL CONSISTING OF 60 MEDICAL/SURGICAL BEDS AND 12 ICU BEDS; A SURGICAL SUITE WITH 4 OPERATING ROOMS AND 2 PROCEDURE ROOMS; EMERGENCY DEPARTMENT, IMAGING DEPARTMENT, NUCLEAR MEDICINE, DIETARY DEPARTMENT, LABORATORY, PHARMACY, WAREHOUSE AND OTHER ANCILLARY SPACES. THIS WILL REDUCE THE BED COUNT BY 72 BEDS FROM 473 TO 401 AT ST. MARY'S MEDICAL CENTER, 900 EAST OAK HILL AVENUE, KNOXVILLE, TN 37917. PHASE 1 OF 1. The certificate of need number is CN0404-032A. Project number 2005-07-18-01.

Please contact me if I can be of further assistance.

Sincerely,

Shirley Jones

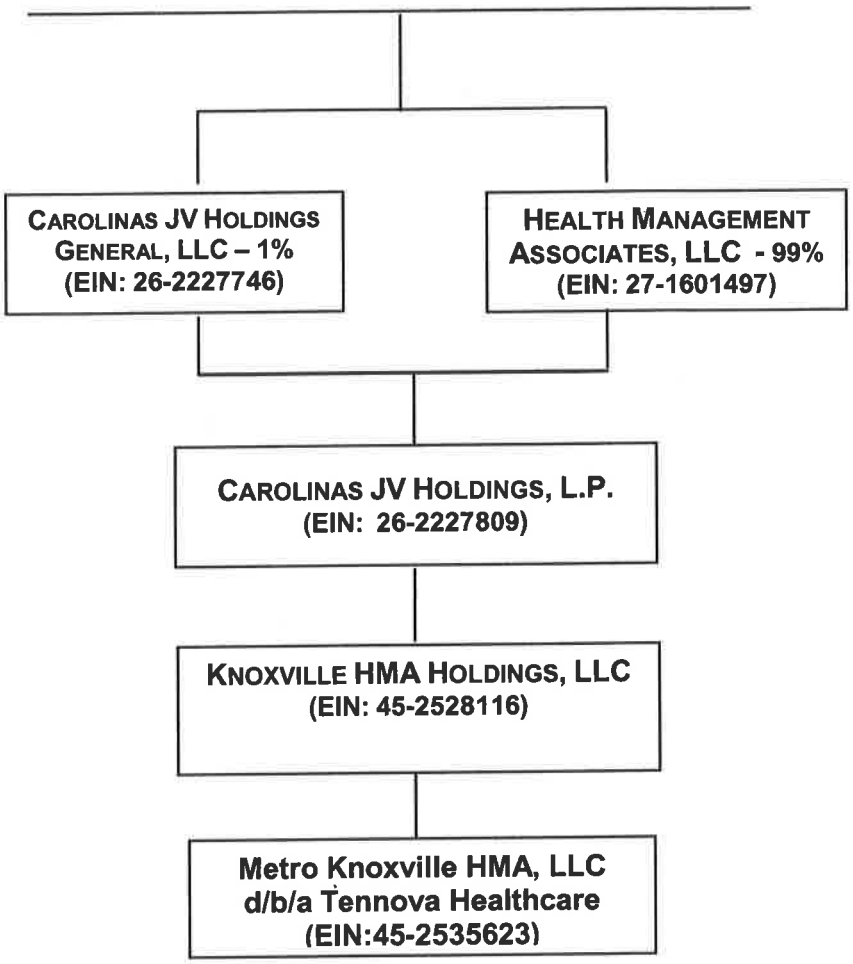
Shirley Jones
Health Care Facilities
Licensure Unit

cc: East Tennessee Regional Administrator
Health Services and Developmental Agency
Bill Harmon, Plans Review

Attachment A.4.c

METRO KNOXVILLE HMA, LLC

DIRECT AND INDIRECT OWNERSHIP



Attachment A.6

2

SHERRY WITT
REGISTER OF DEEDS
KNOX COUNTY

SPECIAL WARRANTY DEED

COUNTERSIGNED
KNOX COUNTY PROPERTY ASSESSOR

OCT 05 2011

BY PHIL BALLARD SC

This instrument was prepared by:
Eric Haselbauer, Esq.
Harter Secrest & Emery LLP
1600 Bausch & Lomb Place
Rochester, New York 14604
11M80845

Address of New Owner as follows:	Send Tax Bill to:	Tax/Parcel Numbers:
Metro Knoxville HMA, LLC 5811 Pelican Bay Blvd., Suite 500 Naples, FL 34108	Property Valuation Services 14400 Metcalf Avenue Overland Park, KS 66223	047-085.01, 047-085.02, 047-085.03, 047-085.04, 047-058.05, 85.05 m SC 047-033.23, 047-033.24 & 047-033.25

STATE OF OHIO

COUNTY OF HAMILTON

The undersigned Affiant affirms that to the best of Affiant's knowledge, information and belief, the actual consideration for the transfer or value of the property transferred, whichever is greater, is $65,600,000, which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

Metro Knoxville HMA, LLC
Affiant/Grantee

By: Timothy R. Parry

Subscribed and sworn to before me this 29th day of September, 2011.

Notary Public

My Commission expires: [illegible] NOTARY PUBLIC • STATE OF OHIO [illegible]

NOTARIAL SEAL STATE OF OHIO

Knox County Page: 1 of 5
REC'D FOR REC 10/05/2011 11:16:46AM
RECORD FEE: $28.00
M. TAX: $0.00 T. TAX: $242,720.00
201110050018470

1150304_2

SPECIAL WARRANTY DEED

Mercy Health System, Inc., a Tennessee non-profit, public benefit corporation, successor by name change to St. Mary's Health System, Inc. ("Grantor"), for valuable consideration paid, has bargained and sold, and by these presents does bargain, sell, grant and convey to **Metro Knoxville HMA, LLC**, a Tennessee limited liability company, whose tax mailing address is identified above ("Grantee"), the real estate described on Exhibit A attached hereto and made a part hereof (the "Property").

Source of Grantor's interest is also described on Exhibit A.

The Property includes improved and unimproved parcels with the following addresses: 7551, 7540, 7541, 7561 & 7557 Dannaher Dr., Emory Road and lots on Dannaher Place, Knoxville, Tennessee.

Grantor covenants with respect to the foregoing conveyance that Grantor (a) is lawfully seized and possessed of the Property, (b) has full power and lawful authority to sell and convey the same, and (c) will forever warrant and defend the title against the lawful claims of all persons claiming by, through or under Grantor but not further nor otherwise. Grantor further covenants that the Property is free and clear of all liens and encumbrances, except liens for real property taxes and assessments due and payable in 2011 and thereafter, which Grantee assumes and agrees to pay. This conveyance is made subject to all (i) easements and restrictions of record, (ii) legal highways and (iii) governmental laws, ordinances and regulations affecting the Property.

TO HAVE AND TO HOLD the said Property, together with all rights and appurtenances thereunto belonging or in any wise appertaining to Grantor, its successors and assigns, forever in fee simple.

(signature page follows)

IN WITNESS WHEREOF, Grantor has caused this Special Warranty Deed to be executed this 29th day of September, 2011.

Mercy Health System, Inc.
By: Mercy Health Partners, Inc., its sole member

By: _____
Print Name: Jeff Ashin
Title: President

STATE OF OHIO)
) SS:
COUNTY OF HAMILTON)

Before me, E. RICHARD OBERSCHMIDT the undersigned, Notary Public in and for the County and State aforesaid, personally appeared Jeff Ashin, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged himself to be President of Mercy Health Partners, Inc., sole member of Mercy Health System, Inc., the within named Grantor, a Tennessee non-profit, public benefit corporation, and that he as such President of the sole member, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as President of the sole member.

Witness my hand and seal, at office in Cincinnati, Ohio this the 29th day of September, 2011.

_____
Notary Public

My commission expires: E. RICHARD OBERSCHMIDT, Attorney at Law
NOTARY PUBLIC - STATE OF OHIO
My Commission has no expiration
Date. Section 147.03 R.C.

Page: 3 OF 5
201110050018470

1150304_2 (1477)

NBU No. **81101477**
Order No. **11M80845**
Mercy Medical Center North – Owner's

LEGAL DESCRIPTION

Exhibit A

TRACT I
SITUATED in the Sixth (6th) Civil District of Knox County, Tennessee, without the corporate limits of the City of Knoxville, Tennessee, and being all of Lots 1R-1R1, 1R-1R2, 1R-1R3, 1R-1R4 and 1R-1R5 of the Resubdivision of Lot 1R-1 of the St Mary's Health System S/D and Lot 5 of the Final Plat of Dannaher Place = Unit 1 and Resubdivision of Lots 1, 2, 3 and 4 of the Final Plat of Dannaher Place = Unit 2, dated April 26, 2010, last revised June 1, 2010, filed for record as Instrument No. 201007150002987 (consisting of five (5) sheets) in the Knox County Register of Deeds Office, to which plat specific reference is hereby made for a more particular description of said lots.

~~LESS AND EXCEPT all buildings, improvements, fixtures, structures, pavement and other~~ facilities or structures for parking and landscaping, as conveyed to St. ~~Mary's Health~~ and Wellness Center, LLC, by that certain Quit-Claim Deed from St. ~~Mary's Health~~ System, Inc. dated December 20, 1999, filed for record as Instrument ~~No. 199912300048538~~, for and during the term of that certain lease between St. ~~Mary's Health~~ System, Inc., Lessor, and St. Mary's Health and Wellness Center, ~~LLC, Lessee~~, dated November 1, 1999, as evidenced by Memorandum of Lease filed for ~~record as Instrument No. 199912300048537.~~

BEING a portion of the same property conveyed to St. Mary's Health System, Inc., by Warranty Deed from Sam Furrow, dated January 27, 1993, filed for record in Warranty Book 2095, page 1038 in the Knox County Register of Deeds Office. ALSO BEING a portion of the same property conveyed to St. Mary's Health System, Inc., by Warranty Deed from Franklin Eugene Watkins and wife, Rose Kathryn Watkins, dated February 5, 2003, filed for record as Instrument No. 200302060069420 in the Knox County Register of Deeds Office. ALSO BEING the property conveyed by Quit Claim Deed from Knox County, Tennessee, to St. Mary's Health System, Inc., dated September 22, 2004, filed for record as Instrument No. 200409230025344 in the Knox County Register of Deeds Office. St. Mary's Health System, Inc. changed its name to Mercy Health System, Inc., pursuant to Articles of Amendment to the Charter (Nonprofit) dated December 18, 2009, filed for record as Instrument No. 200912290043594 in the Knox County Register of Deeds Office. ALSO BEING a portion of the same property conveyed to Mercy Health System, Inc., by Warranty Deed from Birdie Hawkins and the Birdie Lee Hawkins Charitable Remainder Unitrust, Steven A. Albright and Birdie Lee Hawkins, Co-Trustees, dated February 1, 2010, filed for record as Instrument No. 201002030050794 in the Knox County Register of Deeds Office.

TRACT II
SITUATED in the Sixth (6th) Civil District of Knox County, Tennessee, without the corporate limits of the City of Knoxville, Tennessee, and being all of Lots 5R1, 5R2 and 5R3 of the Resubdivision of Lot 1R-1 of the St Mary's Health System S/D and Lot 5 of the Final Flat of Dannaher Place = Unit 1 and Resubdivision of Lots 1, 2, 3 and 4 of the Final Plat of Dannaher Place = Unit 2, dated April 26, 2010, last revised June 1, 2010, filed for record as Instrument No. 201007150002987 (consisting of five (5) sheets) in the Knox

County Register of Deeds Office, to which plat specific reference is hereby made for a more particular description of said lots.

BEING a portion of the same property conveyed to Mercy Health System, Inc., by Warranty Deed from Birdie Hawkins and the Birdie Lee Hawkins Charitable Remainder Unitrust, Steven A. Albright and Birdie Lee Hawkins, Co-Trustees, dated February 1, 2010, filed for record as Instrument No. 201002030050794 in the Knox County Register of Deeds Office.

BEING the same property conveyed to Metro Knoxville HMA, LLC, a Tennessee limited liability company, by Special Warranty Deed from Mercy Health System, Inc., a Tennessee non-profit, public benefit corporation, dated September ____, 2011, filed for record as Instrument No. 201110050018470 in the Knox County Register of Deeds Office.

1186518_1

SHERRY WITT

KNOX County Register of Deeds

CUSTOMER RECEIPT - RECORDING SERVICES

Receipt Number: **T20110054176**
Date/Time: 10/05/2011 11:16:46
Method Received: Walk-In
Clerk: SandyM

Customer Name : EAST TENNESSEE TITLE

PICK UP

Transaction Detail

Instrument Number	Instrument Type	Gen. Fee	Equip. Fee	Transfer Tax	Mortgage Tax	Copy	Cert. Copy	Total Copy Fee	# Pgs	Consideration	Subtotal
201110050018470	WD	$26.00	$2.00	42,720.00	$0.00	N	N	$0.00	5	$65,600,000.00	$242,748.00

First Party Name	Second Party Name
MERCY HEALTH SYSTEM INC	METRO KNOXVILLE HMA LLC

Payment Information

Method of Payment	Payment Control ID	Authorized Agent	Amount
Check	004610		$1,353,841.21

AMOUNT PAID:	**$1,353,841.21**
LESS AMOUNT DUE:	$1,353,841.21
CHANGE RECEIVED:	**$0.00**

Knox County Register of Deeds * 400 Main Street * Suite 225 * Knoxville, TN 37902

Attachment A.9

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 (Med/Surg)	716		382		716
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical	48		32		48
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 *CON-Beds approved but not yet in service	903		553		903

Attachment B.I.Project Description.1

PHILIPS HEALTHCARE
A division of Philips Electronics North America Corporation
22100 Bothell Everett Highway
P.O. Box 3003
Bothell, Washington 98041-3003

PHILIPS

Quotation #: 1-X4CT9T	**Rev:** 1	**Effective From:** 08-Nov-12	**To:** 23-Dec-12

Presented To:
NORTH KNOXVILLE MEDICAL CENTER
7565 DANNAHER WAY
POWELL, TN 37849

ROB FOLLOWELL
CHIEF EXECUTIVE OFFICER
Tel:

Alternate Address:

Presented By:
Steve Wohlford
Account Manager
Tel: (865) 977-5012
Fax: (509) 696-2411

Steve Weiss
Regional Manager
Tel: (678) 924-6087
Fax: (678) 924-6003

Date Printed: 08-Nov-12

Submit Orders To:
22100 BOTHELL EVERETT HWY
BOTHELL WA 98021
Tel: (888) 564-8643
Fax:(425) 458-0390

This quotation contains confidential and proprietary information of Philips Healthcare, a division of Philips Electronics North America Corporation ("Philips") and is intended for use only by the customer whose name appears on this quotation. It may not be disclosed to third parties without the prior written consent of Philips.

IMPORTANT NOTICE: Health care providers are reminded that if the transactions herein include or involve a loan or discount (including a rebate or other price reduction), they must fully and accurately report such loan or discount on cost reports or other applicable reports or claims for payment submitted under any federal or state health care program, including but not limited to Medicare and Medicaid, such as may be required by state or federal law, including but not limited to 42 CFR 1001.952(h).

Quote Solution Summary

Line #	Product	Qty	Price
	100215 Allura Xper FD20	1	$1,600,000.00
		Equipment Total:	$1,600,000.00

Solution Summary Detail

Product	Qty	Each	Monthly	Price
100215 Allura Xper FD20	1	$1,600,000.00		$1,600,000.00

Buying Group: **HEALTHTRUST PURCHASING GROUP** **Contract #:** **500005**

Addt'l Terms:

Each Quotation solution will reference a specific Buying Group/Contract Number representing an agreement containing discounts, fees and any specific terms and conditions which will apply to that single quoted solution. If no Buying Group/Contract Number is shown, Philips' Terms and Conditions of Sale will apply to the quoted solution.

Each equipment system listed on purchase order/orders represents a separate and distinct financial transaction. We understand and agree that each transaction is to be individually billed and paid.

Payment Terms: 0% Down, 80% Upon Delivery, 20% Due When the Product is Available for First Patient Use, Net due 30 days from date of invoice

100215 Allura Xper FD20

System Type: New
Freight Terms: FOB Destination
Warranty Terms: Part numbers beginning with two (2) asterisks (**) are covered by a System 12 Months Warranty. All other part numbers are third (3rd) party items.
Special Notations: Contingencies must be removed 120 days before scheduled shipment to assure delivery on specified date. Any rigging costs are the responsibility of the Purchaser.
Additional Terms:

Line #	Part #	Description	Qty
1	**NNAE311	Allura Xper FD20 C Rel. 8.1	1

Allura Xper FD20 monoplane system is a state of art X-ray imaging system that can be customized to support a wide range of applications including peripheral, abdominal, cerebral, thoracic, cardiac and non-vascular interventional and diagnostic procedures.

The Allura Xper FD20 system uses an integrated single-host concept. The system is comprised of five functional building blocks: Geometry, X-ray Generation, User Interface, Image Detection, and Viewing. Each functional building block is explained in further detail.

GEOMETRY

The Allura Xper FD20 Stand

The Allura stand consists of a ceiling-mounted C-arm. The stand has the following capability:

- The L-arm can be rotated and can be moved in longitudinal direction allowing a three-sided patient approach and total body coverage.
- L-arm rotation around the patient table: +90, 0, -90 degrees.
- L-arm longitudinal movement: 300 cm
- This movement features auto-stops at the parking position, cardio/neuro position and lower peripheral position.

The Allura stand allows a very wide range of projections, including PA and AP imaging.

- In the head position (0 degrees position, L-arm parallel to patient table):
  - C-arm rotation range (degrees): 120 LAO to 185 RAO
  - C-arm angulation range (degrees): 90 CA to 90 CR
  - (Full angulation capability determined by patient position)
- In the side position (+90 / -90 degrees position, L-arm perpendicular to patient table):
  - C-arm rotation range (degrees): 90 LAO to 90 RAO
  - C-arm angulation range (degrees): 185 CA to 120 CR or 120 CA to 185 CR
  - (Full angulation capability determined by patient position)
- The stand provides fully motorized fast movements with variable and configurable maximum speed.
  - Variable C-arm rotation speed, up to 25 degrees per second
  - Variable C-arm angulation speed, up to 18 degrees per second
- L-arm rotation and longitudinal movement: motorized and manual
- C-arm depth is 90 cm
- The FD20 Dynamic Flat Detector features Xper Access which allows the flat detector to be positioned in either portrait or landscape imaging modes in 3 seconds.
- The variable source image distance between focus and Dynamic Flat Detector input screen is motorized from 86.5 to 123 cm.

- The stand features BodyGuard a capacitive sensing collision avoidance system for patient protection.

Patient support

The Xper Table
Patient support with flat carbon fiber tabletop

- Table top length of 319 cm, width 50 cm
- Metal-free overhang 125 cm
- Floating table-top movement of 120 cm longitudinal and 35 cm transversal range.
- Motorized height adjustment from 79 to 107 cm
- Maximum cantilever of 223 cm , for full patient coverage
- Maximum patient weight 250 kg with 25 kg of accessories plus 500 N for CPR in any longitudinal position of the table top
- Xper Geometry and Imaging Modules for exam room controls.
  - The operating modules can be attached to either side of the table.

Patient Support Accessories set

- One cerebral filter
- Three rail accessory clamps
- One IV stand
- One slow recovery foam mattress
- One Set of Arm Supports (FCV0248)
- One Set of Patient Straps (FCV0250)
- One Head Support (FCV0251)
- One Arm Support (FCV0258)
- One Table-mounted Radiation Shield
- One anti-fatigue mat with Philips logo

X-ray Generation

The Allura Xper FD20 comprises an integrated dedicated X-ray system, micro-processor controlled Velara CFD generator based on high frequency converter technique. The user interface control of this X-ray Generator is incorporated in the Xper module, Xper Desktop Viewing Console, and the Xper on-screen displays. The Velara CFD generator comprises:

- X-ray generator 100 kW
- Voltage range is 40 - 125 kV
- Maximum current 1250 mA at 80 kV
- Program selection
  - Pulsed X-ray for pulsed fluoroscopy; 3.75, 7,5, 15 and 30 frames/s
  - Pulsed X-ray for (subtracted) acquisition up to 6 frames/s for vascular applications
  - Minimum exposure time of 1 ms
  - Automatic kV and mA control for optimal image quality prior to run to save dose
  - An X-ray depth collimator with two semi-transparent wedged filters with manual and automatic positioning

- SpectraBeam filtering of low energy radiation to optimize image quality and dose efficiency with MRC-GS 0407 X-ray tube.
- Grid switching at dynamic pulsed fluoroscopy
- Xper Beam Shaping, positioning of both shutters and wedges on the Last image Hold without the need for X-ray radiation

Fluoroscopy

- Three programmable fluoroscopy modes
  - Each mode can be set to different composition of dose rate, pulse speed, filter setting, and image processing (noise reduction, adaptive contour enhancement, and adaptive harmonization).
- Roadmap Pro
  - Roadmap Pro can be selected from the Xper imaging module and/or Xper module.
  - A vessel map is created and superimposed with (un)subtracted live fluoroscopy. Acquisition runs can be done during Roadmap without losing the vessel map. Roadmap Pro features Smart Settings in special clinical modes that are optimized to visualize special materials such as coils and glue. Live processing of the vessel map, the device map and the landmark map can be done on the Xper Module. Xres for vascular procedures is standard part of Roadmap Pro.
    - **Disclaimer:** AMC only corrects movement artifacts in two dimensions. Three dimensional movements such as swallowing or rotation of the head cannot be corrected.
  - In Roadmap Pro R2 "Automatic Motion Compensation" (AMC) is added to the roadmap functionality. During roadmap, small movements of the patient can lead to subtraction artifacts. These artifacts might conceal important clinical information. "Automatic Motion Compensation" compensates for rigid, uniform (skeletal/table) translations and is therefore very effective in interventional (neurology) applications where subtraction imaging is applied.

§ Disclaimer: AMC only corrects movement artifacts in 2 dimensions. 3 dimensional movements like swallowing or rotation of the head cannot be corrected.

- Xper Fluoro Storage, a grab function allows storage and archiving of both a fluoro image and the last 20 seconds of Fluoroscopy, called Xper Fluoro Storage. These fluoro images or fluoro runs can be archived as a regular exposure run.

X-ray tube

The Allura Xper FD20 has the Maximus ROTALIX Ceramic grid switch tube assembly MRC 200 GS 0407 integrated in the C-arc. This MRC tube has an anode heat storage capacity of 2.4 MHU and 0.4/0.7 mm. nominal focal spot values. The tube has a maximal loading of 30 and 67 kW.

Dynamic pulsed fluoroscopy uses grid switching technology to eliminate soft radiation and improve image quality. SpectraBeam allows for filtration of the x-ray beam with (a combination of) 0.2, 0.5 or 1 mm CU-equivalent filters.

Tube housing ROT-GS 1004 is for oil-cooling and has a build-in thermal safety switch. A rotor control unit is build-in for continuous rotation of the anode disk. The heat exchanger CU 3101 is for direct and continuous forced cooling with oil.

IMAGE DETECTION

The Allura Xper FD20 comprises the following image detection chain:

- A 30 cm by 40 cm FD20 Dynamic Flat Detector with eight imaging modes.
  - 30 x 38, 30 x 30, 26 x 26, 22 x 22, 19 x 19, 16 x 16, 13.5 x 13.5, and 11 x 11 cm
- The digital output of the FD20 flat detector is 2k*2.5k image matrix at 14 bits depth for the largest mode
- The flat detector subsystem features Xper Access, the detector can be rotated over 90 degrees, it moves from portrait to landscape back & forth
- DQE (Detective Quantum Efficiency) >73 %
- The pixel pitch: 154 x 154 microns

Viewing

The Allura Xper FD20 comprises the following components in order to display the clinical images in the control and examination room:

Displays

Examination Room

Two 18-inch monochrome LCD monitors designed for medical applications. The first display is used for viewing live images. The second display is the reference monitor.

- 18-inch monochrome TFT-LCD display with a 160 degree viewing angle.
- Native format 1280x1024 SXGA
- 10-bit gray-scale resolution with gray-scale correction

These monitors are not delivered when FlexVision XL, EP Cockpit or EP Cockpit XL is selected.

The monitor ceiling suspension in the exam room can be configured to accommodate 3, 4, 6 or 8 LCD monitors and includes motorized height adjustment. The height-adjust feature is dependent on the room ceiling height. When FlexVision XL, EP Cockpit or EP Cockpit XL is selected the monitor ceiling suspension is configured for one of those options.

- Of the two medical monochrome LCD monitors included in the MCS, one is used for viewing of live images and the other serves as the first reference display. Reference images or runs are controlled by infra-red remote-control Xper ViewPad.
- The On-Screen Display provides status information on stand rotation, angulation, display of system messages, X-ray tube load status, selected fluoroscopy mode, selected detector Field of View, and both the rate and accumulation of the dose area product and skin dose. For cardiac applications, the system also monitors and displays body zone specific Air Kerma data (10 zones).

Control Room

One 19-inch color LCD monitor used as a data monitor.

- 19-inch color TFT-LCD display
- Native format 1280x1024 SXGA

One 18-inch monochrome LCD monitor (Xper review monitor) designed for medical applications.

- 18-inch monochrome TFT-LCD display

- Native format 1280x1024 SXGA
- 10-bit gray-scale resolution with gray-scale correction

These control room monitors are not delivered when EP Cockpit or EP Cockpit XL is selected.

The Graphical User Interface on the monochrome monitor has the following features and functions:

- Step through file, run, or images
- File, and run overview
- Contrast, brightness, and edge enhancement settings
- Flagging of runs or images for transfer
- Applying text annotation in images
- Optional DICOM printing
- Executing Quantitative Analysis Packages if available
- Subtraction functionality
- Zoom/pan functionality
- Electronic shutters
- Video invert
- View trace, stacking of images
- Landmarking

Acquisition

The acquisition segment coordinates the parameters for automatic exposure control. The program is selected via the Xper module or Xper Desktop Console.

Exposure techniques:

- Serial imaging for DA and DSA with automatic exposure setting
- Single shot mode
- Acquisition frame rates: 0.5 to 6 images/s at 2048 x 2048, 12-bit matrix

The Allura Xper FD20 offers a storage capacity of:

- 50,000 images at matrix size of 1024 x 1024
- 12,500 images at matrix size of 2048 x 2048
- Maximum number of examinations is 999, with no limit to the maximum number of images per examination

USER INTERFACE

Xper is comprised of three elements: 1) Xper Settings, which customizes the system to each user preferred settings. 2) Xper User Interface 3) Xper Integration, which makes advanced integration functionality available such as DICOM Query / Retrieve, background archiving, and Xper Fluoro Storage.

The Xper User Interface uses User Interface modules in the Examination Room with On-Screen Display.

The On-Screen Display is positioned on the left side of the reference monitor. The following system information is displayed

- X-ray indicator and X-ray tube temperature condition

- Gantry position in rotation, angulation, and Source Image Distance
- Detector field size display
- General System messages
- Selected Frame speed
- Fluoroscopy mode
- Integrated fluoroscopy time
- Skin Dose and Dose Area Product
- Stopwatch

The Xper ViewPad contains the preprogrammed function settings. The system is provides with two Xper Viewpads. The following functions are provided:

- Run and image selection
- File and run cycle
- File overview
- Store to Reference image file
- Copy image to photo file
- Digital (fixed) zoom and panning
- Recall reference images
- Laser pointer, intended to point at regions of interest on the imaging monitors
  - LED indication of laser pointer on/off and battery low
- Subtraction on/off
- Remasking
- Landmarking

Remote Intercom

The separate intercom which is connected independently from the system that allows separate placement of the intercom at the preferred working position in the control room and examination room.

Table Side Modules

Two Xper Modules are provided for use. The first Xper Module is mounted tableside. The Second Xper Module (NCVA778) is located in the control room. These modules use a touch screen, which can be operated when draped with sterile covers. The Xper Module contains the following functionality:

- Acquisition settings
- Selection of Xper Setting allows the user to set frame rates and X-ray generation settings applicable for the type of the preferred intervention
- Image Processing

The Xper Geometry module can be positioned on all sides of the patient table, while keeping the button operation intuitive. The Xper Geometry module provides the following functionality:

- Tabletop float and table height position
- Source Image Distance selection
- Longitudinal movement of the Gantry along the ceiling
- Gantry rotation in an axis perpendicular to the ceiling

- Store and recall of two scratch gantry positions including SID
- Emergency stop button

The Xper Imaging module can also be positioned on three sides of the patient table, while keeping the button operation intuitive. The Xper Imaging module provides the following functionality:

- Fluoroscopy Flavor selection defined per Xper Setting
- Shutters and Wedge positioning
- Xper Fluoro Storage and Grab
- Selection of the Detector field size
- Shutter positioning
- Reset of the fluoroscopy buzzer

Pan Handle (NCVA081)

- The Pan Handle is an extension of the control facility for floating movementsof the ta bletop.

Control Room

The control room comprises a Xper Review Module, Xper Desktop Module, a keyboard, and a mouse. The Xper Review Module offers the basic functions for review. The Xper Review Module contains the following functionality:

- Power on/off
- Tagarno wheel to control the review of a patient file
- File and run cycle
- Contrast, Brightness, and Edge enhancement settings
- File, Run, Image stepping and run and file overview
- Delete run
- Image invert and digital zoom
- Reset fluoroscopy timer and enable/disable X-ray

System information is displayed on the bottom of the data monitor:

- Stopwatch and Time
- System guidance information
- Dose Area Product (DAP) and Skin Dose, and accumulative dose
- Frame speed settings, fluoroscopy mode, and accumulated fluoroscopy time
- Exposure and fluoroscopy settings as Voltage (kV), Current (mA) and pulse time (ms)
- Geometry information as rotation, angulation, and SID

Scheduling

The patients can be listed and selected per date, physician, and intervention type. Previous DICOM patient studies can be uploaded with the DICOM Query Retrieve function in the Allura system.

Patient management protocols are flexible and allow for multiple studies to be selected under one patient identification number. This means that new studies can be appended to an earlier patient file. Furthermore, each study can contain multiple examinations to allow for split administrative purposes. Each examination contains multiple files, like acquisition file, reference file, and QA results file.

Preparation

The preparation page provides the information of the room and patient preparation of each individual physician. The preparation page is customizable per Xper Setting and allows each physician to provide his own room protocols. This preparation page makes hard copies of the protocol instructions redundant.

Acquisition

The acquisition page contains information on the current selected patient.

Review

The review page allows for reviewing of patients:

- Previous examination cases
- Review of other DICOM XA or DICOM SC studies

Radiation Dose Structured Report

Collection of dose relevant parameters and settings and export to a DICOM database (e.g. PACS, RIS), according IEC60601-2-43, 2nd Edition.

The reported data can be used for, for example:

- Quality improvement: evaluating trends in X-ray dose performance per facility, system and operator.
- RDSR enables analysis of average dose levels & variance for routinely performed exams and procedures.
- Typical system usage can be extracted from the data.

Archive

Continuous Autopush (NCVA090)

Continuous Autopush is an archive accelerator, which ensures that background archiving continues with minimal disruptions.

Clinical studies can be archived to a CD or a PACS. The archive process can be completely automated and customized with Xper Settings. Parameters like multiple destinations, archive formats can be selected to the individual needs and wishes for programming under the Xper Settings,

The Xper DICOM Image Interface enables the export of clinical images to PACS. The export formats are based on DICOM 3.0 protocols. The system exports clinical studies in Cardiac DICOM XA Multi-Frame or DICOM Secondary Capture formats.

Line #	Part #	Description	Qty

- The export format is configurable in 512x512, 1024x1024 2048 x 2048 (unprocessed) matrix.
- The examination can be sent to multiple destinations for archiving and reviewing purposes.
- The Xper DICOM Image Interface provides DICOM Storage and DICOM Storage Commitment Services.
- The DICOM Query/Retrieve function allows older DICOM XA MF and DICOM SC studies to be uploaded in the system. Furthermore, additional information can be appended to a study, while keeping the patient identification the same.

Remote Service

Access to the system from a Remote location is possible via network or modem connection. Remote access to a system can shorten the time needed for e.g. changing system settings or problem diagnosis.

Clinical Education Program for the Allura Xper System

Essentials OffSite Education: Philips will provide up to two (2) Cardiovascular Technologists, Registered Technologists Registered Nurses, or other system operator as selected by customer, with in-depth didactic, tutorial, and hands-on training covering basic functionality and work-flow of the cardiovascular imaging system. In order to provide trainees with the ability to apply all fundamental functioning on their system, and to achieve maximum effectiveness, this class should be attended no earlier than two weeks prior to system installation. This twenty-eight (28) hour class is located in Cleveland, Ohio, and is scheduled based on your equipment configuration and availability. Due to program updates, the number of class hours is subject to change without notice. Customer will be notified of current, total class hours at the time of registration. This class is a prerequisite to your equipment handover OnSite Education. CEU credits may be available for each participant that meets the guidelines provided by Philips. Please refer to guidelines for more information. **Travel and lodging are not included, but may be purchased through Philips. It is highly recommended that 989801292102 (CV Full Travel Pkg OffSite) is purchased with all OffSite courses**

Handover OnSite Education: Philips Education Specialists will provide twenty-eight (28) hours of education for up to four (4) students, selected by customer, including technologists from night/weekend shifts if necessary. Students should attend all 28 hours, and must include the two OffSite education attendees. CEU credits may be available for each participant that meets the guidelines provided by Philips. Please refer to guidelines for more information. Note: Site must be patient-ready. Philips personnel are not responsible for actual patient contact or operation of equipment during education sessions except to demonstrate proper equipment operation. **It is highly recommended for systems that are fully loaded or for customers with a large number of staff members to also purchase 989801292099 (CV Add OnSite Clin Educ 24h).**

The above education entitlements expire one (1) year from equipment delivery date. Ref# 106107318-091207

2	**NCVC050	Non swivel, mounted ON floor	1
3	**NCVB618	HeartNavigator R1	1

Performing a structural heart procedure can be a breath-taking and tense intervention. HeartNavigator Release 1 provides support in planning of the procedure and additional live image guidance during the procedure. Previously acquired DICOM cardiac CT-datasets can be used as input. The CT-dataset can be presented in 3D and overlaid with the live-fluoroscopy to provide 3D real time insight during the procedure.
Planning:
DICOM Cardiac CT dataset can be used for the determination of the optimal intervention strategy. Optimal view planes for the X-ray device can be programmed with CT data. Furthermore, HeartNavigator Rel.1 is able to automatically segment anatomical structures, landmarks and planes out of DICOM cardiac CT-datasets. Different tools are available to help the user with the planning:

- Different anatomical visualization tools can be selected to visualize the desired anatomical structures
- Different anatomical landmark points are available to help the user to better understand the orientation and positioning of devices
- Different sizes of virtual devices which can be selected and projected on the CT data to give a reference on how the device would fit the patient

Image Acquisition en Procedure Execution:
During live image guidance HeartNavigator can be fully operated from table side using the XperModule. The user can overlay the acquired images on the 3D reconstruction of HeartNavigator.
The bidirectional link between the X-ray system and HeartNavigator allows the user to select the optimal stand position for the procedure in two ways. 3D Automatic Position Control allows the gantry to automatically move to the projection shown on the HeartNavigator monitor. 3D Follow C-arc allows the overlay to remain in sync with the 2D projection, automatically adjusting the viewpoint as the gantry is repositioned. Different visualization options are available like 3D volume and vessel outline to select as overlay.

Clinical Education for Heart Navigator:

iXR Heart Navigator OnSite Education: Philips Education specialist will provide sixteen (16) hours of education for up to (4) students selected by the customer . The Physicians performing the procedures are required to be part of the training session. CEU credits may be available for each participant that meet the guidelines provided by Philips. Please refer to guidelines for more information. Note: Site must be patient ready. Philips personnel are not responsible for actual patient contact or operation of the equipment during the educations sessions except to demonstrate proper equipment operation.

iXR Heart Navigator OnSite Live Case Follow Up Education: Philips Education Specialist will provide twenty -four (24) hours of education for Physicians and staff for live case use of the Heart Navigator software. This will be a follow up visit to the initial training of the Heart Navigator software. It is required that Live Valve implantation studies be performed during this education session. No CEU credits will be available for this session. Please refer to guidelines for more information. Note: Site must be patient ready. Philips personnel are not responsible for actual

Line #	Part #	Description	Qty

patient contact or operation of the equipment during the educations sessions except to demonstrate proper equipment operation.

Education expires one (1) year from equipment installation date (or purchase date if sold separately). Ref # 694698-20110915

4	**NCVB629	FlexVision XL,XperHD,Snapshot	1

FlexVision XL is an integrated viewing solution designed to give you full control over your viewing environment.

The FlexVision XL provides the ability to:

- Display 2 to 8 screens simultaneously from up to 16 sources (incl. third party systems) on the Philips 56-inch color LCD in the Exam Room.
- Resize and/or enlarge information at any stage during the case.
- Select and customize viewing lay-outs of the Philips 56-inch color LCD via the Xper table-side module
  XperHD on FlexVision XL brings High Definition viewing for clinical images. Native resolution of FD20 can be displayed. Excellent sharp and crisp clinical images can be displayed at full size without digital zoom.
  Xper HD brings:
  - High Definition imaging
    – Sharp images at full size without zoom
  - High Definition display at native resolution
    – Up to 2k*2k image display fully integrated
  - High Definition for the ultimate detail
    – Enhanced small vessel visualization
  - Overview connected equipment (incl. third party systems) from a single location.

The FlexVision XL consists of:

- OmniSwitch
  - OmniSwitch allows the user to direct and switch the video output of all connected medical equipment to specific sub windows of the Philips 56-inch color LCD in the Exam Room.
  - OmniSwitch is a 16 channel video-switch operated from the Xper tableside module. 16 channels are available for a mix of up to 7 internal and up to 9 external inputs.
  - OmniSwitch supports a wide variety of display formats (up to 1600x1200).
  - External inputs are connected to OmniSwitch via Wall Connection box(es).
- Medical grade, high resolution color LCD in the Exam Room
  - This display supports the image quality requirements for monochrome X-ray images as well as color images and replaces all displays normally delivered with an Allura Xper FD system for the Exam Room.
  - Main characteristics are:
    - 56 inch, 8 Megapixel color LCD
    - Native resolution: 3840x2160
    - Brightness: Max: 450 Cd/m2 (typical) stabilized: 350 Cd/m2
    - Contrast ratio: 1200:1 (typical)
    - Wide viewing angle (approx. 176 degrees)

Line #	Part #	Description	Qty

- Constant brightness stabilization control
- Lookup tables for gray-scale, color and DICOM transfer function
- Full protective screen
- Ingress Protection: IP-21

- Large color LCD control (Xper Module)
  - Resize and/or enlarge information at any stage during the case via the Xper tableside module in the Exam or Control Room
  - Select viewing lay-outs via the Xper table-side module in the Exam Room
  - Create new layouts by matching inputs to desired locations on preset templates.Monitor Ceiling Suspension
  - Monitor ceiling suspension for use in the Exam Room carries the 56 inch color LCD, providing highly flexible viewing capabilities. The monitor ceiling suspension is height-adjustable and moveable along ceiling rails. It can be positioned on either side of the table.
- Isolated Wall Connection Boxes
  - Up to 8 Isolated Wall Connection Boxes can be connected to FlexVision XL.
  - Through Isolated Wall Connection Boxes, 3rd party equipment can be connected to the FlexVision Omniswitch.
- Snapshot
  - The snapshot function allows the user to store/save a screen-capture of any image on the 56" display as a DICOM Secondary Capture image to a connected PACS. The snapshot-all function allows the user to store/save a screen-capture for each displayed image in the Exam Room / Control Room as separate DICOM Secondary Capture images.

5	**FCV0627	**Bracket for Rad. Shield (ER)**	1

Accessory bracket for mounting a radiation shield

6	**NCVB171	**3D-RA R.6**	1

Allura 3D-RA assists physicians in decision making for treatment strategy in endovascular procedures, neuro or vascular surgery or even radiotherapy.
Allura 3D-RA reduces the number of DSA acquisitions and fluoroscopy time needed to perform an examination. This means less X-Ray dose for the patient and the medical staff and a reduced quantity of dye, leading to reduced procedure costs.
Allura 3D-RA provides a unique assessment after treatment due to the use of non-subtracted images that allows to shows devices stents, coils, clips and provide the optimal stand projection for endovascular treatment.
Allura 3D-RA provides a wide range of communication facilities to export 3D images.

1 Image Acquisition
Image acquisition is performed with the Rotational Angiography feature of the Allura Xper FD series with the flexibility to position the C-arm in either head or side position.
C-arm in Head position: the Rotational Angiography run is performed over a scan range of 240 degrees with a rotation speed up to 55 degrees/sec.
C-arm in Side position: the Rotational Angiography run is performed over a scan range of 180 degrees with a rotation speed up to 30 degrees/sec.

2 3D Vessel Reconstruction
The rotational run is automatically transferred and displayed as a 3D vessel model: with the Real-Time digital link (option) 120 images are reconstructed into a 3 dimensional model within seconds. Additional reconstructions, using the Reconstructive Zooming Technique, can be performed as well.

3 Workflow:
Allura 3D-RA in combination with the Allura Xper FD series will provide an optimal workflow via the following workflow enhancers:
Complete automated 3D-RA process from 3D acquisition to 3D Viewing: no user interaction needed.
3D at Xper Module (option); With the Xper module the physician has all required 3D functionality at tableside. At the touch screen module functionality like rotating, panning, zooming, AVA, virtual stenting, 3D-APC and 3D Follow C-arc can be performed. With the mouse tablet all other functios can e performed so that there is is no need for the Physician to leave the examination room.
3D Automatic Position Control (3D-APC); When the optimal working position has been choosen via the Allura 3D-RA interventional tool, the C-arc will automatically steer to this position.
3D Follow C-arc; When the position of the C-arc (not using any X-ray) is changed, the 3D volume will automatically follow the position of the C-arc. This means the position of the C-arc (and therefore the 2D projection) and the 3D volume are always aligned. As last seen; when the user leaves the patient in the model and later selects that patient again, the Allura 3D-RA interventional tool will return to the image last used by the user.
Mouse over: When moving the mouse cursor over a button the mouse over text will show up to explain the function of that specific button.

4 Calibration
Allura 3D-RA calibrations are performed by Philips Healthcare Customer Support. Allura 3D-RA calibration data are stable over at least 6 months time.

5 Viewing
A Real Time user interface is available with 3D-RA, providing 3D object viewing in any space direction. A graphical display of (C-arm) stand position including angulation/rotation for any projection.
Philips' CRM (Contrast Resolution Management) Technology for a considerable increase in contrast resolution in all volumes.
Various Image Rendering possibilities: Volume/Surface Rendering, MIP, Endoscopy, SUM (pseudo x-ray image) Gradient rendering; the possibility to display the vessel structure transparently.
Cut-plane function to get a precise insight of the shape of the pathology
Orthoviewer providing a multi-planar visualization of objects using the different Image Rendering possibilities.
MPR (Multi-Planar Reformatting): enables visualization of the volume in all three standard projections (coronal, sagital and axial) Especially useful for optimal viewing of spine procedures (e.g.Vertebroplasty)
SpineView: special acquisition protocol for optimal viewing of the spine, especially osteoporotic vertebrae
CalciView: allows visualization of Hyper dense plaque in 3D, separately or in relation to the lumen.
5 different distance measurements calculated in the same volume, including "Quick measurement" feature
Volume calculation
Automated Vessel Analysis (AVA), provides information on vessel segment diameter, area and length with only three mouse-clicks. Endoscopic and cross sectional views are available.
Computer Assisted Aneurysm Analysis (CAAA), providing information on Aneurysms, like volume, neck size etc..
Catheter tip shape simulation, providing information on how to shape the catheter tip.
Virtual stenting; Ability to simulate a stent placement in a selected vessel segment for proper stent sizing. All relevant data of the simulated stent are displayed
Annotation: text can be added to a volume to capture comments.
Interpolative Zoom
Reconstructive Zooming Technique, 2 additional user defined reconstructions focused on the Volume Of Interest (VOI) using different cube size and voxel resolution.
Subtraction of reconstructed volumes, allowing to visualize vessels without embolization devices (stents, coils, clips,..) to assess the outcomes of treatment
Automatic Voxelshift: compensates for movement when rendering subtracted or superimposed

Line #	Part #	Description	Qty

volumes
Set the grey values WW/WL
Store/Recall of user defined projections.

6 Archiving
Transfer to:
Optional Hard Copy unit (DICOM Print)
Any optional DICOM compatible device (e.g. PACS/ViewForum/Xcelera), supported are DICOM XA, DICOM SC, DICOM CT and DICOM 3D
Any PC in a standard PC compatible format (JPEG,AVI)
One or multiple DVD's, CD-ROM(s) for easy archiving
Store a subset of exportable objects (snapshots and AVI Movies) to a USB removable memory device.

Clinical Education Specialists will provide sixteen (16) hours of tailored CV 3DRA OnSite Education for up to four (4) students, selected by customer, including technologists from night/weekend shifts if necessary. CEUs are not available in all cases. Please read Guidelines for more information, which will be provided to you during the scheduling process. Education Hours: Mon – Fri 8:00am to 5:00pm, except Monday and Friday are half-days to allow for trainer's travel. Note: Philips personnel are not responsible for actual patient contact or operation of equipment during education sessions except to demonstrate proper equipment operation. Education expires one (1) year from equipment delivery date (or purchase date if not sold with equipment).

7	**NCVB294	**Set of 2 additional 21in. LCDs**	1

Two 21inch additional displays are located on top of the monitor ceiling suspension frame which carry the 56 inch large screen color LCD display.

These 2 additional LCD's can be used to display additional video sources or used as display back up for Hemo and Xray Live images. These LCD's have a fixed content.

Main characteristics of back-up displays are:

- 21.3 inch, 2 Megapixel color LCD display
- Max. resolution: 1600x1200
- Brightness: 450 Cd/m2
- Contrast ratio : 550:1
- Wide viewing angle (approx. 170 degrees)
- Constant brightness stabilization control
- Independently selectable brightness settings for monochrome and color images
- Independently selectable lookup table for gray-scale, color and DICOM transfer function

FCV0587, "XPer Live/Ref Slaving" required when displaying X-Ray Live as back-up.

8	**NCVB173	**CT Trueview Rel2**	1

CT TrueView uses 3D CT segmented dataset for a more robust anatomical roadmap providing the additional perspective on the coronary vessel morphology. It helps to determine the length of the obstructive lesion, view all side branches, get the optimal projection to view a lesion or bifurcation and fit the proper stent without the use of additional X-ray dose or contrast. This allows evaluation and planning to be done prior to the start of the procedure.
The 3D model is based on a segmented coronary dataset from the Philips Extended Brilliance Workspace (R 3.5 and onwards).

Line #	Part #	Description	Qty

Allura CT TrueView Rel 2 functionality includes, but is not limited to:

• TrueView; define the optimal working projections, of the lesion or bifurcation, based on the Philips exclusive intuitive view map.
• TrueLength; view the exact lesion length
• Unique CTO Navigator provides an overlay of a 2D exposure run over the previous acquired segmented cardiac CT data. The images are matched manually or automatically for images in the same cardiac phase.
• 3D Automatic Position Control (3D-APC); When the optimal working projection has been chosen with CT TrueView, the C-arc will automatically reach this position,

The Xper Module control to provides the physician has all CT TrueView functionality needed at tableside
• Switch image views to View Model, True View map and True Length graph
• Selection of the optimal view angle
• Select vessel lesion or bifurcation
• Vessel navigation
• Select volume rendering mode
• Show/Hide Curved MPR reformat
• Image rotation, panning and zoom
• Snapshot
• Store/recall views
• Select 3D APC / Follow stand mode, 3D Automatic Position Control (3D-APC); When the optimal working position has been chosen via the Allura 3D-CA system, the C-arc will automatically steer to this position, 3D Follow C-arc; When the position of the C-arc (not using any X-ray) is changed, the 3D model will automatically follow the position of the C-arc.

Allura CT TrueView includes the following export functionality:
• Image transfer to any DICOM compatible device (e.g. PACS/Printer), supported are DICOM XA, DICOM SC, DICOM CT and DICOM 3D.
• Support archive on one or multiple DVD's, CD-ROM(s)
• Image transfer to a standard PC compatible format (JPEG,AVI)
• Store a subset of exportable objects (snapshots and AVI Movies) to a USB removable memory device.
• Image transfer to any DICOM compatible device (e.g. PACS/Printer), supported are DICOM XA, DICOM SC, DICOM CT and DICOM 3D
• Image transfer to any PC in a standard PC compatible format (JPEG,AVI)

Clinical Education Program for CT Trueview R2 (CTO Navigator)

CT Trueview R2 Handover Onsite Education: Philips Education Specialist will provide sixteen (16 hours of education for up to four (4) students selected by the customer , including technologists from night/weekend shifts if necessary. CEU credits may be available for each participant that meets the guidelines provided by Philips. Please refer to guidelines for more information. Note: Site must be patient-ready. Philips personnel are not responsible for actual patient contact or operation of equipment during education sessions except to demonstrate proper equipment operation. Education expires one (1) year from equipment installation date (or purchase date if sold separately). Ref #494-100615

9	**NCVB174	CT Trueview MultiVendor	1

Line #	Part #	Description	Qty

CT TrueView multivendor prepares DICOM compatible cardiac CT scans for CT TrueView. With CT TrueView multivendor the original acquired CT scans can be segmented automatically and provides a complete cardiac evaluation package allowing simplified workflow and minimal user interaction as available on the Philips Brilliance Extended WorkSpace. It helps to visualize coronary trees, segment the heart, perform detailed coronary artery evaluations and analyze the ventricular function.

Allura CT TrueView Rel MultiVendor functionality includes, but is not limited to:

- A no-click total cardiac segmentation for all phases selected with complete cage removal.
- Globe View (Globe, 3D Map and 2D Map).
- Unique "IVUS-like" view for the central cross-sectional cut.
- Stenosis calculations.
- Volume rendering visualization with coronary tree extraction and complete vessel visualization including its origin from the aorta for ostial morphology assessment.
- Slab tools (including cut planes) on Volume Rendered image in cine.
- LV Functional Assessment, including bulls-eye presentation.
- Continuous identification of C-arm angles.

Clinical Education Program for CT Trueview Multivendor

CT Trueview Multivendor Handover Onsite Education: Philips Education Specialist will provide eight (8) hours of education for up to four (4) students selected by the customer , including technologists from night/weekend shifts if necessary. CEU credits may be available for each participant that meets the guidelines provided by Philips. Please refer to guidelines for more information. Note: Site must be patient-ready. Philips personnel are not responsible for actual patient contact or operation of equipment during education sessions except to demonstrate proper equipment operation. Education expires one (1) year from equipment installation date (or purchase date if sold separately). Ref # 495-100615

10	****NCVA819**	**Stentboost sw Rel 3.0 Package**	**1**

StentBoost is a unique interventional tool to improve visualization of stents in the coronary arteries during interventions. This, Philips exclusive, innovative interventional tool produces a highly augmented image of a deployed stent in coronary arteries in relation to the vessel lumen.

StentBoost enables interventional cardiologists to take any corrective action required immediately, while the patient is still in the exam room.

The way it works
StentBoost automatically detects the stent delivery markers image after image. In each image StentBoost aligns the markers with the markers of the previous image. By doing this all radiopaque material in the close proximity of the markers will be enhanced and items further away from the markers will be greyed out.
Images can be acquired with or without contrast. A run with some contrast-filled vessel images wil result in a dynamic representation of the enhanced stent in relation with the vessel lumen.

StentBoost Workflow

1. Image acquisition
   StentBoost R3 has an optimised protocol of 100 frames out of a cine run, of which 60 frames should be with contrast.
2. Image transfer
   The run will automatically be transferred to the interventional workstation and show up in the StentBoost software.

3. Automatic Stent Enhancement
   The StentBoost software detects automatically the location of the markers and displays the enhanced image of the stent within seconds. If the cine run was acquired with contrast, then the dynamic representation of the stent in relation with the lumen will appear automatically

4. A real time operation user interface is available with StentBoost, to provide:
   - Review of StentBoost runs, before and after processing
   - Viewing tools like Brightness/Contrast, Pan and Zoom to optimize the image displayed
   - Automatic stent delivery system marker identification
   - Reliability feedback regarding the enhanced run
   - Manual quality improvement; Manual correction possibility for marker identification
   - View patient info
   - store the still or dynamic (move) image of the stent

5. Calibration
   - To create a StentBoost image no calibration is needed. For the measurement support tool four calibration methods are included:
     - No calibration
     - Auto calibration based on calibration data generated by the Allura Xper system when the autocall function is installed (MCV5682),
     - Marker distance of the stent delivery markers,
     - Catheter calibration

6. "Measurement"
   - "Measurement" an option within the StentBoost package supports the clinician in his/her decision-making in determining the percentage of remaining stenosis in the stent.

7. Archiving
   Transfer to:
   - Optional Hard Copy unit (DICOM Print)
   - Optional third party station (snapshots images in DICOM Secondary Capture format)
   - Any computer via a web server functionality with images in a standard file format (JPEG, AVI movies)
   - One or multiple DVD's, CD-ROM(s) for easy archiving
   - Store a subset of exportable objects (snapshots and AVI Movies) to a USB removable memory device.

8. StentBoost release 3.0 PACKAGE comprises:
   - NCVA819 StentBoost R3
   - NCVA115 StentBoost on Xper Module
   - NCVA590 Real Time Link

StentBoost release 3.0 Software Package:
Software release bulletin
DICOM Conformance Statement
StentBoost IQ verification Phantom

Compatible with:
Allura Xper FD10 R.3
Allura Xper FD10/10 R2

Line #	Part #	Description	Qty
11	**NCVC018	**replace into 21" monitor size in control room**	1

Ultra high-brightness, medical grade, color LCD displays for conrol room
These displays support the image quality requirements for monochrome X-ray images, color EP signals as well as other images.

Main characteristics are:

- 21.3 inch, 2 Megapixel color LCD display
- Display resolution (up to) : 1600x1200
- Input resolution (up to) : 1920x1200
- Brightness: 550 Cd/m2
- Contrast ratio : 800:1
- Wide viewing angle (approx. 170 degrees)
- Constant brightness stabilization control
- Independently selectable brightness settings for monochrome and color images

Please note that for radiology departments Black/White monitors are recommended

12	**NCVB158	**No existing Philips room**	1
13	**NCVB175	**Ceiling Rail extension set frontal**	1

Extension of ceiling rail at head- or footside side of the table, to enlarge the parking distance of the frontal ceiling mounted stand. Maximum extension is 1.5 meters. Movement of the frontal ceiling mounted stand is motorized over the full length of the rail.

14	**NCVB121	**Unknown (for quoting purposes)**	1
15	**FCV0587	**Xper Live/Ref Slaving**	2

Xper Live/Ref Slaving
The Xper Live/Ref Slaving will enable the option to slave the Live or Ref video source from the Allura Xper. The total amount of Xper Live/Ref Slaving that can be selected is max 4.
Xper Live/Ref Slaving is possible:
- In Control Room icw FCV0011(B/W monitor in Control Room)
- In Philips MCS (additional monitor excluded from this option)
- Icw FCV0519 1 or 2 MCS from Skytron/Steris

16	**NCVA089	**RIS / CIS DICOM interface**	1

This package allows communication of the Allura Xper system with a local information system (CIS or RIS). The interface uses the DICOM Worklist Management (DICOM WLM) and Modality Performed Procedure Step (DICOM MPPS) standards.

If a hospital has an Allura Xper system and an information system it can receive patient and examination request information from the information system and report examination results in order to:

-Eliminate the need for retyping patient information on the Allura Xper
-Prevent errors in typing patient names and registration numbers (ensuring consistency with IS

information to prevent problems in archive clusters ortosearch fora name in case of later retrieval)
-Inform the IS about the acquired images and radiation dose

Upon request from the Allura Xper system the complete worklist with all relevant patient and examination data is returned from the IS to the Allura Xper system. For each patient the following information will be shown on the Allura Xper after it has been retrieved from the IS:

Patient Identification:

- Patient name
- Patient ID
- Birth date
- Sex

Examination/Request Information:

- Accession number
- Scheduled procedure step start time
- Scheduled performing physician's name

It is possible at all times to enter patient demographics information manually within the Allura Xper system in case of an emergency or in case the local Information System connection is down.

On request of the clinical user the Allura Xper will report the following information about the selected patient to the IS:
Patient Identification:

- Patient name
- Patient ID
- Birth date
- Sex

Examination/Request Information:

- Accession number
- Performed procedure step status start/end date and time
- Performing physician's name
- Referenced image sequence

Radiation dose:

- Total time of fluoroscopy
- Accumulated fluoroscopy dose
- Accumulated exposure dose
- Total dose
- Total number of exposures
- Total number of frames

Further detailed information can be found in the Allura Xper DICOM Conformance Statement.

The interface requires an EasyLink (hardware and software) if the IS is not compliant withDICOM Work List Management and Modality Performed Procedure Step.

Line #	Part #	Description	Qty
17	**NCVA088	**Standard Line Rate Video Output**	1

This interface provides image output to standard line rate video peripherals, such as VCRs or paper printers. This option also comprises automatic start and stop of a VCR, synchronous to the generation of X-ray (fluoroscopy and exposures).

18	**NCVA092	**Lab Reporting**	1

Lab Reporting allows the user to generate and print simple reports in modality stand-alone situations. The user is able to incorporate free text and clinical images. The reporting functionality is suited for local printing and email. Part of the report is generated automatically from administrative data (e.g. patient/exam data hospital name) and required data (e.g. run-log dose information and event-log).

19	**NCVA781	**Dicom Print compose**	1

Dicom Print provides the possibility to interface to any DICOM Printer. This is an automated printing protocol. The option provides Print Manual Overrides, Print Job submission, and Print Job management.

20	**NCVA080	**Automatic Position Control (APC)**	1

The Automatic Position Controller (APC) for Integris Allura Flat Detector systems provides two modes of operation:

- Preset Position Sequence; the sequence of projections is determined per Xper Settings. Each set contains a maximum of 10 positions. Positions can be recalled in sequence or directly. The projection sequence comprises rotation, angulation, and SID settings, related to the selected reference image.
- Reference driven positioning. The projections on the reference monitors can be recalled with the push of a button. The reference driven positioning recollects the rotation, angulation, and SID.

21	**NCVA801	**Table APC**	1

The Automatic Position Controller (APC) for the table provides two modes of operation:

- Auto positioning. The tabletop position and table height will be adjusted automatically to the pre-defined default point of interest. This to save time and x-ray dose at the start of an exam or for setting up the system for rotation scans.
- Store/recall of a position of the table top. This includes the height-, longitudinal- and lateral position of the table top.

22	**NCVA695	**FD Rotational Angio**	1

Rotational angiograpy provides real-time 3D impressions of complex vasculature and coronary artery tree. It acquires multiple projections with just one contrast injection via a fast rotational scan of the region of interest.

Rotational Angiograpy can be used during screening procedures to quickly determine the optimal projection for the study as the angle (rotation/angulation) of the projection is indicated on each image.

Compared with traditional angiography, Rotational Angiography can save considerable time, dose and contrast, while providing image detail required for diagnostic and therapeutic decisions.

Line #	Part #	Description	Qty

A rotational scan is possible both with the Allura Xper systems in the side position (ceiling mounted systems) and in the head position, providing the flexibility to perform procedures virtually from head to toe.

C-arm in side position:

- Max. rotation Speed: 30 degrees/s
- Max. rotation Angle: 180 degrees

C-arm in head position:

- Max. rotation Speed: 55 degrees/s
- Max. rotation Angle: 305 degrees

Max. Frame speeds are given by the framespeed specifications of the system configuration.

The speed and range of rotation are the highest available (see table). The very high speed allows using less contrast, whereas the very wide rotation range provides a complete evaluation of the anatomy.

A contrast run can be followed up with a mask run, to allow image/run subtraction.

The stand is designed for a very high mechanical stability. It offers precise positioning and high reproducibility, assuring you of high quality images and excellent subtraction studies.

Operation of Rotational Angiograpy is extremely easy. The procedure is selected, set up and executed virtually in a matter of seconds, supporting the highest patient throughput.
A set of dedicated acquisition programs is available on the Xper Module and can be selected at the touch of a button. The rotation end- and start-positions are easily selected. The procedure is controlled from the exposure hand- or footswitch.

23	**NCVB209	Xper Swing	1

XperSwing allows dual-axis rotational coronary angiography to gather more information in less time and with less X-ray and contrast dose. XperSwing acquires simultaneous RAO/LAO cranial-caudal views in just one acquisition run by moving the C-arm in a curved trajectory instead of multiple acquisitions. XperSwing can be used during screening procedures to quickly determine the optimal projection for the study as the angle (rotation/angulation) of the projection is indicated on each image, providing image detail required for diagnostic and therapeutic decisions and to obtain a real-time 3D impression of the coronary artery tree.

In total seven pre-programmed trajectories are available:
• Three for Left coronary imaging
• Two for Right Coronary imaging,
• Two generic trajectories.
The choice depends on size and weight of the patient. These trajectories are designed to fully cover all conventional projections for a diagnostic coronary angiography. Rotation and angulation movements are combined in one complete scan trajectory, using the maximum rotation and angulation speed of the Allura Xper system. (55 resp 30 degr/sec). XperSwing is possible in the side position (ceiling mounted systems) and in the head position

XperSwing functionality includes, but is not limited to

Line #	Part #	Description	Qty

- 15 frames per seconds acquisition to allows using of less contrast.
- Wide rotation range provides a complete evaluation of the anatomy.
- Precise positioning and high reproducibility, assuring you of high quality images and excellent subtraction studies.
- Set up and executed in a matter of seconds.
- Set of dedicated acquisition programs with the trajectories available on the Xper Module
- The rotation end- and start-positions can be selected.
- Acquisition procedure is controlled from the exposure hand or footswitch.

24 ****NCVA093** **Physio Viewing** **1**

Physio Viewing allows for the acquisition, storage and display of up to four channels of physiological data, in parallel with X-ray acquisition. The user can select one of the recorded physio signals for display, together with the acquired image.

25 ****NCVA694** **Subtracted Bolus Chase** **1**

For visualization of vessel structures when the blood flow is difficult to estimate, in particular in the lower peripherals.

Bolus Chase solves the problem of cumbersome step movements, the mismatch between blood flow and selected program, and lack of real-time image information.

During digital acquisition in non-subtracted mode with uninterrupted real-time image display, the contrast bolus is followed (chased) interactively by a motorized table scan movement using a hand-hold speedcontroller to adapt the speed of the table scan to the contrast flow.The framespeed can be adapted as well.

The bolus run is followed with a mask run while using the same speedcurve and framespeed as generated during the bolus run. Viewing is possible in the subtracted and non-subtracted mode. If subtracted viewing is not required, the mask run can be skipped.

Subtracted Bolus Chase gives fast, accurate results for increased patient throughput and improved patient management. Automated exposure control and precise speed control assure a high quality images and excellent subtraction studies.

Comprising:

- automatic exposure control
- tabletop motordrive and hand-held speed controller (tableside)
- technique selection using Xper module, available both tableside and in control room (Xper FD20, FD20/10)

26 ****NCVA864** **Storage extension** **1**

Storage extension

Storage extension provides an increased storage capacity for Allura Xper FD20 systems

The storage is increased from:
- 50.000 to 100.000 images at 1024x1024 matrix
- 12.500 to 25.000 images at 2048x2048 matrix

Power requirements:
refer to system configuration

100215 Allura Xper FD20

Line #	Part #	Description	Qty
27	**NCVA672	FD SmartMask	1

SmartMask simplifies roadmapping procedures by overlaying a selected reference image with fluoroscopy on the live monitor in the exam room.
The reference image can be faded in/out with variable intensity, controlled from tableside.
SmartMask uses the reference image displayed on the reference monitor.
Any previously acquired image can be used as reference.

SmartMask facilitates pre- and post- intervention comparisons to assess treatment results

28	**NCVB880	extension to 30Fr/sec (mono)	1

Frame Rate Extension increases the system acquisition speed for cardiac applications that require high speed imaging. The frame rate extension increases the acquisition speed to 15fps and 30fps with a 1024x1024 matrix.

29	**NCVA121	FULL AUTOCAL	1

The AutoCal option is a software package to be used in conjunction with quantitative analysis software packages. It provides an auto calibration procedure for an object to be analyzed that is placed in the iso-center. When the object to be analyzed (e.g. Left Ventricle Vessel Segment) is placed in the iso-center AutoCal avoids the need to:

- acquire an additional image series containing a sphere or grid for calibration purposes
- calibrate manually on a calibration object (e.g. catheter) displayed in the image or image series to be analyzed

30	**NCVA784	Ventricular Quant.Sw pkg(Xper)	1

Left Ventricular Quantification Software Package. Software package for the analysis of single plane Left ventricular angiograms. Calculates the Ejection fraction and local wall motion parameters in different formats.

Functions:

- Various LV-volumes
- Ejection Fraction
- Cardiac Output
- Centerline Wall Motion
- Slager Wall Motion
- Regional Wall Motion
- Calibration routines

In addition the package allows manual measurements of line lengths (absolute and ratio's) and angulations. Multiple measurements in one image are possible.

Comprising:

- software license

Compatible with:
. Allura Xper FD 10 Rel 3 and FD10/10 Rel 2 onwards
. Allura Xper FD20 Rel 2, FD20/10 Rel 2 onwards

Line #	Part #	Description	Qty
31	**NCVA793	**Right ventricular quantification software package**	1

Software package for assessment of ejection fraction and right ventricular volumes. This package allows right Ventricular analysis from a single plane or a biplane run: the calculations can be executed from single plane or biplane projections.
The package is especially intended for Pediatric Cardio applications, focussing on easy and efficient wall contour detection.
Comprising:
- Calibration routines
- Various RV-volumes
- Ejection Fraction
- Cardiac Output
- Centerline Wall Motion
- Slager Wall Motion
- Regional Wall Motion
- biplane Ejection Fraction automatic
- biplane Ejection Fraction manual

In addition the package allows manual measurements of line lengths (absolute and ratio's) and angulations. Multiple measurements in one image are possible.

32	**NCVA785	**Coronary Quant.Sw pkg(Xper)**	1

Functions:

- diameter measurement along the selected segment
- cross sectional area
- %-stenosis
- pressure gradient values
- stenotic flow reserve
- calibration routines

In addition the package allows manual measurements of line lengths (absolute and ratio's) and angulations. Multiple measurements in one image are possible.

Comprising:

- software license

Compatible with:
. Allura Xper FD 10 Rel 3 and FD10/10 Rel 2 onwards
. Allura Xper FD20 Rel 2, FD20/10 Rel 2 onwards

33	**NCVA786	**Vascular Quant.Sw pkg(Xper)**	1

Functions:

- vessel diameter / stenotic index
- automated vessel analysis
- calibration routines

In addition the package allows manual measurements of line lengths (absolute and ratio's) and angulations. Multiple measurements in one image are possible.

Line #	Part #	Description	Qty

Compatible with:

- Allura Xper FD10 Rel 3 and FD10/10 Rel 2 onwards
- Allura Xper FD20 Rel 2 and FD20/10 Rel 2 onwards
- Allura CV20 R1 onwards

34 ****NCVA097** **Cath Arm Support** **1**

For brachial catheterisation and digital imaging technique
The support is made of X-ray transparent material with exception of the fixingclamp and pivots.

35 ****NCVA098** **Pulse Cath Arm Support** **1**

Facilitates catheterization trough the pulse and provides room for placing catheterization instruments. It is a flat radio translucent board and is placed under the patient while a part projects at either the left or right side of the tabletop to support the arm.

Size: 100 x 85 cm
Material: carbon-fibre reinforced material

36 ****NCVA101** **Peripheral X-ray Filter** **1**

Set of flexible x-ray filters to provide an uniform density in angiographic examinations of the lower peripheral area.
Comprising:
· one central filter, at the top edge provided with sizing markers at every 5 cm, length : 1 m
· two side filters, length: 1 m

37 ****NCVA783** **Pivot for table base.** **1**

For angiographic- and interventional procedures of the upper peripherals.
Provides improved table access for patient transfer.
Allows pivoting of the table base around its vertical axes.
Pivot range from -90 degrees to + 180 degrees (or -180 to +90 degrees) with locked positions on 0, -13/+13 (facilitating arm-angiography) and -90/+90 and 180 degrees.

Comprising:

- pivot device with graduated scale to be mounted on the universal floor plate of the table.

Compatible with Xper Table

38 ****FCV4894** **Add.op-rail with cable ext.kit** **1**

The content of the additional OP-Rail kit is:

- [A] One additional OP-Rail (mechanical)
- [B] Cable Extension for OP-Rail
  - One Extension cable for Geo Module
  - One Extension cable for Imaging Module
  - One connection box (wherein the extension cables are coupled with the UI-Module cables.

[A]
- An extension for the table op-rail (30cm).

Line #	Part #	Description	Qty

- The additional op-rail can be mounted at the both sides of the tabletop part where no op-rails are mounted.
- The additional op-rail is compatible with AD5 and XperTable (cardio and neuro) patient-tabletops.
- The op-rail has the same profile /dimensions as the current standard op-rail
- The maximum load (downwards) on the additional op-Rail is 100 N (F=100N)
  - (this is limited by the tabletop of the Patient Table)
- The maximum mechanical moment on the additional op-Rail is 40Nm downwards and 20Nm upwards
  - (this is limited by the tabletop of the Patient Table)

[B]

- The cable extension consists out of two cables with a length of 1.3 m; one for the Geo and one for the Imaging module, and an interface box were the coupling to the
- Geo and Imaging module cables can be made.

39	**FCV0017	**CABLE CARRIER CS**	3

Additional carrier for suspension of cable hose from X-ray tube assembly or TV monitor.

40	**NCVB878	**Interventional Tools Hardware**	1

The Interventional Tools hardware is the computer that enables the Allura 3D interventional tools, It allows to import and view DICOM compatible data from other imaging modalities.
The Interventional Hardware comprises at least:
Computer Workstation
19" LCD color monitor
4 GB memory
Primary hard disk for the Operating system and application Software
Secondary 500 GB hard disk for application data
Internal CD-Rom / DVD writer
Mouse tablet to interact with all the interventional tools at the table side.
Operating Software
Microsoft Windows XP Professional UK Operating System
Comprising:
19" SXGA LCD color monitor
Conditionally:
FD Calibration Tool Kit for 3D-RA and XperCT
Phantom for geometry calibration
Phantom for user validation
Verification toolkit for 3D-CA and StentBoost
Phantom for user validation
Compatible with:
Allura Xper series 7 onwards

41	**NCVA116	**3D RA Control for Xper Module**	1

Line #	Part #	Description	Qty

Table Side Module functionality for Allura Xper FD20 used with Integris 3D-RA Release 4.2.

For further improvement of interventional procedures efficiency the following workflow enhancers are made available in the examination room: With the Xper touchscreen module the physician has all 3D functionality needed at tableside. Functionality like rotating panning zooming AVA Virtual stinting 3 and 3D Follow C-arc can be perfomed. No need for the Physician to leave the examination room. 3D Automatic Position Control (3D-APC); when the optimal working position has been chosen via the Integris 3D-RA interventional tool the C-arc will automatically steer to this position.3D Follow C-arc: When the position of the C-arc (not using any X-ray) is changed the 3D volume will automatically follow the position of the C-arc. This means the position of the C-arc (and therefore the 2D projection) and the 3D volume are always aligned.

42	**NCVB168	3D Roadmap	1

3D Roadmap extends the capabilities of the integrated 3D product by providing a sustainable 3D roadmap to support interventional procedures. The 3D Roadmap option matches the real-time 2D fluoroscopy images with the 3D-RA reconstruction of the vessel tree. It provides a 3D real time insight of the advancement of the guide wire, catheter and coils through complex vessel structures. 3D roadmap has automatic motion compensation for the neuro runs. When the automatic motion compensation function is active, this functionality will constantly correct the motion artifacts which can be present in the 3D Roadmap image.

Image Acquisition
The 3D Roadmap is based on the visualization of the vessel tree out of 3D-RA The 3D Roadmap is activated with one button touch at tableside (Xper Module). Select the 3D Roadmap function on the touch screen module, activate fluoroscopy and the 3D Roadmap is activated. The "live" 2D fluoroscopy image is overlaid with the 3D volume of the vessel tree and is automatically displayed on the 3D roadmap monitor in both the examination and control room.

Intuitive, fully controlled from tableside:
The bidirectional link between the X-ray system and the 3D Roadmap allows the user to select the optimal stand position for the procedure in two ways. 3D Automatic Position Control allows the gantry to automatically move to the best interventional projection as shown on the 3D Roadmap monitor. 3D Follow C-arc allows the 3D Roadmap to remain in sync with the 2D projection, automatically adjusting viewpoint as the gantry is repositioned

- Landmarking to adjust the intensity of the anatomical reference surrounding the vessels;
- 3D blending to fade in/out the 3D view;
- WW/WL settings to control the contrast/brightness;
- Store and review runs for reporting and archive purposes;
- Store snapshots and movies.

3D Roadmaps can be sent to:
Any optional DICOM compatible device (e.g. PACS/ViewForum/Xcelera), supported are DICOM XA, DICOM SC, DICOM CT and DICOM 3D
Any PC in a standard PC compatible format (JPEG,AVI)

And stored/archieved on
A PACS systems as DICOM Secondary Capture images or movies
USB removable memory device
One or multiple DVD's, CD-ROM(s) for easy archiving
Hard copy via the (DICOM Print) protocol

43	**NCVA165	1st Xper Module in Exam.Room	1

Line #	Part #	Description	Qty
44	**NCVA169	2nd Xper Mod. in Control Room	1
45	**NNAE391	FlexVision XL 8 Input Package	1

The FlexVision XL8 input package provides eight isolated wall connection boxes and eight legacy converters.

Isolated Wall Connection Box
This Isolated Wall connection Box facilitates connection of the video source via standard DVI cable/connector and lossless
transfer of the video signal over the approximate 30 m cable distance. It can be mounted in the exam room or in the control room, depending on the location of the video source.

The quantity of the VWCB's has to be calculated as follows:

For each video signal to FlexVision XL on Vascular System: 8 VWCB
Note:
No VWCB is required in case a video signal is connected directly to a dedicated LCD from the following sources:
1) Xper Live/ref Slaving
2) Interventional HW (XtraVision), ViewForum, Xcelera (only if workstations are powered by Allura Xper)
3)Xper IM

Legacy Video Convertor
The Legacy Video Convertor enables conversion from VGA towards DVI for supported input resolutions as listed in the table below.

Signal type	Native resolution	Image Aspect Ratio
VGA	640x480	4:3
SVGA	800x600	4:3
XGA	1024x768	4:3
SXGA	1280x1024	5:4
SXGA+	1400x1050	4:3
UXGA	1600x1200	4:3
WXGA	1280x800	16:10 (8:5)
WSXGA	1440x900	16:10 (8:5)
WSXGA+	1680x1050	16:10 (8:5)
WUXGA	1920x1200	16:10 (8:5)
2K	2048x1080	19:10
TV1080I/P	1920x1080	16:9
TV 480I	720x480	4:3
TV 480P	704x480	4:3

NET PRICE $1,600,000.00

Buying Group: HEALTHTRUST PURCHASING GROUP Contract #: 500005

Addt'l Terms:

Each Quotation solution will reference a specific Buying Group/Contract Number representing an agreement containing discounts, fees and any specific terms and conditions which will apply to that single quoted solution. If no Buying Group/Contract Number is shown, Philips' Terms and Conditions of Sale will apply to the quoted solution.

Each equipment system listed on purchase order/orders represents a separate and distinct financial transaction. We understand and agree that each transaction is to be individually billed and paid.

Price above does not include any applicable sales taxes.

The preliminary delivery request date for this equipment is:_____.

If you do not issue formal purchase orders indicate by initialing here_____.

Tax Status:

Taxable_____ Tax Exempt_____

If Exempt, please indicate the Exemption Certification Number:_____, and attach a copy of the certificate.

Delivery/Installation Address:

_____

_____

_____

Invoice Address:

_____

_____

_____

Contact Phone #:

_____

Contact Phone #:

_____

Purchaser approval as quoted:

_____

Date:

_____

Title:

_____

This quotation is signed and accepted by an authorized representative in acknowledgement of the system configuration, terms and conditions stated herein.

Attachment B.I.Project Description.2

North Knoxville Medical Center Cardiac Catheterization / Vascular Lab Project
Quote for Moveable Medical Equipment

Date 11/2/2012

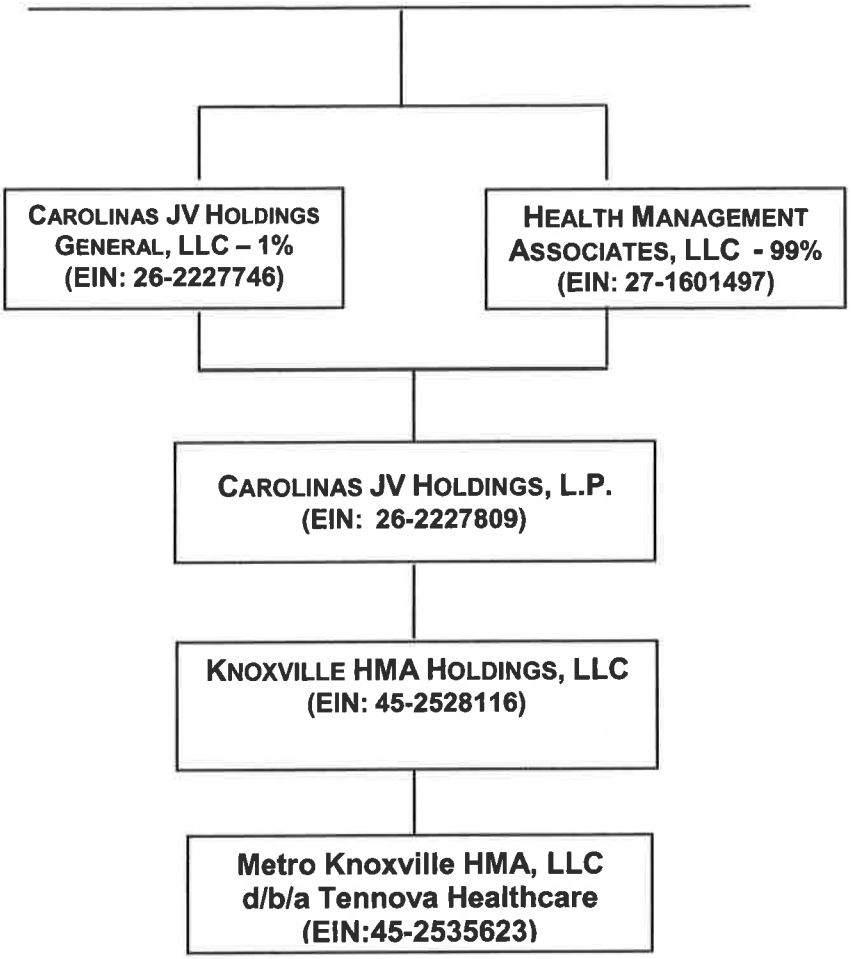
Catalog #	Catalog Item/Desciption	QTY	Unit Price	Total Price
ALL0097	SIGNAGE	1	$ 4,000.00	$ 4,000.00
ALL0164	ACCESSORIES, HEADWALL ACCESSORIES	1	$ 1,100.00	$ 1,100.00
ALL0351	CARPET	1	$ 1,300.00	$ 1,300.00
ALL0451	DRAPERY & CUBICLE CURTAIN	1	$ 1,000.00	$ 1,000.00
ALL0651	FURNISHINGS, FURNITURE	1	$ 6,200.00	$ 6,200.00
ALL0653	FURNISHINGS, ARTWORK	1	$ 350.00	$ 350.00
ALL0654	FURNISHINGS, PLANTS, INTERIOR	1	$ 150.00	$ 150.00
ALL1302	MONITORS	1	$ 162,681.00	$ 162,681.00
ALL1951	SYSTEMS, STRUCTURED CABLE	1	$ 20,000.00	$ 20,000.00
ALL1953	SYSTEMS, NURSE CALL	1	$ 68,000.00	$ 68,000.00
ALL1954	SYSTEMS, CCTV	1	$ 3,000.00	$ 3,000.00
ALL1957	SYSTEMS, BRANCH EXCHANGE	1	$ 8,000.00	$ 8,000.00
ALL1958	SYSTEMS, ACTIVE EQUIPMENT	1	$ 14,000.00	$ 14,000.00
ALL1959	SYSTEMS, DOC DICTATION STATION	1	$ 2,500.00	$ 2,500.00
ALL1962	SYSTEMS, ACCESS CONTROL	1	$ 11,000.00	$ 11,000.00
BIN1901	BIN, STORAGE, WALL RACK SYS	10	$ 350.00	$ 3,500.00
BRK1301	BRACKET, MONITOR, WALL MTD	6	$ 475.00	$ 2,850.00
BRK2042	BRACKET, TELEVISION, WALL MTD 42"	1	$ 95.00	$ 95.00
CAB2901	CABINET, CATHETER STORAGE, WALL MTD	2	$ 1,895.00	$ 3,790.00
CAR0506	CART, EMERGENCY (CRASH)	2	$ 1,905.00	$ 3,810.00
CAR1901	CART, SOILED LINEN COLLECTION	1	$ 950.00	$ 950.00
CAR4507	CART, SUPPLY, 24"X72"	1	$ 1,607.00	$ 1,607.00
CAR6001	CART, HOUSEKEEPING	1	$ 648.00	$ 648.00
CLK2315	CLOCK, WIRELESS, SYNCHRONOUS DIG	6	$ 325.00	$ 1,950.00
CLM0650	COLUMN, FLOOR, MED GAS/ELEC & DATA	1	$ 2,100.00	$ 2,100.00
CMP0810	COMPUTER, IS, WORKSTATION	6	$ 2,800.00	$ 16,800.00
CTR1904	CONTAINER, SHARPS DISPOSAL, WALL MTD	9	$ 20.00	$ 180.00
DFB0012	DEFIBRILLATOR, MONITOR W/ PACING & AED	2	$ 16,800.00	$ 33,600.00
DSP2010	DISPENSERS, TOWEL, AUTOMATIC	10	$ 20.00	$ 200.00
DSP3301	DISPENSER, HAND SANITIZER	10	$ 5.00	$ 50.00
DSP7101	DISPENSER, SOAP	6	$ -	$ -
DSP7105	DISPENSER, SOAP, SCRUB SPONGE	2	$ -	$ -
FLM0101	FLOMETER AIR	7	$ 65.00	$ 455.00
FLM1501	FLOWMETER OXYGEN	7	$ 65.00	$ 455.00
GLB0401	GLOVEBOX, DOUBLE	7	$ 20.00	$ 140.00
HDW4405	HEADWALL UNIT, RECOVERY, 1 PATIENT	5	$ 1,950.00	$ 9,750.00
HMP1203	HAMPER, LINEN W/ LID	7	$ 115.00	$ 805.00
HMP2003	HAMPER, TRASH W/ LID	8	$ 80.00	$ 640.00
HOS1850	HOSE ASSEMBLY, HOSE RETRACTOR	6	$ 250.00	$ 1,500.00
INJ0108	INJECTOR, ANGIOGRAPHIC, CATH/ANGIO TABLE MT	1	$ 31,000.00	$ 31,000.00
MON1633	MONITOR, PHYSIOLOGICAL	1	$ 25,000.00	$ 25,000.00
MON1652	MONITOR, PHYSIOLOGICAL, ECG/NIBP/SAO2	6	$ 11,750.00	$ 70,500.00
MON4201	MONITOR, PHYSIOLOGICAL, CARDIAC CATH	1	$ 165,000.00	$ 165,000.00
NUR0301	NURSE CALL SYSTEM, CODE, BLUE	7	$ -	$ -

NUR0320	NURSE CALL SYSTEM, CODE, STAFF ASSIST NEEDED	6	$ -	$ -
NUR0401	NURSE CALL SYSTEM, DOME LIGHT	7	$ -	$ -
NUR1601	NURSE CALL SYSTEM, PATIENT STATION	6	$ -	$ -
NUR1901	NURSE CALL SYSTEM, STAFF STATION	2	$ -	$ -
PAC1801	PAC'S IMAGING SYS, READING STATION	1	$ 175,000.00	$ 175,000.00
PAC2350	PAC'S IMAGING SYS, WORK STATION	3	$ 30,000.00	$ 90,000.00
PMP0915	PUMP, INFUSION, VOLUMETRIC SINGLE CHANNEL	1	$ 3,600.00	$ 3,600.00
PMP0922	PUMP, INFUSION, 3-CHANNEL	2	$ 7,400.00	$ 14,800.00
PMP0951	PUMP, INFUSION, 1-CHANNEL	2	$ 5,150.00	$ 10,300.00
PRN0301	PRINTER, COMBO/PRINT/FAX/COPY	1	$ 550.00	$ 550.00
PRV0301	PROVISIONS FOR, COMMUNICATIONS, PHONE JACK	2	$ -	$ -
PRV0302	PROVISIONS FOR, COMMUNICATIONS, DATA JACK	2	$ -	$ -
PRV0501	PROVISIONS FOR, ELECTRICAL, 120 VAC 15 AMP SER	5	$ -	$ -
PRV0504	PROVISIONS FOR, ELECTRICAL, 120 VAC 20 AMP SER	4	$ -	$ -
PRV3901	PROVISIONS FOR, MEDICAL GAS, AIR	4	$ -	$ -
PRV3902	PROVISIONS FOR, MEDICAL GAS, OXYGEN	8	$ -	$ -
PRV3903	PROVISIONS FOR, MEDICAL GAS, VACUUM	8	$ -	$ -
PRV3907	PROVISIONS FOR, MEDICAL GAS, EVAC (WAG) ACTI	2	$ -	$ -
PRV7002	PROVISIONS FOR, ACCESS CONTROL PROX/KEYPAD	2	$ 750.00	$ 1,500.00
RAK0107	RACK, APRON/GLOVE, LEAD, 10 APRON STORAGE	4	$ 175.00	$ 700.00
RCP2330	RECEPTACLE, WASTE, SMALL	8	$ 35.00	$ 280.00
RCP2331	RECEPTACLE, WASTE, MEDIUM	10	$ 42.00	$ 420.00
RCP2332	RECEPTACLE, WASTE, LARGE	2	$ 35.00	$ 70.00
REG2201	REGULATOR, VACUUM	13	$ 390.00	$ 5,070.00
SHL2302	SHELVING, WIRE, 5-TIER, SS	2	$ 1,389.00	$ 2,778.00
SNK1904	SINK, SCRUB, DOUBLE BAY W/ CHAIR CARRIER	1	$ 7,600.00	$ 7,600.00
STD1301	STAND, MAYO, LARGE	1	$ 510.00	$ 510.00
STD6102	STAND, IV, MOBILE	2	$ 224.00	$ 448.00
STL0603	STOOL, FOOT, STACKING, 12X18X5	1	$ 115.00	$ 115.00
STR1802	STRETCHER, RECOVERY	7	$ 3,250.00	$ 22,750.00
TBL0908	TABLE, INSTRUMENTS, 24X48 W/ SHELF	1	$ 463.00	$ 463.00
TBL4201	TABLE, PREP, UTILITY, SMALL, 16X20	1	$ 515.00	$ 515.00
TBL6706	TABLE, OVERBED	6	$ 210.00	$ 1,260.00
TEL0042	TELEVISION, 42" WALL MOUNT	1	$ 2,100.00	$ 2,100.00
TEL1610	TELEVISION, PATIENT RM, COLOR, 10" W/ ARM MT	6	$ 1,054.00	$ 6,324.00
TRK0352	TRACK, CUBICLE CURTAIN	6	$ 100.00	$ 600.00
VAC0301	VACUUM CLEANER WET/DRY	1	$ 230.00	$ 230.00
WHC0102	WHEELCHAIR, ADULT, 16" OR 18" SEAT	1	$ 833.00	$ 833.00
WHC3402	WHEELCHAIR, HEAVY DUTY	1	$ 1,040.00	$ 1,040.00
ZCH0701	CHAIR, GUEST/PATIENT	8	$ 560.00	$ 4,480.00
ZCH2021	CHAIR, TASK/OFFICE	8	$ 525.00	$ 4,200.00
ZCH7120	CHAIR, SIDE/VISITOR	6	$ 420.00	$ 2,520.00
ZCH9760	CHAIR, WAITING	39	$ 375.00	$ 14,625.00
ZDE1920	DESK, STANDARD, 60X30	3	$ 550.00	$ 1,650.00
ZTA0501	TABLE, END, 22.5LX27.5DX24H	10	$ 300.00	$ 3,000.00
	SUBTOTAL			$ 1,060,987.00
	TAXES			$ 84,878.96
	SHIPPING			$ 106,439.00
	TOTAL			**$ 1,252,304.96**

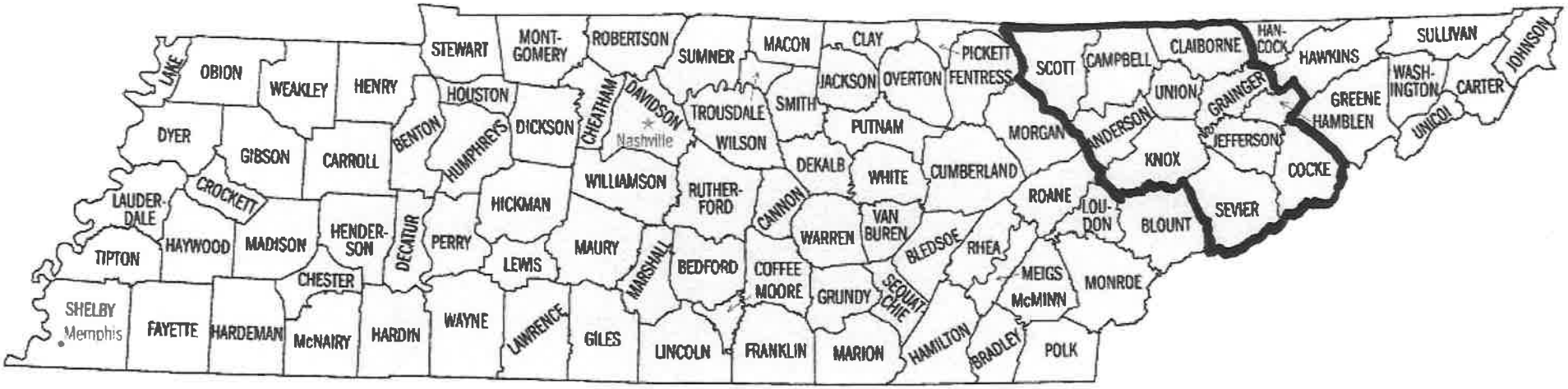
Attachment B.I.Project Description.3

METRO KNOXVILLE HMA, LLC

DIRECT AND INDIRECT OWNERSHIP



Attachment B.I.Project Description.4


LAKE
OBION
WEAKLEY
HENRY
STEWART
MONT-
GOMERY
ROBERTSON
SUMNER
MACON
CLAY
PICKETT
SCOTT
CAMPBELL
CLAIBORNE
HAN-
COCK
HAWKINS
SULLIVAN
JOHNSON
DYER
GIBSON
CARROLL
BENTON
HUMPHREYS
HOUSTON
DICKSON
CHEATHAM
DAVIDSON
Nashville
TROUSDALE
WILSON
SMITH
JACKSON
OVERTON
FENTRESS
PUTNAM
MORGAN
ANDERSON
UNION
GRAINGER
JEFFERSON
GREENE
HAMBLEN
WASH-
INGTON
CARTER
UNICOI
KNOX
COCKE
DEKALB
WHITE
CUMBERLAND
LAUDER-
DALE
CROCKETT
HICKMAN
WILLIAMSON
RUTHER-
FORD
CANNON
ROANE
LOU-
DON
BLOUNT
SEVIER
TIPTON
HAYWOOD
MADISON
HENDER-
SON
DECATUR
PERRY
MAURY
WARREN
VAN
BUREN
BLEDSOE
RHEA
CHESTER
LEWIS
MARSHALL
BEDFORD
COFFEE
MOORE
GRUNDY
SEQUAT-
CHIE
MEIGS
McMINN
MONROE
SHELBY
Memphis
FAYETTE
HARDEMAN
McNAIRY
HARDIN
WAYNE
LAWRENCE
GILES
LINCOLN
FRANKLIN
MARION
HAMILTON
BRADLEY
POLK

Attachment B.I.Project Description.5

Cardiac Catheterization Labs in the North Knoxville Medical Center Service Area
2011 Utilization

Facility	# of Cath Labs	Total	Proc. Per Lab	% of Capacity
Tennova - Physicians Reg.	4	6,535	1,634	82%
Tennova - Turkey Creek	2	3,074	1,537	77%
Ft. Sanders Regional	4	4,572	1,143	57%
Parkwest	5	13,201	2,640	132%
Methodist of Oak Ridge	2	3,286	1,643	82%
Morristown Hamblen	2	3,687	1,844	92%
LeConte	1	484	484	24%
UTMC	4	6,669	1,667	83%
Totals with Ave. Utilization	**24**	**41,508**	**1,730**	**86%**

*Note - Adult patients only; no pediatric patients included.
Source - 2012 JAR

Attachment B.I.Project Description.6

PHILIPS HEALTHCARE
A division of Philips Electronics North America Corporation
22100 Bothell Everett Highway
P.O. Box 3003
Bothell, Washington 98041-3003

PHILIPS

Quotation #: 1-X4CT9T	**Rev:** 1	**Effective From:** 08-Nov-12	**To:** 23-Dec-12

Presented To:

NORTH KNOXVILLE MEDICAL CENTER
7565 DANNAHER WAY
POWELL, TN 37849

ROB FOLLOWELL
CHIEF EXECUTIVE OFFICER
Tel:

Alternate Address:

Presented By:

Steve Wohlford
Account Manager
Tel: (865) 977-5012
Fax: (509) 696-2411

Steve Weiss
Regional Manager
Tel: (678) 924-6087
Fax: (678) 924-6003

Date Printed: 08-Nov-12

Submit Orders To:

22100 BOTHELL EVERETT HWY
BOTHELL WA 98021
Tel: (888) 564-8643
Fax:(425) 458-0390

This quotation contains confidential and proprietary information of Philips Healthcare, a division of Philips Electronics North America Corporation ("Philips") and is intended for use only by the customer whose name appears on this quotation. It may not be disclosed to third parties without the prior written consent of Philips.

IMPORTANT NOTICE: Health care providers are reminded that if the transactions herein include or involve a loan or discount (including a rebate or other price reduction), they must fully and accurately report such loan or discount on cost reports or other applicable reports or claims for payment submitted under any federal or state health care program, including but not limited to Medicare and Medicaid, such as may be required by state or federal law, including but not limited to 42 CFR 1001.952(h).

Quote Solution Summary

Line #	Product	Qty	Price
	100215 Allura Xper FD20	1	$1,600,000.00
		Equipment Total:	$1,600,000.00

Solution Summary Detail

Product	Qty	Each	Monthly	Price
100215 Allura Xper FD20	1	$1,600,000.00		$1,600,000.00

Buying Group: HEALTHTRUST PURCHASING GROUP **Contract #: 500005**

Addt'l Terms:

Each Quotation solution will reference a specific Buying Group/Contract Number representing an agreement containing discounts, fees and any specific terms and conditions which will apply to that single quoted solution. If no Buying Group/Contract Number is shown, Philips' Terms and Conditions of Sale will apply to the quoted solution.

Each equipment system listed on purchase order/orders represents a separate and distinct financial transaction. We understand and agree that each transaction is to be individually billed and paid.

Payment Terms: 0% Down, 80% Upon Delivery, 20% Due When the Product is Available for First Patient Use, Net due 30 days from date of invoice

100215 Allura Xper FD20

System Type: New
Freight Terms: FOB Destination
Warranty Terms: Part numbers beginning with two (2) asterisks (**) are covered by a System 12 Months Warranty. All other part numbers are third (3rd) party items.
Special Notations: Contingencies must be removed 120 days before scheduled shipment to assure delivery on specified date. Any rigging costs are the responsibility of the Purchaser.
Additional Terms:

Line #	Part #	Description	Qty
1	**NNAE311	Allura Xper FD20 C Rel. 8.1	1
2	**NCVC050	Non swivel, mounted ON floor	1
3	**NCVB618	HeartNavigator R1	1
4	**NCVB629	FlexVision XL,XperHD,Snapshot	1
5	**FCV0627	Bracket for Rad. Shield (ER)	1
6	**NCVB171	3D-RA R.6	1
7	**NCVB294	Set of 2 additional 21in. LCDs	1
8	**NCVB173	CT Trueview Rel2	1
9	**NCVB174	CT Trueview MultiVendor	1
10	**NCVA819	Stentboost sw Rel 3.0 Package	1
11	**NCVC018	replace into 21" monitor size in control room	1
12	**NCVB158	No existing Philips room	1
13	**NCVB175	Ceiling Rail extension set frontal	1
14	**NCVB121	Unknown (for quoting purposes)	1
15	**FCV0587	Xper Live/Ref Slaving	2
16	**NCVA089	RIS / CIS DICOM interface	1
17	**NCVA088	Standard Line Rate Video Output	1
18	**NCVA092	Lab Reporting	1
19	**NCVA781	Dicom Print compose	1
20	**NCVA080	Automatic Position Control (APC)	1
21	**NCVA801	Table APC	1
22	**NCVA695	FD Rotational Angio	1

100215 Allura Xper FD20			
Line #	Part #	Description	Qty
23	**NCVB209	Xper Swing	1
24	**NCVA093	Physio Viewing	1
25	**NCVA694	Subtracted Bolus Chase	1
26	**NCVA864	Storage extension	1
27	**NCVA672	FD SmartMask	1
28	**NCVB880	extension to 30Fr/sec (mono)	1
29	**NCVA121	FULL AUTOCAL	1
30	**NCVA784	Ventricular Quant.Sw pkg(Xper)	1
31	**NCVA793	Right ventricular quantification software package	1
32	**NCVA785	Coronary Quant.Sw pkg(Xper)	1
33	**NCVA786	Vascular Quant.Sw pkg(Xper)	1
34	**NCVA097	Cath Arm Support	1
35	**NCVA098	Pulse Cath Arm Support	1
36	**NCVA101	Peripheral X-ray Filter	1
37	**NCVA783	Pivot for table base.	1
38	**FCV4894	Add.op-rail with cable ext.kit	1
39	**FCV0017	CABLE CARRIER CS	3
40	**NCVB878	Interventional Tools Hardware	1
41	**NCVA116	3D RA Control for Xper Module	1
42	**NCVB168	3D Roadmap	1
43	**NCVA165	1st Xper Module in Exam.Room	1
44	**NCVA169	2nd Xper Mod. in Control Room	1
45	**NNAE391	FlexVision XL 8 Input Package	1

100215 Allura Xper FD20

NET PRICE $1,600,000.00

Buying Group: HEALTHTRUST PURCHASING GROUP Contract #: 500005

Addt'l Terms:

Each Quotation solution will reference a specific Buying Group/Contract Number representing an agreement containing discounts, fees and any specific terms and conditions which will apply to that single quoted solution. If no Buying Group/Contract Number is shown, Philips' Terms and Conditions of Sale will apply to the quoted solution.

Each equipment system listed on purchase order/orders represents a separate and distinct financial transaction. We understand and agree that each transaction is to be individually billed and paid.

Price above does not include any applicable sales taxes.

The preliminary delivery request date for this equipment is:_____.

If you do not issue formal purchase orders indicate by initialing here_____.

Tax Status:

Taxable_____ Tax Exempt_____

If Exempt, please indicate the Exemption Certification Number:_____, and attach a copy of the certificate.

Delivery/Installation Address:

_____

_____

_____

Invoice Address:

_____

_____

_____

Contact Phone #:

_____

Contact Phone #:

_____

Purchaser approval as quoted:

_____

Date:

_____

Title:

_____

This quotation is signed and accepted by an authorized representative in acknowledgement of the system configuration, terms and conditions stated herein.

Attachment B.I.Project Description.7

JOHNSON&GALYON
CONSTRUCTION

November 6, 2012

Ms. Melanie Robinson
Tennova Healthcare
900 E. Oak Hill Avenue
Knoxville, TN 37917

Re: **Tennova NKMC**
Cath Lab Renovations
Budget Estimate

Dear Melanie:

We are pleased to recommend a budget of One Million Three Hundred Two Thousand Two Hundred Eighty Nine Dollars ($1,302,289) for the above referenced project. Breakdowns of our cost estimates are attached. The estimates are based on the attached schematic drawing and descriptions of the HVAC System prepared by BarberMcMurry architects.

The estimates are summarized as follows:

Area 1 – Waiting Expansion and Consult	$ 158,901
Area 2 – Cath Lab	$ 979,902
Area 3 – Prep/Recovery Expansion	$ 163,486
Total:	$1,302,289

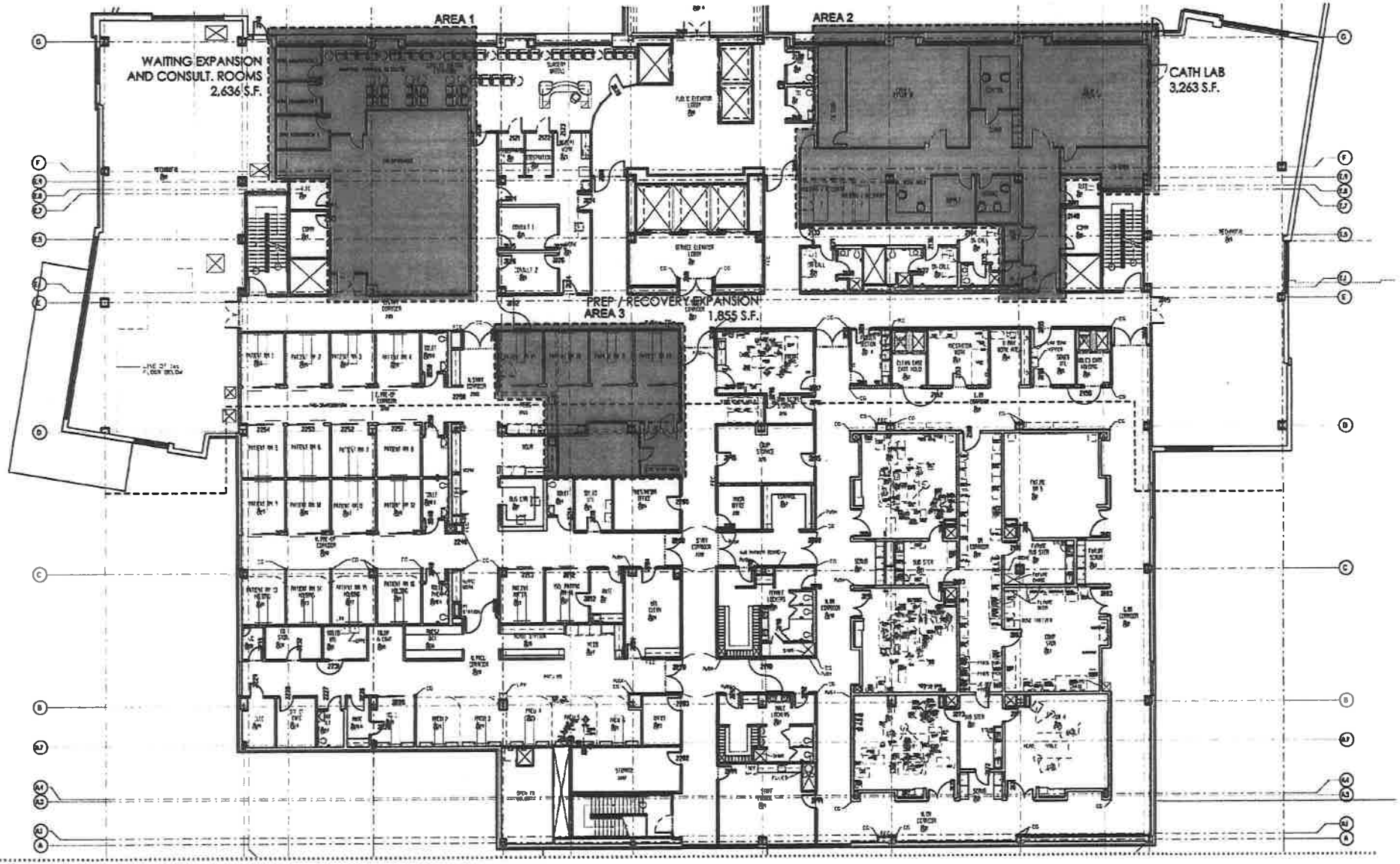
We appreciate the opportunity to be of service to you. Should you have any questions, please call.

Sincerely,

JOHNSON & GALYON, INC.

Mark A. Halcomb
Estimator

Attachments
Cc: Mike Driskill, BMa



12OCT2012

2 EXTENT OF WORK FLOOR PLAN
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 10 20 40

bma BARBER McMURRY
architects since 1915
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122300

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		GENERAL CONDITIONS				
	01312	Supervision				
		Project Superintendent	4.33 wk	1,838.82	7,962	
		Pickup Truck	4.33 wk	192.17	832	
		Supervision	2,636.00 sf	3.34	8,794	
	01320	Construction Documents				
		Extra Plans	1.00 ls	575.46	575	
		Construction Documents	2,636.00 sf	0.22	575	
	01400	Temp Protection - J&G				
		Temporary Protection	1.00 ls	1,587.67	1,588	
		Temp Protection - J&G	2,636.00 sf	0.60	1,588	
	01510	TEMPORARY UTILITIES				
		Jobsite Cell Phones	1.00 mo	97.83	98	
		TEMPORARY UTILITIES	2,636.00 sf	0.04	98	
	01600	Safety				
		First Aid Kits	1.00 ea	157.10	157	
		Fire Extinguisher	1.00 ea	97.82	98	
		Safety	2,636.00 sf	0.10	255	
	01610	Hospital Infection Control				
		Infection Control	4.33 wk	740.91	3,208	
		Hospital Infection Control	2,636.00 sf	1.22	3,208	
	01720	Layout				
		Interior Walls	8.00 hr	68.80	550	
		Layout	2,636.00 sf	0.21	550	
	01740	Clean Up				
		Dumping Fees	1.00 each	374.06	374	
		Clean Building Area	2,636.00 sf	0.84	2,202	
		Sub Final Cleaning	2,636.00 sf	0.30	781	
		Clean Up	2,636.00 sf	1.27	3,357	
		GENERAL CONDITIONS	**2,636.00 sf**	**6.99**	**18,425**	
02000		SITEWORK				
	02015	Cutting & Patching				
		Cutting & Patching	1.00 ls	1,058.44	1,058	
		Cutting & Patching	2,636.00 Sf	0.40	1,058	
	02020	Dust Partition				
		Dust Partitons	1.00 ls	529.22	529	
		Dust Partition	2,636.00 Sf	0.20	529	
	02225	SELECTIVE DEMOLITION				
		General Demolition	2,636.00 sf	1.43	3,766	
		SELECTIVE DEMOLITION	2,636.00 sf	1.43	3,766	
		SITEWORK	**2,636.00 sf**	**2.03**	**5,353**	
06000		WOOD & PLASTICS				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	32.00 sf	0.79	25	
		ROUGH CARPENTRY- Framing	2,636.00 sf	0.01	25	
	06410	Millwork				
		Millwork	1.00 ls	0.02	0	None Shown

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		Millwork	2,636.00 sf	0.00	0	
		WOOD & PLASTICS	**2,636.00 sf**	**0.01**	**25**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofing				
		Firestopping / Fire Proof Patching	1.00 ls	1,058.43	1,058	
		FIRESTOPPING / Fire Proofing	2,636.00 sf	0.40	1,058	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	158.77	159	
		JOINT SEALANTS	2,636.00 sf	0.06	159	
		THERMAL/MOISTURE PROTECT	**2,636.00 sf**	**0.46**	**1,217**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	624.48	624	
		Wood Door Material	1.00 ls	841.46	841	
		Finish Hardware	1.00 ls	1,312.47	1,312	
		Glass for Standard Window	1.00 ls	0.01	0	
		Labor - Door, Frame & Hardware	5.00 ea	328.36	1,642	
		Doors, Frames & Hardware	2,636.00 sf	1.68	4,420	
		DOORS & WINDOWS	**2,636.00 sf**	**1.68**	**4,420**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching	1.00 ls	39,596.24	39,596	
		Acoustical Ceilings	1.00 ls	0.01	0	Included Above
		GYPSUM WALL BOARD	2,636.00 sf	15.02	39,596	
	09680	CARPET				
		Flooring Allowance	1.00 ls	9,039.07	9,039	
		CARPET	2,636.00 sf	3.43	9,039	
	09910	PAINTING				
		Painting	2,636.00 sf	2.12	5,580	
		PAINTING	2,636.00 sf	2.12	5,580	
		FINISHES	**2,636.00 sf**	**20.57**	**54,215**	
15000		**MECHANICAL**				
	15050	Mechanical				
		HVAC & Plumbing	1.00 ls	25,796.29	25,796	
		Mechanical	2,636.00 sf	9.79	25,796	
	15300	Sprinkler System				
		Fire Protection Bid	2,636.00 sf	1.59	4,185	
		Sprinkler System	2,636.00 sf	1.59	4,185	
		MECHANICAL	**2,636.00 sf**	**11.37**	**29,981**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Electrical	1.00 ls	35,944.62	35,945	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		ELECTRICAL	2,636.00 sf	13.64	35,945	
		ELECTRICAL	**2,636.00 sf**	**13.64**	**35,945**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	15.207				5.769 /sf	9.57%
Material	2.040				0.774 /sf	1.28%
Subcontract	131.878				50.029 /sf	82.99%
Equipment	458				0.174 /sf	0.29%
Other						
	149,583	149,583			56.746 /sf	94.14
Knoxville Review Fee	255				0.097 /sf	0.16%
Knoxville City Permit	636				0.241 /sf	0.40%
	891	150,474			57.084 /sf	0.56
General Liability - 0.15%	238		0.150 %	T	0.090 /sf	0.15%
P&P Bond - 2009 rates	1,001				0.380 /sf	0.63%
	1,239	151,713			57.554 /sf	0.78
Fee	7,188		5.000 %		2.727 /sf	4.52%
	7,188	158,901			60.281 /sf	4.52
Total		***158,901***			***60.281 /sf***	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		**GENERAL CONDITIONS**				
	01312	**Supervision**				
		Project Superintendent	13.00 wk	1,837.76	23,891	
		Pickup Truck	13.00 wk	192.03	2,496	
		Supervision	3,263.00 sf	8.09	26,387	
	01320	**Construction Documents**				
		Extra Plans	1.00 ls	575.10	575	
		Construction Documents	3,263.00 sf	0.18	575	
	01400	**Temp Protection - J&G**				
		Temporary Protection	1.00 ls	1,586.53	1,587	
		Temp Protection - J&G	3,263.00 sf	0.49	1,587	
	01510	**TEMPORARY UTILITIES**				
		Jobsite Cell Phones	3.00 mo	97.76	293	
		TEMPORARY UTILITIES	3,263.00 sf	0.09	293	
	01600	**Safety**				
		First Aid Kits	1.00 ea	157.01	157	
		Fire Extinguisher	1.00 ea	97.76	98	
		Safety	3,263.00 sf	0.08	255	
	01610	**Hospital Infection Control**				
		Infection Control	13.00 wk	740.38	9,625	
		Hospital Infection Control	3,263.00 sf	2.95	9,625	
	01720	**Layout**				
		Interior Walls	8.00 hr	68.75	550	
		Layout	3,263.00 sf	0.17	550	
	01740	**Clean Up**				
		Dumping Fees	3.00 each	373.81	1,121	
		Clean Building Area	3,235.00 sf	0.83	2,700	
		Sub Final Cleaning	3,235.00 sf	0.30	958	
		Clean Up	3,263.00 sf	1.46	4,780	
		GENERAL CONDITIONS	**3,263.00 sf**	**13.50**	**44,052**	
02000		**SITEWORK**				
	02015	**Cutting & Patching**				
		Cutting & Patching	1.00 ls	5,288.42	5,288	
		Cutting & Patching	3,263.00 Sf	1.62	5,288	
	02020	**Dust Partition**				
		Dust Partitons	1.00 ls	3,173.05	3,173	
		Dust Partition	3,263.00 Sf	0.97	3,173	
	02225	**SELECTIVE DEMOLITION**				
		General Demolition	3,235.00 sf	1.43	4,619	
		SELECTIVE DEMOLITION	3,263.00 sf	1.42	4,619	
		SITEWORK	**3,263.00 sf**	**4.01**	**13,080**	
05000		**METALS**				
	05510	**MISC. METALS**				
		Equipment Supports	2.00 room	26,970.95	53,942	
		MISC. METALS	3,263.00 sf	16.53	53,942	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		METALS	**3,263.00 sf**	**16.53**	**53,942**	
06000		**WOOD & PLASTICS**				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	3,235.00 sf	0.79	2,566	
		ROUGH CARPENTRY- Framing	3,263.00 sf	0.79	2,566	
	06410	Millwork				
		Millwork	1.00 ls	7,403.79	7,404	
		Millwork	3,263.00 sf	2.27	7,404	
		WOOD & PLASTICS	**3,263.00 sf**	**3.06**	**9,970**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofin				
		Firestopping / Fire Proof Patching	1.00 ls	2,644.21	2,644	
		FIRESTOPPING / Fire Proofin	3,263.00 sf	0.81	2,644	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	264.42	264	
		JOINT SEALANTS	3,263.00 sf	0.08	264	
		THERMAL/MOISTURE PROTECT	**3,263.00 sf**	**0.89**	**2,909**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	5,831.43	5,831	
		Wood Door Material	1.00 ls	8,310.09	8,310	
		Finish Hardware	1.00 ls	8,695.40	8,695	
		Lead Glass	1.00 ls	7,418.68	7,419	
		Glass for Standard Window	1.00 ls	287.55	288	
		Labor - Door, Frame & Hardware	13.00 ea	328.17	4,266	
		Labor - HM Window Frame & Glass	1.00 ea	131.27	131	
		Labor - Lead Glass Window	2.00 ea	656.35	1,313	
		Doors, Frames & Hardware	3,263.00 sf	11.11	36,253	
		DOORS & WINDOWS	**3,263.00 sf**	**11.11**	**36,253**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching, including Lead Lined	1.00 ls	46,322.34	46,322	
		Acoustical Ceilings	1.00 ls	11,444.14	11,444	
		GYPSUM WALL BOARD	3,263.00 sf	17.70	57,766	
	09680	CARPET				
		Flooring Allowance	1.00 ls	26,399.80	26,400	
		CARPET	3,263.00 sf	8.09	26,400	
	09910	PAINTING				
		Painting	3,235.00 ls	2.12	6,843	
		PAINTING	3,263.00 sf	2.10	6,843	
		FINISHES	**3,263.00 sf**	**27.89**	**91,010**	
10000		**SPECIALTIES**				
	10190	Cubicles Curtain Track				

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
	10190	Cubicles Curtain Track				
		Allowance	1.00 ls	1,586.53	1,587	
		Cubicles Curtain Track	3,263.00 sf	0.49	1,587	
	10810	Toilet Accessories				
		Allowance	1.00 ls	353.17	353	
		Toilet Accessories	3,263.00 sf	0.11	353	
		SPECIALTIES	**3,263.00 sf**	**0.59**	**1,940**	
11000		**EQUIPMENT**				
	11710	MEDICAL EQUIPMENT				
		Install Owner Provided Equipment	1.00 ls	0.01	0	Not Included
		MEDICAL EQUIPMENT	3,263.00 sf	0.00	0	
		EQUIPMENT	**3,263.00 sf**	**0.00**	**0**	
13000		**SPECIAL CONSTRUCTION**				
	13090	RADIATION PROTECTION				
		Lead Lined Sheetrock	1.00 ls	0.01	0	w/ Drywall Item
		Lead Glass View Window	1.00 ls	0.01	0	w/ Doors Item
		Lead Lined Door	1.00 ls	0.01	0	w/ Doors Item
		RADIATION PROTECTION	3,263.00 sf	0.00	0	
		SPECIAL CONSTRUCTION	**3,263.00 sf**	**0.00**	**0**	
15000		**MECHANICAL**				
	15050	Mechanical				
		Heart Cath Lab	1.00 ls	118,749.39	118,749	
		Additional AHU	1.00 ls	200,928.30	200,928	
		Mechanical	3,263.00 sf	97.97	319,678	
	15300	Sprinkler System				
		Fire Protection Bid	3,235.00 sf	1.59	5,132	
		Sprinkler System	3,263.00 sf	1.57	5,132	
		MECHANICAL	**3,263.00 sf**	**99.54**	**324,810**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Heart Cath Lab	1.00 ls	330,695.58	330,696	
		Additional AHU	1.00 ls	15,619.88	15,620	
		ELECTRICAL	3,263.00 sf	106.13	346,315	
		ELECTRICAL	**3,263.00 sf**	**106.13**	**346,315**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	36.539				11.198 /sf	3.73%
Material	34.643				10.617 /sf	3.54%
Subcontract	851.723				261.025 /sf	86.92%
Equipment	1.375				0.421 /sf	0.14%
Other						
	924,280	924,280			283.261 /sf	94.32
Knoxville Review Fee	450				0.138 /sf	0.05%
Knoxville City Permit	3,200				0.981 /sf	0.33%
	3,650	927,930			284.379 /sf	0.37
General Liability - 0.15%	1,470		0.150 %	T	0.450 /sf	0.15%
P&P Bond - 2009 rates	6,173				1.892 /sf	0.63%
	7,643	935,573			286.722 /sf	0.78
Fee	44,329		5.000 %		13.585 /sf	4.52%
	44,329	979,902			300.307 /sf	4.52
Total		***979,902***			***300.307 /sf***	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		**GENERAL CONDITIONS**				
	01312	Supervision				
		Project Superintendent	6.00 wk	1,838.96	11,034	
		Pickup Truck	6.00 wk	192.18	1,153	
		Supervision	1,855.00 sf	6.57	12,187	
	01320	Construction Documents				
		Extra Plans	1.00 ls	575.52	576	
		Construction Documents	1,855.00 sf	0.31	576	
	01400	Temp Protection - J&G				
		Temporary Protection	1.00 ls	1,587.81	1,588	
		Temp Protection - J&G	1,855.00 sf	0.86	1,588	
	01510	TEMPORARY UTILITIES				
		Jobsite Cell Phones	1.50 mo	97.85	147	
		TEMPORARY UTILITIES	1,855.00 sf	0.08	147	
	01600	Safety				
		First Aid Kits	1.00 ea	157.11	157	
		Fire Extinguisher	1.00 ea	97.84	98	
		Safety	1,855.00 sf	0.14	255	
	01610	Hospital Infection Control				
		Infection Control	6.00 wk	740.98	4,446	
		Hospital Infection Control	1,855.00 sf	2.40	4,446	
	01720	Layout				
		Interior Walls	8.00 hr	68.81	550	
		Layout	1,855.00 sf	0.30	550	
	01740	Clean Up				
		Dumping Fees	2.00 each	374.09	748	
		Clean Building Area	1,855.00 sf	0.84	1,549	
		Sub Final Cleaning	1,855.00 sf	0.30	550	
		Clean Up	1,855.00 sf	1.53	2,847	
		GENERAL CONDITIONS	**1,855.00 sf**	**12.18**	**22,596**	
02000		**SITEWORK**				
	02015	Cutting & Patching				
		Cutting & Patching	1.00 ls	1,587.81	1,588	
		Cutting & Patching	1,855.00 Sf	0.86	1,588	
	02020	Dust Partition				
		Dust Partitons	1.00 ls	1,587.81	1,588	
		Dust Partition	1,855.00 Sf	0.86	1,588	
	02225	SELECTIVE DEMOLITION				
		General Demolition	1,855.00 sf	1.43	2,650	
		SELECTIVE DEMOLITION	1,855.00 sf	1.43	2,650	
		SITEWORK	**1,855.00 sf**	**3.14**	**5,826**	
06000		**WOOD & PLASTICS**				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	1,855.00 sf	0.79	1,473	
		ROUGH CARPENTRY- Framing	1,855.00 sf	0.79	1,473	
	06410	Millwork				
		Millwork	1.00 ls	4,234.15	4,234	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		Millwork	1,855.00 sf	2.28	4,234	
		WOOD & PLASTICS	**1,855.00 sf**	**3.08**	**5,707**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofing				
		Firestopping / Fire Proof Patching	1.00 ls	1,587.82	1,588	
		FIRESTOPPING / Fire Proofing	1,855.00 sf	0.86	1,588	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	211.71	212	
		JOINT SEALANTS	1,855.00 sf	0.11	212	
		THERMAL/MOISTURE PROTECT	**1,855.00 sf**	**0.97**	**1,800**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	418.13	418	
		Wood Door Material	1.00 ls	682.75	683	
		Finish Hardware	1.00 ls	1,227.91	1,228	
		Recovery Room Sliding Door System	4.00 ea	2,064.16	8,257	
		Labor - Door, Frame & Hardware	2.00 ea	328.39	657	
		Automatic Door Operators	1.00 pr	4,763.43	4,763	
		Doors, Frames & Hardware	1,855.00 sf	8.63	16,006	
		DOORS & WINDOWS	**1,855.00 sf**	**8.63**	**16,006**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching	1.00 ls	24,355.97	24,356	
		Acoustical Ceilings	1.00 ls	0.01	0	Included Above
		GYPSUM WALL BOARD	1,855.00 sf	13.13	24,356	
	09680	CARPET				
		Flooring Allowance	1.00 ls	9,124.62	9,125	
		CARPET	1,855.00 sf	4.92	9,125	
	09910	PAINTING				
		Painting	1,855.00 sf	2.12	3,927	
		PAINTING	1,855.00 sf	2.12	3,927	
		FINISHES	**1,855.00 sf**	**20.17**	**37,408**	
10000		**SPECIALTIES**				
	10130	Wall & Impact Rails				
		Wall Bumper Rails & Corner Guards	1.00 ls	2,054.94	2,055	
		Wall & Impact Rails			2,055	
	10810	Toilet Accessories				
		Allowance	1.00 ls	144.00	144	
		Toilet Accessories	1,855.00 sf	0.08	144	
		SPECIALTIES	**1,855.00 sf**	**1.19**	**2,199**	
11000		**EQUIPMENT**				
	11710	MEDICAL EQUIPMENT				
		Install Owner Provided Equipment	1.00 ls	0.01	0	Not Included

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		MEDICAL EQUIPMENT	1,855.00 sf	0.00	0	
		EQUIPMENT	**1,855.00 sf**	**0.00**	**0**	
15000		**MECHANICAL**				
	15050	Mechanical				
		HVAC & Plumbing / Med Gas	1.00 ls	27,700.96	27,701	
		Mechanical	1,855.00 sf	14.93	27,701	
	15300	Sprinkler System				
		Fire Protection Bid	1,855.00 sf	1.59	2,945	
		Sprinkler System	1,855.00 sf	1.59	2,945	
		MECHANICAL	**1,855.00 sf**	**16.52**	**30,646**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Electrical	1.00 ls	31,713.89	31,714	
		ELECTRICAL	1,855.00 sf	17.10	31,714	
		ELECTRICAL	**1,855.00 sf**	**17.10**	**31,714**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	15,991				8.621 /sf	9.78%
Material	4,341				2.340 /sf	2.66%
Subcontract	132,933				71.662 /sf	81.31%
Equipment	635				0.342 /sf	0.39%
Other						
	153,900	153,900			82.965 /sf	94.14
Knoxville Review Fee	261				0.141 /sf	0.16%
Knoxville City Permit	654				0.353 /sf	0.40%
	915	154,815			83.458 /sf	0.56
General Liability - 0.15%	245		0.150 %	T	0.132 /sf	0.15%
P&P Bond - 2009 rates	1,030				0.555 /sf	0.63%
	1,275	156,090			84.146 /sf	0.78
Fee	7,396		5.000 %		3.987 /sf	4.52%
	7,396	163,486			88.133 /sf	4.52
Total		***163,486***			***88.133 /sf***	

Attachment B.II.A

JOHNSON&GALYON
CONSTRUCTION

November 6, 2012

Ms. Melanie Robinson
Tennova Healthcare
900 E. Oak Hill Avenue
Knoxville, TN 37917

Re: **Tennova NKMC**
Cath Lab Renovations
Budget Estimate

Dear Melanie:

We are pleased to recommend a budget of One Million Three Hundred Two Thousand Two Hundred Eighty Nine Dollars ($1,302,289) for the above referenced project. Breakdowns of our cost estimates are attached. The estimates are based on the attached schematic drawing and descriptions of the HVAC System prepared by BarberMcMurry architects.

The estimates are summarized as follows:

Area 1 – Waiting Expansion and Consult	$ 158,901
Area 2 – Cath Lab	$ 979,902
Area 3 – Prep/Recovery Expansion	$ 163,486
Total:	$1,302,289

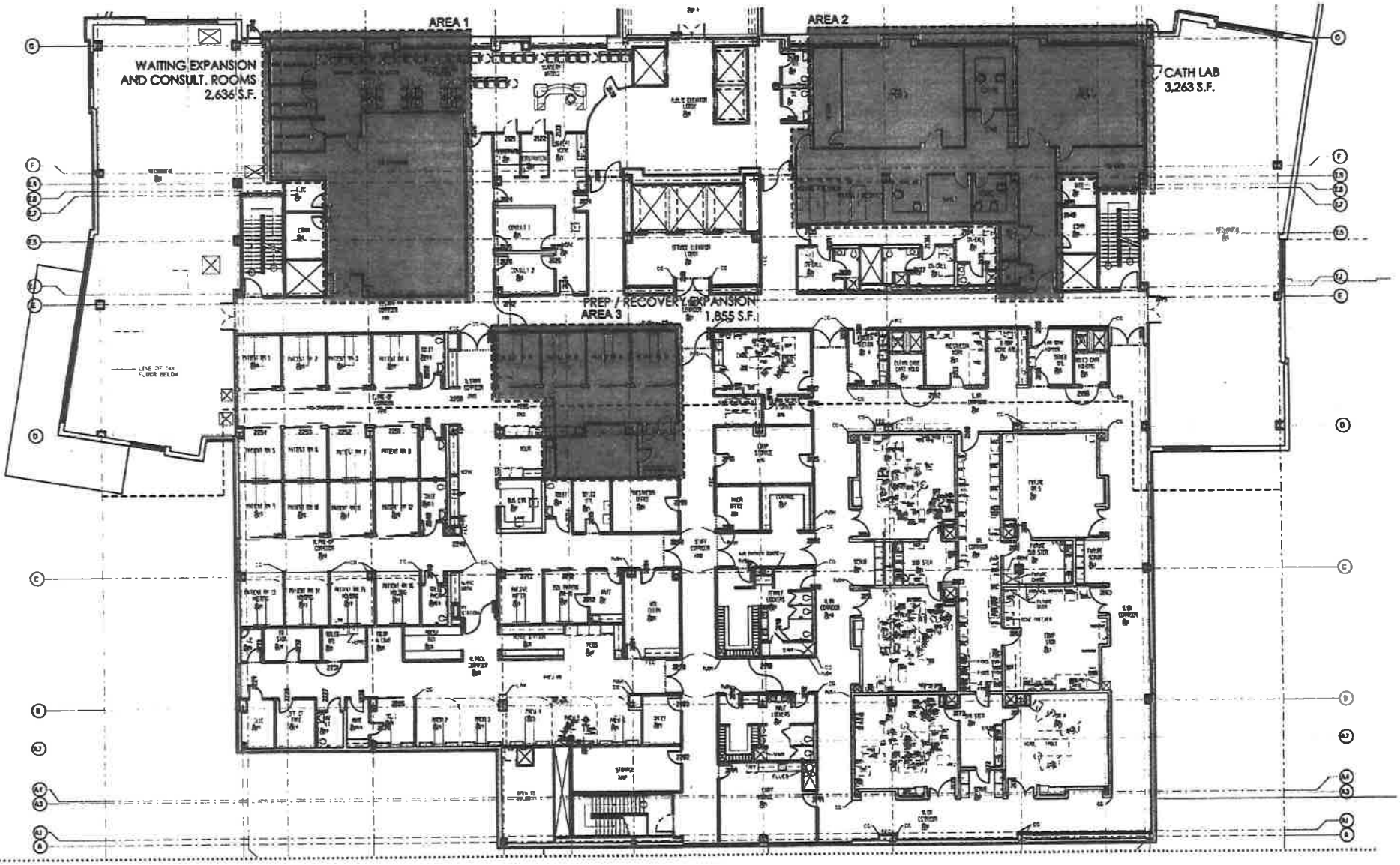
We appreciate the opportunity to be of service to you. Should you have any questions, please call.

Sincerely,

JOHNSON & GALYON, INC.

Mark A. Halcomb
Estimator

Attachments
Cc: Mike Driskill, BMa



12OCT2012

2 EXTENT OF WORK FLOOR PLAN
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 10 20 40

bma BARBER McMURRY
architects since 1915

122300

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		GENERAL CONDITIONS				
	01312	Supervision				
		Project Superintendent	4.33 wk	1,838.82	7,962	
		Pickup Truck	4.33 wk	192.17	832	
		Supervision	2,636.00 sf	3.34	8,794	
	01320	Construction Documents				
		Extra Plans	1.00 ls	575.46	575	
		Construction Documents	2,636.00 sf	0.22	575	
	01400	Temp Protection - J&G				
		Temporary Protection	1.00 ls	1,587.67	1,588	
		Temp Protection - J&G	2,636.00 sf	0.60	1,588	
	01510	TEMPORARY UTILITIES				
		Jobsite Cell Phones	1.00 mo	97.83	98	
		TEMPORARY UTILITIES	2,636.00 sf	0.04	98	
	01600	Safety				
		First Aid Kits	1.00 ea	157.10	157	
		Fire Extinguisher	1.00 ea	97.82	98	
		Safety	2,636.00 sf	0.10	255	
	01610	Hospital Infection Control				
		Infection Control	4.33 wk	740.91	3,208	
		Hospital Infection Control	2,636.00 sf	1.22	3,208	
	01720	Layout				
		Interior Walls	8.00 hr	68.80	550	
		Layout	2,636.00 sf	0.21	550	
	01740	Clean Up				
		Dumping Fees	1.00 each	374.06	374	
		Clean Building Area	2,636.00 sf	0.84	2,202	
		Sub Final Cleaning	2,636.00 sf	0.30	781	
		Clean Up	2,636.00 sf	1.27	3,357	
		GENERAL CONDITIONS	**2,636.00 sf**	**6.99**	**18,425**	
02000		SITEWORK				
	02015	Cutting & Patching				
		Cutting & Patching	1.00 ls	1,058.44	1,058	
		Cutting & Patching	2,636.00 Sf	0.40	1,058	
	02020	Dust Partition				
		Dust Partitons	1.00 ls	529.22	529	
		Dust Partition	2,636.00 Sf	0.20	529	
	02225	SELECTIVE DEMOLITION				
		General Demolition	2,636.00 sf	1.43	3,766	
		SELECTIVE DEMOLITION	2,636.00 sf	1.43	3,766	
		SITEWORK	**2,636.00 sf**	**2.03**	**5,353**	
06000		WOOD & PLASTICS				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	32.00 sf	0.79	25	
		ROUGH CARPENTRY- Framing	2,636.00 sf	0.01	25	
	06410	Millwork				
		Millwork	1.00 ls	0.02	0	None Shown

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		Millwork	2,636.00 sf	0.00	0	
		WOOD & PLASTICS	**2,636.00 sf**	**0.01**	**25**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofing				
		Firestopping / Fire Proof Patching	1.00 ls	1,058.43	1,058	
		FIRESTOPPING / Fire Proofing	2,636.00 sf	0.40	1,058	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	158.77	159	
		JOINT SEALANTS	2,636.00 sf	0.06	159	
		THERMAL/MOISTURE PROTECT	**2,636.00 sf**	**0.46**	**1,217**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	624.48	624	
		Wood Door Material	1.00 ls	841.46	841	
		Finish Hardware	1.00 ls	1,312.47	1,312	
		Glass for Standard Window	1.00 ls	0.01	0	
		Labor - Door, Frame & Hardware	5.00 ea	328.36	1,642	
		Doors, Frames & Hardware	2,636.00 sf	1.68	4,420	
		DOORS & WINDOWS	**2,636.00 sf**	**1.68**	**4,420**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching	1.00 ls	39,596.24	39,596	
		Acoustical Ceilings	1.00 ls	0.01	0	Included Above
		GYPSUM WALL BOARD	2,636.00 sf	15.02	39,596	
	09680	CARPET				
		Flooring Allowance	1.00 ls	9,039.07	9,039	
		CARPET	2,636.00 sf	3.43	9,039	
	09910	PAINTING				
		Painting	2,636.00 sf	2.12	5,580	
		PAINTING	2,636.00 sf	2.12	5,580	
		FINISHES	**2,636.00 sf**	**20.57**	**54,215**	
15000		**MECHANICAL**				
	15050	Mechanical				
		HVAC & Plumbing	1.00 ls	25,796.29	25,796	
		Mechanical	2,636.00 sf	9.79	25,796	
	15300	Sprinkler System				
		Fire Protection Bid	2,636.00 sf	1.59	4,185	
		Sprinkler System	2,636.00 sf	1.59	4,185	
		MECHANICAL	**2,636.00 sf**	**11.37**	**29,981**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Electrical	1.00 ls	35,944.62	35,945	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		ELECTRICAL	2,636.00 sf	13.64	35,945	
		ELECTRICAL	**2,636.00 sf**	**13.64**	**35,945**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	15.207				5.769 /sf	9.57%
Material	2.040				0.774 /sf	1.28%
Subcontract	131.878				50.029 /sf	82.99%
Equipment	458				0.174 /sf	0.29%
Other						
	149,583	149,583			56.746 /sf	94.14
Knoxville Review Fee	255				0.097 /sf	0.16%
Knoxville City Permit	636				0.241 /sf	0.40%
	891	150,474			57.084 /sf	0.56
General Liability - 0.15%	238		0.150 %	T	0.090 /sf	0.15%
P&P Bond - 2009 rates	1,001				0.380 /sf	0.63%
	1,239	151,713			57.554 /sf	0.78
Fee	7,188		5.000 %		2.727 /sf	4.52%
	7,188	158,901			60.281 /sf	4.52
Total		***158,901***			***60.281 /sf***	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		GENERAL CONDITIONS				
	01312	Supervision				
		Project Superintendent	13.00 wk	1,837.76	23,891	
		Pickup Truck	13.00 wk	192.03	2,496	
		Supervision	3,263.00 sf	8.09	26,387	
	01320	Construction Documents				
		Extra Plans	1.00 ls	575.10	575	
		Construction Documents	3,263.00 sf	0.18	575	
	01400	Temp Protection - J&G				
		Temporary Protection	1.00 ls	1,586.53	1,587	
		Temp Protection - J&G	3,263.00 sf	0.49	1,587	
	01510	TEMPORARY UTILITIES				
		Jobsite Cell Phones	3.00 mo	97.76	293	
		TEMPORARY UTILITIES	3,263.00 sf	0.09	293	
	01600	Safety				
		First Aid Kits	1.00 ea	157.01	157	
		Fire Extinguisher	1.00 ea	97.76	98	
		Safety	3,263.00 sf	0.08	255	
	01610	Hospital Infection Control				
		Infection Control	13.00 wk	740.38	9,625	
		Hospital Infection Control	3,263.00 sf	2.95	9,625	
	01720	Layout				
		Interior Walls	8.00 hr	68.75	550	
		Layout	3,263.00 sf	0.17	550	
	01740	Clean Up				
		Dumping Fees	3.00 each	373.81	1,121	
		Clean Building Area	3,235.00 sf	0.83	2,700	
		Sub Final Cleaning	3,235.00 sf	0.30	958	
		Clean Up	3,263.00 sf	1.46	4,780	
		GENERAL CONDITIONS	**3,263.00 sf**	**13.50**	**44,052**	
02000		SITEWORK				
	02015	Cutting & Patching				
		Cutting & Patching	1.00 ls	5,288.42	5,288	
		Cutting & Patching	3,263.00 Sf	1.62	5,288	
	02020	Dust Partition				
		Dust Partitons	1.00 ls	3,173.05	3,173	
		Dust Partition	3,263.00 Sf	0.97	3,173	
	02225	SELECTIVE DEMOLITION				
		General Demolition	3,235.00 sf	1.43	4,619	
		SELECTIVE DEMOLITION	3,263.00 sf	1.42	4,619	
		SITEWORK	**3,263.00 sf**	**4.01**	**13,080**	
05000		METALS				
	05510	MISC. METALS				
		Equipment Supports	2.00 room	26,970.95	53,942	
		MISC. METALS	3,263.00 sf	16.53	53,942	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		METALS	**3,263.00 sf**	**16.53**	**53,942**	
06000		**WOOD & PLASTICS**				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	3,235.00 sf	0.79	2,566	
		ROUGH CARPENTRY- Framing	3,263.00 sf	0.79	2,566	
	06410	Millwork				
		Millwork	1.00 ls	7,403.79	7,404	
		Millwork	3,263.00 sf	2.27	7,404	
		WOOD & PLASTICS	**3,263.00 sf**	**3.06**	**9,970**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofin				
		Firestopping / Fire Proof Patching	1.00 ls	2,644.21	2,644	
		FIRESTOPPING / Fire Proofin	3,263.00 sf	0.81	2,644	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	264.42	264	
		JOINT SEALANTS	3,263.00 sf	0.08	264	
		THERMAL/MOISTURE PROTECT	**3,263.00 sf**	**0.89**	**2,909**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	5,831.43	5,831	
		Wood Door Material	1.00 ls	8,310.09	8,310	
		Finish Hardware	1.00 ls	8,695.40	8,695	
		Lead Glass	1.00 ls	7,418.68	7,419	
		Glass for Standard Window	1.00 ls	287.55	288	
		Labor - Door, Frame & Hardware	13.00 ea	328.17	4,266	
		Labor - HM Window Frame & Glass	1.00 ea	131.27	131	
		Labor - Lead Glass Window	2.00 ea	656.35	1,313	
		Doors, Frames & Hardware	3,263.00 sf	11.11	36,253	
		DOORS & WINDOWS	**3,263.00 sf**	**11.11**	**36,253**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching, including Lead Lined	1.00 ls	46,322.34	46,322	
		Acoustical Ceilings	1.00 ls	11,444.14	11,444	
		GYPSUM WALL BOARD	3,263.00 sf	17.70	57,766	
	09680	CARPET				
		Flooring Allowance	1.00 ls	26,399.80	26,400	
		CARPET	3,263.00 sf	8.09	26,400	
	09910	PAINTING				
		Painting	3,235.00 ls	2.12	6,843	
		PAINTING	3,263.00 sf	2.10	6,843	
		FINISHES	**3,263.00 sf**	**27.89**	**91,010**	
10000		**SPECIALTIES**				
	10190	Cubicles Curtain Track				

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
	10190	Cubicles Curtain Track				
		Allowance	1.00 ls	1,586.53	1,587	
		Cubicles Curtain Track	3,263.00 sf	0.49	1,587	
	10810	Toilet Accessories				
		Allowance	1.00 ls	353.17	353	
		Toilet Accessories	3,263.00 sf	0.11	353	
		SPECIALTIES	**3,263.00 sf**	**0.59**	**1,940**	
11000		**EQUIPMENT**				
	11710	MEDICAL EQUIPMENT				
		Install Owner Provided Equipment	1.00 ls	0.01	0	Not Included
		MEDICAL EQUIPMENT	3,263.00 sf	0.00	0	
		EQUIPMENT	**3,263.00 sf**	**0.00**	**0**	
13000		**SPECIAL CONSTRUCTION**				
	13090	RADIATION PROTECTION				
		Lead Lined Sheetrock	1.00 ls	0.01	0	w/ Drywall Item
		Lead Glass View Window	1.00 ls	0.01	0	w/ Doors Item
		Lead Lined Door	1.00 ls	0.01	0	w/ Doors Item
		RADIATION PROTECTION	3,263.00 sf	0.00	0	
		SPECIAL CONSTRUCTION	**3,263.00 sf**	**0.00**	**0**	
15000		**MECHANICAL**				
	15050	Mechanical				
		Heart Cath Lab	1.00 ls	118,749.39	118,749	
		Additional AHU	1.00 ls	200,928.30	200,928	
		Mechanical	3,263.00 sf	97.97	319,678	
	15300	Sprinkler System				
		Fire Protection Bid	3,235.00 sf	1.59	5,132	
		Sprinkler System	3,263.00 sf	1.57	5,132	
		MECHANICAL	**3,263.00 sf**	**99.54**	**324,810**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Heart Cath Lab	1.00 ls	330,695.58	330,696	
		Additional AHU	1.00 ls	15,619.88	15,620	
		ELECTRICAL	3,263.00 sf	106.13	346,315	
		ELECTRICAL	**3,263.00 sf**	**106.13**	**346,315**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	36.539				11.198 /sf	3.73%
Material	34.643				10.617 /sf	3.54%
Subcontract	851.723				261.025 /sf	86.92%
Equipment	1.375				0.421 /sf	0.14%
Other						
	924,280	924,280			283.261 /sf	94.32
Knoxville Review Fee	450				0.138 /sf	0.05%
Knoxville City Permit	3,200				0.981 /sf	0.33%
	3,650	927,930			284.379 /sf	0.37
General Liability - 0.15%	1,470		0.150 %	T	0.450 /sf	0.15%
P&P Bond - 2009 rates	6,173				1.892 /sf	0.63%
	7,643	935,573			286.722 /sf	0.78
Fee	44,329		5.000 %		13.585 /sf	4.52%
	44,329	979,902			300.307 /sf	4.52
Total		***979,902***			***300.307 /sf***	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		**GENERAL CONDITIONS**				
	01312	**Supervision**				
		Project Superintendent	6.00 wk	1,838.96	11,034	
		Pickup Truck	6.00 wk	192.18	1,153	
		Supervision	1,855.00 sf	6.57	12,187	
	01320	**Construction Documents**				
		Extra Plans	1.00 ls	575.52	576	
		Construction Documents	1,855.00 sf	0.31	576	
	01400	**Temp Protection - J&G**				
		Temporary Protection	1.00 ls	1,587.81	1,588	
		Temp Protection - J&G	1,855.00 sf	0.86	1,588	
	01510	**TEMPORARY UTILITIES**				
		Jobsite Cell Phones	1.50 mo	97.85	147	
		TEMPORARY UTILITIES	1,855.00 sf	0.08	147	
	01600	**Safety**				
		First Aid Kits	1.00 ea	157.11	157	
		Fire Extinguisher	1.00 ea	97.84	98	
		Safety	1,855.00 sf	0.14	255	
	01610	**Hospital Infection Control**				
		Infection Control	6.00 wk	740.98	4,446	
		Hospital Infection Control	1,855.00 sf	2.40	4,446	
	01720	**Layout**				
		Interior Walls	8.00 hr	68.81	550	
		Layout	1,855.00 sf	0.30	550	
	01740	**Clean Up**				
		Dumping Fees	2.00 each	374.09	748	
		Clean Building Area	1,855.00 sf	0.84	1,549	
		Sub Final Cleaning	1,855.00 sf	0.30	550	
		Clean Up	1,855.00 sf	1.53	2,847	
		GENERAL CONDITIONS	**1,855.00 sf**	**12.18**	**22,596**	
02000		**SITEWORK**				
	02015	**Cutting & Patching**				
		Cutting & Patching	1.00 ls	1,587.81	1,588	
		Cutting & Patching	1,855.00 Sf	0.86	1,588	
	02020	**Dust Partition**				
		Dust Partitons	1.00 ls	1,587.81	1,588	
		Dust Partition	1,855.00 Sf	0.86	1,588	
	02225	**SELECTIVE DEMOLITION**				
		General Demolition	1,855.00 sf	1.43	2,650	
		SELECTIVE DEMOLITION	1,855.00 sf	1.43	2,650	
		SITEWORK	**1,855.00 sf**	**3.14**	**5,826**	
06000		**WOOD & PLASTICS**				
	06105	**ROUGH CARPENTRY- Framing**				
		Blocking	1,855.00 sf	0.79	1,473	
		ROUGH CARPENTRY- Framing	1,855.00 sf	0.79	1,473	
	06410	**Millwork**				
		Millwork	1.00 ls	4,234.15	4,234	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		Millwork	1,855.00 sf	2.28	4,234	
		WOOD & PLASTICS	**1,855.00 sf**	**3.08**	**5,707**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofing				
		Firestopping / Fire Proof Patching	1.00 ls	1,587.82	1,588	
		FIRESTOPPING / Fire Proofing	1,855.00 sf	0.86	1,588	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	211.71	212	
		JOINT SEALANTS	1,855.00 sf	0.11	212	
		THERMAL/MOISTURE PROTECT	**1,855.00 sf**	**0.97**	**1,800**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	418.13	418	
		Wood Door Material	1.00 ls	682.75	683	
		Finish Hardware	1.00 ls	1,227.91	1,228	
		Recovery Room Sliding Door System	4.00 ea	2,064.16	8,257	
		Labor - Door, Frame & Hardware	2.00 ea	328.39	657	
		Automatic Door Operators	1.00 pr	4,763.43	4,763	
		Doors, Frames & Hardware	1,855.00 sf	8.63	16,006	
		DOORS & WINDOWS	**1,855.00 sf**	**8.63**	**16,006**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching	1.00 ls	24,355.97	24,356	
		Acoustical Ceilings	1.00 ls	0.01	0	Included Above
		GYPSUM WALL BOARD	1,855.00 sf	13.13	24,356	
	09680	CARPET				
		Flooring Allowance	1.00 ls	9,124.62	9,125	
		CARPET	1,855.00 sf	4.92	9,125	
	09910	PAINTING				
		Painting	1,855.00 sf	2.12	3,927	
		PAINTING	1,855.00 sf	2.12	3,927	
		FINISHES	**1,855.00 sf**	**20.17**	**37,408**	
10000		**SPECIALTIES**				
	10130	Wall & Impact Rails				
		Wall Bumper Rails & Corner Guards	1.00 ls	2,054.94	2,055	
		Wall & Impact Rails			2,055	
	10810	Toilet Accessories				
		Allowance	1.00 ls	144.00	144	
		Toilet Accessories	1,855.00 sf	0.08	144	
		SPECIALTIES	**1,855.00 sf**	**1.19**	**2,199**	
11000		**EQUIPMENT**				
	11710	MEDICAL EQUIPMENT				
		Install Owner Provided Equipment	1.00 ls	0.01	0	Not Included

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		MEDICAL EQUIPMENT	1,855.00 sf	0.00	0	
		EQUIPMENT	**1,855.00 sf**	**0.00**	**0**	
15000		**MECHANICAL**				
	15050	Mechanical				
		HVAC & Plumbing / Med Gas	1.00 ls	27,700.96	27,701	
		Mechanical	1,855.00 sf	14.93	27,701	
	15300	Sprinkler System				
		Fire Protection Bid	1,855.00 sf	1.59	2,945	
		Sprinkler System	1,855.00 sf	1.59	2,945	
		MECHANICAL	**1,855.00 sf**	**16.52**	**30,646**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Electrical	1.00 ls	31,713.89	31,714	
		ELECTRICAL	1,855.00 sf	17.10	31,714	
		ELECTRICAL	**1,855.00 sf**	**17.10**	**31,714**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	15,991				8.621 /sf	9.78%
Material	4,341				2.340 /sf	2.66%
Subcontract	132,933				71.662 /sf	81.31%
Equipment	635				0.342 /sf	0.39%
Other						
	153,900	153,900			82.965 /sf	94.14
Knoxville Review Fee	261				0.141 /sf	0.16%
Knoxville City Permit	654				0.353 /sf	0.40%
	915	154,815			83.458 /sf	0.56
General Liability - 0.15%	245		0.150 %	T	0.132 /sf	0.15%
P&P Bond - 2009 rates	1,030				0.555 /sf	0.63%
	1,275	156,090			84.146 /sf	0.78
Fee	7,396		5.000 %		3.987 /sf	4.52%
	7,396	163,486			88.133 /sf	4.52
Total		***163,486***			***88.133 /sf***	

Attachment B.II.E.1.a

DEC - 9 2003

PHILIPS

Philips Medical Systems Nederland B.V.

510(k) Summary

K033737

The following information is being submitted in accordance with the requirements of 21 CFR 807.92.

Company Name:	Philips Medical Systems North America Company
Address:	22100 Bothell Everett Highway P.O.Box 3003 Bothell, WA 98041-3003, USA
Registration No.:	1217116
Contact Person: Telephone No.:	Lynn Harmer (425) 487-7312
Date Prepared:	November 18, 2003
Device (Trade) Name:	Allura Xper FD20
Classification Names:	Stationary X-ray system, 21CFR892.1680, Class II (code 90KPR) Angiographic X-ray system, 21CFR892.1600, Class II (code 90IZI)

Predicate Device:
The Allura Xper FD20 is substantially equivalent to the Integris Allura, both manufactured by Philips Medical Systems. The Philips Integris Allura received a 510(k) substantially equivalent determination in K002016 on September 6, 2000.

Device description:
The Allura Xper FD20 is a stationary fluoroscopic angiographic X-ray system for vascular, neurovascular and cardiovascular procedures, as well as non-vascular procedures.

Intended use:
The Allura Xper FD20 is intended for:

- Dedicated vascular and neurovascular imaging applications, including diagnostic and interventional procedures. This includes, e.g., peripheral, cerebral, thoracic and abdominal angiography, as well as PTCAs, stent placements, embolisations and thrombolysis.
- Cardiac imaging applications including diagnostics, interventional procedures (such as PTCA, stent placing, atherectomies), pacemaker implantations, and electrophysiology (EP).
- Non-vascular interventions such as drainages, biopsies and vertebroplasties procedures.

PHILIPS

General Safety and Effectiveness Information:
The device and their labeling will comply with the applicable requirements of:

- 21CFR, Subchapter J - Radiological Health, parts 1010, 1020.30, 1020.32 & 1040.10.
- Underwriters Laboratories Standard for Safety UL 2601-1 and be classified by Underwriters Laboratories.
- ACR/NEMA DICOM digital imaging communication standard.

Conclusion:
The Allura Xper FD20 does not introduce any new indications for use, nor does the use of the device result in any new potential hazard. Philips Medical Systems considers the Allura Xper FD20 to be substantially equivalent with the predicate device.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
9200 Corporate Boulevard
Rockville MD 20850

DEC - 9 2003

Philips Medical Systems
North America Company
% Mr. John C. So
Senior Project Engineer
Underwriters Laboratories, Inc.
6200 NW Lake Rd.
CAMAS WA 98607

Re: K033737
Trade/Device Name: Allura Xper FD20
Regulation Number: 21 CFR 892.1600
Regulation Name: Angiographic x-ray system
Regulation Number: 21 CFR 892.1680
Regulation Name: Stationary x-ray system
Regulatory Class: II
Product Code: 90 IZI and KPR
Dated: November 26, 2003
Received: November 28, 2003

Dear Mr. So:

We have reviewed your Section 510(k) premarket notification of intent to market the device referenced above and have determined the device is substantially equivalent (for the indications for use stated in the enclosure) to legally marketed predicate devices marketed in interstate commerce prior to May 28, 1976, the enactment date of the Medical Device Amendments, or to devices that have been reclassified in accordance with the provisions of the Federal Food, Drug, and Cosmetic Act (Act) that do not require approval of a premarket approval application (PMA). You may, therefore, market the device, subject to the general controls provisions of the Act. The general controls provisions of the Act include requirements for annual registration, listing of devices, good manufacturing practice, labeling, and prohibitions against misbranding and adulteration.

If your device is classified (see above) into either class II (Special Controls) or class III (PMA), it may be subject to such additional controls. Existing major regulations affecting your device can be found in the Code of Federal Regulations, Title 21, Parts 800 to 898. In addition, FDA may publish further announcements concerning your device in the Federal Register.

Please be advised that FDA's issuance of a substantial equivalence determination does not mean that FDA has made a determination that your device complies with other requirements of the Act or any Federal statutes and regulations administered by other Federal agencies. You must comply with all the Act's requirements, including, but not limited to: registration and listing (21 CFR Part 807); labeling (21 CFR Part 801); good manufacturing practice requirements as set forth in the quality systems (QS) regulation (21 CFR Part 820); and if applicable, the electronic product radiation control provisions (Sections 531-542 of the Act); 21 CFR 1000-1050.

This letter will allow you to begin marketing your device as described in your Section 510(k) premarket notification. The FDA finding of substantial equivalence of your device to a legally marketed predicate device results in a classification for your device and thus, permits your device to proceed to the market.

If you desire specific advice for your device on our labeling regulation (21 CFR Part 801), please contact the Office of Compliance at one of the following numbers, based on the regulation number at the top of the letter:

8xx.1xxx	(301) 594-4591
876.2xxx, 3xxx, 4xxx, 5xxx	(301) 594-4616
884.2xxx, 3xxx, 4xxx, 5xxx, 6xxx	(301) 594-4616
892.2xxx, 3xxx, 4xxx, 5xxx	(301) 594-4654
Other	(301) 594-4692

Additionally, for questions on the promotion and advertising of your device, please contact the Office of Compliance at (301) 594-4639. Also, please note the regulation entitled, "Misbranding by reference to premarket notification" (21CFR Part 807.97) you may obtain. Other general information on your responsibilities under the Act may be obtained from the Division of Small Manufacturers, International and Consumer Assistance at its toll-free number (800) 638-2041 or (301) 443-6597 or at its Internet address http://www.fda.gov/cdrh/dsma/dsmamain.html.

Sincerely yours,

Nancy C. Brogdon

Nancy C. Brogdon
Director, Division of Reproductive,
Abdominal and Radiological Devices
Office of Device Evaluation
Center for Devices and Radiological Health

Enclosure

510(k) Number (if known): K033737

Device name: **Allura Xper FD20**

Indications for use:

The Allura Xper FD20 is intended for:

- Dedicated vascular and neurovascular imaging applications, including diagnostic and interventional procedures. This includes, e.g., peripheral, cerebral, thoracic and abdominal angiography, as well as PTCAs, stent placements, embolisations and thrombolysis.
- Cardiac imaging applications including diagnostics, interventional procedures (such as PTCA, stent placing, atherectomies), pacemaker implantations, and electrophysiology (EP).
- Non-vascular interventions such as drainages, biopsies and vertebroplasties procedures.

Nancy C. Brogdon

(Division Sign-Off)
Division of Reproductive, Abdominal, and Radiological Devices
510(k) Number K033737

(PLEASE DO NOT WRITE BELOW THIS LINE-CONTINUE ON ANOTHER PAGE IF NEEDED)

Concurrence of CDRH, Office of Device Evaluation (ODE)

Prescription Use ✓ OR Over-The counter Use_____
(Per 21CFR801.109)

Ref. nr: XDB087-030873/RVI/rvi

Attachment B.II.3

PHILIPS HEALTHCARE
A division of Philips Electronics North America Corporation
22100 Bothell Everett Highway
P.O. Box 3003
Bothell, Washington 98041-3003

PHILIPS

Quotation #: 1-X4CT9T **Rev:** 1 **Effective From:** 08-Nov-12 **To:** 23-Dec-12

Presented To:

NORTH KNOXVILLE MEDICAL CENTER
7565 DANNAHER WAY
POWELL, TN 37849

ROB FOLLOWELL
CHIEF EXECUTIVE OFFICER
Tel:

Alternate Address:

Presented By:

Steve Wohlford
Account Manager
Tel: (865) 977-5012
Fax: (509) 696-2411

Steve Weiss
Regional Manager
Tel: (678) 924-6087
Fax: (678) 924-6003

Date Printed: 08-Nov-12

Submit Orders To:

22100 BOTHELL EVERETT HWY
BOTHELL WA 98021
Tel: (888) 564-8643
Fax:(425) 458-0390

This quotation contains confidential and proprietary information of Philips Healthcare, a division of Philips Electronics North America Corporation ("Philips") and is intended for use only by the customer whose name appears on this quotation. It may not be disclosed to third parties without the prior written consent of Philips.

IMPORTANT NOTICE: Health care providers are reminded that if the transactions herein include or involve a loan or discount (including a rebate or other price reduction), they must fully and accurately report such loan or discount on cost reports or other applicable reports or claims for payment submitted under any federal or state health care program, including but not limited to Medicare and Medicaid, such as may be required by state or federal law, including but not limited to 42 CFR 1001.952(h).

Quote Solution Summary

Line #	Product	Qty	Price
	100215 Allura Xper FD20	1	$1,600,000.00
		Equipment Total:	$1,600,000.00

Solution Summary Detail

Product	Qty	Each	Monthly	Price
100215 Allura Xper FD20	1	$1,600,000.00		$1,600,000.00

Buying Group: **HEALTHTRUST PURCHASING GROUP** **Contract #:** **500005**

Addt'l Terms:

Each Quotation solution will reference a specific Buying Group/Contract Number representing an agreement containing discounts, fees and any specific terms and conditions which will apply to that single quoted solution. If no Buying Group/Contract Number is shown, Philips' Terms and Conditions of Sale will apply to the quoted solution.

Each equipment system listed on purchase order/orders represents a separate and distinct financial transaction. We understand and agree that each transaction is to be individually billed and paid.

Payment Terms: 0% Down, 80% Upon Delivery, 20% Due When the Product is Available for First Patient Use, Net due 30 days from date of invoice

100215 Allura Xper FD20

System Type: New
Freight Terms: FOB Destination
Warranty Terms: Part numbers beginning with two (2) asterisks (**) are covered by a System 12 Months Warranty. All other part numbers are third (3rd) party items.
Special Notations: Contingencies must be removed 120 days before scheduled shipment to assure delivery on specified date. Any rigging costs are the responsibility of the Purchaser.
Additional Terms:

Line #	Part #	Description	Qty
1	**NNAE311	Allura Xper FD20 C Rel. 8.1	1
2	**NCVC050	Non swivel, mounted ON floor	1
3	**NCVB618	HeartNavigator R1	1
4	**NCVB629	FlexVision XL,XperHD,Snapshot	1
5	**FCV0627	Bracket for Rad. Shield (ER)	1
6	**NCVB171	3D-RA R.6	1
7	**NCVB294	Set of 2 additional 21in. LCDs	1
8	**NCVB173	CT Trueview Rel2	1
9	**NCVB174	CT Trueview MultiVendor	1
10	**NCVA819	Stentboost sw Rel 3.0 Package	1
11	**NCVC018	replace into 21" monitor size in control room	1
12	**NCVB158	No existing Philips room	1
13	**NCVB175	Ceiling Rail extension set frontal	1
14	**NCVB121	Unknown (for quoting purposes)	1
15	**FCV0587	Xper Live/Ref Slaving	2
16	**NCVA089	RIS / CIS DICOM interface	1
17	**NCVA088	Standard Line Rate Video Output	1
18	**NCVA092	Lab Reporting	1
19	**NCVA781	Dicom Print compose	1
20	**NCVA080	Automatic Position Control (APC)	1
21	**NCVA801	Table APC	1
22	**NCVA695	FD Rotational Angio	1

100215 Allura Xper FD20			
Line #	Part #	Description	Qty
23	**NCVB209	Xper Swing	1
24	**NCVA093	Physio Viewing	1
25	**NCVA694	Subtracted Bolus Chase	1
26	**NCVA864	Storage extension	1
27	**NCVA672	FD SmartMask	1
28	**NCVB880	extension to 30Fr/sec (mono)	1
29	**NCVA121	FULL AUTOCAL	1
30	**NCVA784	Ventricular Quant.Sw pkg(Xper)	1
31	**NCVA793	Right ventricular quantification software package	1
32	**NCVA785	Coronary Quant.Sw pkg(Xper)	1
33	**NCVA786	Vascular Quant.Sw pkg(Xper)	1
34	**NCVA097	Cath Arm Support	1
35	**NCVA098	Pulse Cath Arm Support	1
36	**NCVA101	Peripheral X-ray Filter	1
37	**NCVA783	Pivot for table base.	1
38	**FCV4894	Add.op-rail with cable ext.kit	1
39	**FCV0017	CABLE CARRIER CS	3
40	**NCVB878	Interventional Tools Hardware	1
41	**NCVA116	3D RA Control for Xper Module	1
42	**NCVB168	3D Roadmap	1
43	**NCVA165	1st Xper Module in Exam.Room	1
44	**NCVA169	2nd Xper Mod. in Control Room	1
45	**NNAE391	FlexVision XL 8 Input Package	1

100215 Allura Xper FD20

NET PRICE $1,600,000.00

Buying Group: HEALTHTRUST PURCHASING GROUP Contract #: 500005

Addt'l Terms:

Each Quotation solution will reference a specific Buying Group/Contract Number representing an agreement containing discounts, fees and any specific terms and conditions which will apply to that single quoted solution. If no Buying Group/Contract Number is shown, Philips' Terms and Conditions of Sale will apply to the quoted solution.

Each equipment system listed on purchase order/orders represents a separate and distinct financial transaction. We understand and agree that each transaction is to be individually billed and paid.

Price above does not include any applicable sales taxes.

The preliminary delivery request date for this equipment is:_____.

If you do not issue formal purchase orders indicate by initialing here_____.

Tax Status:

Taxable_____ Tax Exempt_____

If Exempt, please indicate the Exemption Certification Number:_____, and attach a copy of the certificate.

Delivery/Installation Address:

_____

_____

_____

Invoice Address:

_____

_____

_____

Contact Phone #:

_____

Contact Phone #:

_____

Purchaser approval as quoted:

_____

Date:

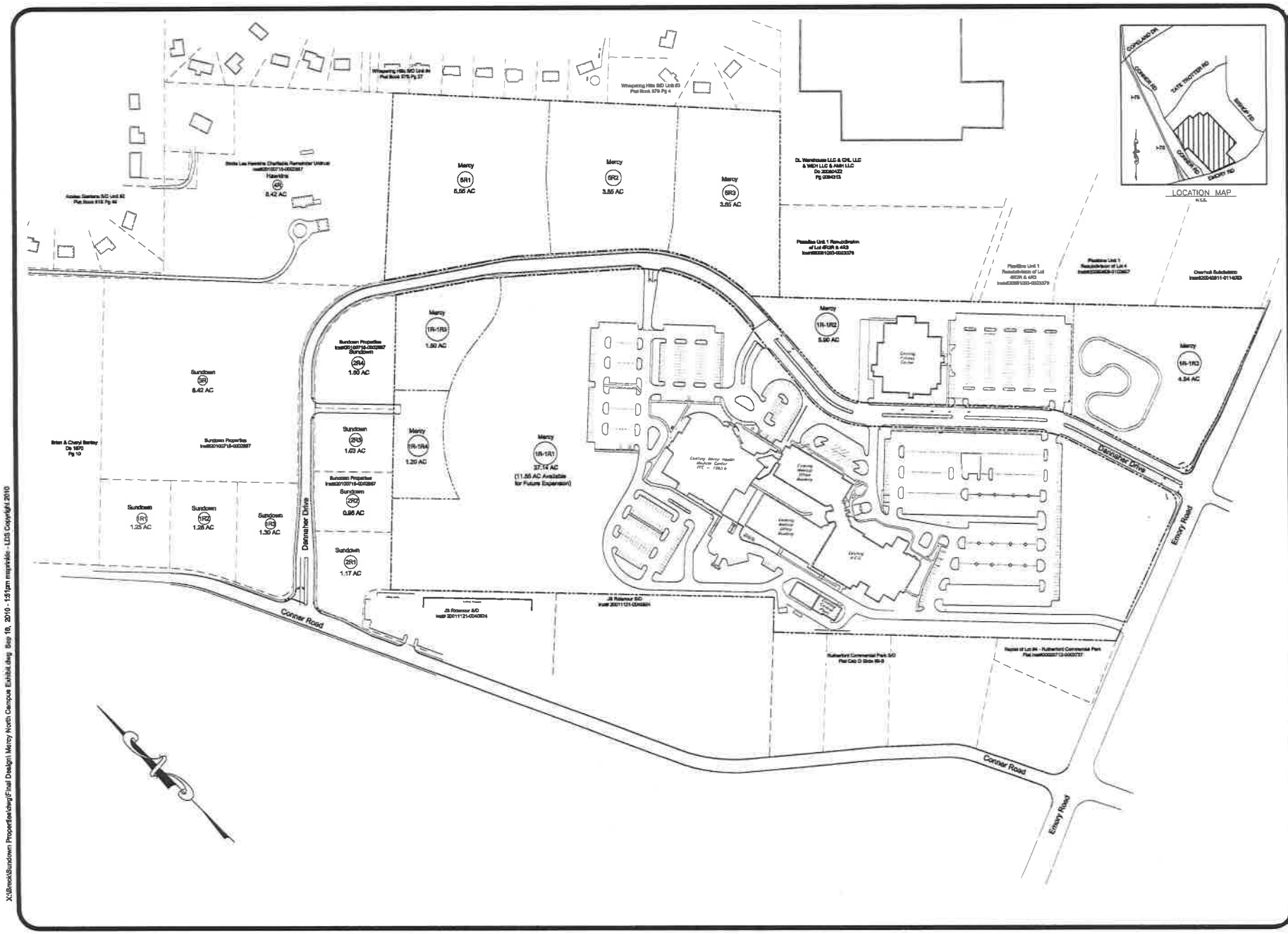
_____

Title:

_____

This quotation is signed and accepted by an authorized representative in acknowledgement of the system configuration, terms and conditions stated herein.

Attachment B.III.(A)



Project: Mercy North Campus
Mercy Health Partners
Knoxville, Tennessee

LAND DEVELOPMENT SOLUTIONS
310 SIMMONS RD., SUITE K-10NOXVILLE, TENNESSEE 37922
PH. 865-671-2281

Drawing Description: Mercy North Campus

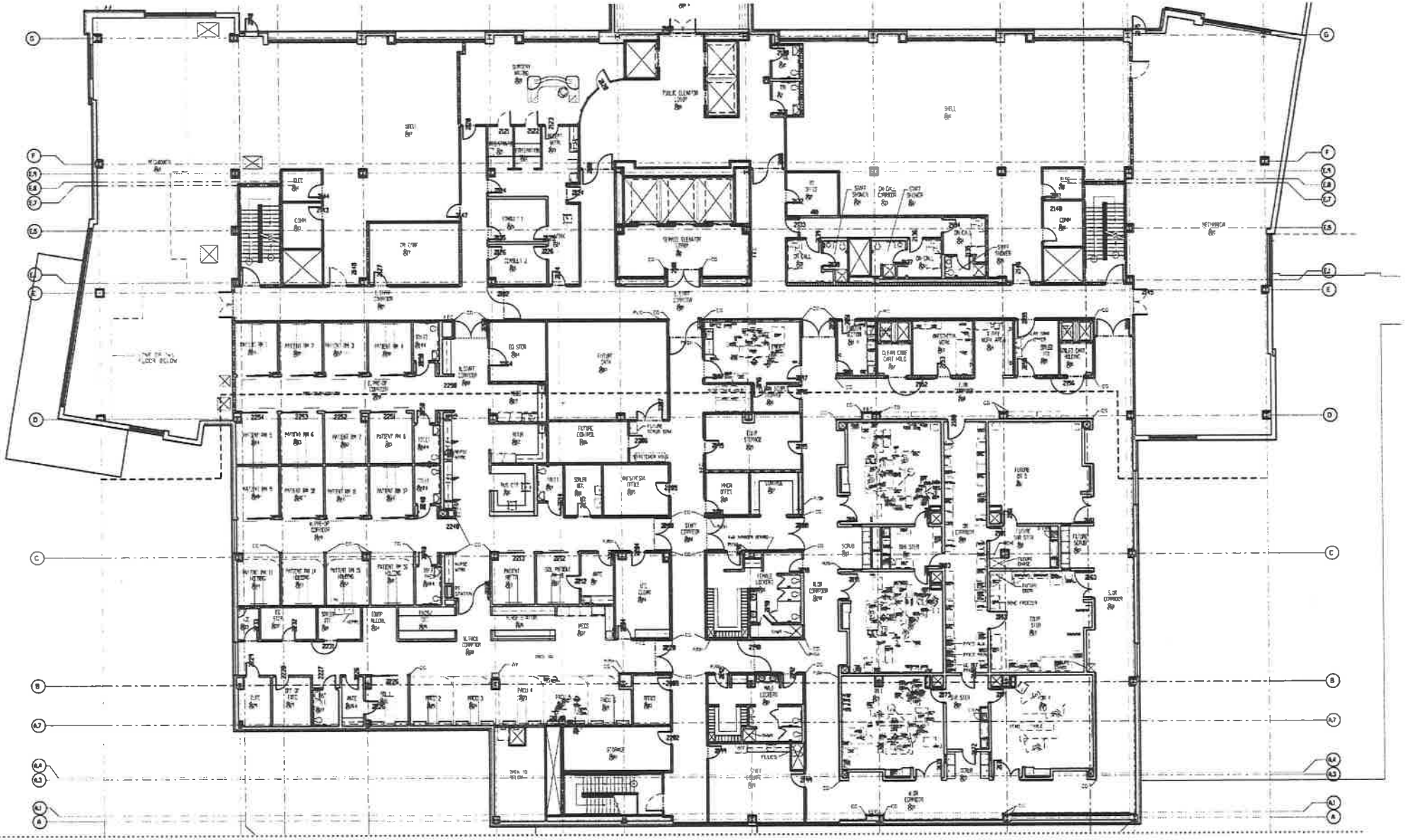
No.	Date	Revision

Drawn By	
Checked	
Approved	
Job No.	210002-3
Scale 1"=120'	Date 9-16-10

Exhibit 1
Sheet No.

X:\Brook\Sundown Properties\dwg\Final Design\ Mercy North Campus Exhibit.dwg Sep 16, 2010 - 1:51pm mspinkle - LDS Copyright 2010

Attachment B.IV



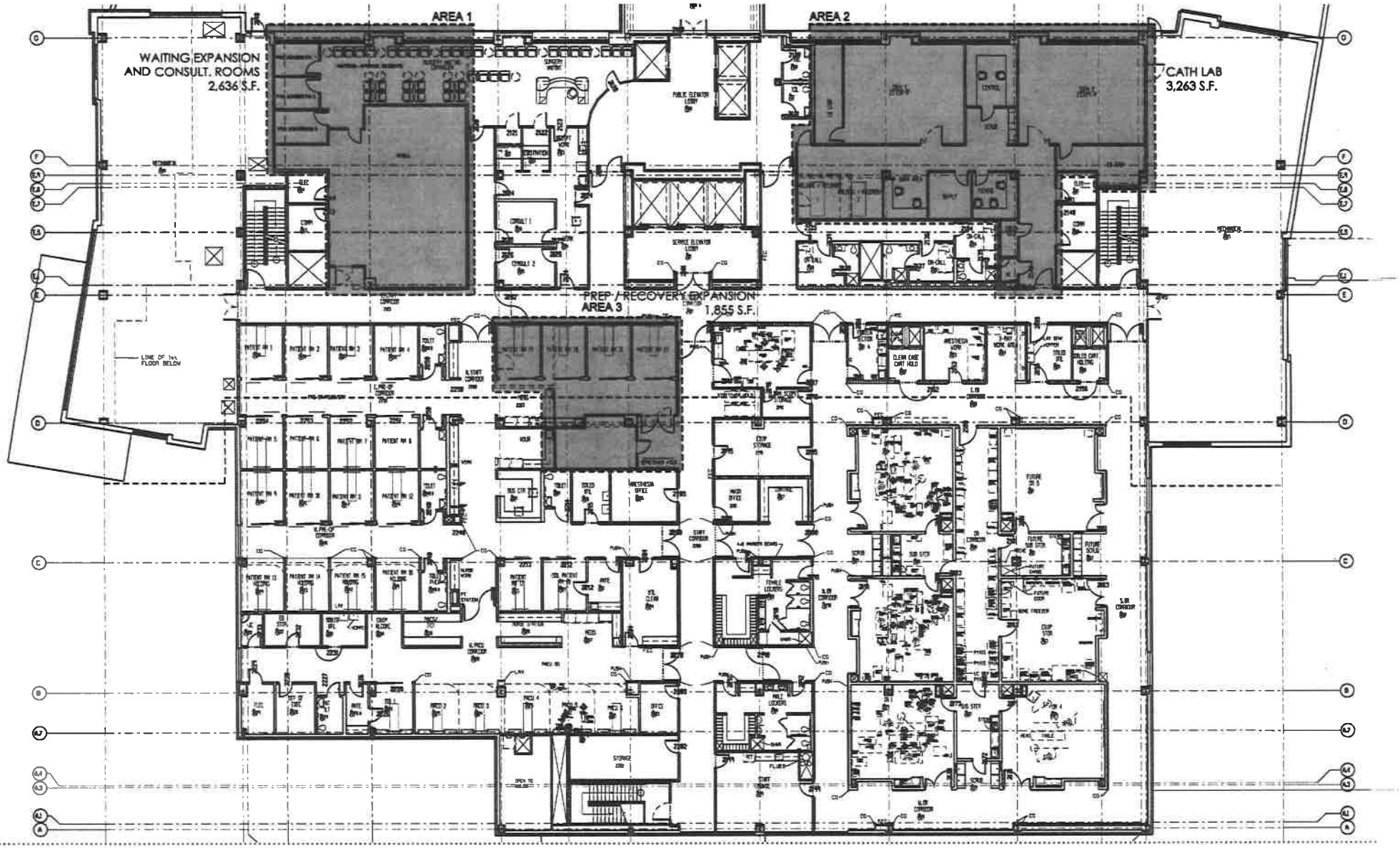
9OCT2012

1 **EXISTING FLOOR PLAN - SECOND FLOOR**
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 10 20 40

bma BARBERMcMURRY
architects since 1915
©2012 BARBERMCMURRY ARCHITECTS

122300



9OCT2012

2 EXTENT OF WORK FLOOR PLAN
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 10 20 40

bma BARBERMcMURRY
architects since 1915
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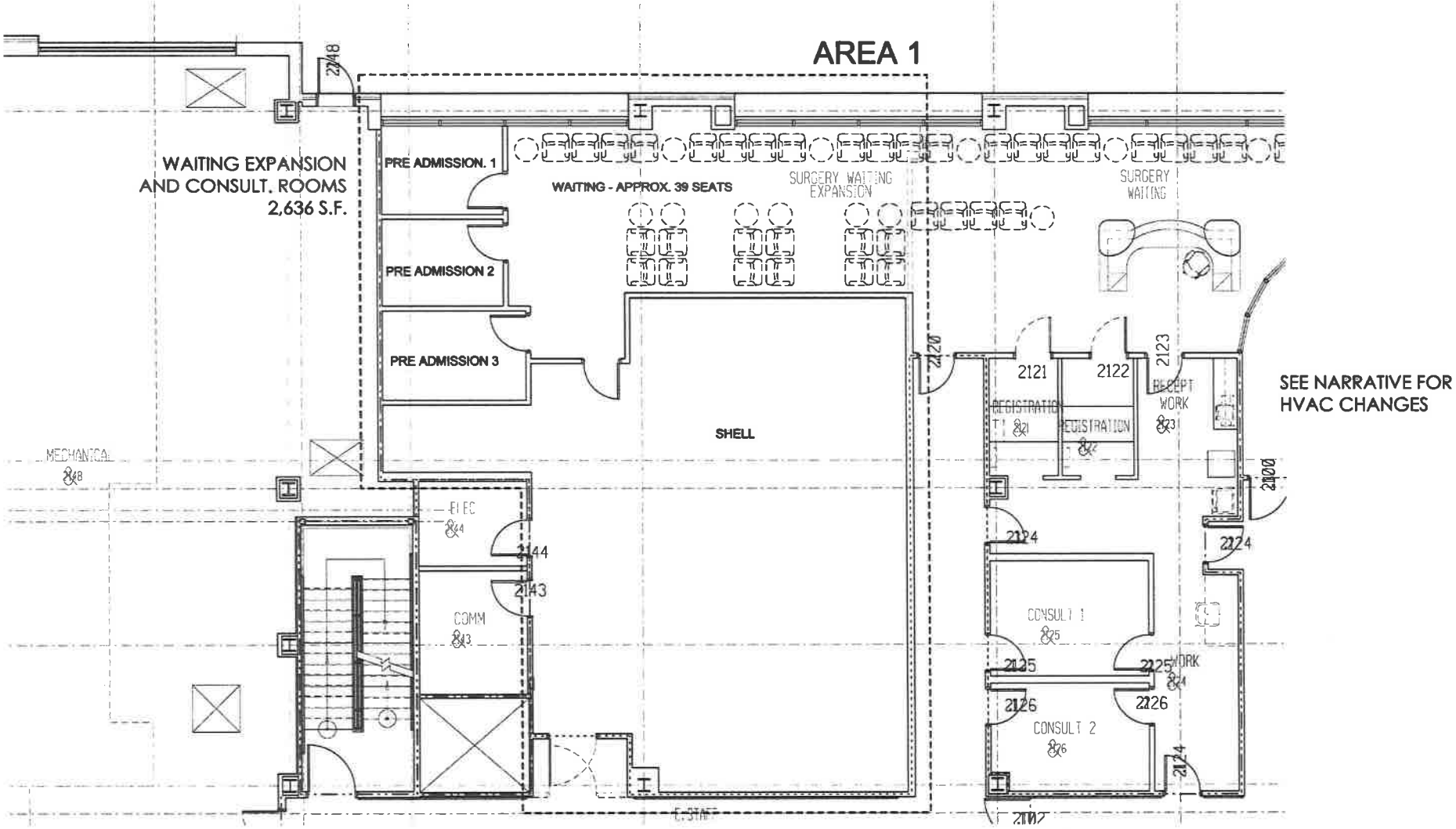
122300

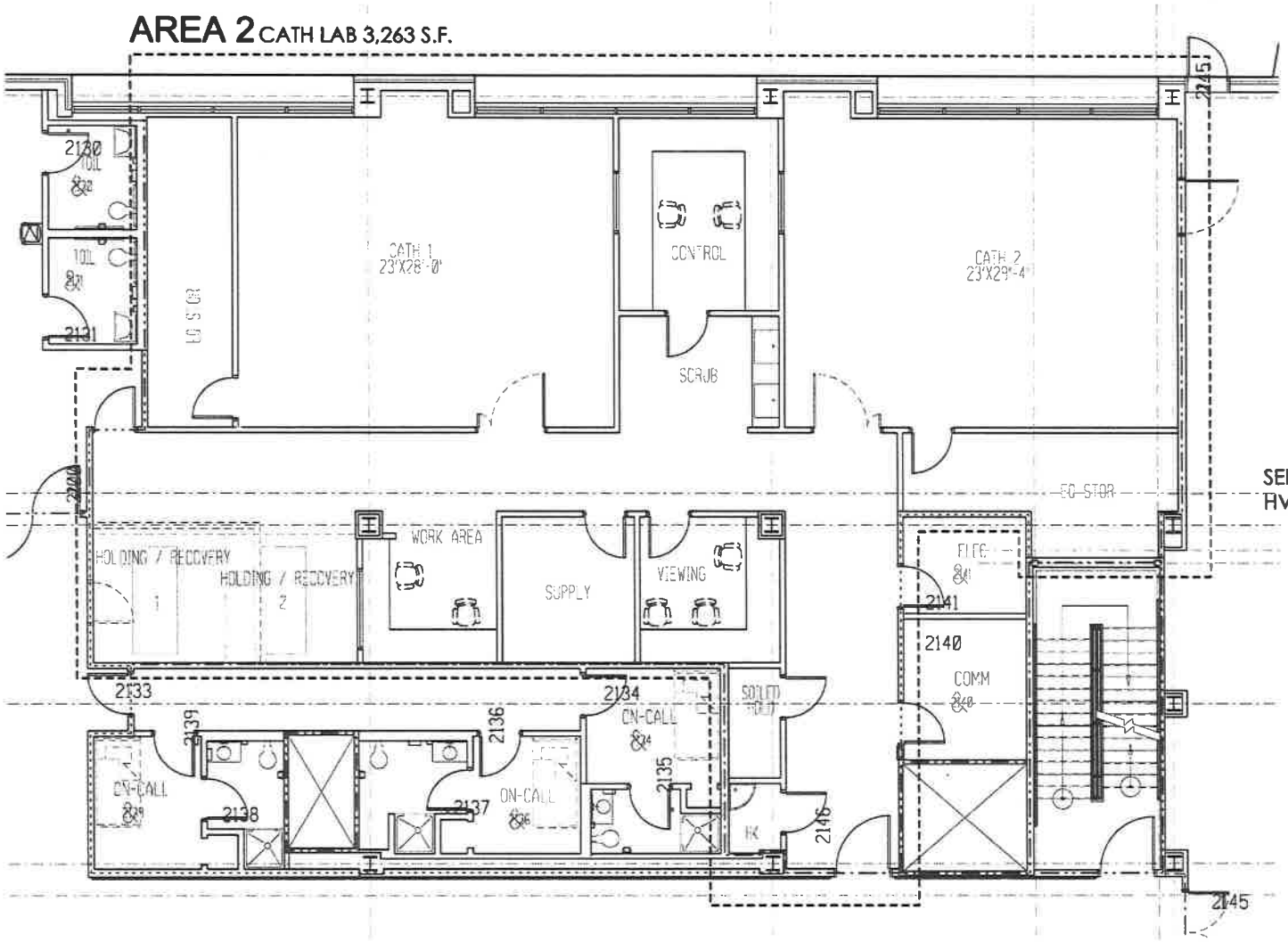


9OCT2012

3 AREA 1 FLOOR PLAN
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 4 8 16

bma BARBERMcMURRY
architects since 1915
122300



SEE NARRATIVE FOR HVAC CHANGES

9OCT2012

4 **AREA 2 FLOOR PLAN**
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 4 8 16

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architects since 1915
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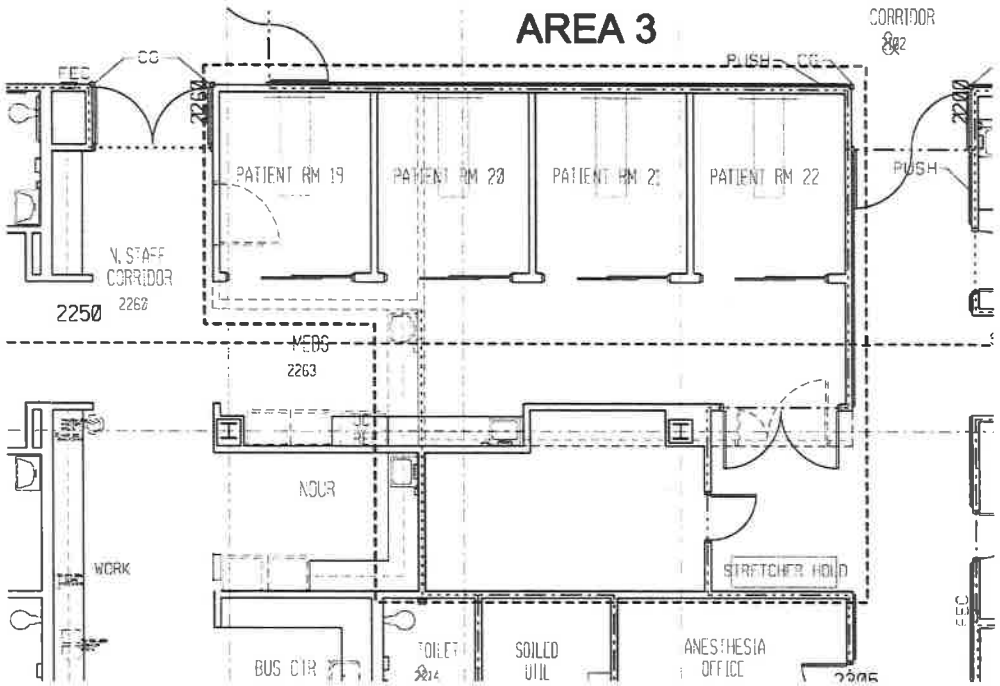
122300

PREP / RECOVERY EXPANSION
1,855 S.F.



SEE NARRATIVE FOR
HVAC CHANGES

9OCT2012

5 **AREA 3 FLOOR PLAN**
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 4 8 16

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122300

Attachment C.Need.A.3

Patient Care - Policies and Procedures

Number	
Category	III Policies and Procedures/Benefits
Title	**Intrafacility** Transfer
Origin Date	07/21/2010
Last Revision	07/21/2010
Last Review	Penny Smith, Regional Quality Officer **on** 7/21/10
Approved by	Executive Management Team **on** 10/12/2010

Please reference the Regional Policy: Emergency Medical Treatment and Labor Act (EMTALA)

Policy: Urgent/Emergent Transfers-**Intra**-facility (Tennova Healthcare facility transfer to a Tennova Healthcare, Metro facility).

Policy Statement: Patient transfers may be necessary from the off site campuses of Tennova Healthcare when services required for the patient may not be available at their current location. A patient with a medical emergency or an acute change in condition requiring transfer will be treated until the patient's condition is stabilized and/or the physician determines medical condition will not deteriorate further by transport.

A physician determines based on reasonable risk and benefits to the patient and based upon information available at the time, the medical benefits reasonable expected from the provision of appropriate medical treatment upon transfer outweigh the increased risk to the individual's medical condition from affecting the transfer.

Once the physician deems the patient able to be transferred, the receipt of the patient at Tennova Healthcare, Metro facilities should occur within 60 minutes.

Times between transfer decision and receipt at Tennova Healthcare, Metro facilities will be reviewed by sending facility on each urgent/emergent transfer.

RESPONSIBILITIES OF THE PHYSICIAN:

1. Obtain informed consent by discussing with the patient/family, the specific risks, benefits and alternatives for transfer.
2. Write an order for the transfer in the medical record. Document the reason and the specific risks/benefits of transfer in the medical record as discussed with the patient/family.
3. Make arrangements directly with the receiving physician and document accepting physician's name, date and time.

4. Order type of transportation desired.
a. Mode of Transportation
b. Personnel and equipment required for transport

RESPONSIBILITIES OF NURSE:

1. Notify Director of Nursing or Nursing Supervisor/Team Leader of patient change in condition and transfer necessity.
2. Arrange for transportation, personnel and equipment according to physician order.
3. Notify physician of estimated time of transportation arrival.
4. Complete hand off communication with receiving department/unit and document date, time and who was spoken with in nursing notes.
5. Prepare and send complete medical records & transfer forms with patient as ordered.
6. Assure that patient remains monitored during transfer arrangements.
7. Return valuables or personal possessions to patient/family.
8. Obtain and document vital signs immediately before discharge.
9. Notify the physician of any significant change in the vital signs.
10. Give transport personnel a report of the patient's condition, including current vital signs.

WHEN A TRANSFER IS DEEMED APPROPRIATE AND THE PATIENT REFUSES:

1. Document in the medical record the benefits/risks discussed with the patient and of the refusal to provide consent for transfer.

Attachment C.Need.A.4

Administration - Policies and Procedures

Number	
Category	III Policies and Procedures/Benefits
Title	**Quality** Improvement/Patient Safety Plan - Metro
Origin Date	01/01/2010
Last Revision	02/15/2012
Last Review	Penny Smith, VP **Quality on** 2/15/12
Approved by	Advisory Board **on** 02/16/2012

TENNOVA HEALTHCARE MEDICAL CENTER
QUALITY IMPROVEMENT/PATIENT SAFETY PLAN
2012

I. INTRODUCTION

This **Quality** Improvement/Performance Improvement/Patient Safety Improvement Plan describes the performance improvement program unique to Tennova Healthcare Medical Center which is comprised of Physicians Regional, Turkey Creek and North Knoxville Medical Centers, a part of Tennova Healthcare and Health Management Associates.

II. PURPOSES OF THE **QUALITY** IMPROVEMENT/PERFORMANCE IMPROVEMENT/PATIENT SAFETY PROGRAM PLAN

The Plan describes our:
- Performance improvement approach to ensure coordinated, effective, and systematically monitored **quality** and performance activities.
- Reporting model and mechanisms for communicating performance improvement activities to committees, leaders, relevant disciplines, departments, and others.
- Evaluation system for determining the effectiveness of the plan
- Expectations for maintenance of confidentiality by all parties involved with performance improvement activities.

Definitions: As used in this **Quality** Improvement/Performance Improvement/Patient Safety Program Plan, the following terms shall have the meanings set forth below:

(a) "Medical Center" refers to Tennova Healthcare which is comprised of Physicians Regional Medical Center, North Knoxville Medical Center, and Turkey Creek Medical Center. Although these campuses are geographically separated they are considered as one hospital with a single medical staff operating under one set of

Bylaws and Rules and Regulations.
(b) "Board of Directors" means the Advisory Board of the Physicians Regional Medical Center which will be the approval body for the Medical Center.

(c) "Chief of Staff" means the chief officer of the Medical Staff.

(d) "Ex-Officio" means to serve as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, said membership includes voting rights.

III. APPROACH TO QUALITY IMPROVEMENT/Performance improvement/pATIENT SAFETY

Quality Mission Statement
To improve the **quality** and safety of care provided by the Medical Center through the implementation of the **Quality** Improvement/Performance Improvement /Patient Safety Plan.

Quality Vision Statement
"Driven by excellence, we will transform our healthcare system to one of seamless, team-based care for all we serve."

Performance and **Quality** Goals
Medical Center facilities are part of Tennova Healthcare and Health Management Associates (HMA) headquartered in Naples, Florida. As a member of HMA, we recognize the importance of supporting **quality** goals. Addtionally, the Medical Center establishes organizational **quality** goals reflecting the unique needs of our facilities, resources and community.

Health Management Associates and Tennova Healthcare Medical Center
2012 **Quality**/Patient Safety Goals:

HMA and Tennova Healthcare Goals	Target
Reduction in Preventable Harm and Hospital Acquired Conditions	Targets will be set at local and corporate level.
Reduction of Inpatient	Targets will be set at local and corporate level

Mortality	
Reduction in Length of Stay	Targets will be set at local and corporate level
Improve Patient Satisfaction	Targets will be set at local and corporate level
Improve Core Measures	Targets will be set at local and corporate level
Reduce Readmission rates for publicaly reported conditions	Targets will be set at local and corporate level
Improve Patient Flow	Targets will be set at local and corporate level

Philosophy

The Medical Center approaches performance improvement with a philosophy of inclusion, accountability, and shared communication. All relevant disciplines and persons are included or represented by teams and / or participation in the committee structure. The committee structure assures accountability. **Quality** and performance improvement activities are communicated through existing committee and staff meetings, displayed on bulletin boards, in newsletters, in committee meeting minutes, and other communication media. Information and updates on performance activities are shared with physicians through collaborative practice sessions, routinely scheduled medical staff committee and department meetings, and physician-targeted newsletters. Performance improvement of sensitive matters that might be confidential is protected under TCA-68-11-272.

Prioritization of Performance Improvement Projects

Prioritization of performance improvement projects is given to high risk, high volume, problem prone or safety risk issues, with additional emphasis on those issues identified by corporate and organizational leaders, and regulatory and accreditation agencies. Resources shall be provided in such manner that reflects Tennova Healthcare's mission to promote a "**quality** environment of healing bringing innovative healthcare to our community."

Integration and Application of Quality and Performance Improvement Principles

Process improvement is inextricably linked with **quality** improvement and patient safety. **Quality** improvement expands and enhances the application of performance beyond mere numbers; therefore, the **Quality** Improvement/ Performance Improvement /Patient Safety Plan incorporates classic **quality** improvement principles and draws upon techniques developed by recognized organizations such as the Institute for Healthcare Improvement (IHI), Association of HealthCare Research and **Quality** (AHRQ), National **Quality** Forum (NQF), Institute of Medicine (IOM).

Structure: What do we want to accomplish?", "What changes can we make?", "How will we know the changes are successful?" and "How can we maintain the improvement?"

Implementation:

Plan

Select PI tools to use
Analyze the data or information
Formulate plan for improvement
Determine goals and targets
Determine methods for reaching goals

Do

Educate and train as necessary
Pilot the plan using small tests of change

Study

Gather data to evaluate outcomes
Determine success
Identify failures and redesign using PDSA as necessary

Act

Modify as needed for full implementation on larger scale
Revise policy and procedures once the changes have been successful
Hold the gained improvement through monitoring activities

Performance Improvement Measures

Any organized group of leaders and/or associates whose actions effect processes and whose intended outcome is to achieve improvement in dimensions of **quality** or in meeting regulatory requirements is considered a **Quality** Improvement/Performance Improvement Team.

The following dimensions of **quality** and compliance are considered when developing measures of performance.

- Appropriateness – relevancy
- Availability –services are rendered when needed
- Effectiveness –provision of care achieves desired result
- Efficacy –producing the desired effect
- Efficiency – relationship between the outcomes and the resource
- Error Rate – frequency of unexpected outcomes

• Productivity – relationship between production of an output and one, some, or all of the resource inputs used; measured as a ratio of output per unit of input over time.
• Satisfaction – the extent to which services or outcomes meet with customer needs and expectations
• Timeliness – provision of a service at the most beneficial or necessary time

Data Collection and Evaluation of Performance Improvement Measures

Performance improvement and **quality** indicators are selected based upon important aspects of care, processes or services provided. The indicators are objective, measurable, and based on current knowledge and clinical experience. Data is collected according to project needs and is subsequently evaluated.

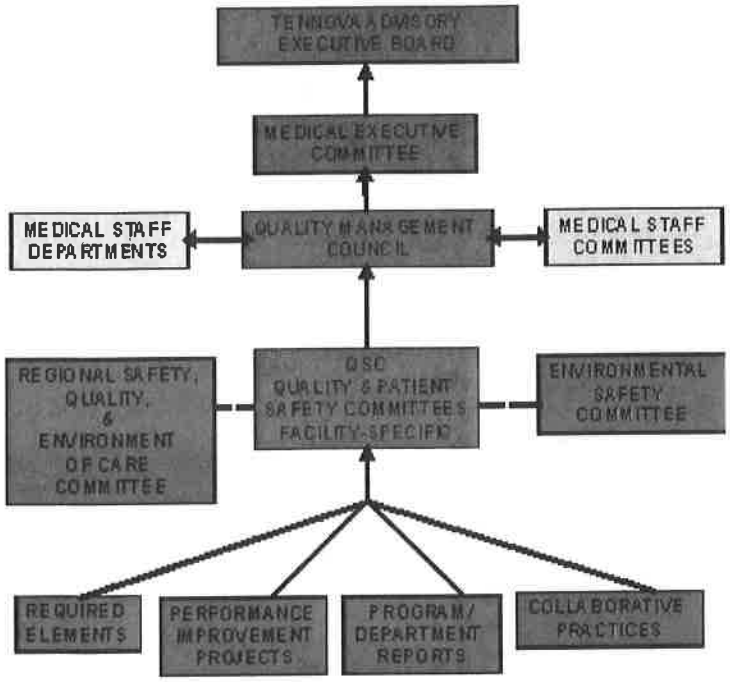
The purpose of the evaluation step is to monitor for acceptable patient outcomes or to identify opportunities for improvement. Evaluation of data includes analysis of variations, patterns/trends, undesirable outcomes, individual performance and other significant variables based on recognized standards or comparison to benchmarks. Documentation of the evaluation may include recommendations related to the improvement of performance with suggested restructure for the design of the process when appropriate.

IV. PERFORMANCE IMPROVEMENT REPORTING MODEL

The Medical Center is organized in a functional, departmental model. All departments, staff and leaders are charged with support of performance improvement projects and are encouraged to create individual departmental process improvement indicators.

The complexities of medical care span many services and departments thus both individual department and process improvement project activities are reported to **Quality** and safety Committee. Performance improvement activity reports are received in a systematic manner to assure information, decisions and important procedural activities or changes are monitored, evaluated and communicated to appropriate bodies and persons.

TENNOVA HEALTHCARE MEDICAL CENTER
QI/PATIENT SAFETY REPORTING MODEL



Quality & Patient Safety Committee (QSC)

Purpose
QSC is delegated by the governing body, medical staff, and the Medical Center administration to coordinate all **quality** and performance improvement activities in accordance with the approved **Quality** Improvement/Patient Safety Plan and the HMA/ Tennova Healthcare Strategic Business/**Quality** Plan.

Composition
QSC is comprised of key leaders from the hospital including but not limited to: nursing, ancillary patient care areas, infection control, mission services, medical records, planning, post acute services, surgery, risk management, case management, **quality** improvement, and others as appropriate. The chairperson is the Clinical **Quality** Leader. Decisions are consensus based.

Work or reports generated from this committee are considered part of our Patient Safety Work Product and may be submitted to our Patient Safety Organization.
Responsibilities

QSC duties include but are not limited to:

- Development and modification of the PI plan for **Quality** Management Committee (QMC) review
- Prioritization of performance improvement projects that are based on actual or potential impact on patient care, **quality** and performance indicators, Sentinel Events, Joint Commission standards, HMA/Tennova Healthcare Strategic Business/**Quality** Plan and other sources
- Commission, direction, support, and monitoring of Process Improvement Team progress
- Support for **quality** and process improvement initiatives outlined in HMA/Tennova Healthcare Strategic Business Plan
- Identification and support of PI and **quality** educational needs of the facility
- Advise departments, persons, committees, and other groups on **quality** and process improvement issues
- Referral of applicable performance improvement projects to QMC for approval
- Report of Process Improvement Team activities to QMC for advice and approval
- Communication of QSC activities to QMC, hospital employees and administration in a timely and accurate fashion
- Evaluation of PI activity effectiveness through submission of the PI Plan's annual evaluation to QMC for review

Meetings

QSC meets as scheduled monthly. Agenda and minutes are maintained by the Clinical **Quality** Leader and are on file.

Accountability and Reporting

QSC receives reports from PI teams, persons responsible for Strategic Business/**Quality** Plan initiatives, and other **quality** and performance functions, and provides summary reports of pertinent activities to QMC. The QMC reviews the reports, returns recommendations as necessary, and communicates relevant **quality** activities to individuals and the Medical Staff Executive Committee (MEC). QMC communicates with QSC as necessary.

Environmental Safety Committee (ESC)

Purpose

The Environmental Safety Committee oversees and receives reports related to safety.

Composition

ESC is comprised of representatives from key patient care, engineering, security,

biomedical, employee health, **quality**, infection control, and emergency management areas.

Responsibilities
ESC duties include but are not limited to:
• Development and modification of the Joint Commission required written plans for each safety domain
• Prioritization of performance improvement projects that are based on actual or potential impact safety concerns
• Commission, direction, support, and monitoring of Process Improvement Team progress
• Advise departments, persons, committees, and other groups on patient and staff safety issues
• Facilitate communication between QSC and ESC in a timely and accurate fashion

Meetings
The committee shall meet monthly or as often as necessary at the request of its chairman.

Accountability and Reporting
ESC reports to QSC.

Quality Management Council (QMC)

Composition
QMC shall consist of the Vice Chief of Staff, who shall be the chairman, the Vice Chief of Staff Elect and the Vice Chairman of each department of the Medical Staff, the Medical Center CEOs or designees, the Chief Nursing Officers and chairman of such committees as may be designated by the Medical Staff Executive Committee. The Director for **Quality**, Department Leaders, and Clinical **Quality** Leaders shall attend the meetings of QMC as ex-officio non-voting members

Responsibilities
The duties of QMC include but are not limited to:
• Recommending for plans to the MEC (Medical Staff Executive Committee) for maintaining **quality** patient care within the Medical Center. These may include mechanisms for:

(1) Establishing systems to identify potential problems in patient care
(2) Referring priority problems for assessment and corrective action to appropriate departments or committees
(3) Monitoring the results of **quality** management activities throughout the

facilities
(4) Coordinating **quality** management activities and
(5) Acting on recommendations from physician peer review for patient treatment

• Submitting regular confidential reports to MEC on the **quality** of medical care provided and on **quality** review activities conducted.
• Forming such ad hoc committees as are needed to fulfill its duties.
• Pursuant to approval by MEC, overseeing and coordinating the activities of the following committees:
(1) Infection Control
(2) Pharmacy and Therapeutics
(3) Utilization Management
(3) Such other appropriate special committees as designated by MEC.

Meetings
The committee shall meet monthly or as often as necessary at the request of its chairman.

Accountability and Reporting
QMC has a cooperative peer relationship with other medical staff departments and committees and directs QSC medical **quality** activities. QMC submits summary reports of its activities to MEC and the Board of Directors, which in turn review the reports and return recommendations as necessary. The minutes of the QMC meetings may be shared with our Patient Safety Organization.

Medical Staff Executive Committee (MEC)

Composition
MEC shall consist of the Chief of the Medical Staff, the Vice Chief of Medical Staff, the Vice Chief of Medical Staff Elect, the Secretary, the chairman of each of the Medical Staff Departments, and one at large member from each campus appointed annually by the Chief of Medical Staff.

Responsibilities
The duties of MEC shall include, but not be limited to:
• Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by the Medical Staff Bylaws.
• Coordinating and implementing the professional and organizational activities and policies of the Medical Staff.
• Receiving and acting upon reports and recommendations from Medical Staff

departments, divisions, committees, and assigned activity groups.
• Recommending action to the Advisory Board on matters of a medical-administrative nature.
• Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of performance improvement activities and mechanisms of the Medical Staff, termination of Medical Staff appointments and fair hearing procedures, as well as other matters relevant to the operation of the Medical Staff.
• Evaluating the medical care rendered to patients in the Medical Center.
• Participating in the development of all Medical Staff and Medical Center policy, practice, and planning.
• Reviewing the qualifications, credentials, performance and professional competence and character of applicants and staff members and making recommendations to the Board of Directors regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action.
• Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted.
• Taking reasonable steps to develop continuing education activities and programs for the Medical Staff.
• Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff.
• Reporting to the Medical Staff at each regular staff meeting.
• Assisting in the obtaining and maintaining of accreditation.
• Adjudicating those practice areas and privileges that cross department lines.

Meetings
MEC shall meet as often as necessary, but at least once a month, and shall maintain a record of its proceedings and actions. The Medical Center CEO or designees, the Chief Nursing Officers or designees, and the Risk Manager shall attend the meetings of the MEC as ex-officio non-voting members.

Accountability and Reporting
MEC receives reports from Medical Staff departments, divisions, committees, and assigned activity groups and is accountable to the Board of Directors.

Board of Directors

Composition
The Board of Directors is an advisory board of the Medical Center and is comprised of the following members: an equal number of community laypersons (one of whom

shall be designated as the Chairperson of the committee) and physicians (one of whom will be the Chief of Medical Staff), and the Medical Center CEO.

Responsibilities

- Receive from Medical Staff written recommendations on individual applications for staff appointment, reappointment, departmental and staff category assignments, clinical privileges and corrective actions, and take actions thereon.
- Cooperate with and assist the Medical Staff and other professionals providing patient care services in the Medical Center organizations with implementing measures to review the **quality** and efficiency of care delivered within the Medical Center and receive periodic reports on the general findings, and specific recommendations resulting from the review of activities.
- Review results and effectiveness of the **quality** maintenance and improvement programs conducted by the Medical Staff and by other professionals providing patient care services. Evaluate changes that have been or should be made to improve the **quality** and efficiency of patient care within the Medical Center organization as warranted by the findings of this review and evaluation.
- Receive Medical Staff recommendations on the adoption, amendment, or repeal of bylaws, rules and regulations governing the Medical Staff.
- Review Risk Management and Patient Safety information, including but not limited to, aggregate claims and adverse clinical event data, occurrence reporting trends, and corresponding corrective action plans. Support an integrated approach to Risk and **Quality** Management activities to facilitate appropriate follow through.
- Take appropriate action as indicated if leadership groups do not fulfill their duties and responsibilities.

Meetings

The Board of Directors meets quarterly, supplemented by monthly credentialing teleconferences.

Accountability

The Board of Directors has ultimate responsibility for the oversight of all performance improvement activities, as well as all other facility functions. The Board of Directors reviews these activities reported by QMC and MEC. The Board of Directors minutes may be shared with our Patient Safety Organization.

V. PERFORMANCE IMPROVEMENT SUPPORT STRUCTURES

Medical Center Administration and Leadership

Administrative leaders set the framework for supporting **quality** patient care,

treatment and services. Leadership creates an environment that fulfills our mission and facilitates meeting and exceeding goals for **quality** care. This mission is reflected in strategic and operational objectives, service design, resource allocation and organizational policies. These are communicated in such a way as to integrate care, treatment, and services throughout the hospital.

Leaders are ultimately responsible for the safety and **quality** of care for all patients. Safety expectations, plans, and priorities are managed through performance improvement programs that measure, assess and improve our governance, management, clinical and support functions. Medical Center leaders promote safe care through the adoption of nationally recognized, evidenced-based clinical practice guidelines.

Medical Staff Committees

The Medical Staff is a self-governing body that is charged with oversight of the **quality** of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process. The Medical Staff operates under the authority and responsibilities outlined in the Medical Staff Bylaws. **Quality** oversight and related responsibilities include but are not limited to:

- Credentials review
- Ongoing physician professional practice evaluation reviews
- Medical Record Review
- Medication Management
- Blood/blood product use
- Operative and other invasive procedures
- Infection Control
- Tissue Review
- Restraint Use
- Behavior Management and Treatment
- Resuscitation Outcomes
- Compliance with evidence-based practices including but not limited to the following: Core Measures, Utilization Review, NQF standards, and others.

Quality Department Support

Quality Department staff support **Quality** Improvement/Patient Safety/PI activities through coordination of QSC and QMC committees, consultation activities, education, team training, team facilitation, etc. and provide information on topics such as:

- Regional, individual facility, and departmental **quality** initiatives
- PI teams and committees descriptions and activities, Joint Commission activities and other information

- PI, data analysis, team management and communication tools
- **Quality** and PI principles and techniques

Resource Management Support

Resource managers perform the essential functions of utilization management. Utilization management is an interdisciplinary approach to balancing cost, **quality** and risk concerns in the provision of patient care. Resource managers are responsible to the Director of Case Management and the facility CFOs. Their responsibilities include but are not limited to:

- Coordination of care for individual patients
- Utilization Review and coordination with payors for authorization of payments
- Effective Discharge Planning associated with expected length of stay
- Coordination of Discharge Planning with physicians and other disciplines
- Continually improve **quality** of care through interdisciplinary collaborative team meetings
- Generate **quality** data through chart review and data abstraction both concurrently and retrospectively

Educational Support

Educational programming is designed and provided to meet the multiple needs of committees within the Medical Center. **Quality** department staff shall have specialized training and exhibit competency with **quality** and process improvement principles. Team leaders, team facilitators and department management shall have access to educational resources addressing topics such as **quality** principles, Joint Commission, meeting management, team management roles, PI tools etc. The QI Department staff is available for consultation or additional assistance. "Just in time" training will be provided to newly established teams and will address meeting management, communication, PI tools and other topics.

VI. CONFIDENTIALITY

All information, data, incidents and other reports, decisions, opinions, actions, interviews, statements or records of proceedings furnished to or generated by QSC, QMC, or any other group acting within the scope and function of Performance Improvement Program,including Physician's Peer Review are confidential and are protected are protected under the Tennessee Code Annotated (TCA-68-11-272).

All such information, in any form whatsoever, will be maintained internally in a confidential manner and shall be used only in the exercise of the function and purpose of the **Quality**/Patient Safety and Performance Improvement Program. Information shall not be considered as public record or be available for court subpoena or for discovery proceedings.

The disclosure of confidential, privileged, performance improvement committee information may only be made as required by law or as authorized by the Medical Center CEOs to the following:

- MEC
- Board of Directors
- Credentials for use in reappointment
- Joint Commission (JC)
- Tennessee Board of Licensure
- Board of Medical Examiners
- Other licensing agencies
- Physicians under review
- Private or governmental insurance carriers
- National Practitioner Data Bank
- Office of the Inspector General

Attachment C.Need.A.11

2013 Projected Demand - Diagnostic Cardiac Catheterizations

	Population													
	0-18	19-29	30-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	Total
Anderson	17,892	9,072	8,546	4,582	5,058	5,519	5,469	5,044	4,081	3,042	2,264	1,748	2,200	74,517
Campbell	10,010	4,910	5,204	2,897	2,755	2,827	2,809	2,785	2,553	1,985	1,438	934	929	42,036
Claiborne	7,671	4,129	4,141	2,246	2,185	2,279	2,278	2,199	1,901	1,392	1,000	648	648	32,717
Cocke	8,782	4,447	4,500	2,480	2,500	2,714	2,666	2,502	2,190	1,613	1,175	780	652	37,001
Grainger	5,873	2,818	2,992	1,750	1,731	1,750	1,659	1,512	1,402	1,019	684	428	325	23,943
Hamblen	16,427	7,514	8,618	4,523	4,352	4,334	3,967	3,653	3,366	2,625	1,943	1,336	1,289	63,947
Jefferson	13,880	7,110	7,276	3,749	3,768	3,786	3,325	2,950	2,855	2,139	1,487	949	869	54,143
Knox	107,421	63,638	53,740	27,846	30,265	31,841	29,831	26,074	20,158	14,386	10,493	7,802	8,496	431,991
Scott	6,444	2,948	3,145	1,546	1,558	1,559	1,494	1,383	1,179	854	586	369	400	23,465
Sevier	20,791	11,351	11,731	6,203	6,149	6,724	6,467	5,919	5,330	3,782	2,563	1,605	1,527	90,142
Union	5,767	2,745	2,702	1,394	1,534	1,583	1,383	1,181	999	742	523	307	287	21,147
Total	**220,958**	**120,682**	**112,595**	**59,216**	**61,855**	**64,916**	**61,348**	**55,202**	**46,014**	**33,579**	**24,156**	**16,906**	**17,622**	**895,049**

	Utilization Rates (based on data from State)												
	0-18	19-29	30-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Anderson	16.5	12.6	291.4	627.9	1,522.5	1,772.2	2,039.5	2,303.7	2,897.5	3,586.7	3,664.5	2,905.1	1,342.4
Campbell	26.2	72.7	437.1	1,050.6	1,847.6	2,479.4	2,539.5	2,996.9	3,754.8	3,607.0	3,300.3	2,583.6	823.2
Claiborne	4.8	34.1	297.0	927.8	2,150.5	2,384.1	2,890.1	4,053.2	4,625.0	3,977.3	3,533.8	2,980.1	745.0
Cocke	21.3	51.2	510.9	1,408.6	2,297.0	2,975.0	3,506.9	4,363.9	4,898.0	4,988.3	4,273.0	3,914.9	1,989.5
Grainger	19.7	50.3	316.5	906.4	1,680.3	2,279.9	2,562.4	3,444.3	4,442.6	4,025.1	5,153.5	4,041.3	800.0
Hamblen	36.7	40.3	302.8	1,090.4	1,677.7	2,277.8	3,292.3	3,812.3	4,949.7	4,985.9	4,957.0	3,774.1	1,516.1
Jefferson	23.7	7.8	326.0	1,055.8	1,267.1	2,141.9	2,907.0	3,280.6	4,116.7	4,325.3	3,891.2	3,195.1	955.1
Knox	17.9	29.7	217.1	708.7	1,061.8	1,550.5	1,974.7	2,471.7	3,230.1	3,527.3	3,599.1	2,988.3	1,264.7
Scott	11.9	37.3	246.9	1,269.5	1,681.8	2,540.3	3,021.8	3,493.8	4,386.8	4,323.8	4,993.4	3,497.2	822.7
Sevier	32.8	36.6	279.4	745.9	1,367.4	1,884.6	2,273.9	2,889.4	3,376.0	3,912.6	3,995.8	2,981.0	1,258.6
Union	34.8	41.9	329.9	823.8	1,346.2	1,633.8	2,214.8	2,622.8	2,849.3	3,278.7	2,880.4	2,252.8	258.7

	Projected Demand													
	0-18	19-29	30-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	Total
Anderson	2.95	1.14	24.90	28.77	77.01	97.81	111.54	116.20	118.25	109.11	82.96	50.78	29.53	850.96
Campbell	2.62	3.57	22.75	30.44	50.90	70.09	71.33	83.46	95.86	71.60	47.46	24.13	7.65	581.86
Claiborne	0.37	1.41	12.30	20.84	46.99	54.33	65.84	89.13	87.92	55.36	35.34	19.31	4.83	493.96
Cocke	1.87	2.28	22.99	34.93	57.43	80.74	93.49	109.18	107.27	80.46	50.21	30.54	12.97	684.36
Grainger	1.16	1.42	9.47	15.86	29.09	39.90	42.51	52.08	62.29	41.02	35.25	17.30	2.60	349.93
Hamblen	6.03	3.03	26.10	49.32	73.01	98.72	130.61	139.26	166.61	130.88	96.31	50.42	19.54	989.84
Jefferson	3.29	0.55	23.72	39.58	47.74	81.09	96.66	96.78	117.53	92.52	57.86	30.32	8.30	695.95
Knox	19.23	18.90	116.67	197.34	321.35	493.69	589.07	644.47	651.12	507.44	377.65	233.15	107.45	4,277.55
Scott	0.77	1.10	7.77	19.63	26.20	39.60	45.15	48.32	51.72	36.93	29.26	12.90	3.29	322.63
Sevier	6.82	4.15	32.78	46.27	84.08	126.72	147.05	171.02	179.94	147.97	102.41	47.85	19.22	1,116.29
Union	2.01	1.15	8.91	11.48	20.65	25.86	30.63	30.98	28.46	24.33	15.06	6.92	0.74	207.19
Total	**47.11**	**38.70**	**308.35**	**494.46**	**834.46**	**1,208.57**	**1,423.88**	**1,580.88**	**1,666.97**	**1,297.61**	**929.79**	**523.61**	**216.12**	**10,570.51**

Attachment C.Need.A.13

TENNOVA HEALTHCARE

PHYSICIANS REGIONAL MEDICAL CENTER

NORTH KNOXVILLE MEDICAL CENTER

TURKEY CREEK MEDICAL CENTER

Cardiology/Cardiovascular Disease Clinical Privileges

Name:_____

To be eligible to apply for core privileges in cardiology/cardiovascular disease, the applicant must meet the following qualifications:

Successful completion of an ACGME or AOA accredited post-graduate training program in internal medicine followed by an accredited post-graduate training program in cardiology **AND** current certification by the American Board of Medical Specialties or the American Osteopathic Board in cardiology.

Or

- Successful completion of an ACGME- or AOA-accredited post-graduate training program in internal medicine followed by an accredited post-graduate training program in cardiology within the last six months **AND** active participation in the examination process leading to certification by the American Board of Medical Specialties or the American Osteopathic Board in cardiology prior to the second reappointment cycle.

- New applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

Cardiology core privileges

☐ **Requested** Admit, evaluate, diagnose, document, treat and provide consultation to patients of all ages presenting with diseases of the heart, lungs, and blood vessels and manage complex cardiac conditions such as heart attacks, and life-threatening, abnormal heartbeat rhythms. Privileges include but are not limited to; advanced cardiac life support (ACLS), cardioversion, insertion and management of central venous and pulmonary artery catheters, use of thrombolytic agents, pericardiocentesis, echocardiography interpretation including stress echocardiography and transesophageal echocardiography, Holter scanning, treadmill testing, including radio nuclide studies, temporary transvenous pacemaker placement, intra-aortic balloon pump placement, and electrical cardioversion. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Invasive cardiology core privileges

☐ **Requested** Admit, evaluate, treat, document, and provide consultation to patients of all ages except as specifically excluded from practice with acute and chronic coronary artery disease. The core privileges in this specialty include right and left heart catheterization, including coronary and aortic angiography and the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Interventional cardiology core privileges

☐ **Requested** Admit, evaluate, treat, document, and provide consultation to patients of all ages except as specifically excluded from practice with acute and chronic coronary artery disease, acute coronary syndromes and valvular heart disease including the provision of consultation, including but not limited to chronic ischemic heart disease, acute ischemic syndromes, and valvular heart disease and technical procedures and medications to treat abnormalities that impair the function of the heart including PTCA and stenting. The care of patients in the cardiac care units, emergency department or other intensive care units.

Clinical cardiac electrophysiology core privileges

☐ **Requested** Admit, evaluate, treat, document and provide consultation to acute and chronically ill patients of all ages except as specifically excluded from practice, with a variety of heart rhythm disorders; including but not limited to sinus node dysfunction, intraventricular block, and supraventricular and ventricular tachyarrhythmias; clinical conditions of unexplained syncope, aborted sudden cardiac death, palpitations, Wolff-Parkinson-White (WRW) syndrome, and long QT syndrome, care of patients in the cardiac care unit, emergency room, or other intensive care settings, care of patient in the cardiac care unit, emergency room, or other invasive settings; before and after an electrophysiologic procedure; with temporary and permanent pacemakers; with postoperative arrhythmias and care of patients with ICDs. ***Requires:*** *Successful completion of an ACGME-or AOA-accredited training program in cardiology followed by completion of an accredited training program in CCEP. Required Previous Experience: Demonstration of the performance of at least 150 intracardiac procedures during the past 12 months.*

General internal medicine core privileges

☐ **Requested** Admit, evaluate, diagnose, document, treat and provide consultation to patients above the age of 12 admitted with both common and complex illnesses. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Special procedures/techniques (see Qualifications and/or specific criteria*)
To be eligible to apply for a special procedure listed below, the applicant must maintain core privileges, must demonstrate successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable experience, and provide documentation of competence in performing that procedure consistent with the criteria set forth in medical staff policies governing the exercise of specific privileges

Administration of moderate sedation
☐ **Requested** See Guidelines for Use of Moderate Sedation

AV Nodal Ablations
☐ **Requested**
Fluoroscopic Usage
☐ **Requested** *See Delineation of Privileges for Fluoroscopic Usage for Non-Radiologists*

IABP
☐ **Requested**

ICD implantation, bi-ventricular
☐ **Requested** **Requires:** Successful completion of an ACGME or AOA accredited training program in cardiology followed by completion of an accredited training program in CCEP.

Myocardial Biopsies
☐ **Requested**

Nuclear Cardiology
☐ **Requested** ***Requires:*** Board eligibility or certification from the American Board of Internal Medicine and Cardiovascular Disease, Radiology or Nuclear Medicine. Documented clinical training providing the essentials in nuclear medicine and nuclear cardiology. Included in this are the requirements for interpretation under supervision of a minimum of 300 cases, consisting of diverse types of procedures. NRC licensure or equivalent. Grandfather all physicians in who are currently credentialed to and who are currently providing Nuclear Cardiology services at Mercy Medical Center as of 6/3/94. A Nuclear Medicine trained physician should be the head of the department.

_____ I am licensed for therapies _____ I am not licensed for therapies

_____ I am licensed by the State _____ I am not licensed by the State

Permanent Pacemaker placement including Implantable Loop Recorders
☐ **Requested**

PTCA
☐ **Requested**

Valvuloplasty
☐ **Requested**

Cardiac CT
☐ **Requested** CME Requirements: 40 hours CME in CT cardiac imaging for initial training; 75 cases reviewed in training or proctoring. Minimum 50 cases every two years to maintain competence.

Peripheral Angiography and Angioplasty
☐ **Requested**
Introduction: Peripheral angiography and angioplasty is a rapidly growing field of medical care in which forecasts expect a shortage of practitioners. Specialties that currently claim privileges in this field include interventional radiology, vascular surgery, and interventional cardiology. These specialties have each recommended qualifications for privileges and have collaborated nationally on these qualifications. Those applying for such privileges will be expected to be available on call for such privileges. There shall also be a committee formed of those with such privileges to review and determine quality outcomes. Those having existing privileges will be 'grandfathered' in at the outset. This privilege excludes intracranial **OR CAROTID/VERTEBRAL ARTERY** procedures.
Requirements for additional privileging in diagnostic and interventional peripheral angiography

1. MD/DO degree with valid Tennessee license.
2. Board Certification/eligibility in vascular surgery, interventional cardiology or radiology
3. Experience in peripheral angiography/interventions
   a. Documented training in residency for new graduates. This may be fellowship of no less than three months to one year and include 100 cases where the physician is primary operator in at least 50 cases. A minimum number of cases must fall into each of the below categories.
   b. For those whose residency training did not include peripheral angiography/intervention a minimum 50 hours CME with at least one live seminar on peripheral angioplasty with hands on experience and then 100 proctored cases where the physician is primary operator in at least 50 cases.
4. Cases to be included in the 100 must include:
   - 10 cases that include thrombolysis
   - 10 cases of renal or visceral experience
   - 10 selective/extremity.
5. The Chief of Staff will appoint a committee with members from each specialty to monitor issues related to quality, outcomes and administration and indications. The committee will report to the Medical Staff Executive Committee.

- Restricted Requested

Requires: Documentation of a minimum 50 hours CME with at least one live seminar on peripheral angioplasty with hands on experience is required. Peripheral Angiography and Angioplasty procedures require the presence of a proctor with full privileges for Peripheral Angiography and Angioplasty.

Stress Echocardiography
☐ **Requested**

Transesophageal Echocardiography
☐ **Requested**

Carotid Ultrasound
☐ **Requested** ***Requires***: Minimum one month experience performing, supervising and interpreting Carotid Ultrasound AND Minimum fifty supervised interpretations of Carotid Ultrasound

Use of laser
☐ **Requested** ***Requires:*** *Completion of an approved eight hour minimum CME course which includes training in laser principles and safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty field and hands-on experience with lasers. A letter outlining the content and successful completion of course must be submitted, or documentation of successful completion of an approved residency in a specialty or subspecialty which included training in laser principles and safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty field and a minimum of six hours observation and hands-on experience with lasers.*

Carotid Artery Stenting
☐ **Requested You must select one of the pathways below under current competence**
Carotid artery stents preferably will be placed with embolic protection device unless, in the opinion of the operator, there is a documented reason to not use the embolic protection device. The Endovascular Committee will monitor issues related to quality, outcomes and administration and indications. Any major complication will be reviewed by the Endovascular Committee within ninety days. The committee will report to the Medical Staff Executive Committee.

ELIGIBILITY REQUIREMENTS:

Education: M.D. or D.O.

Training: Successful completion of a either: a general surgery residency and fellowship in vascular surgery, a radiology residency and interventional radiology fellowship, a cardiology residency and an interventional cardiology fellowship, a neurosurgery/neurology residency and an interventional neurosurgery/neurology fellowship, or prior to November,

2008 completing either a general surgery residency with vascular surgery privileges at a Mercy Health Partners facility, a radiology residency with peripheral vascular intervention privileges at a Mercy Health Partners facility, or a cardiology residency with peripheral vascular intervention privileges at a Mercy Health Partners facility. All residencies and fellowships must be approved by the ACGME or a program deemed acceptable by the Credentials Committee and approved by the Medical Executive Committee and Board of Directors.

AND

Privileges in non-coronary diagnostic peripheral angiography

AND

Previous experience and recent training in non-coronary endovascular procedures and stent placement (vascular surgeons, diagnostic radiologists and neurosurgeons already credentialed in peripherals)

CURRENT COMPETENCE

In each pathway, if all of the requirements are met except for the required number of CAS cases, the applicant may apply for the privilege and will have direct proctoring by a physician with current CAS privileges on each CAS case for the remaining number of required cases. Following completion of proctored CAS cases, the Credentials Committee will review the recommendation of the proctor for unrestricted CAS privileges

Pathway A

_____ Completion of an approved residency or fellowship as described under eligibility requirements and with special training in peripheral vascular intervention and carotid stenting with embolic protection device in the past 36 months.

- Must provide case log that includes at least 25 CAS cases, half as primary operator and at least 30 selective carotid arteriograms as primary operator.

- Must have letter of competency from program director

Pathway B

_____ Prior experience and competency demonstrated in peripheral vascular intervention and carotid stenting with embolic protection device.

- Previously held unrestricted privileges in carotid stenting
- Successful completion of the manufacturer's/FDA required training course and simulation for the specific carotid stenting device and embolic protection device to be used
- Documentation of twenty-five (25) CAS cases, half as primary operator
- Documentation of at least 30 selective carotid arteriograms as primary operator

Pathway C

_____ Documentation of experience and training in the diagnosis, management and treatment of carotid artery disease and

understanding of the pathophysiology of carotid artery disease and

cerebrovascular disease, including stroke.

- Part of a training program
- Courses attended

AND

_____ Previous experience and recent training in carotid artery

angiography.

- Documentation of at least 30 selective carotid arteriograms as primary operator

AND

_____ Successful completion of the manufacture's/FDA required training course and simulation for the specific carotid stenting device and embolic protection device to be used.

- Documentation of at least 25 CAS with at least half as the primary operator

Carotid Angiography
☐ **Requested**
ELIGIBILITY REQUIREMENTS:

Education: M.D. or D.O.

Training: Successful completion of a residency or fellowship program accredited by the ACGME in general and vascular surgery, diagnostic radiology, or invasive cardiology.

AND

Privileges in non-coronary diagnostic peripheral angiography

AND

Previous experience and recent training in carotid angiography

CURRENT COMPETENCE
Must provide documentation of case log that includes at least 30 Carotid Angiography cases, half as primary operator and half as first assistant.

Cardiovascular Magnetic Resonance
☐ **Requested** Requires: Applicant must demonstrate completion of formal training in Level 2 Cardiovascular Magnetic Resonance (CMR), which included: at least three (3) months full time training in CMR; and at least 150 mentored interpretations, by a Level 2 or Level 3 qualified CMR physician, including at least fifty (50) as primary interpreter (and operator, if possible)

Placement of Patent Foramen Ovale (PFO)/Atrial Septal Defect (ASD) Closure Devices
•• Requested Requires: Current Interventional Cardiology Core Privileges

AND

Training: Obtained training during an Interventional Cardiology fellowship to perform PFO/ASD closures and have performed at least 10 cases during the training

OR

Obtained training during their practice and have been satisfactorily proctored in 10 cases.

• Restricted Requested

Requires: Documentation of training either in fellowship or during their practice as outlined above. PFO/ASD closure procedures require the presence of a proctor with privileges for Placement of PFO/ASD Closure Devices.

Cardiology/Cardiovascular Disease Clinical Privileges

Name:_____

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at **Physicians Regional Medical Center, North Knoxville Medical Center and Turkey Creek Medical Center,** and I understand that (a) in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation (b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents

I wish to exclude the following privileges from the core privileges that I have requested:

Privilege	
1.	5.
2.	6.
3.	7.
4.	8.
Notes:	

Signed:_____ Date: _____

Department Chair's Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐Recommend all requested privileges
☐Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

Department Chair Signature: _____ Date: _____

Cardiology/Cardiovascular Medicine Core Privileges

- Abdominal paracentesis
- Arterial line placement
- Cardioversion, electrical, elective
- CDI non-invasive hemodynamic monitoring
- Central line placement
- Chest tube placement
- Defibrilator
- ECG interpretation
- Echocardiography
- EKG interpretation
- Electrical cardioversion (elective)
- Exercise right heart catheterization
- Holter monitor interpretation
- Infusion and management of Gp lib/llla agents
- Insertion and management of pulmonary artery catheters
- Intravenous thrombolytic therapy
- Intubation and ACLS
- Lumbar puncture
- Pericardiocentesis
- Signal average ECG
- Streptokinase infusion of coronary arteries
- Stress testing (exercise and pharmacologic)
- Swan Ganz catheter placement and right heart catheterization
- Temporary pacemaker insertion
- Thoracentesis
- Tilt table
- Transtracheal aspiration
- Ventilator management
- Coronary Artery Stents

Invasive Cardiology

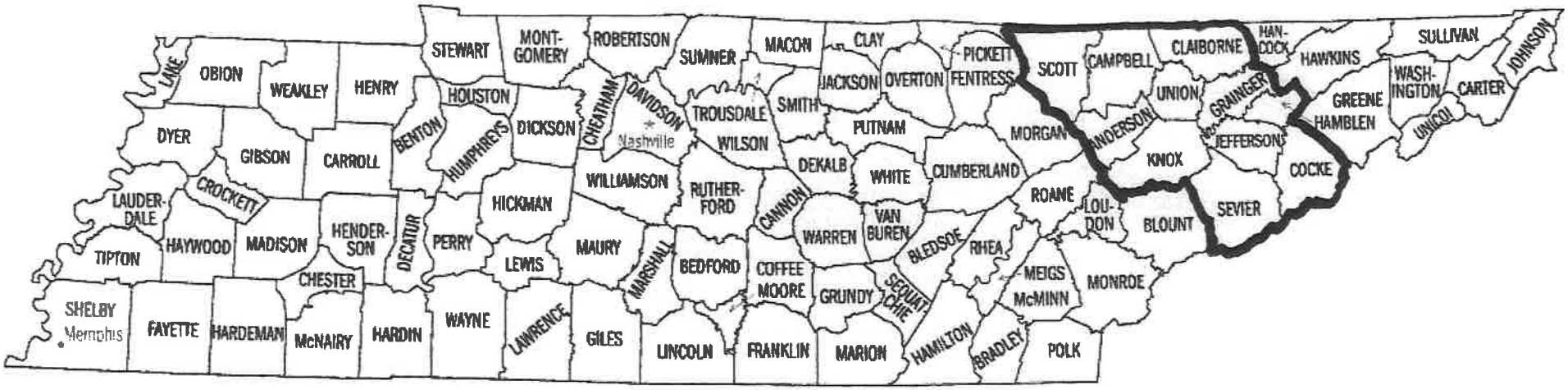
- Right and left heart catheterization, including coronary and aortic angiography
- Transesophageal Echocardiography
- Electrophysiology
- Intra-aortic balloon pump insertion and management

Internal Medicine Core Privileges

- Arterial puncture
- Central line insertion and management
- ECG interpretation
- Endotracheal intubation (emergency)
- Exercise testing
- Flexible sigmoidoscopy
- Lumbar puncture
- Needle aspiration of joint
- Needle injection of bursa & joints
- Paracentesis
- Placement of venous catheters
- Proctosigmoidoscopy with biopsy
- Skin biopsy
- Suprapubic bladder aspiration
- Thoracentesis
- Tracheostomy (emergency)
- Venous cutdown
- Ventilator management

DPNEWCardiology.doc

Attachment C.Need.3


LAKE
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ROBERTSON
SUMNER
MACON
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SCOTT
CAMPBELL
CLAIBORNE
HAN-COCK
HAWKINS
SULLIVAN
JOHNSON
WASH-INGTON
CARTER
UNICOI
GREENE
HAMBLEN
GRAINGER
UNION
ANDERSON
JEFFERSON
KNOX
COCKE
SEVIER
BLOUNT
LOU-DON
ROANE
MORGAN
CUMBERLAND
WHITE
DEKALB
PUTNAM
JACKSON
OVERTON
SMITH
TROUSDALE
WILSON
DAVIDSON
Nashville
CHEATHAM
DICKSON
HOUSTON
HUMPHREYS
BENTON
DYER
GIBSON
CARROLL
CROCKETT
LAUDER-DALE
TIPTON
HAYWOOD
MADISON
HENDER-SON
CHESTER
DECATUR
PERRY
HICKMAN
WILLIAMSON
RUTHER-FORD
CANNON
WARREN
VAN BUREN
BLEDSOE
RHEA
MEIGS
McMINN
MONROE
LEWIS
MAURY
MARSHALL
BEDFORD
COFFEE
MOORE
GRUNDY
SEQUATCHIE
HAMILTON
BRADLEY
POLK
SHELBY
Memphis
FAYETTE
HARDEMAN
McNAIRY
HARDIN
WAYNE
LAWRENCE
GILES
LINCOLN
FRANKLIN
MARION

Attachment C.Need.6

2013 Projected Demand - Diagnostic Cardiac Catheterizations

Population

	0-18	19-29	30-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	Total
Anderson	17,892	9,072	8,546	4,582	5,058	5,519	5,469	5,044	4,081	3,042	2,264	1,748	2,200	74,517
Campbell	10,010	4,910	5,204	2,897	2,755	2,827	2,809	2,785	2,553	1,985	1,438	934	929	42,036
Claiborne	7,671	4,129	4,141	2,246	2,185	2,279	2,278	2,199	1,901	1,392	1,000	648	648	32,717
Cocke	8,782	4,447	4,500	2,480	2,500	2,714	2,666	2,502	2,190	1,613	1,175	780	652	37,001
Grainger	5,873	2,818	2,992	1,750	1,731	1,750	1,659	1,512	1,402	1,019	684	428	325	23,943
Hamblen	16,427	7,514	8,618	4,523	4,352	4,334	3,967	3,653	3,366	2,625	1,943	1,336	1,289	63,947
Jefferson	13,880	7,110	7,276	3,749	3,768	3,786	3,325	2,950	2,855	2,139	1,487	949	869	54,143
Knox	107,421	63,638	53,740	27,846	30,265	31,841	29,831	26,074	20,158	14,386	10,493	7,802	8,496	431,991
Scott	6,444	2,948	3,145	1,546	1,558	1,559	1,494	1,383	1,179	854	586	369	400	23,465
Sevier	20,791	11,351	11,731	6,203	6,149	6,724	6,467	5,919	5,330	3,782	2,563	1,605	1,527	90,142
Union	5,767	2,745	2,702	1,394	1,534	1,583	1,383	1,181	999	742	523	307	287	21,147
Total	**220,958**	**120,682**	**112,595**	**59,216**	**61,855**	**64,916**	**61,348**	**55,202**	**46,014**	**33,579**	**24,156**	**16,906**	**17,622**	**895,049**

Utilization Rates (based on data from State)

	0-18	19-29	30-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Anderson	16.5	12.6	291.4	627.9	1,522.5	1,772.2	2,039.5	2,303.7	2,897.5	3,586.7	3,664.5	2,905.1	1,342.4
Campbell	26.2	72.7	437.1	1,050.6	1,847.6	2,479.4	2,539.5	2,996.9	3,754.8	3,607.0	3,300.3	2,583.6	823.2
Claiborne	4.8	34.1	297.0	927.8	2,150.5	2,384.1	2,890.1	4,053.2	4,625.0	3,977.3	3,533.8	2,980.1	745.0
Cocke	21.3	51.2	510.9	1,408.6	2,297.0	2,975.0	3,506.9	4,363.9	4,898.0	4,988.3	4,273.0	3,914.9	1,989.5
Grainger	19.7	50.3	316.5	906.4	1,680.3	2,279.9	2,562.4	3,444.3	4,442.6	4,025.1	5,153.5	4,041.3	800.0
Hamblen	36.7	40.3	302.8	1,090.4	1,677.7	2,277.8	3,292.3	3,812.3	4,949.7	4,985.9	4,957.0	3,774.1	1,516.1
Jefferson	23.7	7.8	326.0	1,055.8	1,267.1	2,141.9	2,907.0	3,280.6	4,116.7	4,325.3	3,891.2	3,195.1	955.1
Knox	17.9	29.7	217.1	708.7	1,061.8	1,550.5	1,974.7	2,471.7	3,230.1	3,527.3	3,599.1	2,988.3	1,264.7
Scott	11.9	37.3	246.9	1,269.5	1,681.8	2,540.3	3,021.8	3,493.8	4,386.8	4,323.8	4,993.4	3,497.2	822.7
Sevier	32.8	36.6	279.4	745.9	1,367.4	1,884.6	2,273.9	2,889.4	3,376.0	3,912.6	3,995.8	2,981.0	1,258.6
Union	34.8	41.9	329.9	823.8	1,346.2	1,633.8	2,214.8	2,622.8	2,849.3	3,278.7	2,880.4	2,252.8	258.7

Projected Demand

	0-18	19-29	30-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	Total
Anderson	2.95	1.14	24.90	28.77	77.01	97.81	111.54	116.20	118.25	109.11	82.96	50.78	29.53	850.96
Campbell	2.62	3.57	22.75	30.44	50.90	70.09	71.33	83.46	95.86	71.60	47.46	24.13	7.65	581.86
Claiborne	0.37	1.41	12.30	20.84	46.99	54.33	65.84	89.13	87.92	55.36	35.34	19.31	4.83	493.96
Cocke	1.87	2.28	22.99	34.93	57.43	80.74	93.49	109.18	107.27	80.46	50.21	30.54	12.97	684.36
Grainger	1.16	1.42	9.47	15.86	29.09	39.90	42.51	52.08	62.29	41.02	35.25	17.30	2.60	349.93
Hamblen	6.03	3.03	26.10	49.32	73.01	98.72	130.61	139.26	166.61	130.88	96.31	50.42	19.54	989.84
Jefferson	3.29	0.55	23.72	39.58	47.74	81.09	96.66	96.78	117.53	92.52	57.86	30.32	8.30	695.95
Knox	19.23	18.90	116.67	197.34	321.35	493.69	589.07	644.47	651.12	507.44	377.65	233.15	107.45	4,277.55
Scott	0.77	1.10	7.77	19.63	26.20	39.60	45.15	48.32	51.72	36.93	29.26	12.90	3.29	322.63
Sevier	6.82	4.15	32.78	46.27	84.08	126.72	147.05	171.02	179.94	147.97	102.41	47.85	19.22	1,116.29
Union	2.01	1.15	8.91	11.48	20.65	25.86	30.63	30.98	28.46	24.33	15.06	6.92	0.74	207.19
Total	**47.11**	**38.70**	**308.35**	**494.46**	**834.46**	**1,208.57**	**1,423.88**	**1,580.88**	**1,666.97**	**1,297.61**	**929.79**	**523.61**	**216.12**	**10,570.51**

Attachment C.Economic Feasibility.1

JOHNSON&GALYON
CONSTRUCTION

November 6, 2012

Ms. Melanie Robinson
Tennova Healthcare
900 E. Oak Hill Avenue
Knoxville, TN 37917

Re: **Tennova NKMC**
Cath Lab Renovations
Budget Estimate

Dear Melanie:

We are pleased to recommend a budget of One Million Three Hundred Two Thousand Two Hundred Eighty Nine Dollars ($1,302,289) for the above referenced project. Breakdowns of our cost estimates are attached. The estimates are based on the attached schematic drawing and descriptions of the HVAC System prepared by BarberMcMurry architects.

The estimates are summarized as follows:

Area 1 – Waiting Expansion and Consult	$ 158,901
Area 2 – Cath Lab	$ 979,902
Area 3 – Prep/Recovery Expansion	$ 163,486
Total:	$1,302,289

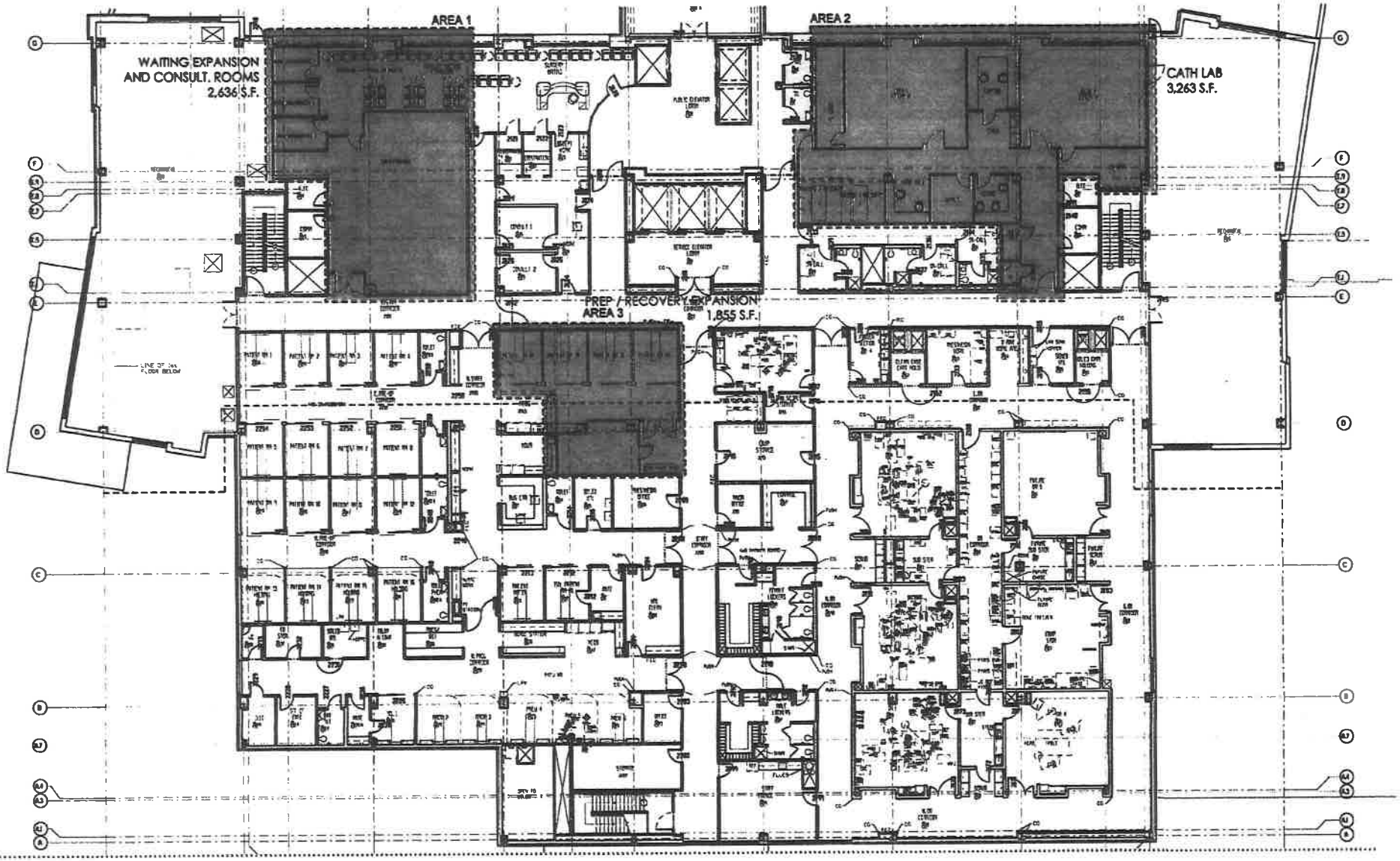
We appreciate the opportunity to be of service to you. Should you have any questions, please call.

Sincerely,

JOHNSON & GALYON, INC.

Mark A. Halcomb
Estimator

Attachments
Cc: Mike Driskill, BMa



12OCT2012

2 EXTENT OF WORK FLOOR PLAN
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 10 20 40

bma BARBER McMURRY
architects since 1915

122300

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		**GENERAL CONDITIONS**				
	01312	**Supervision**				
		Project Superintendent	4.33 wk	1,838.82	7,962	
		Pickup Truck	4.33 wk	192.17	832	
		Supervision	2,636.00 sf	3.34	8,794	
	01320	**Construction Documents**				
		Extra Plans	1.00 ls	575.46	575	
		Construction Documents	2,636.00 sf	0.22	575	
	01400	**Temp Protection - J&G**				
		Temporary Protection	1.00 ls	1,587.67	1,588	
		Temp Protection - J&G	2,636.00 sf	0.60	1,588	
	01510	**TEMPORARY UTILITIES**				
		Jobsite Cell Phones	1.00 mo	97.83	98	
		TEMPORARY UTILITIES	2,636.00 sf	0.04	98	
	01600	**Safety**				
		First Aid Kits	1.00 ea	157.10	157	
		Fire Extinguisher	1.00 ea	97.82	98	
		Safety	2,636.00 sf	0.10	255	
	01610	**Hospital Infection Control**				
		Infection Control	4.33 wk	740.91	3,208	
		Hospital Infection Control	2,636.00 sf	1.22	3,208	
	01720	**Layout**				
		Interior Walls	8.00 hr	68.80	550	
		Layout	2,636.00 sf	0.21	550	
	01740	**Clean Up**				
		Dumping Fees	1.00 each	374.06	374	
		Clean Building Area	2,636.00 sf	0.84	2,202	
		Sub Final Cleaning	2,636.00 sf	0.30	781	
		Clean Up	2,636.00 sf	1.27	3,357	
		GENERAL CONDITIONS	**2,636.00 sf**	**6.99**	**18,425**	
02000		**SITEWORK**				
	02015	**Cutting & Patching**				
		Cutting & Patching	1.00 ls	1,058.44	1,058	
		Cutting & Patching	2,636.00 Sf	0.40	1,058	
	02020	**Dust Partition**				
		Dust Partitons	1.00 ls	529.22	529	
		Dust Partition	2,636.00 Sf	0.20	529	
	02225	**SELECTIVE DEMOLITION**				
		General Demolition	2,636.00 sf	1.43	3,766	
		SELECTIVE DEMOLITION	2,636.00 sf	1.43	3,766	
		SITEWORK	**2,636.00 sf**	**2.03**	**5,353**	
06000		**WOOD & PLASTICS**				
	06105	**ROUGH CARPENTRY- Framing**				
		Blocking	32.00 sf	0.79	25	
		ROUGH CARPENTRY- Framing	2,636.00 sf	0.01	25	
	06410	**Millwork**				
		Millwork	1.00 ls	0.02	0	None Shown

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		Millwork	2,636.00 sf	0.00	0	
		WOOD & PLASTICS	**2,636.00 sf**	**0.01**	**25**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofing				
		Firestopping / Fire Proof Patching	1.00 ls	1,058.43	1,058	
		FIRESTOPPING / Fire Proofing	2,636.00 sf	0.40	1,058	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	158.77	159	
		JOINT SEALANTS	2,636.00 sf	0.06	159	
		THERMAL/MOISTURE PROTECT	**2,636.00 sf**	**0.46**	**1,217**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	624.48	624	
		Wood Door Material	1.00 ls	841.46	841	
		Finish Hardware	1.00 ls	1,312.47	1,312	
		Glass for Standard Window	1.00 ls	0.01	0	
		Labor - Door, Frame & Hardware	5.00 ea	328.36	1,642	
		Doors, Frames & Hardware	2,636.00 sf	1.68	4,420	
		DOORS & WINDOWS	**2,636.00 sf**	**1.68**	**4,420**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching	1.00 ls	39,596.24	39,596	
		Acoustical Ceilings	1.00 ls	0.01	0	Included Above
		GYPSUM WALL BOARD	2,636.00 sf	15.02	39,596	
	09680	CARPET				
		Flooring Allowance	1.00 ls	9,039.07	9,039	
		CARPET	2,636.00 sf	3.43	9,039	
	09910	PAINTING				
		Painting	2,636.00 sf	2.12	5,580	
		PAINTING	2,636.00 sf	2.12	5,580	
		FINISHES	**2,636.00 sf**	**20.57**	**54,215**	
15000		**MECHANICAL**				
	15050	Mechanical				
		HVAC & Plumbing	1.00 ls	25,796.29	25,796	
		Mechanical	2,636.00 sf	9.79	25,796	
	15300	Sprinkler System				
		Fire Protection Bid	2,636.00 sf	1.59	4,185	
		Sprinkler System	2,636.00 sf	1.59	4,185	
		MECHANICAL	**2,636.00 sf**	**11.37**	**29,981**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Electrical	1.00 ls	35,944.62	35,945	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		ELECTRICAL	2,636.00 sf	13.64	35,945	
		ELECTRICAL	**2,636.00 sf**	**13.64**	**35,945**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	15,207				5.769 /sf	9.57%
Material	2,040				0.774 /sf	1.28%
Subcontract	131,878				50.029 /sf	82.99%
Equipment	458				0.174 /sf	0.29%
Other						
	149,583	149,583			56.746 /sf	94.14
Knoxville Review Fee	255				0.097 /sf	0.16%
Knoxville City Permit	636				0.241 /sf	0.40%
	891	150,474			57.084 /sf	0.56
General Liability - 0.15%	238		0.150 %	T	0.090 /sf	0.15%
P&P Bond - 2009 rates	1,001				0.380 /sf	0.63%
	1,239	151,713			57.554 /sf	0.78
Fee	7,188		5.000 %		2.727 /sf	4.52%
	7,188	158,901			60.281 /sf	4.52
Total		***158,901***			***60.281 /sf***	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		**GENERAL CONDITIONS**				
	01312	**Supervision**				
		Project Superintendent	13.00 wk	1,837.76	23,891	
		Pickup Truck	13.00 wk	192.03	2,496	
		Supervision	3,263.00 sf	8.09	26,387	
	01320	**Construction Documents**				
		Extra Plans	1.00 ls	575.10	575	
		Construction Documents	3,263.00 sf	0.18	575	
	01400	**Temp Protection - J&G**				
		Temporary Protection	1.00 ls	1,586.53	1,587	
		Temp Protection - J&G	3,263.00 sf	0.49	1,587	
	01510	**TEMPORARY UTILITIES**				
		Jobsite Cell Phones	3.00 mo	97.76	293	
		TEMPORARY UTILITIES	3,263.00 sf	0.09	293	
	01600	**Safety**				
		First Aid Kits	1.00 ea	157.01	157	
		Fire Extinguisher	1.00 ea	97.76	98	
		Safety	3,263.00 sf	0.08	255	
	01610	**Hospital Infection Control**				
		Infection Control	13.00 wk	740.38	9,625	
		Hospital Infection Control	3,263.00 sf	2.95	9,625	
	01720	**Layout**				
		Interior Walls	8.00 hr	68.75	550	
		Layout	3,263.00 sf	0.17	550	
	01740	**Clean Up**				
		Dumping Fees	3.00 each	373.81	1,121	
		Clean Building Area	3,235.00 sf	0.83	2,700	
		Sub Final Cleaning	3,235.00 sf	0.30	958	
		Clean Up	3,263.00 sf	1.46	4,780	
		GENERAL CONDITIONS	**3,263.00 sf**	**13.50**	**44,052**	
02000		**SITEWORK**				
	02015	**Cutting & Patching**				
		Cutting & Patching	1.00 ls	5,288.42	5,288	
		Cutting & Patching	3,263.00 Sf	1.62	5,288	
	02020	**Dust Partition**				
		Dust Partitons	1.00 ls	3,173.05	3,173	
		Dust Partition	3,263.00 Sf	0.97	3,173	
	02225	**SELECTIVE DEMOLITION**				
		General Demolition	3,235.00 sf	1.43	4,619	
		SELECTIVE DEMOLITION	3,263.00 sf	1.42	4,619	
		SITEWORK	**3,263.00 sf**	**4.01**	**13,080**	
05000		**METALS**				
	05510	**MISC. METALS**				
		Equipment Supports	2.00 room	26,970.95	53,942	
		MISC. METALS	3,263.00 sf	16.53	53,942	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		METALS	**3,263.00 sf**	**16.53**	**53,942**	
06000		**WOOD & PLASTICS**				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	3,235.00 sf	0.79	2,566	
		ROUGH CARPENTRY- Framing	3,263.00 sf	0.79	2,566	
	06410	Millwork				
		Millwork	1.00 ls	7,403.79	7,404	
		Millwork	3,263.00 sf	2.27	7,404	
		WOOD & PLASTICS	**3,263.00 sf**	**3.06**	**9,970**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofin				
		Firestopping / Fire Proof Patching	1.00 ls	2,644.21	2,644	
		FIRESTOPPING / Fire Proofin	3,263.00 sf	0.81	2,644	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	264.42	264	
		JOINT SEALANTS	3,263.00 sf	0.08	264	
		THERMAL/MOISTURE PROTECT	**3,263.00 sf**	**0.89**	**2,909**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	5,831.43	5,831	
		Wood Door Material	1.00 ls	8,310.09	8,310	
		Finish Hardware	1.00 ls	8,695.40	8,695	
		Lead Glass	1.00 ls	7,418.68	7,419	
		Glass for Standard Window	1.00 ls	287.55	288	
		Labor - Door, Frame & Hardware	13.00 ea	328.17	4,266	
		Labor - HM Window Frame & Glass	1.00 ea	131.27	131	
		Labor - Lead Glass Window	2.00 ea	656.35	1,313	
		Doors, Frames & Hardware	3,263.00 sf	11.11	36,253	
		DOORS & WINDOWS	**3,263.00 sf**	**11.11**	**36,253**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching, Including Lead Lined	1.00 ls	46,322.34	46,322	
		Acoustical Ceilings	1.00 ls	11,444.14	11,444	
		GYPSUM WALL BOARD	3,263.00 sf	17.70	57,766	
	09680	CARPET				
		Flooring Allowance	1.00 ls	26,399.80	26,400	
		CARPET	3,263.00 sf	8.09	26,400	
	09910	PAINTING				
		Painting	3,235.00 ls	2.12	6,843	
		PAINTING	3,263.00 sf	2.10	6,843	
		FINISHES	**3,263.00 sf**	**27.89**	**91,010**	
10000		**SPECIALTIES**				
	10190	Cubicles Curtain Track				

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
	10190	Cubicles Curtain Track				
		Allowance	1.00 ls	1,586.53	1,587	
		Cubicles Curtain Track	3,263.00 sf	0.49	1,587	
	10810	Toilet Accessories				
		Allowance	1.00 ls	353.17	353	
		Toilet Accessories	3,263.00 sf	0.11	353	
		SPECIALTIES	**3,263.00 sf**	**0.59**	**1,940**	
11000		**EQUIPMENT**				
	11710	MEDICAL EQUIPMENT				
		Install Owner Provided Equipment	1.00 ls	0.01	0	Not Included
		MEDICAL EQUIPMENT	3,263.00 sf	0.00	0	
		EQUIPMENT	**3,263.00 sf**	**0.00**	**0**	
13000		**SPECIAL CONSTRUCTION**				
	13090	RADIATION PROTECTION				
		Lead Lined Sheetrock	1.00 ls	0.01	0	w/ Drywall Item
		Lead Glass View Window	1.00 ls	0.01	0	w/ Doors Item
		Lead Lined Door	1.00 ls	0.01	0	w/ Doors Item
		RADIATION PROTECTION	3,263.00 sf	0.00	0	
		SPECIAL CONSTRUCTION	**3,263.00 sf**	**0.00**	**0**	
15000		**MECHANICAL**				
	15050	Mechanical				
		Heart Cath Lab	1.00 ls	118,749.39	118,749	
		Additional AHU	1.00 ls	200,928.30	200,928	
		Mechanical	3,263.00 sf	97.97	319,678	
	15300	Sprinkler System				
		Fire Protection Bid	3,235.00 sf	1.59	5,132	
		Sprinkler System	3,263.00 sf	1.57	5,132	
		MECHANICAL	**3,263.00 sf**	**99.54**	**324,810**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Heart Cath Lab	1.00 ls	330,695.58	330,696	
		Additional AHU	1.00 ls	15,619.88	15,620	
		ELECTRICAL	3,263.00 sf	106.13	346,315	
		ELECTRICAL	**3,263.00 sf**	**106.13**	**346,315**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	36.539				11.198 /sf	3.73%
Material	34.643				10.617 /sf	3.54%
Subcontract	851.723				261.025 /sf	86.92%
Equipment	1.375				0.421 /sf	0.14%
Other						
	924,280	924,280			283.261 /sf	94.32
Knoxville Review Fee	450				0.138 /sf	0.05%
Knoxville City Permit	3,200				0.981 /sf	0.33%
	3,650	927,930			284.379 /sf	0.37
General Liability - 0.15%	1,470		0.150 %	T	0.450 /sf	0.15%
P&P Bond - 2009 rates	6,173				1.892 /sf	0.63%
	7,643	935,573			286.722 /sf	0.78
Fee	44,329		5.000 %		13.585 /sf	4.52%
	44,329	979,902			300.307 /sf	4.52
Total		***979,902***			***300.307 /sf***	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		GENERAL CONDITIONS				
	01312	Supervision				
		Project Superintendent	6.00 wk	1,838.96	11,034	
		Pickup Truck	6.00 wk	192.18	1,153	
		Supervision	1,855.00 sf	6.57	12,187	
	01320	Construction Documents				
		Extra Plans	1.00 ls	575.52	576	
		Construction Documents	1,855.00 sf	0.31	576	
	01400	Temp Protection - J&G				
		Temporary Protection	1.00 ls	1,587.81	1,588	
		Temp Protection - J&G	1,855.00 sf	0.86	1,588	
	01510	TEMPORARY UTILITIES				
		Jobsite Cell Phones	1.50 mo	97.85	147	
		TEMPORARY UTILITIES	1,855.00 sf	0.08	147	
	01600	Safety				
		First Aid Kits	1.00 ea	157.11	157	
		Fire Extinguisher	1.00 ea	97.84	98	
		Safety	1,855.00 sf	0.14	255	
	01610	Hospital Infection Control				
		Infection Control	6.00 wk	740.98	4,446	
		Hospital Infection Control	1,855.00 sf	2.40	4,446	
	01720	Layout				
		Interior Walls	8.00 hr	68.81	550	
		Layout	1,855.00 sf	0.30	550	
	01740	Clean Up				
		Dumping Fees	2.00 each	374.09	748	
		Clean Building Area	1,855.00 sf	0.84	1,549	
		Sub Final Cleaning	1,855.00 sf	0.30	550	
		Clean Up	1,855.00 sf	1.53	2,847	
		GENERAL CONDITIONS	**1,855.00 sf**	**12.18**	**22,596**	
02000		SITEWORK				
	02015	Cutting & Patching				
		Cutting & Patching	1.00 ls	1,587.81	1,588	
		Cutting & Patching	1,855.00 Sf	0.86	1,588	
	02020	Dust Partition				
		Dust Partitons	1.00 ls	1,587.81	1,588	
		Dust Partition	1,855.00 Sf	0.86	1,588	
	02225	SELECTIVE DEMOLITION				
		General Demolition	1,855.00 sf	1.43	2,650	
		SELECTIVE DEMOLITION	1,855.00 sf	1.43	2,650	
		SITEWORK	**1,855.00 sf**	**3.14**	**5,826**	
06000		WOOD & PLASTICS				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	1,855.00 sf	0.79	1,473	
		ROUGH CARPENTRY- Framing	1,855.00 sf	0.79	1,473	
	06410	Millwork				
		Millwork	1.00 ls	4,234.15	4,234	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		Millwork	1,855.00 sf	2.28	4,234	
		WOOD & PLASTICS	**1,855.00 sf**	**3.08**	**5,707**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofing				
		Firestopping / Fire Proof Patching	1.00 ls	1,587.82	1,588	
		FIRESTOPPING / Fire Proofing	1,855.00 sf	0.86	1,588	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	211.71	212	
		JOINT SEALANTS	1,855.00 sf	0.11	212	
		THERMAL/MOISTURE PROTECT	**1,855.00 sf**	**0.97**	**1,800**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	418.13	418	
		Wood Door Material	1.00 ls	682.75	683	
		Finish Hardware	1.00 ls	1,227.91	1,228	
		Recovery Room Sliding Door System	4.00 ea	2,064.16	8,257	
		Labor - Door, Frame & Hardware	2.00 ea	328.39	657	
		Automatic Door Operators	1.00 pr	4,763.43	4,763	
		Doors, Frames & Hardware	1,855.00 sf	8.63	16,006	
		DOORS & WINDOWS	**1,855.00 sf**	**8.63**	**16,006**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching	1.00 ls	24,355.97	24,356	
		Acoustical Ceilings	1.00 ls	0.01	0	Included Above
		GYPSUM WALL BOARD	1,855.00 sf	13.13	24,356	
	09680	CARPET				
		Flooring Allowance	1.00 ls	9,124.62	9,125	
		CARPET	1,855.00 sf	4.92	9,125	
	09910	PAINTING				
		Painting	1,855.00 sf	2.12	3,927	
		PAINTING	1,855.00 sf	2.12	3,927	
		FINISHES	**1,855.00 sf**	**20.17**	**37,408**	
10000		**SPECIALTIES**				
	10130	Wall & Impact Rails				
		Wall Bumper Rails & Corner Guards	1.00 ls	2,054.94	2,055	
		Wall & Impact Rails			2,055	
	10810	Toilet Accessories				
		Allowance	1.00 ls	144.00	144	
		Toilet Accessories	1,855.00 sf	0.08	144	
		SPECIALTIES	**1,855.00 sf**	**1.19**	**2,199**	
11000		**EQUIPMENT**				
	11710	MEDICAL EQUIPMENT				
		Install Owner Provided Equipment	1.00 ls	0.01	0	Not Included

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		MEDICAL EQUIPMENT	1,855.00 sf	0.00	0	
		EQUIPMENT	**1,855.00 sf**	**0.00**	**0**	
15000		**MECHANICAL**				
	15050	Mechanical				
		HVAC & Plumbing / Med Gas	1.00 ls	27,700.96	27,701	
		Mechanical	1,855.00 sf	14.93	27,701	
	15300	Sprinkler System				
		Fire Protection Bid	1,855.00 sf	1.59	2,945	
		Sprinkler System	1,855.00 sf	1.59	2,945	
		MECHANICAL	**1,855.00 sf**	**16.52**	**30,646**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Electrical	1.00 ls	31,713.89	31,714	
		ELECTRICAL	1,855.00 sf	17.10	31,714	
		ELECTRICAL	**1,855.00 sf**	**17.10**	**31,714**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	15,991				8.621 /sf	9.78%
Material	4,341				2.340 /sf	2.66%
Subcontract	132,933				71.662 /sf	81.31%
Equipment	635				0.342 /sf	0.39%
Other						
	153,900	153,900			82.965 /sf	94.14
Knoxville Review Fee	261				0.141 /sf	0.16%
Knoxville City Permit	654				0.353 /sf	0.40%
	915	154,815			83.458 /sf	0.56
General Liability - 0.15%	245		0.150 %	T	0.132 /sf	0.15%
P&P Bond - 2009 rates	1,030				0.555 /sf	0.63%
	1,275	156,090			84.146 /sf	0.78
Fee	7,396		5.000 %		3.987 /sf	4.52%
	7,396	163,486			88.133 /sf	4.52
Total		***163,486***			***88.133 /sf***	

Attachment B.II.A

JOHNSON&GALYON
CONSTRUCTION

November 6, 2012

Ms. Melanie Robinson
Tennova Healthcare
900 E. Oak Hill Avenue
Knoxville, TN 37917

Re: **Tennova NKMC**
Cath Lab Renovations
Budget Estimate

Dear Melanie:

We are pleased to recommend a budget of One Million Three Hundred Two Thousand Two Hundred Eighty Nine Dollars ($1,302,289) for the above referenced project. Breakdowns of our cost estimates are attached. The estimates are based on the attached schematic drawing and descriptions of the HVAC System prepared by BarberMcMurry architects.

The estimates are summarized as follows:

Area 1 – Waiting Expansion and Consult	$ 158,901
Area 2 – Cath Lab	$ 979,902
Area 3 – Prep/Recovery Expansion	$ 163,486
Total:	$1,302,289

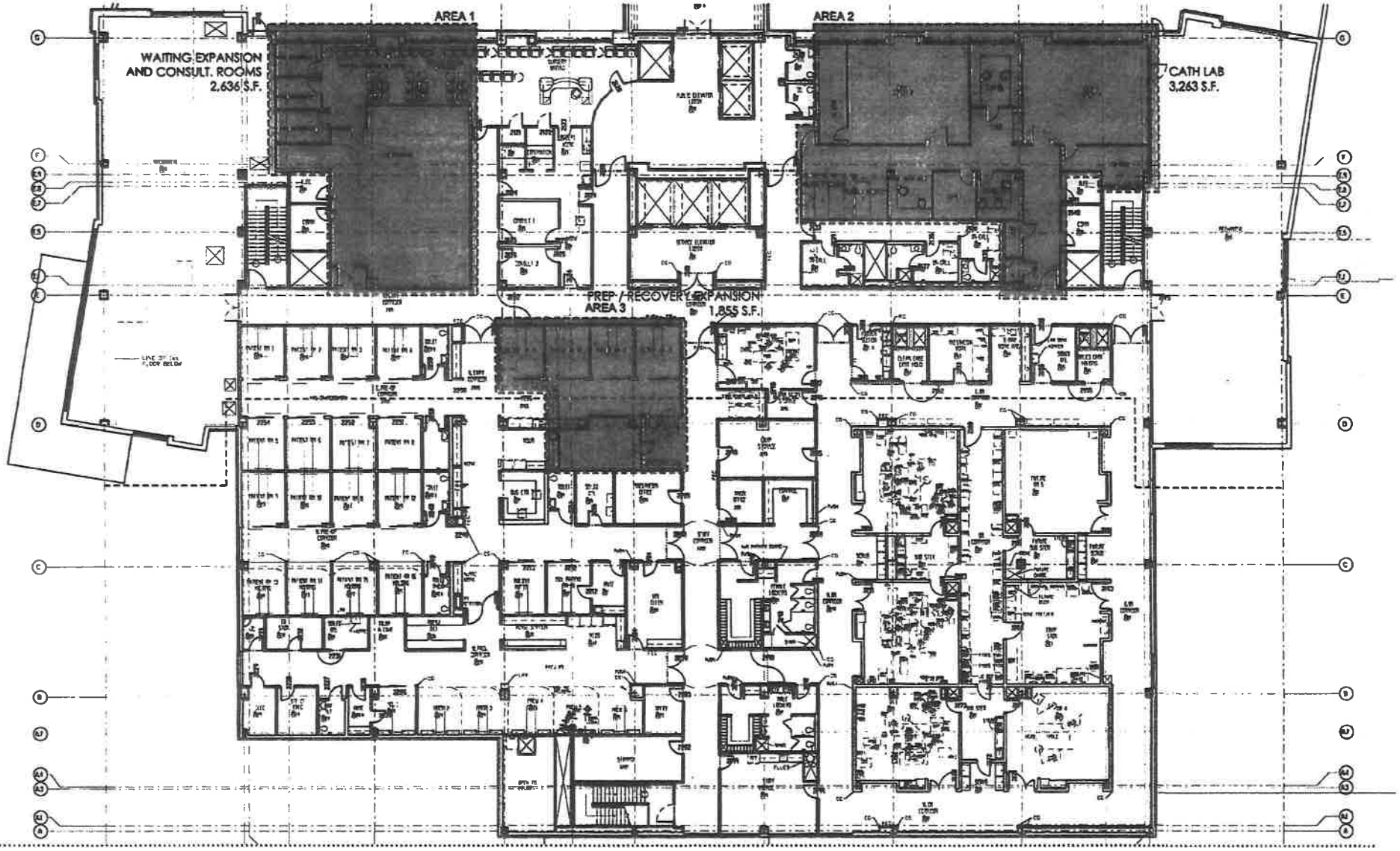
We appreciate the opportunity to be of service to you. Should you have any questions, please call.

Sincerely,

JOHNSON & GALYON, INC.

Mark A. Halcomb
Estimator

Attachments
Cc: Mike Driskill, BMa



12OCT2012

2 EXTENT OF WORK FLOOR PLAN
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

0 10 20 40

bma BARBER McMURRY
architects since 1915

122300

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		GENERAL CONDITIONS				
	01312	Supervision				
		Project Superintendent	4.33 wk	1,838.82	7,962	
		Pickup Truck	4.33 wk	192.17	832	
		Supervision	2,636.00 sf	3.34	8,794	
	01320	Construction Documents				
		Extra Plans	1.00 ls	575.46	575	
		Construction Documents	2,636.00 sf	0.22	575	
	01400	Temp Protection - J&G				
		Temporary Protection	1.00 ls	1,587.67	1,588	
		Temp Protection - J&G	2,636.00 sf	0.60	1,588	
	01510	TEMPORARY UTILITIES				
		Jobsite Cell Phones	1.00 mo	97.83	98	
		TEMPORARY UTILITIES	2,636.00 sf	0.04	98	
	01600	Safety				
		First Aid Kits	1.00 ea	157.10	157	
		Fire Extinguisher	1.00 ea	97.82	98	
		Safety	2,636.00 sf	0.10	255	
	01610	Hospital Infection Control				
		Infection Control	4.33 wk	740.91	3,208	
		Hospital Infection Control	2,636.00 sf	1.22	3,208	
	01720	Layout				
		Interior Walls	8.00 hr	68.80	550	
		Layout	2,636.00 sf	0.21	550	
	01740	Clean Up				
		Dumping Fees	1.00 each	374.06	374	
		Clean Building Area	2,636.00 sf	0.84	2,202	
		Sub Final Cleaning	2,636.00 sf	0.30	781	
		Clean Up	2,636.00 sf	1.27	3,357	
		GENERAL CONDITIONS	**2,636.00 sf**	**6.99**	**18,425**	
02000		SITEWORK				
	02015	Cutting & Patching				
		Cutting & Patching	1.00 ls	1,058.44	1,058	
		Cutting & Patching	2,636.00 Sf	0.40	1,058	
	02020	Dust Partition				
		Dust Paritons	1.00 ls	529.22	529	
		Dust Partition	2,636.00 Sf	0.20	529	
	02225	SELECTIVE DEMOLITION				
		General Demolition	2,636.00 sf	1.43	3,766	
		SELECTIVE DEMOLITION	2,636.00 sf	1.43	3,766	
		SITEWORK	**2,636.00 sf**	**2.03**	**5,353**	
06000		WOOD & PLASTICS				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	32.00 sf	0.79	25	
		ROUGH CARPENTRY- Framing	2,636.00 sf	0.01	25	
	06410	Millwork				
		Millwork	1.00 ls	0.02	0	None Shown

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		Millwork	2,636.00 sf	0.00	0	
		WOOD & PLASTICS	**2,636.00 sf**	**0.01**	**25**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	**FIRESTOPPING / Fire Proofing**				
		Firestopping / Fire Proof Patching	1.00 ls	1,058.43	1,058	
		FIRESTOPPING / Fire Proofing	2,636.00 sf	0.40	1,058	
	07920	**JOINT SEALANTS**				
		Interior Caulking/Sealing	1.00 ls	158.77	159	
		JOINT SEALANTS	2,636.00 sf	0.06	159	
		THERMAL/MOISTURE PROTECT	**2,636.00 sf**	**0.46**	**1,217**	
08000		**DOORS & WINDOWS**				
	08010	**Doors, Frames & Hardware**				
		HM Frame Material	1.00 ls	624.48	624	
		Wood Door Material	1.00 ls	841.46	841	
		Finish Hardware	1.00 ls	1,312.47	1,312	
		Glass for Standard Window	1.00 ls	0.01	0	
		Labor - Door, Frame & Hardware	5.00 ea	328.36	1,642	
		Doors, Frames & Hardware	2,636.00 sf	1.68	4,420	
		DOORS & WINDOWS	**2,636.00 sf**	**1.68**	**4,420**	
09000		**FINISHES**				
	09250	**GYPSUM WALL BOARD**				
		Drywall & Patching	1.00 ls	39,596.24	39,596	
		Acoustical Ceilings	1.00 ls	0.01	0	Included Above
		GYPSUM WALL BOARD	2,636.00 sf	15.02	39,596	
	09680	**CARPET**				
		Flooring Allowance	1.00 ls	9,039.07	9,039	
		CARPET	2,636.00 sf	3.43	9,039	
	09910	**PAINTING**				
		Painting	2,636.00 sf	2.12	5,580	
		PAINTING	2,636.00 sf	2.12	5,580	
		FINISHES	**2,636.00 sf**	**20.57**	**54,215**	
15000		**MECHANICAL**				
	15050	**Mechanical**				
		HVAC & Plumbing	1.00 ls	25,796.29	25,796	
		Mechanical	2,636.00 sf	9.79	25,796	
	15300	**Sprinkler System**				
		Fire Protection Bid	2,636.00 sf	1.59	4,185	
		Sprinkler System	2,636.00 sf	1.59	4,185	
		MECHANICAL	**2,636.00 sf**	**11.37**	**29,981**	
16000		**ELECTRICAL**				
	16010	**ELECTRICAL**				
		Electrical	1.00 ls	35,944.62	35,945	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		ELECTRICAL	2,636.00 sf	13.64	35,945	
		ELECTRICAL	**2,636.00 sf**	**13.64**	**35,945**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	15,207				5.769 /sf	9.57%
Material	2,040				0.774 /sf	1.28%
Subcontract	131,878				50.029 /sf	82.99%
Equipment	458				0.174 /sf	0.29%
Other						
	149,583	149,583			56.746 /sf	94.14
Knoxville Review Fee	255				0.097 /sf	0.16%
Knoxville City Permit	636				0.241 /sf	0.40%
	891	150,474			57.084 /sf	0.56
General Liability - 0.15%	238		0.150 %	T	0.090 /sf	0.15%
P&P Bond - 2009 rates	1,001				0.380 /sf	0.63%
	1,239	151,713			57.554 /sf	0.78
Fee	7,188		5.000 %		2.727 /sf	4.52%
	7,188	158,901			60.281 /sf	4.52
Total		***158,901***			***60.281 /sf***	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		GENERAL CONDITIONS				
	01312	Supervision				
		Project Superintendent	13.00 wk	1,837.76	23,891	
		Pickup Truck	13.00 wk	192.03	2,496	
		Supervision	3,263.00 sf	8.09	26,387	
	01320	Construction Documents				
		Extra Plans	1.00 ls	575.10	575	
		Construction Documents	3,263.00 sf	0.18	575	
	01400	Temp Protection - J&G				
		Temporary Protection	1.00 ls	1,586.53	1,587	
		Temp Protection - J&G	3,263.00 sf	0.49	1,587	
	01510	TEMPORARY UTILITIES				
		Jobsite Cell Phones	3.00 mo	97.76	293	
		TEMPORARY UTILITIES	3,263.00 sf	0.09	293	
	01600	Safety				
		First Aid Kits	1.00 ea	157.01	157	
		Fire Extinguisher	1.00 ea	97.76	98	
		Safety	3,263.00 sf	0.08	255	
	01610	Hospital Infection Control				
		Infection Control	13.00 wk	740.38	9,625	
		Hospital Infection Control	3,263.00 sf	2.95	9,625	
	01720	Layout				
		Interior Walls	8.00 hr	68.75	550	
		Layout	3,263.00 sf	0.17	550	
	01740	Clean Up				
		Dumping Fees	3.00 each	373.81	1,121	
		Clean Building Area	3,235.00 sf	0.83	2,700	
		Sub Final Cleaning	3,235.00 sf	0.30	958	
		Clean Up	3,263.00 sf	1.46	4,780	
		GENERAL CONDITIONS	**3,263.00 sf**	**13.50**	**44,052**	
02000		SITEWORK				
	02015	Cutting & Patching				
		Cutting & Patching	1.00 ls	5,288.42	5,288	
		Cutting & Patching	3,263.00 Sf	1.62	5,288	
	02020	Dust Partition				
		Dust Partitons	1.00 ls	3,173.05	3,173	
		Dust Partition	3,263.00 Sf	0.97	3,173	
	02225	SELECTIVE DEMOLITION				
		General Demolition	3,235.00 sf	1.43	4,619	
		SELECTIVE DEMOLITION	3,263.00 sf	1.42	4,619	
		SITEWORK	**3,263.00 sf**	**4.01**	**13,080**	
05000		METALS				
	05510	MISC. METALS				
		Equipment Supports	2.00 room	26,970.95	53,942	
		MISC. METALS	3,263.00 sf	16.53	53,942	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		METALS	**3,263.00 sf**	**16.53**	**53,942**	
06000		**WOOD & PLASTICS**				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	3,235.00 sf	0.79	2,566	
		ROUGH CARPENTRY- Framing	3,263.00 sf	0.79	2,566	
	06410	Millwork				
		Millwork	1.00 ls	7,403.79	7,404	
		Millwork	3,263.00 sf	2.27	7,404	
		WOOD & PLASTICS	**3,263.00 sf**	**3.06**	**9,970**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofin				
		Firestopping / Fire Proof Patching	1.00 ls	2,644.21	2,644	
		FIRESTOPPING / Fire Proofin	3,263.00 sf	0.81	2,644	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	264.42	264	
		JOINT SEALANTS	3,263.00 sf	0.08	264	
		THERMAL/MOISTURE PROTECT	**3,263.00 sf**	**0.89**	**2,909**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	5,831.43	5,831	
		Wood Door Material	1.00 ls	8,310.09	8,310	
		Finish Hardware	1.00 ls	8,695.40	8,695	
		Lead Glass	1.00 ls	7,418.68	7,419	
		Glass for Standard Window	1.00 ls	287.55	288	
		Labor - Door, Frame & Hardware	13.00 ea	326.17	4,266	
		Labor - HM Window Frame & Glass	1.00 ea	131.27	131	
		Labor - Lead Glass Window	2.00 ea	656.35	1,313	
		Doors, Frames & Hardware	3,263.00 sf	11.11	36,253	
		DOORS & WINDOWS	**3,263.00 sf**	**11.11**	**36,253**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching, including Lead Lined	1.00 ls	46,322.34	46,322	
		Acoustical Ceilings	1.00 ls	11,444.14	11,444	
		GYPSUM WALL BOARD	3,263.00 sf	17.70	57,766	
	09680	CARPET				
		Flooring Allowance	1.00 ls	26,399.80	26,400	
		CARPET	3,263.00 sf	8.09	26,400	
	09910	PAINTING				
		Painting	3,235.00 ls	2.12	6,843	
		PAINTING	3,263.00 sf	2.10	6,843	
		FINISHES	**3,263.00 sf**	**27.89**	**91,010**	
10000		**SPECIALTIES**				
	10190	Cubicles Curtain Track				

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
	10190	Cubicles Curtain Track				
		Allowance	1.00 ls	1,586.53	1,587	
		Cubicles Curtain Track	3,263.00 sf	0.49	1,587	
	10810	Toilet Accessories				
		Allowance	1.00 ls	353.17	353	
		Toilet Accessories	3,263.00 sf	0.11	353	
		SPECIALTIES	**3,263.00 sf**	**0.59**	**1,940**	
11000		**EQUIPMENT**				
	11710	MEDICAL EQUIPMENT				
		Install Owner Provided Equipment	1.00 ls	0.01	0	Not Included
		MEDICAL EQUIPMENT	3,263.00 sf	0.00	0	
		EQUIPMENT	**3,263.00 sf**	**0.00**	**0**	
13000		**SPECIAL CONSTRUCTION**				
	13090	RADIATION PROTECTION				
		Lead Lined Sheetrock	1.00 ls	0.01	0	w/ Drywall Item
		Lead Glass View Window	1.00 ls	0.01	0	w/ Doors Item
		Lead Lined Door	1.00 ls	0.01	0	w/ Doors Item
		RADIATION PROTECTION	3,263.00 sf	0.00	0	
		SPECIAL CONSTRUCTION	**3,263.00 sf**	**0.00**	**0**	
15000		**MECHANICAL**				
	15050	Mechanical				
		Heart Cath Lab	1.00 ls	118,749.39	118,749	
		Additional AHU	1.00 ls	200,928.30	200,928	
		Mechanical	3,263.00 sf	97.97	319,678	
	15300	Sprinkler System				
		Fire Protection Bid	3,235.00 sf	1.59	5,132	
		Sprinkler System	3,263.00 sf	1.57	5,132	
		MECHANICAL	**3,263.00 sf**	**99.54**	**324,810**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Heart Cath Lab	1.00 ls	330,695.58	330,696	
		Additional AHU	1.00 ls	15,619.88	15,620	
		ELECTRICAL	3,263.00 sf	106.13	346,315	
		ELECTRICAL	**3,263.00 sf**	**106.13**	**346,315**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	36.539				11.198 /sf	3.73%
Material	34.643				10.617 /sf	3.54%
Subcontract	851.723				261.025 /sf	86.92%
Equipment	1.375				0.421 /sf	0.14%
Other						
	924,280	924,280			283.261 /sf	94.32
Knoxville Review Fee	450				0.138 /sf	0.05%
Knoxville City Permit	3,200				0.981 /sf	0.33%
	3,650	927,930			284.379 /sf	0.37
General Liability - 0.15%	1,470		0.150 %	T	0.450 /sf	0.15%
P&P Bond - 2009 rates	6,173				1.892 /sf	0.63%
	7,643	935,573			286.722 /sf	0.76
Fee	44,329		5.000 %		13.585 /sf	4.52%
	44,329	979,902			300.307 /sf	4.52
Total		***979,902***			***300.307 /sf***	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
01000		GENERAL CONDITIONS				
	01312	Supervision				
		Project Superintendent	6.00 wk	1,838.96	11,034	
		Pickup Truck	6.00 wk	192.18	1,153	
		Supervision	1,855.00 sf	6.57	12,187	
	01320	Construction Documents				
		Extra Plans	1.00 ls	575.52	576	
		Construction Documents	1,855.00 sf	0.31	576	
	01400	Temp Protection - J&G				
		Temporary Protection	1.00 ls	1,587.81	1,588	
		Temp Protection - J&G	1,855.00 sf	0.86	1,588	
	01510	TEMPORARY UTILITIES				
		Jobsite Cell Phones	1.50 mo	97.85	147	
		TEMPORARY UTILITIES	1,855.00 sf	0.08	147	
	01600	Safety				
		First Aid Kits	1.00 ea	157.11	157	
		Fire Extinguisher	1.00 ea	97.84	98	
		Safety	1,855.00 sf	0.14	255	
	01610	Hospital Infection Control				
		Infection Control	6.00 wk	740.98	4,446	
		Hospital Infection Control	1,855.00 sf	2.40	4,446	
	01720	Layout				
		Interior Walls	8.00 hr	68.81	550	
		Layout	1,855.00 sf	0.30	550	
	01740	Clean Up				
		Dumping Fees	2.00 each	374.09	748	
		Clean Building Area	1,855.00 sf	0.84	1,549	
		Sub Final Cleaning	1,855.00 sf	0.30	550	
		Clean Up	1,855.00 sf	1.53	2,847	
		GENERAL CONDITIONS	**1,855.00 sf**	**12.18**	**22,596**	
02000		SITEWORK				
	02015	Cutting & Patching				
		Cutting & Patching	1.00 ls	1,587.81	1,588	
		Cutting & Patching	1,855.00 Sf	0.86	1,588	
	02020	Dust Partition				
		Dust Partitions	1.00 ls	1,587.81	1,588	
		Dust Partition	1,855.00 Sf	0.86	1,588	
	02225	SELECTIVE DEMOLITION				
		General Demolition	1,855.00 sf	1.43	2,650	
		SELECTIVE DEMOLITION	1,855.00 sf	1.43	2,650	
		SITEWORK	**1,855.00 sf**	**3.14**	**5,826**	
06000		WOOD & PLASTICS				
	06105	ROUGH CARPENTRY- Framing				
		Blocking	1,855.00 sf	0.79	1,473	
		ROUGH CARPENTRY- Framing	1,855.00 sf	0.79	1,473	
	06410	Millwork				
		Millwork	1.00 ls	4,234.15	4,234	

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		Millwork	1,855.00 sf	2.28	4,234	
		WOOD & PLASTICS	**1,855.00 sf**	**3.08**	**5,707**	
07000		**THERMAL/MOISTURE PROTECT**				
	07840	FIRESTOPPING / Fire Proofing				
		Firestopping / Fire Proof Patching	1.00 ls	1,587.82	1,588	
		FIRESTOPPING / Fire Proofing	1,855.00 sf	0.86	1,588	
	07920	JOINT SEALANTS				
		Interior Caulking/Sealing	1.00 ls	211.71	212	
		JOINT SEALANTS	1,855.00 sf	0.11	212	
		THERMAL/MOISTURE PROTECT	**1,855.00 sf**	**0.97**	**1,800**	
08000		**DOORS & WINDOWS**				
	08010	Doors, Frames & Hardware				
		HM Frame Material	1.00 ls	418.13	418	
		Wood Door Material	1.00 ls	682.75	683	
		Finish Hardware	1.00 ls	1,227.91	1,228	
		Recovery Room Siding Door System	4.00 ea	2,064.16	8,257	
		Labor - Door, Frame & Hardware	2.00 ea	328.39	657	
		Automatic Door Operators	1.00 pr	4,763.43	4,763	
		Doors, Frames & Hardware	1,855.00 sf	8.63	16,006	
		DOORS & WINDOWS	**1,855.00 sf**	**8.63**	**16,006**	
09000		**FINISHES**				
	09250	GYPSUM WALL BOARD				
		Drywall & Patching	1.00 ls	24,355.97	24,356	
		Acoustical Ceilings	1.00 ls	0.01	0	Included Above
		GYPSUM WALL BOARD	1,855.00 sf	13.13	24,356	
	09680	CARPET				
		Flooring Allowance	1.00 ls	9,124.62	9,125	
		CARPET	1,855.00 sf	4.92	9,125	
	09910	PAINTING				
		Painting	1,855.00 sf	2.12	3,927	
		PAINTING	1,855.00 sf	2.12	3,927	
		FINISHES	**1,855.00 sf**	**20.17**	**37,408**	
10000		**SPECIALTIES**				
	10130	Wall & Impact Rails				
		Wall Bumper Rails & Corner Guards	1.00 ls	2,054.94	2,055	
		Wall & Impact Rails			2,055	
	10810	Toilet Accessories				
		Allowance	1.00 ls	144.00	144	
		Toilet Accessories	1,855.00 sf	0.08	144	
		SPECIALTIES	**1,855.00 sf**	**1.19**	**2,199**	
11000		**EQUIPMENT**				
	11710	MEDICAL EQUIPMENT				
		Install Owner Provided Equipment	1.00 ls	0.01	0	Not Included

Group	Phase	Description	Takeoff Quantity	Grand Total Unit Price	Grand Total	Sub/Vendor (Est)
		MEDICAL EQUIPMENT	1,855.00 sf	0.00	0	
		EQUIPMENT	**1,855.00 sf**	**0.00**	**0**	
15000		**MECHANICAL**				
	15050	Mechanical				
		HVAC & Plumbing / Med Gas	1.00 ls	27,700.96	27,701	
		Mechanical	1,855.00 sf	14.93	27,701	
	15300	Sprinkler System				
		Fire Protection Bid	1,855.00 sf	1.59	2,945	
		Sprinkler System	1,855.00 sf	1.59	2,945	
		MECHANICAL	**1,855.00 sf**	**16.52**	**30,646**	
16000		**ELECTRICAL**				
	16010	ELECTRICAL				
		Electrical	1.00 ls	31,713.89	31,714	
		ELECTRICAL	1,855.00 sf	17.10	31,714	
		ELECTRICAL	**1,855.00 sf**	**17.10**	**31,714**	

Estimate Totals

Description	Amount	Totals	Rate		Cost per Unit	Percent of Total
Labor	15,991				8.621 /sf	9.78%
Material	4,341				2.340 /sf	2.66%
Subcontract	132,933				71.662 /sf	81.31%
Equipment	635				0.342 /sf	0.39%
Other						
	153,900	153,900			82.965 /sf	94.14
Knoxville Review Fee	261				0.141 /sf	0.16%
Knoxville City Permit	654				0.353 /sf	0.40%
	915	154,815			83.458 /sf	0.56
General Liability - 0.15%	245		0.150 %	T	0.132 /sf	0.15%
P&P Bond - 2009 rates	1,030				0.555 /sf	0.63%
	1,275	156,090			84.146 /sf	0.78
Fee	7,396		5.000 %		3.987 /sf	4.52%
	7,396	163,486			88.133 /sf	4.52
Total		***163,486***			***88.133 /sf***	

Attachment C.Economic Feasibility.2

Tennova™
Healthcare

November 12, 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 $4,377,421 associated with the application to initiate diagnostic cardiac catheterization services at North Knoxville Medical Center (estimate includes legal and administrative costs, construction costs, equipment 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

Attachment C.Economic Feasibility.10

2012 NOV 14 AM 10 04

Health Management™ Associates

2011 ENABLING AMERICA'S BEST LOCAL HEALTH CARE.

ANNUAL REPORT TO SHAREHOLDERS

OUR GUIDING PRINCIPLES

Learn how Health Management is enabling the best local health care in communities throughout the United States.

Health Management Associates provides the people, processes, capital and expertise necessary for our hospital and physician partners to fulfill their local missions of delivering superior health care services.

Our strategy of ensuring that the most modern, highest quality care remains close to the citizens of America's rural and non-urban towns gains ever increasing importance as local resources are stretched thin in this difficult economy.

Now, as much as ever, Health Management stands ready to enable the success of our current and prospective partners.

are servant leaders. don't settle. do the right thing.

The Joint Commission recognized nearly 60 percent of the hospitals Health Management operates as Top Performers on Key Quality Measures—well above national quality performance levels.

On September 30, the seven-hospital system operated by Mercy Health Partners in Knoxville, TN, officially became part of the Health Management family of hospitals and began operating as Tennova Healthcare.

Fortune magazine named Health Management one of the World's Most Admired Companies in Health Care: Medical Facilities. Within that category, Health Management was named the No. 1 company in quality of products/services and in social responsibility.

TO OUR SHAREHOLDERS AND PARTNERS:

Looking back, if there were one phrase to describe the reason for the company's 2011 record financial results for our shareholders and outstanding quality of care for our patients, it would be "local partnerships."

Thirty-five years ago, Health Management was founded to ensure the availability and vitality of health care in non-urban communities throughout the United States. Today, despite an ever-changing health care and economic landscape, our single mission remains much the same—to enable America's best local health care.

It is our localized focus that drives us to develop very personal partnerships with local Associates, physicians and community leaders. It's through their view of local needs that we shape the vision and strategic plans for each individual health system. Every community needs something unique from its hospital and physicians. In essence, each has its own local mission.

It is our job then to provide the people, processes, capital and expertise that our hospitals and physician partners need to fulfill their local missions of delivering superior health care in their communities. At every level, this is accomplished by being guided by three principles: 1) We are servant leaders; 2) We do the right thing; and 3) We don't settle.

In 2012 and beyond, in whatever form federal regulations take, the need for health care services will continue to grow. Health Management is ready for the growth. We are ready to serve our existing communities. Additionally, we are ready to apply our financial, technological, operational, and patient-centered approach to develop new partnerships with hospitals seeking to continue and expand their local missions of meeting their communities' health care needs.

STRONG OPERATING RESULTS

By staying true to our guiding principles and maintaining the course set three years ago, 2011 was another outstanding year for the company. Health Management grew its net revenue by 14% to a record $5.8 billion, increased its income from continuing operations by more than 11% to $206.3 million, and grew diluted earnings per share by nearly 17% to $0.70. Operating cash flow from these earnings totaled more than $544.0 million and was used to acquire or partner with eight new hospitals, representing approximately $650 million of annual revenue, and to invest in more than $300 million in capital to expand and upgrade our hospitals' breadth of services.

We remained disciplined in our approach in 2011, staying focused on three fundamental operating initiatives: emergency room operations, physician recruitment, and market service development. This will continue in 2012.

A STRONG CULTURE

These outstanding 2011 financial results were achieved while—most importantly—reaching our most essential goals: delivering the highest quality care, and developing an outstanding company culture. We were very proud to recently be named as **one of *Fortune* magazine's Most Admired Companies in Health Care**, ranking number one in both Quality of Services and Social Responsibility in the Health Care: Medical Facilities category. These accolades are based on results generated from our patient-centered culture which, in our belief, was the strongest deciding factor in our being chosen in September to acquire seven hospitals in eastern Tennessee from Catholic Health Partners—the largest single acquisition in the company's history.

In order to be an effective, long-term partner with our hospitals and communities, we must not only possess financial strength, but we also must have a sound culture. One focus of 2011 was to build upon the foundation of our cultural initiative, *Getting 2 Great® (G2G)*. G2G is a company-wide initiative to build a stronger, more cohesive culture for Health Management's team of Associates, physicians, caregivers and leaders. While each of our hospitals is distinctly different, G2G is designed to ensure we are all working toward our common goals and providing outstanding experiences for patients, families, physicians and Associates.

Six Pillars—**People, Service, Quality, Innovation, Finance** and **Growth**—provide the foundation for G2G and the care that our hospitals provide each day.

PEOPLE

It is only through an engaged and happy team of service providers that each hospital's patients have an excellent experience. Our Associates are truly the backbone of our success.

We reward and recognize the contributions of Associates and physicians, create a positive work environment where teamwork is encouraged and provide opportunities for individual growth and achievement.

As Health Management continues to evolve and grow, we must continually reengineer the organizational structure for growth—one that leverages our resources across a wide geographic base and ensures that effective leaders are in

William J. Schoen, Chairman
Gary D. Newsome, President & Chief Executive Officer

place to enable success. In 2011, we initiated a new organizational structure and bolstered our corporate and divisional leadership ranks with executives capable of leading us through what we believe will be an extended period of strong growth. Associate surveys, which we conduct on a daily basis, are just one measure of our organizational success. In 2011, those surveys indicate that our new structure and leaders are creating a stronger, happier work environment, with more than 83% of our Associates reporting high overall job satisfaction—which in turn leads to high physician and patient satisfaction.

SERVICE

At Health Management, we are committed to providing outstanding customer service, one patient experience at a time.

In every role, every day, we serve our physicians, fellow Associates, and most importantly, our patients and their families. Service is all encompassing and never ending. Examples of our commitment include: providing world-class chest pain/stroke centers in partnership with nationally recognized Shands HealthCare/affiliated with the University of Florida; launching hourly patient rounding programs for hospital leadership to ensure frequent interaction with patients and Associates; color coding uniforms for easier recognition of department personnel by patients; and, redesigning our billing statements so they are easier to read and more customer friendly. Every day, we are looking for ways to better serve which has resulted in dramatic improvements in our patient satisfaction scores, and in some cases, setting new highs for the company.

QUALITY

Service at the highest level of excellence is quality. We strive in everything we do to provide the highest degree of quality health care services to the communities we serve, and to be the recognized leader in outcomes and quality. Indeed during 2011, thirty-five of our then 59 hospitals or nearly 60%, were named as ***Top Performers on Key Quality Measures*** **by The Joint Commission** the leading accreditor of health care organizations in America. Likewise, Health Management set the highest Medicare Core Measure Composite Score in company history. Lastly, early this year, two Health Management hospitals, Sparks Health System in Ft. Smith, Arkansas, and Riverview Regional Medical Center in Gadsden, Alabama, were named as **two of the Best Regional Hospitals in the United States by *U.S. News & World Report*.**

INNOVATION

Health Management is always striving to elicit and implement ideas for advancing operational, clinical, and service excellence to the benefit of our physicians, Associates and patients.

We continue to invest in technology, having introduced more than 60 state-of-the-art robotic surgical systems to our communities over the last two years, allowing for outpatient orthopedic and other surgeries that were unheard of, and unavailable locally, just five years ago. We are working with our physicians and nurses to develop mobile applications to securely access real-time patient information to better implement care plans. But innovation at Health Management in 2011 reached beyond just technologically advanced equipment. We now successfully deploy data and predictive analytics to enhance revenue cycle management, improve collection efforts, reduce risk through more accurate coding and effectively manage resources and staffing levels. Predictive analytics offers us unlimited future opportunities to operate more efficiently and improve the hospital experience.

FINANCE

We are a stronger company today. In 2011 we successfully completed a balance sheet restructuring during the fourth quarter and took advantage of improving capital markets and attractive interest rates to refinance approximately $3.5 billion of our debt and extend maturities, allowing us to maintain our goal of being an industry leader in financial efficiency, thus enabling capital expenditures in existing markets and enhancing development opportunities in new areas.

GROWTH

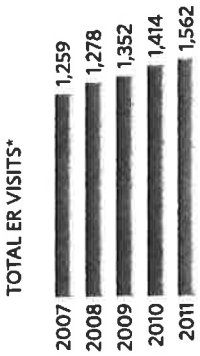
We expect continued growth. Internally, for example, to meet the health care needs of our communities, we have added more than 600 physicians to our medical staffs each year over the past three years, with approximately 670 physicians being added in 2011. That will continue. Externally, we completed two transactions in 2011. First, we partnered with physicians to joint venture the 112-bed Tri-Lakes Medical Center in Batesville, Mississippi. Then, we completed our largest single acquisition of the seven-hospital Mercy Health System in and around Knoxville, Tennessee, which was rebranded Tennova Healthcare. Combined, these hospitals bring approximately $650 million of additional annual revenue to the company.

Faced with the challenges of restrictive capital markets, limited IT resources, health care reform, and a languishing economy, many hospitals are seeking partners, such as Health Management, who have access to capital, operational expertise, and a positive culture, to help them survive and continue to achieve their missions of care in non-urban communities. The opportunity to partner with quality hospitals and health systems is as good as we have ever seen it.

These successful partnerships are indicative of our confidence in Health Management's current growth, operational strategies and cultural change. We are discovering that our Associates are finding themselves by losing themselves in the service of others. The prospects of servant leadership, doing the right thing and never settling are attracting Associates of high caliber to our organization and they are making differences in the lives of the people they serve. We are proud to partner with our physicians, nurses, and Associates to continue to innovate health care and deliver the value our patients and stakeholders expect as we enable America's best local health care.

Bill and Gary

Naples, FL
March 27, 2012



*All chart data is from continuing operations (in thousands).

ALABAMA
Riverview Regional, Gadsden
ngfellow Memorial Hospital, Anniston

ARKANSAS
Sparks Health System, Fort Smith
Summit Medical Center, Van Buren

FLORIDA
Bartow Regional, Bartow
Brooksville Regional, Brooksville
Charlotte Regional, Punta Gorda
Heart of Florida Regional, Greater Haines City
Highlands Regional, Sebring
Lehigh Regional, Lehigh Acres
Lower Keys Medical Center, Key West
Pasco Regional, Dade City
Peace River Regional, Port Charlotte
Physicians Regional-Collier Blvd, Naples
Physicians Regional-Pine Ridge, Naples
Santa Rosa Medical Center, Milton
Sebastian River Medical Center, Sebastian
Seven Rivers Regional, Crystal River
Shands Lake Shore Regional, Lake City
Shands Live Oak Regional, Live Oak
Shands Starke Regional, Starke
Spring Hill Regional, Spring Hill
St. Cloud Regional, St. Cloud
Venice Regional, Venice
Wuesthoff Medical Center-Melbourne, Melbourne
Wuesthoff Medical Center-Rockledge, Rockledge

GEORGIA
Barrow Regional, Winder
East Georgia Regional, Statesboro
Walton Regional, Monroe

KENTUCKY
Paul B. Hall Regional, Paintsville

MISSISSIPPI
Biloxi Regional, Biloxi
ntral Mississippi Medical Center, Jackson
sgates River Oaks Hospital, Brandon
more Memorial Regional, Amory
Madison River Oaks, Canton
Natchez Community Hospital, Natchez
Northwest Mississippi Regional, Clarksdale
River Oaks Hospital, Flowood
Tri-Lakes Medical Center, Batesville
Woman's Hospital at River Oaks, Flowood

MISSOURI
Poplar Bluff Regional, Poplar Bluff
Twin Rivers Regional, Kennett

NORTH CAROLINA
Davis Regional, Statesville
Lake Norman Regional, Mooresville
Sandhills Regional, Hamlet

OKLAHOMA
Medical Center of Southeastern Oklahoma, Durant
Midwest Regional, Midwest City

PENNSYLVANIA
Carlisle Regional, Carlisle
Heart of Lancaster Regional, Lititz
Lancaster Regional, Lancaster

SOUTH CAROLINA
Carolina Pines Regional, Hartsville
Chester Regional, Chester

TENNESSEE
Harton Regional, Tullahoma
Jamestown Regional, Jamestown
Jefferson Memorial Hospital, Jefferson City
LaFollette Medical Center, LaFollette
Newport Medical Center, Newport
North Knoxville Medical Center, Powell
Physicians Regional, Knoxville
St. Mary's Medical Center of Scott County, Oneida
key Creek Medical Center, Knoxville
ersity Medical Center, Lebanon

TEXAS
Dallas Regional, Mesquite

WASHINGTON
Toppenish Community Hospital, Toppenish
Yakima Regional, Yakima

WEST VIRGINIA
Williamson Memorial Hospital, Williamson

COMPANY PROFILE

Health Management Associates, Inc. (NYSE: HMA) is an owner and operator of general acute care hospitals in non-urban communities located throughout the United States, primarily in the southeast.

Health Management's mission is to enable America's best local health care. We provide the people, processes, capital and expertise that we believe ensures our local hospitals can achieve their mission to deliver compassionate, high quality health care services that significantly improve the lives of the patients, physicians and communities they serve.

In support of its mission, Health Management:

- Provides dynamic hospital and home office leadership
- Invests capital to renew hospital facilities
- Recruits physicians to expand a hospital's breadth of services in response to community needs
- Introduces proven hospital best practices designed to improve the quality of care, promote wise use of resources, and increase patient and physician satisfaction

At December 31, 2011, Health Management had grown to include 66 hospitals located in 15 states, with a total of approximately 10,300 licensed beds. During 2011, Health Management generated more than $5.8 billion of net revenue.

Founded in 1977, Health Management's common stock was owned by approximately 900 shareholders of record as of December 31, 2011, including several hundred institutional investors.

GROUP OPERATIONAL LEADERSHIP

EASTERN GROUP

John M. Starcher, Jr.
Group President

Chris R. Hilton
Group Chief Financial Officer

Angela M. Marchi
Atlantic Division President

Michael W. Garfield
Tennessee Division President

FLORIDA GROUP

Alan M. Levine
Group President

David W. Rothenberger
Group Chief Financial Officer

Michael M. Fencel
North Florida Division President

Kathy A. Burke
South Florida Division President

SOUTHERN AND WESTERN GROUP

Joe D. Pinion
Group President

Bashar A. Abunaser
Group Chief Financial Officer

William V. Williams, III
Southern Division President

Ann M. Barnhart
Western Division President

EXECUTIVE LEADERSHIP

Gary D. Newsome
President and Chief Executive Officer

Kelly E. Curry
Executive Vice President and Chief Financial Officer

Robert E. Farnham
Senior Vice President – Finance

Kerry E. Gillespie
Executive Vice President – Operations Finance

Linda A. Epstein
Acting General Counsel

HOME OFFICE LEADERSHIP

Kenneth R. Chatfield
Chief Information Officer

Lisa Gore
Senior Vice President – Clinical Affairs

Paul A. Hurst, III
Senior Vice President – Government Relations

James L. Jordan
Senior Vice President – MIS

Kenneth M. Koopman
Senior Vice President – Reimbursement

Peter M. Lawson
Executive Vice President – Development

Gary J. Link
Senior Vice President – Administration

Patrick E. Lombardo
Senior Vice President – Human Resources

Johnny A. Owenby
Senior Vice President – Support Services

Ronald N. Riner, M.D.
Chief Medical Officer

Jack D. Towsley, Jr.
Senior Vice President – Payor Relations

Eric L. Waller
Chief Marketing Officer

OUTSTANDING DEPARTMENT DIRECTORS OF THE YEAR

Carlos Felix
Bartow Regional Medical Center

Larry Jervis
Paul B. Hall Regional Medical Center

Ron Kubiak
Venice Regional Medical Center

Michelle Miller
Medical Center of Southeastern Oklahoma

Margaret Stubblefield
Crossgates River Oaks Hospital

OUTSTANDING NURSES OF THE YEAR

Lishia Biliter, RN
Williamson Memorial Hospital

Kristine Conroy, RN
Charlotte Regional Medical Center

Randy Parker, RN
Gilmore Memorial Regional Medical Center

Helen Russo, RN
Spring Hill Regional Hospital

LeeAnn Stuart, RN
Twin Rivers Regional Medical Center

OUTSTANDING ASSOCIATES OF THE YEAR

Patricia Albin
River Oaks Hospital

Elizabeth Black
Sebastian River Medical Center

Carmen Cappacetti
St. Cloud Regional Medical Center

Robert Conatser
Jamestown Regional Medical Center

Wayne McCloud
Chester Regional Medical Center

PRESIDENT'S LEADERSHIP AWARD

The President's Leadership Award was created in 2010 and was awarded posthumously to Bradley E. Jones, our dear Associate who lost his battle to lung disease in February 2010. This annual honor recognizes those individuals with the same qualities we so greatly admired in Brad: selflessness, servant leadership, high-achievement, positivity and a caring spirit.

The distinguished honorees are:

2009	Bradley E. Jones
2010	John I. Erickson, Jr., Lisa Gore
2011	D. Melody Trimble
2012	MaryAnn Hodge, Judson Ivy

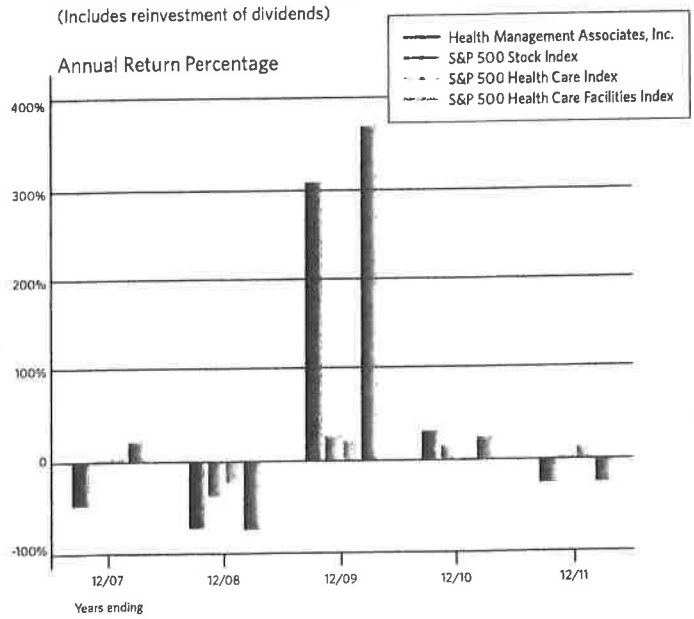
FINANCIAL HIGHLIGHTS

(Dollars in thousands, except per share amounts)	YEAR ENDED DEC. 31, 2011	YEAR ENDED DEC. 31, 2010
OPERATING DATA (From continuing consolidated operations)		
Net revenue	$ 5,804,451	$ 5,092,166
Income before income taxes [a]	312,405	286,823
Net income attributable to Health Management Associates, Inc.[b]	178,710	150,069
Earnings per share from continuing operations attributable to Health Management Associates, Inc. common stockholders (diluted)	$0.71	$0.65
Cash flow from continuing operating activities	$ 544,022	$ 434,691

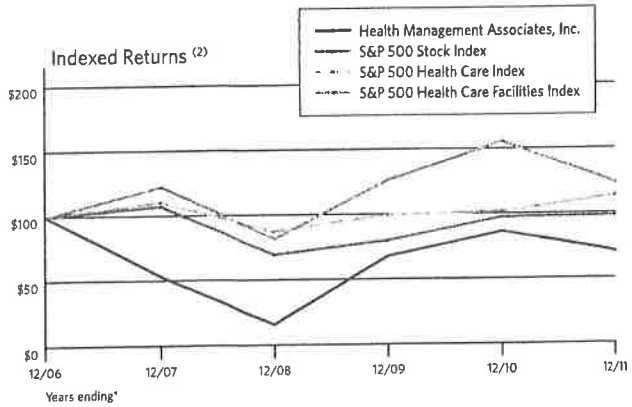
	2011	2010
YEAR-END DATA		
Total assets	$ 6,004,189	$ 4,910,085
Long-term debt	3,574,998	3,018,464
Stockholders' equity [a]	785,116	533,486
Number of employees	40,600	35,800
Number of hospitals	66	59

(a) Includes amounts attributable to noncontrolling interests.
(b) Includes discontinued operations.

Total Return to Shareholders [1]
(Includes reinvestment of dividends)



Stock Price Performance Graph [1]



(1) The graphs on this page compare total return to shareholders (including reinvestment of dividends) and stock price performance, respectively, of Health Management's common stock with the companies in the S&P 500 Stock Index, the S&P 500 Health Care Index and the S&P 500 Health Care Facilities Index during the periods indicated.

(2) Assumes $100 invested on December 31, 2006.

There can be no assurances that Health Management's stock performance will continue into the future with the same or similar trends depicted in the graphs above. Health Management neither makes nor endorses any predictions as to future stock performance.

2011 BOARD OF DIRECTORS

William J. Schoen
Chairman of the Board of Directors
Health Management Associates, Inc.

Gary D. Newsome
President and Chief Executive Officer
Health Management Associates, Inc.

Kent P. Dauten
Managing Director
Keystone Capital, Inc.

Pascal J. Goldschmidt, M.D.
Senior Vice President for
Medical Affairs and Dean
University of Miami Leonard M.
Miller School of Medicine

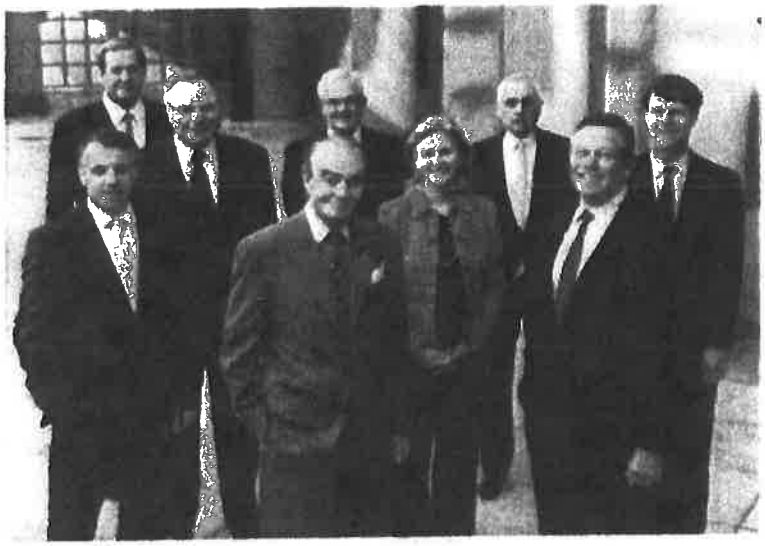
Donald E. Kiernan
Senior Executive Vice President
and Chief Financial Officer
SBC Communications, Inc. (retired)

Robert A. Knox
Senior Managing Director
Cornerstone Equity Investors, LLC

Vicki A. O'Meara
Executive Vice President
Pitney Bowes Inc.

William C. Steere, Jr.
Chairman Emeritus
Pfizer Inc.

Randolph W. Westerfield, Ph.D.
Dean Emeritus and the Charles B.
Thornton Professor of Finance,
Marshall School of Business
University of Southern California



BOARD OF DIRECTORS (L-R): Pascal J. Goldschmidt, M.D., Robert A. Knox, Randolph W. Westerfield, Ph.D., William J. Schoen, Donald E. Kiernan, Vicki A. O'Meara, William C. Steere, Jr., Gary D. Newsome and Kent P. Dauten

TECHNOLOGY AND INNOVATION

Technology systems are becoming an increasingly important component of health care delivery. As part of The American Recovery and Reinvestment Act of 2009, the federal government established incentives for health care providers to utilize electronic health records to reduce errors, increase records and data availability, provide clinical decision support, and develop e-prescribing/refill automation. In 2011, Health Management's proprietary information system, the PULSE System , was certified compliant by the federal government and Health Management began receiving additional reimbursement for its systems. Hospitals that partner with us utilize our PULSE System and qualify for additional reimbursement. In 2012, Health Management expects to receive between $90 and $120 million dollars of additional reimbursement related to this program.

In today's complex health care landscape, reactive decision making isn't good enough; we must be proactive to best position our company for the future. More data is required and the quality of that data must improve if we are to make effective decisions. Recently, Health Management developed a predictive analytical tool designed to evaluate our millions of patient encounters each year. By utilizing predictive analytics we use a variety of statistical modeling techniques to analyze current and historical facts to forecast future events. These predictive models make use of patterns found in historical and transactional data to identify risks and opportunities and assist us in capital deployment, service line expansion, and revenue cycle management.

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 (State or other jurisdiction of incorporation or organization)	**61-0963645** (I.R.S. Employer Identification No.)
5811 Pelican Bay Boulevard, Suite 500 **Naples, Florida** (Address of principal executive offices)	**34108-2710** (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.

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HEALTH MANAGEMENT ASSOCIATES, INC.

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PART I

Item 1. Business.

Overview

Health Management Associates, Inc. by and through its subsidiaries (collectively, "we," "our" or "us") operates general acute care hospitals and other health care facilities in non-urban communities. As of December 31, 2011, we operated 66 hospitals with a total of 10,330 licensed beds in Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, Missouri, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Washington and West Virginia. See Notes 10 and 15 to the Consolidated Financial Statements in Item 8 of Part II for information about our pending acquisition and divestiture activities.

Services provided by our hospitals include general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care and pediatric services. We also provide outpatient services such as one-day surgery, laboratory, x-ray, respiratory therapy, cardiology and physical therapy. Additionally, some of our hospitals provide specialty services in, among other areas, cardiology (e.g., open-heart surgery, etc.), neuro-surgery, oncology, radiation therapy, computer-assisted tomography ("CT") scanning, magnetic resonance imaging ("MRI"), lithotripsy and full-service obstetrics. Our facilities benefit from centralized resources, such as purchasing, information technology, finance and accounting systems, legal services, facilities planning, physician recruiting services, administrative personnel management, marketing and public relations.

Our Class A common stock is listed on the New York Stock Exchange under the symbol "HMA." We were incorporated in Delaware in 1979 but began operations through a subsidiary that was formed in 1977. We became a public company in 1991. We have been named to the list of *Fortune Magazine's* World's Most Admired Companies for four of the past six years, appearing as the top hospital company in the "Health Care: Medical Facilities" category for two of those years.

Recent Acquisitions and Divestitures

Part of our strategic business plan calls for us to acquire underperforming non-urban general acute care hospitals that are available at a reasonable price, align with our business model and otherwise meet our strict acquisition criteria. We proactively identify acquisition targets and respond to requests for proposals from entities that are seeking to sell or lease hospital facilities. In addition to continually evaluating various hospital and other ancillary health care business acquisition candidates, we are also (i) improving, developing and enhancing the operations of our existing health care facilities and (ii) identifying opportunities to augment our position in the markets where we already have health care operations. We believe that the strength of our balance sheet and cash flow, as well as our available borrowing capacity, provide us the resources needed to pursue acquisition opportunities at this time; however, there can be no assurances that we will close any hospital or other acquisition transactions in 2012 and beyond.

We regularly review and evaluate our portfolio of hospitals and, if an individual hospital no longer meets our short and long-term performance criteria, we consider strategic alternatives, including, in some cases, divestiture. Where appropriate, and consistent with our performance criteria and other strategic objectives, we also explore collaborative relationships with physicians and other health care entities. At any given time, we are actively involved in negotiations concerning possible acquisitions, divestitures and joint ventures. Certain of our recently completed transactions are set forth below.

Acquisitions

Completed

- On September 30, 2011, one of our subsidiaries acquired from Catholic Health Partners and its subsidiary Mercy Health Partners, Inc. ("Mercy") substantially all of the assets of Mercy's seven general acute care hospitals in east Tennessee (collectively licensed to operate 833 beds). Our subsidiary also acquired (i) substantially all of Mercy's ancillary health care operations that are affiliated with the acquired hospitals (collectively, those ancillary facilities are licensed to operate 74 beds) and (ii) Mercy's former Riverside hospital campus (which is licensed to operate 293 beds). Our east Tennessee hospital and health care network is now collectively referred to as Tennova Healthcare. The total purchase price for this acquisition was approximately $532.4 million.

- Effective May 1, 2011, one of our subsidiaries acquired a 95% equity interest in a company that owns and operates Tri-Lakes Medical Center, a 112-bed general acute care hospital in Batesville, Mississippi, and certain related health care operations. The total purchase price for our 95% equity interest was approximately $38.8 million.

- Effective October 1, 2010, certain of our subsidiaries acquired from Wuesthoff Health Systems, Inc. the following general acute care hospitals and certain related health care operations: (i) 298-bed Wuesthoff Medical Center in Rockledge, Florida; and (ii) 115-bed Wuesthoff Medical Center in Melbourne, Florida. The total purchase price for this acquisition was approximately $152.0 million.

- Effective July 1, 2010, certain of our subsidiaries acquired from Shands HealthCare a 60% equity interest in each of the following general acute care hospitals and certain related health care operations: (i) 99-bed Shands Lake Shore hospital in Lake City, Florida; (ii) 15-bed Shands Live Oak hospital in Live Oak, Florida; and (iii) 25-bed Shands Starke hospital in Starke, Florida. Shands HealthCare or one of its affiliates continues to hold a 40% equity interest in each of these hospitals. The total purchase price for our 60% interests in these three hospitals was approximately $21.5 million.

See Note 4 to the Consolidated Financial Statements in Item 8 of Part II for further discussion of our recently completed acquisitions.

Pending

- On February 3, 2012, one of our subsidiaries signed a definitive agreement with a subsidiary of INTEGRIS Health, Inc. ("INTEGRIS") to acquire an 80% equity interest in each of five Oklahoma-based general acute care hospitals (collectively licensed to operate 226 beds) and certain related health care operations. A subsidiary of INTEGRIS will retain a 20% equity interest in such entities. The total purchase price for our 80% equity interests will be $60.0 million. This pending acquisition, which we expect to close during the quarter ending June 30, 2012, is discussed at Note 15 to the Consolidated Financial Statements in Item 8 of Part II.

Divestitures

- During May 2011, one of our subsidiaries entered into a lease termination agreement for Fishermen's Hospital, a 25-bed hospital in Marathon, Florida, that became effective on July 1, 2011. As part of the agreement, the hospital's remaining equipment, as well as certain working capital items, were sold to our former lessor for approximately $1.5 million.

- Effective December 31, 2010, certain of our subsidiaries completed the sale of Riley Hospital, a 140-bed general acute care hospital in Meridian, Mississippi, and its related health care operations. The selling price was $24.0 million, plus a working capital adjustment, and yielded a loss of approximately $12.4 million.

Our "Discontinued Operations," which include the aforementioned divestitures, are identified at Note 10 to the Consolidated Financial Statements in Item 8 of Part II.

Certain Other Important Developments During 2011

Debt Refinancing

On November 18, 2011, we completed a restructuring of our long-term debt. See Note 2 to the Consolidated Financial Statements in Item 8 of Part II for details of such restructuring and our outstanding long-term debt at December 31, 2011.

Meaningful Use Incentive Program Certification

During July 2011, our Pulse System® was deemed compliant and was certified by the Certification Commission for Health Information Technology (CCHIT®), in accordance with the applicable hospital certification criteria adopted by the Secretary of the U.S. Department of Health and Human Services. Our 2011/2012 criteria support the Stage 1 meaningful use measures required to qualify eligible providers and hospitals for funding under the American Recovery and Reinvestment Act of 2009. As a result of our certification and successful compliance with other related criteria, we received approximately $38.3 million of CCHIT® funds during 2011 from Medicare and Medicaid. Moreover, we expect to receive approximately $90 million to $120 million of additional reimbursement during the year ending December 31, 2012.

Market

Our markets are generally non-urban communities with populations of 30,000 to 400,000 people located primarily in the southeastern United States. Typically, the hospitals we operate are, or we believe can become, the sole or preferred provider of health care services in their respective markets.

Our target markets generally have the following characteristics:

- *A history of being medically underserved.* We believe that we can enhance and increase the level and quality of health care services in many underserved markets.
- *Favorable demographics, including a growing elderly population.* We believe that this growing population uses a higher volume and more acute level of health care services.
- *The existence of patient outmigration trends to urban medical centers.* We believe that, in many instances, we can recruit primary care and specialty physicians based on community needs and purchase new equipment that is necessary to reverse outmigration trends.
- *States in which a certificate of need is required to construct a hospital and add licensed beds to an existing hospital.* We believe that states requiring certificates of need have appropriate barriers to prevent others from building a new hospital, adding licensed beds to an existing hospital or providing additional health care services. We further believe that, in many instances, these factors permit us to be the sole or preferred service provider within a geographic area.

Business Strategy

Our business strategy is to deliver high quality health care services and improve patient and physician satisfaction, improve the operations of our hospitals, utilize efficient management and acquire strategic hospitals and other ancillary health care businesses in non-urban communities.

Deliver High Quality Health Care Services and Improve Patient and Physician Satisfaction

All but two of our hospitals (and substantially all of our laboratories and home health agencies) are accredited by The Joint Commission, an independent not-for-profit organization that accredits and certifies more than 15,000 health care organizations and programs based on certain performance standards. We seek to continually improve the quality of the health care services we deliver and the satisfaction of our patients and physicians. To help us in this regard, we use a physician and patient satisfaction survey process to gauge their satisfaction with the level and quality of our services. Surveyed physicians and patients are asked to complete a confidential survey that seeks their perception of, among other things, a hospital's medical treatment, nursing care, attention to physician and patient concerns, communication, admission process, cleanliness and quality of dietary services. The survey results are compared and benchmarked against results from other hospitals across the country. We believe that these surveys provide us with additional data to help improve our hospitals' quality and satisfaction as they compare to our peers and competitors. Each hospital's management team receives the detailed results of the surveys and comparative data regarding their ranking against benchmark statistics. To stress the importance of the survey results, part of our hospital management teams' incentive compensation is based on the levels of quality and satisfaction indicated in those surveys.

As evidence of our commitment to quality, Lake Norman Regional Medical Center, our 123-bed hospital in Mooresville, North Carolina, achieved Magnet Status designation for excellence in nursing services by the American Nurses Credentialing Center's Magnet Recognition Program. The Magnet Recognition Program recognizes health care organizations that demonstrate excellence in nursing practice and adherence to national standards for the organization and delivery of nursing services. Additionally, Venice Regional Medical Center, our 312-bed hospital in Venice, Florida, has been ranked among the nation's Top 100 Acute Care Hospitals and Top 50 Cardiovascular Hospitals according to independent studies by Thomson Reuters. The general acute care hospital study evaluated 3,000 short-term, acute care, non-federal hospitals in nine areas: mortality, medical complications, patient safety, average length of stay, expenses, profitability, cash-to-debt ratio, patient satisfaction and adherence to clinical standards of care. The cardiovascular hospital study examined the performance of 1,022 hospitals by analyzing outcomes for patients with heart failure and heart attacks and those who had coronary bypass surgery and percutaneous coronary interventions such as angioplasties. Venice Regional Medical Center is a five-year recipient of this award. In 2010, Thomson Reuters made the list more exclusive by narrowing it from the top 100 cardiovascular hospitals to the top 50. Seven Rivers Regional Medical Center, our 128-bed hospital in Crystal River, Florida, was identified in 2010 as a recipient of the Patient Safety Excellence Award™ by HealthGrades, Inc. ("HealthGrades"), indicating that its patient safety ratings are in the top 5% of U.S. hospitals. HealthGrades is a leading health care ratings organization, providing ratings and profiles of hospitals, nursing homes and physicians. Seven Rivers Regional Medical Center is one of only 238 hospitals in the country to receive this designation and one of only 15 in Florida. Physicians Regional Health System, our two-hospital system in Naples, Florida, was also recognized by HealthGrades for 2010. Physicians Regional Health System's spine surgery program is among the top 5% in the nation and top ranked in Florida according to HealthGrades. The HealthGrades' study annually assesses patient outcomes - mortality and complication rates - at virtually all of the nearly 5,000 non-federal hospitals in the country.

During 2011, 35 of our hospitals were named as Top Performers on Key Quality Measures according to a report released by The Joint Commission. From a universe of approximately 2,900 Joint Commission-accredited general acute care and critical access hospitals that report core measure performance data, only 405 hospitals nationwide, or approximately 14% of the evaluated hospitals, earned recognition as top performers. In contrast, our 35 hospitals recognized as top performers represented nearly 60% of the 59 hospitals that we operated at the time of the study. To be recognized as a top performer on key quality measures, an organization must meet two 95% performance thresholds. First, it must achieve a composite performance score of 95% or higher after the results of all the accountability measures reported to The Joint Commission are factored into a single score, including measures that had less than 30 eligible cases or patients. Second, it must meet or exceed a 95% performance target score for every single accountability measure for which it reports data, excluding any measures with less than 30 eligible cases or patients.

Listed below are some of the actions that we have undertaken in our ongoing effort to further improve the quality of our health care services.

- *We continue to enhance our medication error prevention program.* An important component of the program is a handheld bedside medication administration system, which is continuing to evolve, designed to help eliminate medication errors by using a clinician-designed bar code scanning device to verify medication orders at the point of care.
- *We continue to implement a program to enhance and upgrade our emergency room clinical systems to more effectively manage patient flow and outcomes.* Thus far, the enhancements have included hardware and software upgrades, as well as the development of uniform clinical guidelines to be implemented company-wide to ensure consistent patient treatment and accurate benchmarking of outcomes. Additionally, our program calls for comprehensive training of all clinical personnel and physicians responsible for emergency room patient care. Our emergency room initiatives are expected to continue for the next couple of years.
- *During 2011, we initiated an electronic document management solution with McKesson Corporation's Horizon Patient Folder™ hospital document management product.* Horizon Patient Folder™ is designed to provide our physicians, health information management personnel and other hospital staff the ability, anytime or anywhere, to review, analyze, code and complete electronic charts within our electronic medical records system. We believe that the adoption of this software will improve patient care, enhance staffing and further ensure regulatory compliance.
- *We sought to improve our computer-based physician access portal system in 2011.* These improvements are designed to allow physicians to access hospital inpatient information using a mobile device such as a smartphone or tablet. To that end, we are working with PatientKeeper, Inc. to design a mobile platform for our physicians so that they can monitor updated patient clinical data from anywhere and at any time. The system, known as PatientKeeper Mobile Clinical Results, will improve care for our patients by allowing physicians to make more timely and accurate decisions regarding a patient's care plan.

Improve the Operations of our Hospitals

We seek to increase revenue at our hospitals by providing quality health care, which we believe will ultimately increase admissions, surgical volume, emergency room visits and outpatient business. Our hospitals are administered and directed on a local level by a chief executive officer. A key element of our strategy is establishing and maintaining cooperative relationships with our physicians. We maintain a physician recruitment and development program designed to attract and retain qualified specialists and primary care physicians, in conjunction with our existing physicians and community needs, to broaden the services offered by our hospitals. To this end, we developed a unique program designed to: (i) create attractive practice opportunities for qualified physicians in the communities that are served by our hospitals in order to build outstanding medical staffs; (ii) improve the satisfaction and retention of physicians in our markets; and (iii) create practice models that are sustainable in a competitive health care environment.

Our hospitals seek to increase their patient volume through local marketing programs. Our overall marketing strategy and the individual programs for each of our hospitals are consolidated under central and divisional leadership. One of the benefits of this approach is a streamlined cost-effective process that utilizes a limited number of marketing firms. Using our consolidated marketing programs, we can devise uniform and consistent themes that only require the change of logo and hospital colors to implement company-wide. Additionally, changes to our marketing strategies can be quickly deployed to all of our hospitals and other health care facilities.

We also pursue various clinical means to increase utilization of the services provided by our hospitals, particularly emergency and outpatient services. These include:

- "ER Extra®," an emergency room operational initiative that is designed to reduce patient wait times, enhance patient satisfaction and improve the quality and scope of patient assessments;
- "Nurse First™," an emergency room service program that provides for a well-qualified nurse to quickly assess the condition of a patient upon arrival in the emergency room;
- "MedKey™," a free identification and patient information card that streamlines the registration process; and
- "One Call Scheduling™," a dedicated phone system that physicians and other medical personnel can use to simultaneously schedule various diagnostic tests and services.

There are numerous opportunities to increase the number of patients who seek treatment at our hospitals and other health care facilities. We believe that improving patient volume rests, in part, on our ability to improve relationships with physicians in the communities where our hospitals operate. In addition to establishing local physician leadership councils where we listen and respond to physician concerns, we routinely evaluate innovative service delivery alternatives that address the ever-changing health care climate. Often times, there already exists a high level of competition for health care services in our markets. We believe that our ultimate success will depend on our ability to improve our quality of care, access to services and patient outcomes, as well as our flexibility, creativity and responsiveness to all involved constituencies.

In our markets, we employ physicians who provide health care services outside of the hospital setting. Our hospitals also assume active roles managing local physician relationships in their markets. As a result of various employed physician initiatives, such as converting physicians to production-based employment arrangements, we have experienced favorable changes in physician referral patterns. We believe that additional opportunities exist to further improve our hospital operations through more efficient management of our employed physicians, which increased in number from approximately 700 at December 31, 2010 to 900 at December 31, 2011.

Utilize Efficient Management

We consider our management structure to be decentralized but with centralized support and control. Our hospitals are run by experienced chief executive officers, chief financial officers and chief nursing officers who have both the authority and responsibility for day-to-day hospital operations. Incentive compensation programs have been implemented to reward our managers for achieving and exceeding pre-established goals. We employ a centralized staff at our home office in Naples, Florida to provide support services such as systems design and development, training, human resource management, reimbursement, accounting support, legal services, marketing, purchasing, risk management and construction management. We maintain centralized financial control through fiscal and accounting policies established by our home office for use at all of our subsidiary hospitals. Financial information is consolidated using our proprietary Pulse System® and is monitored daily by our management team. We also participate in a group purchasing organization with other proprietary hospital systems. We believe that this participation allows us to procure medical equipment and supplies at advantageous pricing by leveraging the buying power of the organization's members.

During 2011, our operational reporting structure was comprised of five divisions, each with a divisional senior leader who reported directly to our President and Chief Executive Officer. Each of the five divisions had its own president, chief financial officer and physician recruiting manager with aligned individual hospital and divisional objectives. Effective January 1, 2012, our management structure was changed so as to better address the dynamic growth that we have experienced in recent years. We are now organized into three regional groups (Eastern, Florida, and Southern and Western), each with a group leader who is a senior officer of our company that reports directly to our President and Chief Executive Officer, as well as a chief financial officer who reports to the group leader. In addition, each of the regional groups has two divisions and each division has its own president, chief financial officer and physician recruiting manager with aligned individual hospital and divisional objectives.

During the past several years, we have also recruited and promoted new leadership for centralized support functions such as clinical affairs, marketing, government relations, strategy and analytics, physician recruitment, contracting, human resources, physician relations, nursing and quality.

Acquire Additional Hospitals and Other Ancillary Health Care Businesses

We believe that the hospitals we acquire are, or can become, the provider of choice for health care services in their respective communities. When we make an initial evaluation of a potential acquisition, we require that a hospital's market service area have a demonstrated need for the hospital, along with an established physician base

that we believe can benefit from our ability to attract additional qualified physicians to the area based on community needs. In addition to whole hospital acquisitions, we also consider (i) partnering with not-for-profit entities in areas and markets that otherwise meet our acquisition criteria and (ii) investing in or acquiring ancillary health care businesses such as physician practices, ambulatory surgery centers, diagnostic imaging and outpatient urgent care.

We believe that many of the hospitals we acquire are underperforming at the time of acquisition. Upon acquiring a hospital, we conduct a thorough review and, where appropriate, retain existing administrative leadership. We also take other steps, including, among other things, employing a well-qualified chief executive officer, chief financial officer and chief nursing officer, implementing our proprietary management information system (the Pulse System®) and other technological enhancements, recruiting physicians, establishing supplemental quality assessment and efficiency measures, introducing volume purchasing under company-wide agreements, and spending the necessary capital to renovate facilities and upgrade equipment. Our Pulse System® and the other technological enhancements that we implement are designed to provide each hospital's management team with the financial and operational information necessary to operate the hospital efficiently and effectively. We can also assist physicians with case management.

Additionally, we expand and improve the services offered at our acquired hospitals. We strive to provide at least 90% of the acute care needs of each community our hospitals serve and reduce the outmigration of patients to hospitals in larger urban areas. Generally, we have been successful in achieving significant improvement in the operating performance of our newly acquired facilities within 24 to 36 months of acquisition. Moreover, we seek to recover our initial cash investment in an acquired health care facility within four to five years. Once a facility has matured, we seek to achieve incremental growth through the investment of capital, recruitment of physicians based on community needs, expansion and enhancement of health care services, renegotiated agreements with commercial health insurance providers and favorable demographic trends.

Selected Operating Statistics

The table below summarizes selected operating statistics, exclusive of our Discontinued Operations, that are typically used by our management, investors and other readers of our consolidated financial statements.

	Years Ended December 31,		
	2011	2010	2009
Licensed beds at the end of the year, excluding inactive facilities (1)	9,868	8,839	8,220
Admissions (2)	338,637	323,917	306,184
Adjusted admissions (3)	635,934	586,060	533,101
Emergency room visits (4)	1,562,028	1,413,831	1,352,044
Surgeries (5)	342,421	314,564	281,285
Patient days (6)	1,424,500	1,350,697	1,281,093
Acute care average length of stay in days (7)	4.2	4.2	4.2
Occupancy rates (8)	42.8%	43.9%	45.3%

(1) Licensed beds are beds for which a hospital has obtained approval to operate from the applicable state licensing agency.

(2) Admissions are patients admitted to our hospitals for inpatient treatment. This statistic is a measure of inpatient volume.

(3) Adjusted admissions are total admissions adjusted for outpatient volume. Adjusted admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient charges and gross outpatient charges and then dividing the resulting amount by gross inpatient charges. This statistic is a measure of total inpatient and outpatient volume.

(4) The number of emergency room visits is an operational measure that is used to gauge our patient volume. Much of our inpatient volume is a byproduct of a patient's initial encounter with one of our hospitals through an emergency room visit.

(5) The number of surgeries includes both inpatient and outpatient surgeries. This statistic is indicative of overall patient volume and business trends.

(6) Patient days is the total number of days that patients are admitted in our hospitals. This statistic is a measure of inpatient volume.

(7) Acute care average length of stay in days represents the average number of days admitted patients stay in our hospitals. This statistic is a measure of our utilization of resources.

(8) Occupancy rates are affected by many factors, including the population size and general economic conditions within individual market service areas, the degrees of variation in medical and surgical products, outpatient use of hospital services, quality and treatment availability at competing hospitals and seasonality. This statistic is a measure of inpatient volume.

Competition

Existing hospitals

In many of the geographic areas where we operate, there are other hospitals and health care entities that provide services comparable to those offered by our hospitals. Generally, competition is limited to a single or small number of hospital competitors in each hospital's market service area. With respect to the delivery of general acute care inpatient services, we believe that most of our hospitals face less competition in their immediate market service area than they would likely face in larger, more urban, communities. However, the health care environment has become more competitive in every market as physicians and ancillary service providers introduce outpatient services. Regardless of the level of competition, we strive to distinguish ourselves based on the quality and scope of the medical services we provide.

Certain of our competitors may have greater resources than we do, may be better equipped than we are and may offer a broader range of services than we do. For example, some hospitals that compete with us are owned by government agencies and are supported by tax revenue, and others are owned by not-for-profit entities and may be supported, to a large extent, by endowments and charitable contributions. Such support is not available to our hospitals. Additionally, outpatient treatment and diagnostic imaging facilities, outpatient surgical centers and freestanding ambulatory surgical centers (including many in which physicians have an ownership interest), specialized care providers (e.g., oncology, physical therapy, etc.), and a growing number of health care clinics located in large retail stores also introduce competitors to the health care marketplace.

A majority of our hospitals are located in states that have certificate of need laws. These laws limit competition by placing restrictions on the construction of new hospital and/or other health care facilities, the addition of new licensed beds or the addition of significant new services. We believe that such states have appropriate barriers to entry and, in many instances, permit us to be the sole or preferred service provider in a particular geographic area.

The competitive position of our hospitals is also increasingly affected by our ability to negotiate service contracts with purchasers of group health care services. Such purchasers include employers, preferred provider organizations ("PPOs") and health maintenance organizations ("HMOs"). PPOs and HMOs attempt to direct and control the use of hospital services by managing care and either receive discounts from a hospital's established charges or pay based on a fixed per diem or a capitated basis, where a hospital receives fixed periodic payments based on the number of members of the organization regardless of the actual services provided. To date, PPOs and HMOs have not adversely affected the competitive position of our hospitals. Employers and traditional health insurers are also increasingly interested in reducing their costs through negotiations with hospitals for managed care programs and discounts from established charges. In return, hospitals secure commitments for a larger number of potential patients. We believe that we have been proactive in establishing or joining such programs to maintain, and even increase, the hospital services we provide. We do not believe that such programs will have a significant adverse impact on our business or operations.

We are in an industry that has a competitive labor market. As such, we face competition attracting and retaining health care professionals. In recent years, there has been a nationwide shortage of qualified nurses and other medical support personnel. To address this shortage, we have improved hospital working conditions and fostered relationships with local nursing schools.

Another important factor contributing to a hospital's competitive advantage is the number and quality of physicians on its staff. Physicians make admitting and other decisions regarding the appropriate course of patient treatment which, in turn, affect hospital revenue. Admitting physicians may also be on the medical staffs of hospitals that we do not operate. By offering quality services and facilities, convenient locations and state-of-the-art medical equipment, we attempt to attract our physicians' patients. Our hospitals try to increase the number, quality and specialties of the physicians in their communities based on local needs. Excluding our 2011 acquisition activity, approximately 650 physicians were recruited or otherwise joined our medical staff during the year ended December 31, 2011. During 2012, we intend to actively recruit a like number of physicians to join our medical staff. When a recruited physician relocates to a community where one of our hospitals is located and agrees to engage in private practice, our subsidiary hospital often advances funds to the physician pursuant to a recruiting agreement to provide financial assistance for the physician to establish a practice. The actual amounts advanced will depend on the financial results of each physician's private practice during a predetermined period, referred to as the measurement period, which generally approximates one to two years. Amounts advanced under these recruiting agreements are considered to be loans and are generally forgiven on a pro rata basis over a period of 12 to 24 months, contingent on the physician continuing to practice in the community served by our hospital.

Acquisitions

We typically face competition for acquisitions from other for-profit health care companies and not-for-profit multi-hospital groups. Some of those competitors may have greater financial and other resources than we do. Historically, we have been able to complete our acquisitions at prices that we believe are reasonable. However, competitive bidding for acquisition targets could adversely impact our ability to acquire hospitals and other ancillary health care businesses in the future on favorable terms.

Sources of Revenue

General

Our revenue from patient charges is dependent on many factors, including surgical volume, inpatient occupancy levels, the level of medical and ancillary services ordered by physicians and provided to patients and the volume of outpatient procedures. We record gross patient service charges on a patient-by-patient basis in the period in which the services are rendered. Patient accounts are billed after the patient is discharged. When a patient's account is billed, our accounting system calculates the reimbursement that we expect to receive based on the services rendered, the type of payor and the contract terms with such payor. We record the difference between gross patient service charges and expected reimbursement as contractual adjustments.

At the end of each month, we estimate our expected reimbursement for unbilled accounts. Estimated reimbursement amounts are calculated on a payor-specific basis and are recorded based on the best information available to us at the time regarding applicable laws, rules, regulations and contract terms. We continually review our contractual adjustment estimation process to consider the effects of changes in applicable laws, rules and regulations, as well as changes to contract terms with managed care health plans that result from negotiations and renewals.

We receive payment for services rendered primarily from:

- the federal government under the Medicare program;
- the states where we operate under each state's Medicaid program;
- commercial insurance and other programs; and
- patients, including co-payments and deductibles.

Co-payments and deductibles are the portion of the patient's bill for medical services that many private and government payors require the patient to pay. Co-payment and deductible amounts vary among payors and are based on the provisions of the health plan in which the patient participates. We estimate that we are currently collecting approximately 50% to 55% of such amounts. In recent years, we have increased our efforts to collect patient co-payments and deductibles at the time services are rendered. Co-payments and deductibles are subject to the same collection practices as other patient accounts receivable.

Our policy is to verify insurance coverage prior to rendering service in order to facilitate timely identification of the payor and the benefits covered. However, under federal law, when the necessity of service and patient condition (e.g., emergency room services, active labor and other similar situations, etc.) are present, those conditions preclude the verification of coverage. We do not track the percent of encounters where coverage is not verified prior to services being rendered.

Virtually all of our billing is processed electronically via our proprietary Pulse System® or a third party billing software program. Charges for services rendered are automatically entered into our billing systems, which edit bills for inconsistencies and improper charges. Inconsistencies are reviewed by billing personnel who resolve such matters before a bill is released. Once a preliminary bill clears the edit process, our systems automatically generate a final bill. Approximately 95% of these bills are sent electronically to third party payors. For the remaining 5% of our bills, paper copies are printed and mailed to third party payors and/or individuals.

Reimbursement rates for routine inpatient services vary significantly depending on the type of service (e.g., acute care, intensive care, etc.) and the geographic location of the hospital where the services are provided. In recent years, outpatient services have steadily increased and presently constitute approximately half of our consolidated net revenue. This increased level of outpatient services is primarily due to advances in medical technology that allow more services to be provided on an outpatient basis, as well as increased pressure from Medicare, Medicaid and commercial insurers to reduce hospital stays and provide services, where possible, on a less expensive outpatient basis. We believe that our outpatient levels are representative of the general trend in the health care industry.

The table below sets forth the approximate percent of hospital net revenue, defined as revenue from all sources after deducting contractual allowances and discounts from established billing rates, that we derive from our primary payor sources.

	Years Ended December 31,		
	2011	2010	2009
Medicare	31%	32%	32%
Medicaid	9	9	9
Commercial insurance and other	50	50	49
Self-pay	10	9	10
	100%	100%	100%

Overview of the Impact of Recent Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, which we refer to together as the Health Care Reform Act, were signed into law by President Obama in March 2010 and will dramatically change how health care services are covered, delivered and reimbursed. The Health Care Reform Act is intended to decrease the number of uninsured Americans and reduce health care costs. Among other things, the Health Care Reform Act provides for expanded Medicaid coverage of uninsured individuals, reduced growth in Medicare spending, reductions in Medicare and Medicaid disproportionate share hospital payments and the establishment of programs designed to tie reimbursement to quality (known as value-purchasing programs). The Health Care Reform Act is intended to accomplish its goals and objectives through a combination of public program expansion and private sector health insurance reforms.

Over time, the expansion of private sector and Medicaid coverage under the Health Care Reform Act will likely increase the revenue we receive for services provided to individuals who were previously uninsured. Under the Health Care Reform Act, health insurance coverage is expected to be expanded to cover approximately 32 to 34 million additional people by 2014 through, among other things, the expansion of existing Medicaid programs to cover non-pregnant adults under age 65 with incomes of up to 138% of the federal poverty level (133% of the federal poverty level plus an additional 5% income "disregard" factor). However, reductions in the growth of Medicare payments and decreases in disproportionate share and other hospital reimbursement payments will adversely affect our revenue. To the extent such revenue reductions are not offset by increased revenue from providing care to previously uninsured individuals, the full implementation of the Health Care Reform Act could adversely affect our business and results of operations.

The Health Care Reform Act also contains a number of measures that are intended to further reduce fraud and abuse in the Medicare and Medicaid programs, such as increased funding for fraud and abuse investigations and enforcement, and the required use of recovery audit contractors under the individual state Medicaid programs. Additionally, the law contains significant limitations on hospitals that are partially owned by physicians, including restrictions that generally prohibit increases in the percent of physician ownership and the number of licensed beds, procedure rooms and operating rooms at such joint venture hospitals. At December 31, 2011, we had 24 joint venture hospitals with physician owners.

Many of the Health Care Reform Act's provisions will not take effect until 2014, or later, while others have already become effective or will become effective prior to 2014. The federal government and individual state governments must also interpret and implement the new regulatory requirements, the vast majority of which have yet to be considered. Additionally, the Health Care Reform Act remains subject to significant legislative debate, including possible repeal and/or amendment, and there are substantial legal challenges to various aspects of the Health Care Reform Act that have been made on constitutional grounds. On November 14, 2011, the United States Supreme Court agreed to decide the constitutionality of the Health Care Reform Act (a ruling is expected by July 2012). As a result of these various uncertainties, we are currently unable to predict the overall impact that the full implementation of the Health Care Reform Act will have on us. Other provisions of the Health Care Reform Act that might affect our business and results of operations are discussed below and elsewhere in this Annual Report on Form 10-K, including Item 1A under "Risk Factors."

The Budget Control Act of 2011, or the BCA, was enacted on August 2, 2011. Among other things, the BCA established the Joint Select Committee on Deficit Reduction (the "Deficit Reduction Committee"), a twelve-member bipartisan joint committee of Congress. The primary goal of the Deficit Reduction Committee was to propose legislation to reduce the federal deficit by $1.5 trillion over the next ten years. Pursuant to the BCA, if the legislation proposed by the Deficit Reduction Committee was not approved by Congress by December 23, 2011 and enacted into law by January 15, 2012, then spending cuts aggregating $1.2 trillion over the next ten years (less any amount that resulted from earlier Congressional action) would automatically begin in January 2013. The Deficit Reduction Committee failed to propose legislation by December 23, 2011. Therefore, barring action by Congress to the contrary, the reductions and spending cuts dictated by the BCA, which are required to be split equally between defense and non-defense programs, will take effect beginning in January 2013. Although payments to Medicare providers are included in the automatic spending cuts, the BCA provides that Medicare payments may be reduced by no more than 2%. Moreover, the BCA provides that certain other programs, including Medicaid, are exempt from the automatic spending cuts. Although we are unable to determine how the automatic spending cuts required by the BCA will affect Medicare and Medicaid reimbursement in the future, significant reimbursement reductions or other program modifications that result from the BCA could harm our business and results of operations.

Medicare and Medicaid

Overview

Medicare is a federal health insurance program, administered by the U.S. Department of Health and Human Services, or HHS, that currently provides health care benefits to individuals age 65 and over, certain disabled persons and certain other individuals with qualifying conditions. Medicaid is a joint federal-state health care benefit program, operating pursuant to a plan developed and administered by each participating state, subject to broadly defined federal requirements, that provides health care benefits to uninsured individuals who are otherwise unable to afford such services. Our hospitals and other health care facilities derive a substantial portion of their net revenue from the Medicare and Medicaid programs. Both such programs are heavily regulated and subject to frequent changes that typically affect reimbursement payments and beneficiary eligibility.

Medicare

This section should be read in conjunction with the section below entitled "Impact of the Health Care Reform Act on Medicare Reimbursement."

Inpatient Payments. The Medicare program provides payment for inpatient hospital services under a prospective payment system, or PPS. Under the inpatient PPS, hospitals are paid a prospectively determined fixed amount for each hospital discharge. The fixed payment amount per inpatient discharge is established based on each patient's diagnosis related group, or DRG. Each patient admitted for care is assigned to a DRG based on his or her primary admitting diagnosis. Every DRG is assigned a payment rate based on the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. DRG payment rates are based on national average costs from an historic base period and the actual costs incurred by a hospital to provide care are not considered in setting such rates. Although based on national average costs, the DRG standardized amounts and capital payment rates are adjusted by the wage index and geographic adjustment factor for the geographic region in which a particular hospital is located, or reclassified to, and are weighted based on a statistically normal distribution of severity. DRG rates are usually adjusted by an update factor each federal fiscal year, which begins on October 1. The index used as the basis to adjust the DRG rates, known as the "market basket update factor," takes into consideration annual inflation in the purchasing of goods and services experienced by hospitals and other entities. In recent years, the market basket update factor has been lower than the percent increase in costs experienced by hospitals. For federal fiscal years 2011, 2010 and 2009, the market basket update factors were 2.4%, 2.1% and 3.6%, respectively. For federal fiscal year 2012, the market basket update factor is 1.9%, which reflects a 0.1% reduction required by the Health Care Reform Act. Reimbursement rates were increased by another 1.1% for federal fiscal year 2012 to correct a previous misapplication of an urban-rural wage index adjustment that was required by the Balanced Budget Act of 1997 and is referred to as the rural floor budget neutrality adjustment.

The Centers for Medicare & Medicaid Services, or CMS, established Medicare Severity DRGs, or MS-DRGs, which refine the DRG weighting system to more fully capture differences in severity of illness among patients. For example, when MS-DRGs became effective in 2007, 538 DRGs were replaced with 745 MS-DRGs. MS-DRGs are designed to reduce incentives for hospitals to treat only the healthiest and most profitable patients by better taking into account severity of illness in Medicare payment rates. MS-DRGs are also intended to encourage hospitals to improve their coding and documentation of patient diagnoses. To ensure that improvements in coding and documentation do not lead to an increase in aggregate payments without corresponding growth in actual patient severity, CMS uses a negative documentation and coding adjustment. On September 29, 2007, the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007, or the TMA Act, was signed into law, thereby reducing the documentation and coding adjustment for MS-DRGs for

federal fiscal year 2008 by 0.6%. For federal fiscal year 2009, the negative documentation and coding adjustment for MS-DRGs was 0.9%, yielding a cumulative reduction of 1.5% for federal fiscal year 2009. The TMA Act did not address the adjustment CMS proposed for federal fiscal year 2010. For federal fiscal year 2011, the negative documentation and coding adjustment for MS-DRGs was 2.9%. The TMA Act required CMS to conduct a retrospective review of claims data from federal fiscal years 2008 and 2009 to determine if changes in documentation and coding practices resulted in case mix changes that differ from the adjustments made by the TMA Act. Based on the results of the retrospective data review, CMS is directed to revise payments over federal fiscal years 2011 and 2012 to restore budget neutrality. CMS determined that a negative 5.8% adjustment is necessary to recoup overpayments. The negative 2.9% adjustment for federal fiscal year 2011 was one-half of the recoupment amount, with the second half to be recovered during federal fiscal year 2012. While CMS is completing the recoupment process by applying the remaining 2.9% adjustment, it is simultaneously restoring the negative 2.9% adjustment from federal fiscal year 2011 by adding 2.9% back to the federal fiscal year 2012 reimbursement rates. These adjustments will effectively offset each other and there will be no year-over-year change in the standardized amount due to this recoupment adjustment. CMS is also adopting a prospective adjustment of negative 2.0% in federal fiscal year 2012. This adjustment is designed to ensure that increases in hospital payments due to documentation and coding are not incorporated into the payments made in federal fiscal year 2012 and thereafter.

The net effect of the update factors and adjustments described in the preceding paragraph is a 1.0% increase for federal fiscal year 2012.

Outpatient Payments. The majority of hospital outpatient services and certain Medicare Part B services that are furnished to hospital inpatients with no Part A coverage are also paid by Medicare on a PPS basis. However, certain outpatient services, including physical therapy, occupational therapy, speech therapy, durable medical equipment, clinical diagnostic laboratory services and services at freestanding surgical centers and diagnostic facilities, are paid based on fee schedules established by Medicare.

Under the Medicare PPS, services that are clinically related and use similar resources are grouped together into ambulatory payment classifications, or APCs. Depending on the service rendered during an encounter, a patient may be assigned to a single APC or multiple APCs. Medicare pays a set price or rate for each APC, regardless of the actual costs incurred to provide care. Medicare sets the payment rate for each APC based on historical median cost data, subject to geographic modification. The APC payment rates are updated each federal fiscal year based on the market basket. For federal fiscal years 2011, 2010 and 2009, the payment rate update factors were 2.4%, 2.1% and 3.6%, respectively. For federal fiscal year 2012, the payment rate update factor is 1.9%, which reflects a 0.1% reduction required by the Health Care Reform Act.

Outlier Payments. In addition to DRG and capital payments, certain of our hospitals qualify for and receive "outlier" payments from Medicare for certain inpatient hospital services. Outlier payments are estimated by CMS to be approximately 5.1% of total inpatient DRG payments. Outlier payments are made for those inpatient discharges where the total cost of care (as determined by using the gross charges adjusted by the hospital's cost-to-charge ratio) exceeds the total DRG payment plus a fixed threshold amount. In determining the cost-to-charge ratio, Medicare uses the latest of either a hospital's most recently submitted or most recently settled cost report. The threshold amounts used in the outlier computation for federal fiscal years 2011, 2010 and 2009 were $23,075, $23,140 and $20,045, respectively. The amount for federal fiscal year 2012 is $22,385. Excluding our Discontinued Operations, 3.0%, 2.2% and 2.1% of our Medicare inpatient DRG payments were for outlier payments during the years ended December 31, 2011, 2010 and 2009, respectively.

Medicare fiscal intermediaries have been given specific criteria for identifying hospitals that may have received inappropriate outlier payments. The intermediaries are authorized to recover overpayments, including interest, if the actual cost of the DRG stay (which was reflected in the settled cost report) was less than claimed, or if there were indications of abuse. To avoid overpayment or underpayment of outlier cases, hospitals may request changes to their cost-to-charge ratios.

Disproportionate Share Payments. An additional reimbursement payment is made to hospitals that serve a significantly disproportionate share of low income Medicare and Medicaid patients. This additional payment is based on a hospital's DRG payments and is paid according to formulae that take into consideration a hospital's percent of low income patients, status, geographic designation and number of licensed beds. As of December 31, 2011, 42 of our hospitals were located in Florida, Mississippi and Tennessee, states that have a significantly disproportionate share of low income Medicare and Medicaid patients.

Rural Health Clinic Payments. A rural health clinic is an outpatient facility primarily engaged in furnishing physician and other health services in accordance with federal guidelines. To qualify, a clinic must be located in a medically under-served area that is non-urbanized, as defined by the U.S. Census Bureau. Payments to rural health clinics for covered services are made via an all-inclusive per visit rate. As of December 31, 2011, we operated seven rural health clinics in Missouri and two in each of Florida and Tennessee.

Ambulatory Surgical Center Payments. Ambulatory surgical centers are distinct facilities that provide surgical services to patients not requiring hospitalization. Such centers may be licensed by the state in which they operate, depending on individual state requirements. Medicare pays for services provided in ambulatory surgical centers that voluntarily sought and received certification and are approved by CMS. Effective January 1, 2008, CMS instituted a new system for reimbursing ambulatory surgical centers, as was mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or the 2003 Act. The new reimbursement system is based on the outpatient PPS system, taking into account the lower relative costs of procedures performed in an ambulatory surgical center as compared to a hospital outpatient department. As of December 31, 2011, we had a controlling ownership interest in ten ambulatory surgical centers.

Physician Fees. The Medicare physician fee schedule for federal fiscal year 2012 contained a 27.4% reduction to the physician fee schedule. However, on February 22, 2012, President Obama signed legislation deferring such reduction to December 31, 2012. Without further legislative action, CMS will be required by Medicare to implement the physician payment reduction on January 1, 2013. As of December 31, 2011, we employed approximately 900 physicians.

Reimbursement for Bad Debts. Medicare reimburses hospitals and other health care providers for certain allowable costs that are attributable to uncollectible Medicare beneficiary deductible and coinsurance amounts. Hospitals generally receive an interim pass-through payment for bad debts in an amount determined by the Medicare fiscal intermediary, based on the prior period's bad debt amounts as reported in the hospital's cost report. To be an allowable bad debt, the underlying accounts receivable must be related to a covered service and derived from a deductible and/or coinsurance amount. Additionally, the following conditions must be met: (i) a hospital must be able to establish that reasonable collection efforts were undertaken prior to classification as a bad debt; (ii) the debt was actually uncollectible when classified as worthless; and (iii) sound business judgment established that there was no likelihood of recovery of the debt at any time in the future. In determining reasonable cost subject to reimbursement, the amount of bad debts otherwise treatable as allowable is reduced 30% by Medicare. Amounts received by a hospital as reimbursement for bad debts are subject to audit and recoupment by the fiscal intermediary. Bad debt reimbursement has been a focus of fiscal intermediary audit/recoupment efforts in the past. As part of the payroll tax cut extension that was signed into law on February 22, 2012, allowable bad debt expense will be reduced by 35% for Medicare reimbursement purposes beginning in federal fiscal year 2013.

General Legislative Changes. Prior to the passage of the Health Care Reform Act, legislative changes to the Medicare program were historically focused on limiting growth rates for reimbursement and, in some cases, reducing levels of reimbursement for the types of health care services that we provide. For example, the Balanced Budget Act of 1997 included significant reductions in spending levels for the Medicare and Medicaid programs. The Balanced Budget Refinement Act of 1999 mitigated some of the adverse effects of the Balanced Budget Act of 1997 through a "corridor reimbursement approach," whereby a percent of losses under the Medicare outpatient PPS were reimbursed through 2003. The 2003 Act provided an extension, until January 1, 2006, of certain provisions of the Balanced Budget Refinement Act of 1999 for small rural and sole community hospitals. Some of our hospitals qualified for relief under this provision.

The Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement Act of 2000, or BIPA, made a number of changes to the Medicare and Medicaid programs that affected payments to hospitals. All of our hospitals qualify for some relief under BIPA. Some of the changes made by BIPA that affect our hospitals include: (i) lowering the threshold by which hospitals qualify as rural or small urban disproportionate share hospitals; (ii) decreasing reductions in payments to disproportionate share hospitals that had been mandated by the Balanced Budget Act of 1997 and other Congressional enactments; (iii) capping Medicare beneficiary ambulatory service co-payment amounts; and (iv) increasing the categories and items eligible for increased reimbursement to hospitals for certain outpatient services rendered, such as certain cancer therapy drugs, biologicals and other medical devices.

The 2003 Act made a number of significant changes to the Medicare program. In addition to a prescription drug benefit program that was intended to provide direct relief to Medicare beneficiaries, the 2003 Act also provided a number of benefits to hospitals, including, but not limited to:

- a permanent increase in the base payment rate for rural and small urban hospitals of 1.6%, up to the large urban payment rate;

- the cap on disproportionate share payments for rural and small urban hospitals was set at 12.0% of total inpatient payments; and
- establishment of a physician incentive program for primary care and certain specialty physicians who provide services to individuals in areas having the fewest physicians available to serve, among others, Medicare beneficiaries.

Under the 2003 Act, Medicare payment considerations have been tied to hospital performance and hospital reporting of quality data and measures. Beginning with federal fiscal year 2009, hospitals have been required to report on 30 quality indicators to qualify for their full market basket update. Those hospitals that did not provide the required information have had their market basket update reduced by 2.0%. Our hospitals participated in the quality data reporting, which we believe will form the basis for future payments. We anticipate that more quality data reporting will be required in the future as government payors continue their analysis and possible movement toward a "pay for performance" model and/or value-purchasing programs.

Impact of the Health Care Reform Act on Medicare Reimbursement

Inpatient Reimbursement. The Health Care Reform Act provides for annual decreases to the market basket update factors, including a 0.25% reduction for discharges that occurred on or after April 1, 2010. The Health Care Reform Act also provides for reductions to the market basket update factors for federal fiscal years 2011 through 2019 of 0.25% (2011), 0.1% (2012-13), 0.3% (2014), 0.2% (2015-16) and 0.75% (2017-19). For federal fiscal year 2012 and each subsequent federal fiscal year, the Health Care Reform Act provides for the annual market basket update factors to be further reduced by a productivity adjustment. The amount of that reduction will be based on the projected nationwide productivity gains over the ten years preceding the implementation of the Health Care Reform Act, as measured by the U.S. Bureau of Labor Statistics (which typically uses data that is a few years old). The federal fiscal year 2012 market basket update factor reduction resulting from this productivity adjustment is 1.0%. CMS estimates that the combined market basket update factor and productivity adjustments will increase payments to general acute care hospitals by approximately $1.13 billion during federal fiscal year 2012, as compared to federal fiscal year 2011, but will also reduce Medicare payments under the inpatient PPS by $112.6 billion for the federal fiscal years from 2010 to 2019. Decreases in reimbursement rates or increases in such rates below our cost increases would adversely affect our business and results of operations.

The Health Care Reform Act also provides for reduced payments to hospitals based on readmission rates. Beginning in federal fiscal year 2013, inpatient payments will be reduced if a hospital experiences "excessive" readmissions within a period of 30 days from a patient's discharge due to heart attack, heart failure, pneumonia or other conditions designated by HHS. The reduced payments are applicable to all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Moreover, each hospital's performance will be publicly reported by HHS. HHS has the discretion to determine what constitutes "excessive" readmissions, the amount of the payment reduction and other elements of this program.

Under the Health Care Reform Act, reimbursement will also be reduced based on "hospital acquired condition," or HAC, rates. An HAC is a condition that a patient develops while admitted as an inpatient in a hospital, such as a surgical site infection. Beginning in federal fiscal year 2015, hospitals that nationally rank in the top 25% of HACs for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Moreover, effective July 1, 2011, the Health Care Reform Act prohibited the use of federal funds under the Medicaid program to reimburse providers for medical services provided to treat HACs.

Outpatient Reimbursement. The Health Care Reform Act provides for reductions to the market basket update factor for outpatient hospital payments for calendar years 2011 through 2019 of 0.25% (2011), 0.1% (2012-13), 0.3% (2014), 0.2% (2015-16) and 0.75% (2017-19). For calendar year 2012 and each subsequent calendar year, the Health Care Reform Act provides for the annual market basket update factor to be further reduced by a productivity adjustment. The amount of that reduction will be based on the projected nationwide productivity gains over the preceding ten years.

Disproportionate Share Payments. Under the Health Care Reform Act, beginning in federal fiscal year 2014, Medicare disproportionate share payments will be reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid as Medicare disproportionate share payments will be pooled, and this pool will be further reduced each year by a formula that reflects reductions in the level of uninsured individuals who are under 65 years of age. Under this provision, the greater the level of coverage for the uninsured, the more the Medicare disproportionate share payment pool will be reduced. Each eligible hospital will ultimately be paid an allocated amount from the pool based on its level of uncompensated care.

Ambulatory Surgical Center Payments. Beginning in federal fiscal year 2011, the Health Care Reform Act reduced reimbursement for ambulatory surgical centers through a productivity adjustment to the market basket update factor similar to the productivity adjustment for inpatient and outpatient hospital services.

Value-Based Purchasing. The Health Care Reform Act establishes a value-based purchasing program to further link reimbursement payments to quality and efficiency. Beginning with federal fiscal year 2013, HHS will implement a value-based purchasing program that will reduce inpatient PPS payment amounts for all discharges by federal fiscal year as follows: 1.0% for 2013; 1.25% for 2014; 1.5% for 2015; 1.75% for 2016; and 2.0% for 2017 and subsequent years. For each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to hospitals that meet certain quality performance standards. HHS will have the authority to determine the quality performance measures, the quality performance standards hospitals must achieve to meet the quality performance measures and the methodology for calculating payments to hospitals that meet the required quality threshold. HHS will also determine the amount each eligible hospital will receive from the pool created by the reductions under the value-based purchasing program.

Bundled Payment Pilot Programs. The Health Care Reform Act requires HHS to establish a five-year, voluntary national bundled payment program for Medicare services beginning no later than January 1, 2013. Under the program, providers would agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. HHS will have discretion to determine how the program will function, including a determination of the medical conditions that will be covered by the program and the reimbursement amount for each condition.

Electronic Health Records. The Health Care Reform Act provided for Medicare and Medicaid incentive payments beginning in federal fiscal year 2011 for eligible hospitals and calendar year 2011 for eligible professionals that have adopted and meaningfully use certified electronic health record, or EHR, technology. A total of at least $20 billion in incentives is being made available through the Medicare and Medicaid EHR incentive programs to eligible hospitals and eligible professionals. Through November 2011, CMS reports that it had paid nearly $2 billion in combined meaningful use incentive payments for Medicare and Medicaid.

Under the Medicare incentive program, general acute care hospitals that demonstrate meaningful use of EHR technology in each year of participation will receive incentive payments for up to four fiscal years. To maximize their incentive payments, hospitals must participate in the incentive program by federal fiscal year 2013. Beginning in federal fiscal year 2015, hospitals that fail to demonstrate meaningful use of certified EHR technology will receive reduced market basket updates under inpatient PPS.

Eligible professionals who demonstrate meaningful use of EHR technology in each year of participation are entitled to incentive payments for up to five payment years in an amount equal to 75% of their estimated Medicare allowed charges for covered professional services furnished during the relevant calendar year, subject to an annual limit. Eligible professionals must participate in the incentive payment program by calendar year 2012 to maximize their incentive payments and must participate by calendar year 2014 to receive any incentive payments. Beginning in calendar year 2015, eligible professionals who do not demonstrate meaningful use of certified EHR technology will face Medicare payment reductions.

States may voluntarily implement a Medicaid EHR incentive program. For participating states, the Medicaid EHR incentive program will provide incentive payments to (i) general acute care hospitals and eligible professionals that meet certain volume percentages of Medicaid patients and (ii) children's hospitals. Eligible professionals can only participate in either the Medicaid EHR incentive program or the Medicare EHR incentive program and can change this election only one time. Hospitals may participate in both the Medicare and Medicaid EHR incentive programs.

To qualify for incentive payments under the Medicaid program, providers must adopt, implement, upgrade or demonstrate meaningful use of, certified EHR technology during their first participation year or successfully demonstrate meaningful use of certified EHR technology in subsequent participation years. Payments may be received for up to six participation years. There is no penalty for hospitals or professionals under Medicaid for failing to meet EHR meaningful use requirements.

Medicaid

This section should be read in conjunction with the section below entitled "Impact of the Health Care Reform Act on Medicaid Reimbursement."

Each state is responsible for administering its own Medicaid program, payment rates and methodologies, as well as covered services, all of which vary from state to state. Although the actual rates vary by state, between 50% and 73% of Medicaid funding comes from the federal government, with the balance shared by state and local

governments. The most common payment methodologies include prospective payment systems and programs that negotiate payment rates with individual hospitals. Generally, Medicaid payments are less than Medicare payments and are often less than a hospital's patient care costs. Hospitals that have an unusually large number of low-income patients (i.e., those with a Medicaid utilization rate of at least one standard deviation above the mean Medicaid utilization, or have a low income patient utilization rate exceeding 25%) are eligible to receive a disproportionate share adjustment. However, Congress has established a national limit on disproportionate share hospital adjustments.

In light of continued economic uncertainty, projected increases to Medicaid program costs and burgeoning budget deficits, the federal government and many states are currently considering ways to limit increases and/or cut Medicaid funding, which could adversely affect future Medicaid payments that we receive. The American Recovery and Reinvestment Act of 2009, or the Economic Stimulus Bill, was signed into law in 2009 and, among other things, allocated supplemental federal funding to each state that could be used to benefit individual state Medicaid programs. Although some states used portions of these funds to support their Medicaid programs in 2011 and 2010, we cannot predict whether Congress will reallocate funds for 2012 and beyond. Additionally, the federal government has taken steps to address some of the insurance coverage challenges facing citizens by enacting the Children's Health Insurance Program Reauthorization Act of 2009, which expanded and extended the benefits available under BIPA, and extending the period of benefit coverage under the Consolidated Omnibus Budget Reconciliation Act, or COBRA, to unemployed individuals through the Economic Stimulus Bill.

We cannot predict what further action the federal government or the states may take under existing and future legislation to close budget gaps or reduce deficit spending.

Impact of the Health Care Reform Act on Medicaid Reimbursement

Medicaid Coverage. The Health Care Reform Act requires that by 2014 states expand Medicaid coverage to all individuals under age 65 with incomes up to 138% (after giving effect to a 5% "income disregard" provision) of the federal poverty level. The Health Care Reform Act requires states to, at a minimum, maintain Medicaid eligibility standards established prior to the enactment of the Health Care Reform Act for adults until January 1, 2014 and for children until October 1, 2019. However, states with budget deficits may seek exemptions from this requirement to address eligibility standards that apply to adults making more than 133% of the federal poverty level.

Disproportionate Share Payments. The Health Care Reform Act reduces funding for the Medicaid disproportionate share payment program for hospitals in federal fiscal years 2014 through 2020. How such cuts are allocated among the states and how the states allocate these cuts among providers have yet to be determined. Additionally, as part of the payroll tax cut extension that was signed into law on February 22, 2012, Medicaid disproportionate share payments will be reduced beginning in federal fiscal year 2021.

Bundled Payment Pilot Programs. The Health Care Reform Act provides for a five-year bundled payment pilot program for Medicaid services. HHS may select up to eight states to participate based on the potential to lower costs under the Medicaid program while improving care. As of December 31, 2011, two states are participating and at least two more states are pursuing legislation to allow their participation in the pilot program. State programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes. The bundled payments may implicate existing laws, including the Anti-Kickback Statute, as defined below under "Fraud and Abuse Provisions," and the Health Insurance Portability and Accountability Act of 1996, or HIPAA, privacy, security and transaction standard requirements. However, the Health Care Reform Act does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in the pilot programs, such as antitrust laws.

Medicare and Medicaid Regulatory and Audit Impacts

In addition to legislative changes, such as those brought about by the Health Care Reform Act, Medicare and each of the state Medicaid programs are subject to regulatory changes, administrative rulings, interpretations and determinations, post-payment audits, requirements for utilization review and new government funding restrictions, all of which could materially increase or decrease payments we receive, impact our cost of patient care and affect the timing of payments. The final determination of amounts we receive under the Medicare and Medicaid programs often takes many years to resolve because of audits by the programs' representatives, providers' rights of appeal and the application of numerous technical reimbursement provisions. We believe that we have made adequate provisions for such potential adjustments. Nevertheless, until final adjustments are made, certain issues remain unresolved and our established allowances may be higher or lower than what is ultimately required.

The Medicare program utilizes a system of contracted carriers and fiscal intermediaries across the country to process claims and conduct post-payment audits. CMS is in the midst of an initiative to reform the carrier and fiscal intermediary functions. As part of such reform, CMS has and will continue to competitively bid the carrier and fiscal intermediary functions to Medicare Administrative Contractors, or MACs. At the present time, CMS has awarded all fifteen of the planned multi-state jurisdiction MAC contracts. Hospital operators have the option to either (i) have each of their hospitals work with the MAC in the jurisdiction where the individual hospital is located or (ii) use the MAC in the jurisdiction where their home office is located for all of their affiliated hospitals. Every year, each MAC is required to complete an Error Rate Reduction Program that includes initiatives to reduce and recover improper payments and may include more robust pre-payment and post-payment reviews for particular claim types. CMS also uses Zone Program Integrity Contractors to identify potential problem areas in coordination with their internal and external partners. The completed and future changes by CMS could affect claims processing, auditing and cash flow to Medicare providers. We cannot predict what, if any, impact such changes will ultimately have on our business.

The Health Care Reform Act increased federal funding for Medicaid Integrity Contractors, or MICs. MICs are private contractors that perform post-payment audits of Medicaid claims to identify overpayments. Through the Deficit Reduction Act of 2005, Congress expanded the federal government's involvement in fighting fraud, waste and abuse in the Medicaid program. MICs are currently assigned to five geographic regions and have commenced audits in several of the states assigned to those regions.

The Health Care Reform Act contains provisions relating to recovery audit contractors, or RACs, which are third party organizations under contract with CMS that identify underpayments and overpayments under the Medicare program and recoup overpayments on behalf of the government. The Health Care Reform Act expanded the RAC program's scope to include Medicaid claims and required all states to enter into contracts with RACs by December 31, 2010. If a state was unable to implement a RAC program by the implementation date of January 1, 2012, then the state was required to request an exception by submitting to CMS a revised State Plan Amendment, or SPA, through the normal SPA process. States have considerable flexibility regarding the design, procurement and operation of their individual RAC programs. RACs are paid a contingency fee based on the overpayments they identify and collect. We expect that RACs will look very closely at claims submitted by hospital operators in an attempt to identify possible overpayments.

Commercial Insurance and Other

In recent years, a number of commercial insurers have undertaken efforts to limit the costs of hospital services by adopting prospective payment or DRG-based systems. To the extent that such efforts are successful and those insurers fail to reimburse hospitals for the costs of providing services to their beneficiaries, such efforts may have a negative impact on our business and results of operations.

We also provide services to individuals covered by private health insurance plans. Private insurance carriers typically reimburse a provider after the claim is filed; however, reimbursement can be sent directly to the patient based on the underlying insurance policy's stipulations. Reimbursement from private insurance carriers is often based on rates such as prospective payment systems, per diems or other discounted fee schedules. Private insurance reimbursement varies among payors and states and is generally based on contracts negotiated between the provider and the payor.

Additionally, we provide health care services to individuals covered under workers' compensation programs, TRICARE/CHAMPUS (for retired military personnel) and other private and government programs. Those programs pay under prospective payment systems, per-diem systems or other discounted fee systems.

Beginning in 2014, the Health Care Reform Act requires individuals to obtain, and employers to provide, health insurance coverage. Additionally, the law requires states to establish health insurance exchanges. The Health Care Reform Act also establishes a number of health insurance market reforms, including bans on lifetime limits and pre-existing condition exclusions, new benefit mandates and increased dependent coverage. By way of example, group health plans and health insurance issuers offering group or individual coverage:

- may not establish lifetime limits or, beginning in 2014, annual limits on the dollar value of benefits;
- may not rescind coverage of an enrollee, except in instances where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact;
- must reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place; and
- effective for health plan policy years that began on or after September 23, 2010 (for plans that offer dependent coverage), must continue to make dependent coverage available to unmarried dependents until age 26 (coverage for the dependents of unmarried adult children is not required).

We do not yet know what impact the abovementioned increased obligations on managed care payors and other payors will have on our ability to negotiate contracts with such payors.

Self-Pay

We provide services to individuals who have no form of health care insurance. These are the types of individuals for whom the Health Care Reform Act is intended to provide insurance coverage. Presently, these patients are evaluated at the time of service or shortly thereafter for their ability to pay based on federal and state poverty guidelines and/or qualifications for Medicaid or other state assistance programs, as well as our company-wide charity and indigent care policy. Gross charges to uninsured patients for non-elective procedures are discounted by 60% or more. Local hospital personnel and our collection agencies pursue payments on accounts receivable from self-pay patients who do not meet our charity and indigent care criteria.

A significant portion of our self-pay patients are admitted through, or treated in, our hospitals' emergency departments and often require high-acuity treatment. The Emergency Medical Treatment and Active Labor Act, or EMTALA, requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to a hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. We believe that self-pay patient volume has been impacted during the last several years by a combination of broad economic factors, including high levels of unemployment and reductions in state Medicaid budgets, an increasing number of individuals and employers that choose not to purchase insurance and an increased co-payment and deductible burden that is borne by patients rather than insurers and/or employers.

The Health Care Reform Act requires health plans to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place. The Health Care Reform Act also contains provisions that seek to decrease the number of uninsured individuals, including requirements that individuals obtain, and employers provide, health insurance coverage beginning in 2014. However, many factors are unknown regarding the impact of the Health Care Reform Act, including, among other things, how many previously uninsured individuals will take the steps necessary to obtain insurance coverage as a result of the new law. It is also unknown what change, if any, we will see in the volume of inpatient and outpatient services that are sought by and provided to previously uninsured individuals once they obtain insurance coverage. Moreover, it is difficult to predict the full impact of the Health Care Reform Act due to the law's complexity, lack of implementing regulations or interpretive guidance, gradual implementation, possible Congressional repeal or amendment and court challenges.

Certain Other Aspects of the Health Care Reform Act

Whole Hospital Exception. The Health Care Reform Act makes changes to the "whole hospital" exception under Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law"). Those changes effectively prohibit new physician-owned hospitals under the whole hospital exception and limit capacity expansion and the level of physician ownership at grandfathered physician-owned hospitals. As revised, the Stark law prohibits physicians from referring Medicare patients to a hospital in which they have an ownership or investment interest unless the hospital had physician ownership and a Medicare provider agreement in effect as of March 23, 2010 (or, for those hospitals under development, as of December 31, 2010). A physician-owned hospital that meets these requirements will still be subject to restrictions that limit the hospital's aggregate physician ownership percentage and, with certain narrow exceptions for high Medicaid utilization hospitals, prohibit expansion of the number of operating rooms, procedure rooms and licensed beds. The Health Care Reform Act also subjects physician-owned hospitals to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements. At December 31, 2011, we had joint ventures with physicians at 24 of our hospitals under the whole hospital exception of the Stark law and there were Medicare provider agreements in effect at all such hospitals. Those grandfathered joint venture hospitals are now subject to the physician ownership and expansion restrictions contained in the Health Care Reform Act.

Accountable Care Organizations and Pilot Projects. The Health Care Reform Act required HHS to establish a Medicare shared savings program that promotes accountability and coordination of care through the creation of Accountable Care Organizations, or ACOs. The shared savings program is intended to allow providers (including hospitals), physicians and other designated health care professionals and suppliers to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the Medicare program's cost savings.

During October 2011, CMS released its final rules on ACOs, ostensibly making it easier for hospitals and physicians to participate in the program. In response to objections raised by the health care industry after release of proposed rules on March 31, 2011, CMS made several concessions in its final rules, including: (i) providers will be allowed to participate in an ACO and share in the cost savings with Medicare without the risk of losing money; (ii) ACOs will be able to start sharing in any cost savings earlier in the process, rather than having Medicare initially retain all such cost savings; (iii) the number of quality measures that ACOs will have to meet to qualify for performance bonuses was reduced from 65 to 33; (iv) at their formation, ACOs will be notified as to which Medicare beneficiaries are likely to be part of their system (under the proposed rules, ACOs would not know which patients were in the ACO until the end of each contract year); (v) community health centers and rural health clinics will be allowed to lead ACOs; and (vi) the timetable for the formation of an ACO was modified, with groups allowed to apply for start dates of January 1, 2012, April 1, 2012, July 1, 2012 or January 1, 2013. To entice providers to form ACOs, CMS stated that it will give physician-owned and rural providers early access to some of the expected savings, specifically $170 million, so that they can have money available upfront to defray ACO start-up costs, including the development and implementation of electronic health records.

Fraud and Abuse Provisions. Medicare and Medicaid anti-kickback and anti-fraud and abuse laws, referred to as the Anti-Kickback Statute, prohibit certain business practices and relationships that might affect the provision and cost of health care services under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. The Health Care Reform Act provides that knowledge of the law or the intent to violate the law is not required and also provides that submission of a claim for services or items generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act of 1863. Sanctions for violating the Anti-Kickback Statute include criminal and civil penalties, as well as fines and possible exclusion from government programs, such as Medicare and Medicaid.

Miscellaneous. The Health Care Reform Act contains numerous other provisions that could affect our business and results of operations, including provisions relating to:

- the establishment of a Center for Medicare and Medicaid Innovation within CMS, which will have the authority to develop and test new reimbursement methodologies designed to improve the quality of patient care and lower costs;
- the creation of an Independent Payment Advisory Board that will make recommendations to Congress regarding additional changes to provider reimbursement methodologies and other aspects of the nation's health care system; and
- new taxes on manufacturers and distributors of pharmaceuticals and medical devices, as well as a requirement that manufacturers file annual reports of payments made to physicians.

Utilization Review

In accordance with the requirements of CMS' Services Conditions of Participation, hospital services provided to Medicare and Medicaid beneficiaries are evaluated to ensure that the care meets professionally recognized standards of practice and are medically necessary. Our hospitals are required to conduct utilization review activities, including medical necessity reviews (admission, continued stay and retrospective), discharge planning and quality improvement initiatives to address identified trends, extended lengths of stay and high cost cases. Additionally, many managed care organizations require utilization reviews.

Compliance Program

Our company-wide compliance program, which was first adopted in 1997, has been designed, implemented and maintained to deter, detect and prevent fraud, abuse and mistakes. We believe that our compliance program meets the standards of an effective compliance program as set forth in the compliance guidance for hospitals issued by the Office of the Inspector General of HHS, the standards of an effective compliance program as set forth in the U.S. Sentencing Commission Guidelines and the provisions of the Health Insurance Portability and Accountability Act, commonly referred to as HIPAA. We regularly review our compliance program and make changes from time to time and we continue to do so.

Our compliance program consists of an infrastructure that begins at the Board of Directors and executive management levels and runs through our centralized Compliance Office to all home office, divisional and facility operations. Our compliance program includes written guidance such as a Compliance Manual, a Code of Business Conduct and Ethics, and Compliance Policies and Procedures. Among other things, the Compliance Office has developed processes for: (i) the development and delivery of compliance training; (ii) anonymous and confidential reporting; (iii) investigating reported and suspected wrongdoing; (iv) assisting with the development and implementation of corrective actions; and (v) monitoring and auditing of compliance in high risk areas. When they

are initially hired and at least annually thereafter, all of our employees receive compliance training relating to these processes as well as our Compliance Manual, Code of Business Conduct and Ethics, and Compliance Policies and Procedures.

Day-to-day leadership of our compliance program is provided by our Vice President of Compliance who reports to our President and Chief Executive Officer and also reports, at least quarterly, to our Corporate Compliance Committee and our Board of Directors through the Audit Committee. At the operational level, each hospital has a designated and trained hospital compliance officer who reports on compliance matters to a divisional compliance officer, who ultimately reports to our Vice President of Compliance.

Employees and Medical Staff

As of December 31, 2011, we had approximately 40,600 employees, including 8,600 part-time employees. At such date, 1,224 of our employees were covered by collective bargaining agreements. We believe that our employee relations are satisfactory.

Physicians on the medical staffs of our hospitals are, in most cases, not our employees. Such non-employee physicians may also be staff members of other hospitals. As of December 31, 2011, we employed approximately 900 physicians, about half of whom are primary care physicians at practices we own and operate. Additionally, our hospitals provide emergency room, radiology, pathology and anesthesiology services through service contracts with physician groups that are generally cancelable with 90 days advance notice.

Professional Liability and Other Risks

As is typical in the health care industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. We use our wholly owned captive insurance subsidiary and our risk retention group subsidiary, which are domiciled in the Cayman Islands and South Carolina, respectively, to self-insure a significant portion of our professional liability risks. Those subsidiaries provide (i) claims-made insurance coverage to all of our hospitals and other health care facilities and (ii) occurrence-basis coverage to most of our employed physicians. The employed physicians not covered by our insurance company subsidiaries generally maintain claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the self-insured program covering the hospitals and other health care facilities, our insurance company subsidiaries buy claims-made reinsurance policies from unrelated third parties for claims above certain self-retention levels.

We also maintain directors' and officers', property and other typical insurance policies with commercial carriers, subject to self-insurance retention levels. We believe that our insurance is adequate in amount and coverage. However, in the future, insurance may not be available at reasonable prices or we may have to increase our self-insurance retention levels.

Environmental Regulation

We are subject to compliance with various federal, state and local environmental laws, rules and regulations, including, but not limited to, the disposal of medical waste generated by our hospitals and other health care facilities. Our environmental compliance costs are not significant and we do not anticipate that they will be significant in the future.

Seasonality

We typically experience higher patient volume and net revenue in the first and fourth quarters of each calendar year because, generally, more people become ill during the winter months, which in turn increases the number of patients that we treat during those months.

Available Information

We are subject to the informational requirements of the Securities Exchange Act of 1934. Therefore, we file periodic reports, proxy statements and other information with the Securities and Exchange Commission (the "SEC"). Such reports may be read and copied at the SEC's Public Reference Room at 100 F Street NE, Washington, D.C. 20549. Information regarding the operation of the Public Reference Room may be obtained by calling the SEC at (800) SEC-0330. The SEC also maintains a website (www.sec.gov) that includes our reports, proxy statements and other information.

We maintain a website at www.hma.com where we make available, free of charge, documents that we file with, or furnish to, the SEC, including our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, proxy statements and any amendments to those reports. We make this information available as soon as reasonably practicable after we electronically file such materials with, or furnish such information to, the SEC. Our SEC reports can be found under "Investor Relations" on our website. The other information found on our website is not part of this or any other report we file with, or furnish to, the SEC.

Item 1A. Risk Factors.

Our business and operations are subject to numerous risks, many of which are described below and elsewhere in this Annual Report on Form 10-K, including those under "Business" in Item 1 and "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 of Part II. The risks described therein and elsewhere in this report are incorporated into this Item 1A by reference.

If any of the events described below occur, our business and results of operations could be harmed. Additional risks and uncertainties that are not presently known to us, or which we currently deem to be immaterial, could also harm our business and results of operations.

We are subject to extensive government regulation regarding the conduct of our operations. If we fail to comply with any existing or new laws or regulations, we could suffer administrative, civil or criminal penalties or be required to make significant changes to our operations.

Companies such as ours that provide health care services are required to comply with many highly complex laws and regulations at the federal, state and local levels, including, but not limited to, those relating to the adequacy of medical care, billing for services, patient privacy, equipment, personnel, operating policies and procedures and maintenance of records. Our policy is to comply with all applicable laws and regulations; however, if we fail to comply with any such laws or regulations, we could become subject to civil and criminal penalties, including the loss of licenses to operate our facilities. We could also be excluded from participating in Medicare, Medicaid and other federal and state health care programs that contribute significantly to our revenue.

Many of the laws and regulations that govern our operations are highly complex and, in certain cases, we do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations or enforcement of such laws and regulations, as well as modifications thereof, could require us to make changes in our facilities, equipment, personnel, services or capital expenditure programs. Any such changes could harm our business and results of operations.

We are unable to predict the impact that the Health Care Reform Act, which will significantly change the health care industry, will have on our business and results of operations.

The Health Care Reform Act will dramatically change how health care services are covered, delivered and reimbursed through, among other things: a requirement that most Americans obtain health insurance; expanded Medicaid eligibility and coverage for uninsured individuals; reduced growth in Medicare program spending; reductions in Medicare and Medicaid payments; the establishment of value-based purchasing programs where reimbursement is tied to quality; and the elimination of the ability of health care providers like us to enter into new partnerships with physicians in the ownership of certain health care facilities. Additionally, the Health Care Reform Act contains provisions designed to strengthen fraud and abuse enforcement, modifies the health insurance industry and expands existing efforts to tie Medicare and Medicaid reimbursement to performance and quality.

We believe that the expansion of health insurance coverage under the Health Care Reform Act could increase the number of patients using our facilities who have either private or public program health care coverage. As a result of the increased income eligibility limits under the law, we believe that a large percentage of the new Medicaid coverage will be in states that currently have relatively low income eligibility requirements. Three such states are Florida, Mississippi and Tennessee where we operated 42 hospitals as of December 31, 2011. It is difficult to predict the impact of changes resulting from the Health Care Reform Act on us because of numerous issues surrounding the implementation of such law, including, but not limited to, uncertainty regarding:

- the possibility that portions of the Health Care Reform Act, such as those expanding health insurance or Medicaid coverage, will be delayed or blocked due to court challenges, or revised or repealed as a result of legislative action, including an appeal currently pending before the United States Supreme Court that will determine the constitutionality of the Health Care Reform Act (a ruling is expected by July 2012);
- how many previously uninsured individuals will obtain coverage;
- what percent of newly insured patients will be covered under Medicaid or private health insurance programs;
- the pace at which health care insurance coverage expands;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- changes in rates paid to hospitals by private payors;
- changes in rates paid by state governments under the Medicaid program;
- the ability of states to fund their portion of Medicaid payments;
- the extent to which states will enroll new Medicaid participants in managed care programs;

- how the performance and quality programs mandated by the Health Care Reform Act will be implemented; and
- whether the Health Care Reform Act will ultimately cause health insurers to seek to reduce reimbursement payments.

The Health Care Reform Act also provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid payments and the establishment of value-based purchasing programs. It is possible that these changes could more than offset other favorable effects from the Health Care Reform Act. It is difficult to predict the impact of the potentially adverse changes on us because of a number of factors, including, but not limited to, uncertainty regarding:

- whether reductions required by the Health Care Reform Act will be modified prior to becoming effective;
- the revenue we will generate from Medicare and Medicaid business when the various reductions and adjustments planned under the Health Care Reform Act are implemented;
- whether the Health Care Reform Act's performance and quality initiatives will have a negative impact on our business;
- how successful "Accountable Care Organizations" in which we may participate will be at coordinating care and reducing costs;
- changes to revenue as a result of value-based purchasing;
- changes to revenue as a result of bundled payment programs;
- the scope and nature of potential changes to Medicare reimbursement methods; and
- reductions in payments we might receive from Medicare for "excessive readmissions" or "hospital acquired conditions."

As summarized above and elsewhere in these risk factors, we cannot predict the full impact of the Health Care Reform Act on our business or results of operations because of, among other things: (i) the law's complexity; (ii) the lack of implementing regulations and/or interpretive guidance; (iii) the timing of the law's implementation (and possible delays in such implementation); (iv) pending and future legal challenges that seek to delay or block certain of the law's provisions; and (v) possible legislative amendment or repeal of the law. Additionally, we cannot predict how individuals and businesses will respond to the new mandates and alternatives established under the Health Care Reform Act.

We are subject to "anti-kickback" and "self-referral" laws and regulations that provide for criminal and civil penalties if they are violated.

The health care industry is subject to many laws and regulations that are designed to deter and prevent practices deemed by the government to be fraudulent, abusive or otherwise contrary to government policies. Unless a safe harbor applies, federal and state anti-kickback laws prohibit giving or receiving any consideration in return for physician referrals. Similarly, unless an exception applies, Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law") prohibits physicians from referring Medicare and Medicaid patients to providers of enumerated "designated health services" with whom the physician or a member of the physician's immediate family has an ownership interest or compensation arrangement. Such referrals are deemed to be "self-referrals" due to the physician's financial relationship with the entity providing the designated health services. Moreover, many states have adopted or are considering similar legislative proposals, some of which extend beyond the scope of the Stark law to prohibit the payment or receipt of remuneration for the prohibited referral of patients for designated health care services and physician self-referrals, regardless of the source of payment for the patient's care. The Health Care Reform Act provides that submission of a claim for services generated or items provided in violation of the Stark law constitutes a false or fraudulent claim that may be subject to additional penalties under the federal False Claims Act of 1863, referred to as the False Claims Act.

The Health Care Reform Act provides greater resources to enforce the Stark law, including supplemental federal funding of $350 million over ten years to fight health care fraud, waste and abuse. The Health Care Reform Act also changes the intent requirement for health care fraud such that a person need not have actual knowledge or specific intent to commit a violation of the law. This change in the intent requirement will likely make it easier for fraud claims to be brought against a health care provider.

We systematically review our operations on a regular basis to monitor compliance with anti-kickback laws, the Stark law and similar state statutes. When evaluating collaborative relationships with physicians, we consider the scope and effect of these statutes and seek to structure the arrangements in full compliance with their provisions. We also maintain a company-wide compliance program to monitor and promote our continued compliance with these and other statutory prohibitions and requirements. Nevertheless, if it is determined that any of our practices or operations violate the anti-kickback laws, the Stark law or similar state statutes, we could become subject to civil

and criminal penalties, including exclusion from Medicare, Medicaid and other federal and state health care programs that contribute significantly to our revenue. The imposition of penalties for alleged or actual violations of the anti-kickback laws, the Stark law and/or similar state statutes, our inability to comply with changes in such laws and/or significant compliance costs associated with any modified laws and regulations could each harm our business.

Additionally, the anti-kickback laws, the Stark law and similar state statutes are subject to change and interpretations and we may not be able to comply with the modified laws and regulations. Moreover, our continued compliance with any such modified laws and regulations could require us to devote extensive resources, financial and otherwise, to achieving and maintaining compliance.

Providers in the hospital industry have been the subject of federal and state investigations and we could become subject to such investigations or whistleblower lawsuits in the future.

Historically, significant media and public attention has been focused on the hospital industry due to investigations related to referrals, cost reporting and billing practices, laboratory and home health care services and physician ownership of joint ventures involving hospitals. Federal and state government agencies have heightened and coordinated their civil and criminal enforcement efforts. Additionally, the Office of the Inspector General of HHS ("HHS-OIG") and the U.S. Department of Justice have, from time to time, established enforcement initiatives that focus on specific areas of suspected fraud and abuse. Recent and recently announced initiatives have focused on hospital billing practices (e.g., kyphoplasty, implantable cardioverter defibrillators, or ICDs, etc.), health care provider bad debts, disproportionate share payments, reliability of hospital-reported quality measure data, compliance with the Emergency Medical Treatment and Active Labor Act of 1986, MS-DRG coding and serious medical errors.

In March 2005, CMS began implementing a pilot recovery audit contractor program, known as RAC, which covered health care providers in certain states. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and expanded it to all fifty states. Among other things, RAC auditors, who are independent contractors, focus on the clinical documentation supporting billings under the Medicare program. If an auditor concludes that such documentation does not support the provider's Medicare billings, CMS will revise the amount due to the provider, compare such amount to what was previously paid and withhold the difference from a current remittance. The affected facility can appeal the auditor's findings through an administrative process. During federal fiscal year 2011, approximately $797.4 million in overpayments to Medicare providers was identified and collected and $141.9 million in underpayments was returned to Medicare providers under the RAC program. Effective January 1, 2012, a new three-year Recovery Audit Prepayment Review Demonstration was implemented by CMS, which will allow RAC auditors to conduct prepayment claim reviews. CMS believes such prepayment reviews will both assist in lowering the improper payment rate and identifying potential fraud and abuse, as opposed to the traditional post-payment review mechanisms.

The Health Care Reform Act expanded the RAC program's scope to all of Medicare, including managed Medicare plans and Medicaid claims, and required all states to enter into contracts with RACs by December 31, 2010. If a state was unable to implement a RAC program by the implementation date of January 1, 2012, then the state was required to request an exception by submitting to CMS a revised State Plan Amendment. The Health Care Reform Act also increased federal funding for Medicaid Integrity Contractors (private contractors that perform post-payment audits of Medicaid claims) for federal fiscal year 2011 and beyond. Additionally, several other contractors, including state Medicaid agencies, have increased their audit and review activities.

The federal government may investigate and bring suit under the False Claims Act. Additionally, the False Claims Act permits private individuals to bring qui tam lawsuits, or "whistleblower" actions, against companies on behalf of the government, alleging that a hospital or health care provider has defrauded a federal or state government program, such as Medicare or Medicaid. As discussed under "Legal Proceedings" in Item 3 and Note 13 to the Consolidated Financial Statements in Item 8 of Part II, we have been named, and may be named, in qui tam actions. Because qui tam lawsuits are filed under seal, we could be named in other such lawsuits of which we are not aware. Additionally, as further discussed under "Legal Proceedings" in Item 3 and Note 13 to the Consolidated Financial Statements in Item 8 of Part II, we are subject to government False Claims Act investigations. If the government intervenes in a qui tam action, or brings its own False Claims Act action after an investigation, and prevails, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Typically, each false bill submitted by a health care provider to the government is considered a separate false claim and, therefore, penalties under the False Claims Act can be substantial. If the government does not intervene in an action, the qui tam plaintiff may continue to pursue the action independently and the government may seek leave to intervene in the action later in the proceedings. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment.

There are many potential bases for liability under the False Claims Act. Liability often arises when an entity "knowingly" submits a false claim for reimbursement to the federal government. The False Claims Act defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the False Claims Act, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the False Claims Act and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the False Claims Act by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Health Care Reform Act, the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later, constitutes a violation of the False Claims Act. Thus, if a provider is aware that it has retained an overpayment that it has an obligation to refund, there may be a basis for a False Claims Act violation even if the provider did not know the claim was "false" when it was submitted. Further, the Health Care Reform Act expands the scope of the False Claims Act to cover payments in connection with the new health insurance exchanges to be created by the law, if those payments include any federal funds.

The Health Care Reform Act also significantly changes the False Claims Act by removing the jurisdictional bar for allegations based on publicly disclosed information and reducing the requirements for a qui tam relator to qualify as an "original source." These changes may increase the False Claims Act exposure for health care providers by enabling a greater number of whistleblowers to bring claims.

We closely monitor our billing and other health care practices to maintain compliance with prevailing industry interpretations of applicable laws and regulations. As further discussed under "Legal Proceedings" in Item 3 and Note 13 to the Consolidated Financial Statements in Item 8 of Part II, we are investigating our compliance in the areas that we believe are the subject of the government investigations, and have undertaken a review of our compliance program. Moreover, government investigations could be initiated that are inconsistent with industry practices and prevailing interpretations of existing laws and regulations. In public statements, government authorities have from time to time taken positions on issues for which little official interpretation was available. Some of those positions appear to be inconsistent with practices that have been common within our industry and, in some cases, have not been challenged. Additionally, some government investigations that were previously conducted under civil provisions of federal law are now being conducted as criminal investigations under fraud and abuse laws and certain government investigations that were previously handled administratively are now being conducted as either civil or criminal investigations under civil and criminal fraud and abuse laws.

We cannot predict the outcome of existing government investigations and qui tam lawsuits or whether we will be the subject of future government investigations, inquiries or whistleblower lawsuits. Any determination that we have violated applicable laws or regulations or even a public announcement that we are being investigated for possible violations could harm our business and results of operations. Government investigations, as well as qui tam lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government health care programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require monetary payments, which could have a materially adverse effect on our business, financial condition, results of operations and/or cash flows.

Additionally, HHS-OIG regularly negotiates corporate integrity agreements, or CIAs, with health care providers as part of the settlement of federal health care program investigations arising under the False Claims Act and other laws. HHS-OIG has the power to exclude providers from federal health care programs and often threatens to exercise that power unless a provider agrees to the terms of a CIA. Although each CIA is different, there are some common provisions. For instance, a CIA generally lasts five years, requires the implementation of specified HHS-OIG compliance policies and procedures and mandates the retention of an independent review organization that is authorized to conduct reviews of the provider. If we were to enter into a CIA as part of a settlement with HHS-OIG in connection with any existing or future proceeding, these and other terms of a CIA could have a materially adverse effect on our business, financial condition, results of operations and/or cash flows.

We could fail to comply with laws and regulations regarding patient privacy and patient information security that could subject us to civil and criminal penalties or harm our results of operations.

There have been numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy and security standards related to patient information. In particular, federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, contain provisions that required us to implement and, in the future, may require us to implement additional costly electronic media security systems and to adopt new business practices designed to protect the privacy and security of each of our patient's health and related financial information. Such privacy and security regulations impose extensive administrative, physical and technical requirements on us, restrict our use and disclosure of certain patient health and financial information, provide patients with rights with respect to their health information and require us to enter into contracts extending many of the privacy and security regulatory requirements to third parties that perform duties and services on our behalf. We

are also required to make certain expenditures to help ensure our continued compliance with such laws and regulations and, in the future, such expenses could negatively impact our results of operations. The American Recovery and Reinvestment Act of 2009, referred to as the Economic Stimulus Act, included provisions for heightened enforcement of HIPAA and stiffer penalties for HIPAA violations. If we violate or fail to comply with any such laws or regulations, we could be subject to civil and criminal penalties or it might be necessary for us to increase the personnel, financial and technological resources we devote to our operations to achieve compliance. Moreover, a violation or failure to comply with any such laws or regulations could cause harm to our reputation which, in turn, could result in our patients seeking health care services at facilities that are not operated by us. If any of the foregoing events were to occur, our business and results of operations could be harmed.

If any of our existing health care facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under the Medicare, Medicaid and other federal and state health programs, which could harm our business and adversely affect our results of operations.

The construction and operation of health care facilities are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with the relevant standards.

All of our hospitals (and substantially all of our laboratories, home health agencies and other health care facilities) are accredited, meaning that they are properly licensed under the relevant state laws and regulations and certified under the Medicare program. The effect of maintaining accredited facilities is to allow such facilities to participate in the Medicare and Medicaid programs. Should any of our health care facilities lose their accredited status and thereby lose certification under the Medicare or Medicaid programs, such facilities would be unable to receive reimbursement from either of those programs and our business and results of operations could be harmed. Because the requirements for accreditation are subject to modification, it may be necessary for us to affect changes in our facilities, equipment, personnel and services to maintain accreditation. Such changes could be expensive and could adversely affect our results of operations.

State efforts to regulate the construction or expansion of health care facilities could impair our ability to expand.

The construction of new health care facilities, the acquisition of existing health care facilities and the addition of new beds or services at existing health care facilities may be reviewed by state regulatory agencies under certificate of need and similar laws. Except for Arkansas, Oklahoma, Pennsylvania and Texas, all other states where our hospitals operate have certificate of need or similar laws. Such laws generally require state agency determination of public need and local agency approval prior to the construction of a new hospital facility and/or the addition of new beds or significant services to a hospital, or a related capital expenditure. Failure to obtain the necessary approvals in these states could: (i) result in our inability to complete a particular hospital acquisition, expansion or replacement; (ii) make a facility ineligible to receive reimbursement under the Medicare and/or Medicaid programs; (iii) result in the revocation of a facility's license; or (iv) impose civil and criminal penalties on us, any of which could harm our business and results of operations.

Our operations are subject to occupational health, safety and other similar regulations and failure to comply with such regulations could harm our business and results of operations.

We are subject to a wide variety of federal, state and local occupational health and safety laws and regulations. Regulatory requirements affecting us include, but are not limited to, those covering: (i) air and water quality control; (ii) occupational health and safety (e.g., standards regarding blood-borne pathogens and ergonomics, etc.); (iii) waste management; (iv) the handling of asbestos, polychlorinated biphenyls and radioactive substances; and (v) other hazardous materials. If we fail to comply with those standards, we may be subject to sanctions and penalties that could harm our business and results of operations.

We could fail to comply with the federal Emergency Medical Treatment and Active Labor Act of 1986, or EMTALA, which could subject us to civil monetary penalties or cause us to be excluded from participation in the Medicare program.

All of our facilities are subject to EMTALA, which requires every hospital participating in the Medicare program to conduct a medical screening examination of each person presented for treatment at its emergency room. If a patient is in active labor or suffering from an emergency medical condition, the hospital must either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition, regardless of

the patient's ability to pay for care. EMTALA imposes severe penalties if a hospital fails to screen, appropriately stabilize or transfer a patient, or if a hospital delays service while first inquiring about the patient's ability to pay. Such penalties include, but are not limited to, civil monetary penalties and exclusion from participation in the Medicare program. In addition to civil monetary penalties, an aggrieved patient, a patient's family or a medical facility that ultimately suffers a financial loss as a direct result of a transferring hospital's EMTALA violation can commence a civil suit under EMTALA. Although we believe that our facilities comply with EMTALA, there can be no assurances that claims will not be brought against us and, if successfully asserted against one or more of our hospitals, such claims could adversely affect our business and results of operations.

Increased state regulation of the rates we charge for our services could adversely affect our results of operations.

We currently operate one hospital in West Virginia, a state that requires us to submit annual requests for increases in our rates. Accordingly, the operating margins for our West Virginia hospital may be adversely affected if we are unable to increase our rates as our expenses increase, or if the rates we charge are decreased as a result of regulatory action. If other states in which we operate enact similar rate-setting laws, those actions could harm our business and results of operations.

Continued weak economic conditions could adversely impact our business and results of operations.

Our future patient volume, the ability to collect our accounts receivable and our overall future results of operations could be materially adversely impacted by a continuation of the current weak economic conditions, especially levels of unemployment that are substantially higher than historical trends. While certain health care spending is considered non-discretionary and may not be significantly impacted by economic downturns, other types of health care spending may be adversely impacted by these conditions. When individuals are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. Moreover, a greater number of uninsured patients may seek care in our emergency rooms. We believe that a persistent weak economy could: (i) increase the number of uninsured people, which would likely increase our costs for uncompensated patient care; (ii) reduce our revenue due to decreased funding from Medicaid and other state health care programs that are struggling financially; (iii) reduce the number of elective surgeries and other procedures performed at our hospitals and other health care facilities; and (iv) threaten the solvency of managed care health plans and others that do business with us, each of which could adversely impact our business and results of operations.

Growth in the number of uninsured and underinsured patients or deterioration in the collectability of the accounts of such patients could adversely affect our results of operations.

The principal collection risks for our accounts receivable relate to uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts required by the applicable agreement but patient responsibility amounts (e.g., deductibles, co-payments, other amounts not covered by insurance, etc.) remain outstanding. Our provision for doubtful accounts provides for, among other things, amounts due from such patients. The determination of the amount of our provision for doubtful accounts is based on, among other things, our assessment of historical cash collections and accounts receivable write-offs, expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other relevant key indicators. If we experience significant increases in uninsured and underinsured patients and/or uncollectible accounts receivable, our results of operations could be adversely affected.

In accordance with our Code of Business Conduct and Ethics, as well as the provisions of EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals while in active labor and/or seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency medical condition. If it is determined that such person has an emergency medical condition, we provide further medical treatment as is required to stabilize the patient's medical condition, within the facility's capability, or arrange for the transfer of such patient to another medical facility in accordance with applicable law and the treating hospital's written procedures. If our volume of indigent and charity care patients with emergency medical conditions increases significantly, our results of operations may be adversely impacted.

The Health Care Reform Act seeks to decrease, over time, the uninsured population. Among other things, the Health Care Reform Act will, effective January 1, 2014, expand Medicaid eligibility and incentivize employers to offer, and require individuals to carry, health insurance or be subject to penalties. Even after full implementation of the Health Care Reform Act, we may continue to experience a high level of uncollectible accounts and provide discounts to, and charity care for, certain individuals who are not enrolled in a health care program under the law.

If government programs or managed care companies reduce the payments we receive as reimbursement for the health care services we provide, whether as a result of the implementation of the Health Care Reform Act or otherwise, our revenue could decline and our business and results of operations could be adversely affected.

We derive a substantial portion of our revenue from federal and state government reimbursement programs, including Medicare and Medicaid. Such programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations concerning, among other things: (i) patient eligibility requirements and the method of calculating payments or reimbursement; (ii) requirements for utilization review activities; and (iii) federal and state funding restrictions, all of which could materially increase or decrease the payments to us in the future, as well as affect the timing of such payments.

Previous changes in the Medicare and Medicaid programs have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for health care services. Specifically, the Health Care Reform Act provides for significant reductions in the growth of Medicare program spending, including reductions in market basket update factors and disproportionate share payments. Reductions to our Medicare and Medicaid reimbursement by the Health Care Reform Act could harm our business and adversely impact our results of operations, especially in the short-term before we experience any potential increases in revenue from providing care to previously uninsured individuals.

Pressure on federal and state programs, which has increased as a result of the prolonged economic downturn, may also impact the availability of taxpayer funds for the Medicare and Medicaid programs. For example, a number of states are experiencing substantial budget shortfalls and, as a result, have adopted legislation, or are considering legislation, designed to reduce their Medicaid expenditures and/or reduce the number of Medicaid enrollees. We are unable to predict the potential effects that future government health care funding policy changes will have on our operations. Moreover, in response to the Health Care Reform Act and state budgetary fiscal pressures, many states are seeking waivers and demonstration program approval from CMS with respect to their Medicaid programs. The proposals are varied and include, among other things, features such as mandatory managed care, capitated managed care and a prioritized list of health care services to define a state program's benefit package. We cannot predict which, if any, of these or other waivers and demonstrations will be permitted within the states where we operate. If the rates paid by government payors are reduced or if the scope of services covered by government payors is limited, our business and results of operations could be adversely affected.

In addition to changes in government reimbursement programs, third party payors, including managed care health plans, are increasingly demanding discounted fee structures or the assumption by health care providers of all or a portion of the financial risk through, among other means, capitation arrangements under which health care providers are paid a fixed fee per enrolled participant, regardless of the level of services provided to that participant. Efforts by third parties to aggressively manage reimbursement levels and enforce stringent cost controls are expected to continue. In fact, as the Health Care Reform Act is implemented over time, third party payors may increasingly demand reduced fees. Our future success will depend, in part, on our ability to retain and renew our managed care contracts and enter into new managed care contracts on terms that are favorable to us. It would harm our business if we were unable to enter into arrangements with managed care health plans on economic terms that are acceptable to us. Material reductions in the payments that we receive for our services or difficulties collecting our accounts receivable from managed care health plans could each adversely affect our business and results of operations.

If unfavorable Medicare or Medicaid reimbursement changes result from the Budget Control Act of 2011, our business and results of operations could be harmed.

The Budget Control Act of 2011, or the BCA, was enacted on August 2, 2011. Among other things, the BCA (i) increased the federal debt ceiling by approximately $900 billion and (ii) immediately cut and capped federal discretionary spending, excluding the Medicare and Medicaid programs, thereby saving an estimated $917 billion over the next ten years. The BCA also established the Joint Select Committee on Deficit Reduction (the "Deficit Reduction Committee"), a twelve-member bipartisan joint committee of Congress. The primary goal of the Deficit Reduction Committee was to propose legislation by November 23, 2011 to further reduce the federal deficit by $1.5 trillion over the next ten years. Those deficit reduction measures were expected to be in addition to those already contained in the Health Care Reform Act. Pursuant to the BCA, if the legislation proposed by the Deficit Reduction Committee was not approved by Congress by December 23, 2011 and enacted into law by January 15, 2012 or if the Congressionally approved legislation did not achieve a federal deficit reduction in an amount of at least $1.2 trillion, then spending cuts aggregating $1.2 trillion over the next ten years (less any amount that resulted from earlier Congressional action) would automatically begin in January 2013. The Deficit Reduction Committee failed to propose legislation by December 23, 2011. Therefore, the reductions and spending cuts dictated by the BCA, which are required to be split equally between defense and non-defense programs, are scheduled to take effect beginning in

January 2013. Payments to Medicare providers are included in the automatic spending cuts; however, the BCA provides that Medicare payments may be reduced by no more than 2% and certain other programs, including Medicaid, would be exempt from the automatic spending cuts. At this time, we are unable to determine how the automatic Congressional spending cuts will affect Medicare and Medicaid reimbursement in the future; however, significant reimbursement reductions or other program modifications that result from the BCA could harm our business and results of operations.

Controls designed by third parties to reduce inpatient services may reduce our revenue.

Controls imposed by third party payors that are designed to reduce admissions and average length of hospital stays, commonly referred to as "utilization reviews," have affected and are expected to continue to affect our operations. Utilization reviews entail an evaluation of a patient's admission and course of treatment by managed care health plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively impacted by payor-required pre-admission authorization, utilization reviews and payor pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Efforts to impose stringent cost controls are expected to continue. For example, the Health Care Reform Act expands the use of prepayment and postpayment reviews by Medicare and Medicaid contractors. Although we cannot predict the effect that these changes will have on our operations, limitations on the scope of services for which we are reimbursed and/or downward pressure on reimbursement rates and fees as a result of utilization reviews could adversely affect our results of operations.

Our substantial borrowings have, and will continue to have, a significant effect on our business and may affect our ability to secure additional financing when needed.

As of December 31, 2011, we had approximately $3.6 billion of long-term debt and capital lease obligations, as well as availability of $400.3 million under a long-term revolving credit facility. Our ability to service, repay or refinance our indebtedness or secure additional capital resources to fund our operational, acquisition and other growth strategies will depend on, among other things, our future operating performance. Those operating results may be affected by general economic, competitive, regulatory, business and other factors beyond our control. We believe that our future cash flow from operating activities, together with currently available and potentially new financing arrangements, will be sufficient to fund our operating, strategic growth, capital expenditure and debt service requirements. However, if we fail to meet our financial obligations or if supplemental financing is not available to us on satisfactory terms when needed, our business could be harmed.

Our substantial leverage, debt service requirements and covenant restrictions/limitations could have other important consequences to us, including, but not limited to, the following:

- Our senior secured credit facilities, which are described at Note 2 to the Consolidated Financial Statements in Item 8 of Part II, and the indentures governing our senior notes and our convertible senior subordinated notes contain, and any future debt obligations that we incur will likely contain, covenants and restrictions that, among other things, require us to maintain compliance with certain financial ratios. If we do not comply with these or other financial covenants in those arrangements, an event of default may result, which, if not cured or waived, could require us to immediately repay or refinance our indebtedness. Additionally, an event of default under our senior secured credit facilities would permit the lenders to terminate all commitments to extend further credit to us under such facility. Furthermore, if we become unable to repay the amounts due and payable under our senior secured credit facilities, the lenders could proceed against the collateral granted to them to secure that indebtedness. In the event that our lenders accelerate the repayment of our borrowings, we may not have sufficient assets to repay that indebtedness. Moreover, covenant violations could also subject us to higher interest and financing costs on our debt obligations and our credit ratings could be adversely affected.

- In the event of a default under one or more of our debt arrangements, we may be forced to pursue alternative strategies, such as restructuring or refinancing our indebtedness, selling core assets, reducing or delaying capital expenditures or seeking additional equity capital. There can be no assurances that any of these strategies could be effectuated on satisfactory terms, if at all, or that sufficient funds could be obtained to make required debt service payments. Additionally, a debt restructuring could subject us to higher interest and financing costs and our credit ratings could be adversely affected.

- In the event of higher interest rates in the marketplace or if we fail to timely register certain of our debt with the Securities and Exchange Commission, as described at Note 2(b) to the Consolidated Financial Statements in Item 8 of Part II, we could be exposed to higher interest and financing costs on our variable rate long-term borrowings.

- We are required to dedicate a substantial portion of our cash flow to the payment of principal and interest on our indebtedness, which may reduce the amount of discretionary funds available for our other operational needs and growth objectives.
- Because of the need for increased cash flow to service our debt arrangements, we may be more vulnerable to a decline in our business, changes in the health care industry or prolonged weak economic conditions.
- Our flexibility in planning for, or reacting to, changes in our business and the health care industry may be limited.
- We may be at a disadvantage in the markets where our hospitals and other health care facilities operate when compared to our competitors and peers that have less debt or less restrictive covenants.
- We may be limited in our ability to obtain financing in the future for working capital, capital expenditures, acquisitions or other purposes on acceptable terms on a timely basis, or at all.

The terms of our senior secured credit facilities and the indentures governing our senior notes and our convertible senior subordinated notes restrict our current and future operations, particularly our ability to take certain actions, which could harm our business.

Our senior secured credit facilities and the indentures governing our senior notes and our convertible senior subordinated notes contain a number of restrictive covenants that impose significant operational and financial restrictions on us and may limit our ability to engage in activities that may be in our long-term best interest. Among other things, those covenants impose restrictions on our ability to:

- incur additional indebtedness;
- pay dividends or make other distributions or repurchase or redeem capital stock;
- prepay, redeem or repurchase certain debt;
- make loans and investments;
- consolidate, merge or sell all or substantially all of our assets;
- incur liens;
- grant additional security interests and provide new guarantees;
- enter into transactions with affiliates;
- enter into sale-leaseback transactions;
- invest in joint ventures and make capital expenditures; and
- alter the businesses we conduct.

As a result of these restrictions, we may be: (i) limited in how we conduct our business; (ii) unable to raise additional debt or equity financing when necessary or desirable; or (iii) unable to compete effectively or take advantage of new business opportunities. These restrictions could materially affect our ability to grow our business in accordance with our strategic operational and growth initiatives, which would harm our business.

If credit markets become unstable and we are not able to access them to obtain financing on commercially reasonable terms when needed or desirable, our business could be materially harmed and our results of operations could be adversely affected.

Our ability to secure additional capital resources to fund our operational and growth strategies may depend on our ability to access the credit markets. During the past few years, credit markets have experienced unstable conditions and, for a period of time, they were essentially unavailable due to a severe banking crisis. We cannot predict whether we will be able to access the credit markets when necessary or desirable. If we are not able to access credit markets and obtain financing on commercially reasonable terms when needed, our business could be materially harmed and our results of operations could be adversely affected.

We are presently the subject of legal proceedings that, if resolved unfavorably, could have an adverse effect on us.

We are a party to various ongoing government investigations, legal proceedings and other related matters, which are described under "Legal Proceedings" in Item 3 and Note 13 to the Consolidated Financial Statements in Item 8 of Part II. Those proceedings include, among other things, government investigations. Should an unfavorable outcome occur in some or all of our current legal proceedings, or if successful claims and other actions are brought against us in the future, there could be a materially adverse effect on our financial position, results of operations and liquidity.

As described above in further detail, government investigations, as well as qui tam lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government health care programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require both monetary payments and corporate integrity agreements, each of which could have a materially adverse effect on our business, financial condition, results of operations and/or cash flows.

We may incur liabilities not covered by our insurance or which exceed our insurance limits, or a party to our insurance program could become insolvent or otherwise not meet its contractual obligations.

In the ordinary course of business, our subsidiary hospitals and other health care facilities and our employed physicians are subject to medical malpractice lawsuits, product liability lawsuits and other legal actions. Some of these actions may involve large claims, as well as significant defense costs. We self-insure a substantial portion of our professional liability risks. Based on our past experience and current actuarial estimates, we believe that our insurance coverage and our self-insurance reserves are sufficient to cover claims arising from the operations of our subsidiary hospitals and other health care facilities and our physician practices. However, if payments for indemnity claims and related expenses exceed our estimates or if payments are required to be made by us that are not covered by insurance, our business could be harmed and our results of operations could be adversely impacted. Also, one or more of the unrelated insurance and reinsurance companies that provide us coverage could become insolvent or otherwise be unable to fulfill their contractual obligations to us, each of which could adversely affect our business and results of operations.

Our facilities are heavily concentrated in Florida, Mississippi and Tennessee, which makes us sensitive to regulatory, economic and competitive changes in those states, as well as the harmful effects of hurricanes and other severe weather activity in regions in and around the Gulf of Mexico.

As of December 31, 2011, we operated 66 hospitals, including 42 in Florida, Mississippi and Tennessee. Our home office is also located in Florida. Such geographic concentration makes us particularly sensitive to regulatory, economic, environmental and competitive conditions in those states. Any material changes in those factors in Florida, Mississippi or Tennessee could have a disproportionate effect on our business and results of operations.

Moreover, regions in and around the Gulf of Mexico commonly experience hurricanes and other extreme weather conditions. As a result, certain of our health care facilities, especially those in Florida and Mississippi, and our home office are susceptible to physical damage and business interruption from an active hurricane season or a single severe storm. Moreover, global climate change could increase the intensity of individual hurricanes or the number of hurricanes that occur each year. Even if our facilities are not directly damaged, we may experience considerable disruptions in our operations due to property damage experienced in storm-affected areas by our patients, physicians, payors, vendors and others. Additionally, long-term adverse weather conditions, whether caused by global climate change or otherwise, could cause an outmigration of people from the communities where our hospitals are located. If any of the circumstances described above occurred, there could be a harmful effect on our business and our results of operations could be adversely affected.

The failure of certain employers or the closure of certain facilities could have a disproportionate impact on our hospitals and harm our business.

The economies in the non-urban communities where our hospitals operate are often dependant on a small number of large employers. Those employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals and other health care facilities for their care. The failure of one or more large employer or the closure or substantial reduction in the number of individuals employed at facilities located in or near the communities where our hospitals operate, could cause affected employees to move elsewhere to seek employment or lose insurance coverage that was otherwise available to them. The occurrence of these events could adversely affect our revenue and results of operations, thereby harming our business.

Our growth strategy depends, in part, on acquisitions. However, we may not be able to continue to acquire hospitals and other ancillary health care businesses that meet our target criteria. We may also have difficulty acquiring hospitals from not-for-profit entities due to regulatory scrutiny and other restrictions.

Acquisitions of general acute care hospitals and other ancillary health care businesses in non-urban markets are part of our overall growth strategy. We face competition for potential acquisition targets primarily from other for-profit health care companies. Some of our competitors have greater resources than we do. Additionally, many states have enacted, or from time to time consider enacting, laws that affect the conversion or sale of not-for-profit hospitals to for-profit entities. These laws generally require prior approval from state attorneys general, advance notification and community involvement. Moreover, attorneys general in states without specific conversion

legislation may exercise broad discretionary authority over such transactions. Although the level of government involvement varies from state to state, the trend is to provide increased regulatory review and, in some cases, approval of a transaction where a not-for-profit entity sells a health care facility to a for-profit entity. The adoption of new or expanded conversion legislation, increased review of not-for-profit hospital conversions or our inability to effectively compete against other potential buyers could make it more difficult for us to acquire hospitals and other ancillary health care businesses, increase our acquisition costs and/or make it difficult for us to complete acquisitions that otherwise meet our target criteria, any of which could adversely affect our growth strategy and results of operations.

The Health Care Reform Act restricts our ability to enter into new joint ventures with physicians and subjects our existing joint ventures to substantial limitations. Because these joint ventures were an important part of our growth strategy prior to the enactment of the Health Care Form Act, the new restrictions may have an adverse effect on our business.

At a number of our hospitals, we have partnered with local physicians in the ownership of the facility. Such arrangements were entered into under a provision of the Stark law that allowed physicians to invest in an entire hospital, such provision is commonly referred to as the "whole hospital" exception. The Health Care Reform Act changed the whole hospital exception such that existing physician investments in a whole hospital are only permitted to continue under a grandfather clause if the arrangement satisfies certain requirements. However, physicians are now prohibited from increasing their aggregate ownership percentage in any grandfathered joint venture hospital and/or entering into new hospital joint ventures. Additionally, the Health Care Reform Act restricts the ability of existing physician-owned hospitals to expand the number of operating rooms, procedure rooms and licensed beds that they operate. Prior to the passage of the Health Care Reform Act, joint ventures with physician partners had been an important component of our growth strategy. Our inability to enter into future hospital joint ventures with physicians may slow our strategic growth plans. Moreover, we may be unable to expand the services at our affected hospitals and/or effectively compete in certain markets if the Health Care Reform Act or other laws and regulations materially restrict our grandfathered joint venture hospitals from increasing their operating rooms, procedure rooms and licensed beds, each of which could adversely affect our results of operations and harm our business.

We may fail to improve or integrate the operations of the hospitals we acquire, which could harm our results of operations.

Prior to their acquisition, most of the hospitals we acquire were experiencing operating losses or had significantly lower operating margins than the hospitals we operate. We may be unable to timely and effectively integrate the hospitals that we acquire with our ongoing operations or we may experience delays implementing operating procedures and systems at those hospitals. Integrating a new hospital can be expensive and time consuming and could disrupt our ongoing business, negatively affect our cash flow and distract management and other key personnel. Acquired hospitals require transitions from, and the integration of, operations, personnel and information systems. If we are unable to improve the operating margins of the hospitals we acquire, operate such hospitals profitably or effectively and timely integrate their operations, our results of operations could be harmed.

The availability of approved Medicare and Medicaid provider numbers may be delayed following our acquisition of a hospital.

Following an acquisition, we generally seek approval to use the predecessor hospital's provider numbers for Medicare and Medicaid reimbursement. If we are unable to obtain the necessary approvals to use such provider numbers on a timely basis, our receipt of Medicare and Medicaid reimbursement could be delayed. Such delays could temporarily harm our cash flows.

If we acquire hospitals or other ancillary health care businesses with unknown or contingent liabilities, we could become liable for material obligations.

Hospitals and other ancillary health care businesses that we acquire may have unknown or contingent liabilities, including, but not limited to, liabilities for failure to comply with health care laws and regulations, medical and general professional liabilities, workers' compensation liabilities, tax liabilities and liabilities for unacceptable business practices. Although we typically exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers for these matters, we could experience difficulty enforcing those obligations or we could incur material liabilities for the pre-acquisition activities of the hospitals and other ancillary health care facilities that we acquire. Such liabilities and related legal or other costs could harm our business and results of operations.

Other hospitals and freestanding outpatient facilities provide services similar to ours, which may raise the level of competition we face and adversely affect our results of operations.

The health care industry is highly competitive and competition among hospitals and other health care providers has intensified in recent years. In some of the geographic areas where we operate, there are other hospitals that provide services comparable to those offered by our hospitals and other health care facilities. Some of those competitor hospitals are owned by government agencies and supported by tax revenue and others are owned by not-for-profit corporations and may be supported, in part, by endowments and charitable contributions. Such support is not available to our hospitals. In some cases, our competitors may be a significant distance away from our facilities; however, patients in our markets may migrate, may be referred by local physicians or may be required by their health plan to travel to these hospitals for care. Furthermore, some of our competitors may be better equipped than us and can offer a broader range of services than we do. Additionally, outpatient treatment and diagnostic imaging facilities, outpatient surgical centers, specialized care providers (e.g., oncology, physical therapy, etc.) and freestanding ambulatory surgical centers (each of which may have physician ownership interests) have increased in number and accessibility in recent years. This broader selection of health care facilities in the communities that we serve has challenged our market share. If our hospitals and other health care facilities are not able to effectively attract patients, our business and results of operations could be harmed.

If we are not able to provide high quality medical care at a reasonable price, patients may choose to receive their health care from our competitors.

In recent years, the number of quality measures that hospitals are required to report publicly has increased. CMS publishes performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with the Medicare program. Federal law provides for the future expansion of the number of quality measures that must be reported. Additionally, the Health Care Reform Act requires all hospitals to annually establish, update and make public a list of their standard charges for products and services. If any of our hospitals achieve poor results on their quality measures or patient satisfaction surveys (or results that are lower than our competitors) or if our standard charges are higher than our competitors, our patient volume could decline because patients may elect to use competing hospitals or other health care providers that have better metrics and pricing. This circumstance could harm our business and results of operations.

Our performance depends on our ability to recruit and retain quality physicians.

Physicians make admitting and other decisions regarding the appropriate course of patient treatment, which, in turn, affect hospital revenue. Therefore, the success of our hospitals depends, in part, on the number and quality of the physicians on their medical staffs, the admitting practices of those physicians and continued good relations with such physicians. Many of the physicians working at our hospitals are not our employees and, in a number of the markets that we serve, they have admitting privileges at hospitals other than our own. If we are unable to provide adequate support personnel or technologically advanced equipment and facilities that meet physicians' needs, they may be discouraged from referring patients to our facilities and our results of operations could be adversely affected.

Additionally, we could find it difficult to attract an adequate number of physicians to practice in certain of the non-urban communities where our hospitals are located. An inability to recruit physicians to those communities or the loss of physicians in those communities could make it difficult to attract patients to our hospitals and thereby harm our business and results of operations. On a national level, a shortage of physicians is a possible unintended consequence of the Health Care Reform Act. The millions of uninsured individuals who will obtain insurance under the new law will eventually be in need of primary care and other physicians, whose numbers may not increase proportionately. In the future, this shortage may require us to enhance wages and benefits to recruit and retain qualified physicians or require us to hire expensive temporary and per diem personnel.

If we do not continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

The technology used in medical equipment and related devices is constantly evolving and, as a result, manufacturers and distributors continue to offer new and upgraded products to health care providers. To compete effectively, we must continually assess our equipment needs and upgrade when significant technological advances occur. If our hospitals do not stay current with technological advances in the health care industry, patients may seek treatment from other providers and/or physicians may refer their patients to alternate sources, which could adversely affect our results of operations and harm our business.

Our hospitals face competition for medical support staff, including nurses, pharmacists, medical technicians and other personnel, which may increase our labor costs and adversely affect our business.

We are highly dependent on our experienced medical support personnel, including nurses, pharmacists and lab technicians, seasoned local hospital management and other medical personnel. We compete with other health care providers to recruit and retain these health care professionals. On a national level, a shortage of nurses and certain other medical support personnel has been a significant operating issue for a number of health care providers. In the future, this shortage may require us to enhance wages and benefits to recruit and retain such personnel or require us to hire expensive temporary and per diem personnel. Additionally, to the extent that a significant portion of our employee base unionizes, or attempts to unionize, our labor costs could increase. Certain proposed changes in federal labor laws, such as the Employee Free Choice Act of 2009, could increase the likelihood of unionization at our facilities. If our wages and related expenses rise, we may not be able to correspondingly increase our reimbursement rates. Our inability to recruit and retain qualified hospital management, nurses and other medical support personnel or our inability to modulate labor costs could adversely affect our results of operations and harm our business.

We depend heavily on key management personnel and the loss of the services of one or more of our key executives or a significant portion of our local hospital management personnel could harm our business.

Our success depends, in large part, on the skills, experience and efforts of our senior management team and the efforts, ability and experience of key members of our local hospital management teams. We do not maintain employment agreements with our management personnel. The loss of the services of one or more members of our senior management team or a significant portion of our local hospital management teams could significantly weaken our ability to efficiently deliver health care services, which could harm our business.

Our business could be harmed by a failure of our proprietary information technology system.

The performance of our proprietary management information system, known as the Pulse System®, is critical to our business operations. Any failure that causes a material interruption in the availability of the Pulse System® could adversely affect our operations or delay our cash collections. Although we have implemented antivirus, network security and disaster recovery measures, our servers could become vulnerable to computer viruses, break-ins, disruptions from unauthorized tampering, hurricane-related failures and other extreme weather conditions. Any of these circumstances could result in interruptions, delays, the loss or corruption of data, or a general lack of availability of the Pulse System®, each of which could harm our business and results of operations. Moreover, in the event of a failure of the Pulse System®, we may be required to devote substantial personnel, financial and technological resources to correct any then existing deficiencies and/or enhance the system design to prevent such a failure from occurring again in the future, which could also harm our business and results of operations.

If we fail to effectively and timely implement electronic health record systems, our operations could be harmed.

As required by the portion of the Economic Stimulus Act commonly referred to as "HITECH," CMS has developed and is implementing an incentive payment program for eligible hospitals and health care professionals that adopt and meaningfully use certified electronic health record technology. HHS is using the Provider Enrollment, Chain and Ownership System, or PECOS, to verify Medicare enrollment prior to making electronic health record incentive program payments. If our hospitals or physicians are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing an electronic health record system. Further, beginning in federal fiscal year 2015, eligible hospitals and professionals that fail to demonstrate meaningful use of certified electronic health record technology will be subject to reduced payments from Medicare. Any failure by us to effectively implement an electronic health record system in a timely manner, or maintain currently compliant systems, could have an adverse effect on our results of operations.

HITECH provides that patients have the right to receive information regarding their treatment and the payments made for their health care services during the three years prior to their request. HHS released a proposed rule on May 31, 2011 that would require hospitals and health care professionals to keep records about not only disclosures of, but also internal access to, certain patient health records. If implemented, such proposed rule would mean, among other things, that patients would have a right to request the names of every person who viewed their records. If implemented in its current form, the proposed rule could require us to devote significant resources to further enhance our recordkeeping systems.

Item 1B. Unresolved Staff Comments.

Not applicable.

Item 2. Properties.

The table below presents certain information with respect to our hospitals as of December 31, 2011. For more information regarding the utilization of our facilities, see "Business - Selected Operating Statistics" in Item 1.

Hospital	City	Licensed Beds	Operational Status	Date Acquired
Alabama				
Riverview Regional Medical Center (1)	Gadsden	281	Owned	July 1991
Stringfellow Memorial Hospital (1)	Anniston	125	Leased	January 1997
Arkansas				
Summit Medical Center (1)	Van Buren	103	Leased	May 1987
Sparks Health System	Fort Smith	492	Owned	December 2009
Florida				
Highlands Regional Medical Center	Sebring	126	Leased	August 1985
Heart of Florida Regional Medical Center (1)	Greater Haines City	194	Owned	August 1993
Sebastian River Medical Center	Sebastian	154	Owned	September 1993
Charlotte Regional Medical Center	Punta Gorda	208	Owned	December 1994
Brooksville Regional Hospital (1)	Brooksville	120	Leased	June 1998
Spring Hill Regional Hospital (1)	Spring Hill	124	Leased	June 1998
Lower Keys Medical Center	Key West	167	Leased	May 1999
Pasco Regional Medical Center (1)	Dade City	120	Owned	September 2000
Lehigh Regional Medical Center	Lehigh Acres	88	Owned	December 2001
Santa Rosa Medical Center	Milton	129	Leased	January 2002
Seven Rivers Regional Medical Center	Crystal River	128	Owned	November 2003
Peace River Regional Medical Center	Port Charlotte	219	Owned	February 2005
Venice Regional Medical Center	Venice	312	Owned	February 2005
Bartow Regional Medical Center	Bartow	72	Owned	April 2005
St. Cloud Regional Medical Center (1)	St. Cloud	84	Owned	February 2006
Physicians Regional Medical Center-Pine Ridge	Naples	101	Owned	May 2006
Physicians Regional Medical Center-Collier Boulevard	Naples	100	Owned	Not applicable (2)
Shands Lake Shore Regional Medical Center (1)	Lake City	99	Leased	July 2010
Shands Live Oak Regional Medical Center (1)	Live Oak	15	Owned	July 2010
Shands Starke Regional Medical Center (1)	Starke	25	Owned	July 2010
Wuesthoff Medical Center - Rockledge	Rockledge	298	Owned	October 2010
Wuesthoff Medical Center - Melbourne	Melbourne	115	Owned	October 2010
Georgia				
East Georgia Regional Medical Center (1)	Statesboro	150	Owned	October 1995
Walton Regional Medical Center (3)	Monroe	77	Owned	September 2003
Barrow Regional Medical Center	Winder	56	Owned	January 2006
Kentucky				
Paul B. Hall Regional Medical Center (1)	Paintsville	72	Owned	January 1979
Mississippi				
Biloxi Regional Medical Center	Biloxi	198	Leased	September 1986
Natchez Community Hospital (1)	Natchez	101	Owned	September 1993
Northwest Mississippi Regional Medical Center	Clarksdale	195	Leased	January 1996
Crossgates River Oaks Hospital	Brandon	149	Leased	January 1997
River Oaks Hospital	Flowood	160	Owned	January 1998
Woman's Hospital at River Oaks	Flowood	109	Owned	January 1998
Central Mississippi Medical Center	Jackson	429	Leased	April 1999
Madison River Oaks Medical Center (4)	Canton	67	Owned	January 2003
Gilmore Memorial Regional Medical Center	Amory	95	Owned	December 2005
Gulf Coast Medical Center (5)	Biloxi	144	Inactive	Not applicable
Tri-Lakes Medical Center (1)	Batesville	112	Owned	May 2011
Missouri				
Twin Rivers Regional Medical Center	Kennett	116	Owned	November 2003
Poplar Bluff Regional Medical Center (1) (6)	Poplar Bluff	423	Owned	November 2003

Hospital	City	Licensed Beds	Operational Status	Date Acquired
North Carolina				
Lake Norman Regional Medical Center (1)	Mooresville	123	Owned	January 1986
Sandhills Regional Medical Center	Hamlet	64	Owned	August 1987
Davis Regional Medical Center	Statesville	143	Owned	October 2000
Oklahoma				
Medical Center of Southeastern Oklahoma (1)	Durant	148	Owned	May 1987
Midwest Regional Medical Center (1)	Midwest City	255	Leased	June 1996
Pennsylvania				
Heart of Lancaster Regional Medical Center (1)	Lititz	148	Owned	July 1999
Lancaster Regional Medical Center (1)	Lancaster	214	Owned	July 2000
Carlisle Regional Medical Center (1)	Carlisle	165	Owned	June 2001
South Carolina				
Carolina Pines Regional Medical Center (1)	Hartsville	116	Owned	September 1995
Chester Regional Medical Center	Chester	82	Leased	October 2004
Tennessee				
Jamestown Regional Medical Center	Jamestown	85	Owned	January 2002
University Medical Center (1)	Lebanon	245	Owned	November 2003
Harton Regional Medical Center (1)	Tullahoma	135	Owned	November 2003
Physicians Regional Medical Center (7)	Knoxville	419	Owned	September 2011
Turkey Creek Medical Center	Knoxville	101	Owned	September 2011
Jefferson Memorial Hospital	Jefferson City	58	Leased	September 2011
Newport Medical Center (7)	Newport	130	Owned	September 2011
LaFollette Medical Center	LaFollette	66	Leased	September 2011
North Knoxville Medical Center	Powell	108	Owned	September 2011
St. Mary's Medical Center of Scott County (8)	Oneida	25	Leased	September 2011
Riverside hospital campus	Knoxville	293	Owned/Inactive	September 2011
Texas				
Dallas Regional Medical Center at Galloway	Mesquite	202	Owned	January 2002
Washington				
Yakima Regional Medical and Cardiac Center (1)	Yakima	214	Owned	August 2003
Toppenish Community Hospital (1)	Toppenish	63	Owned	August 2003
West Virginia				
Williamson Memorial Hospital (1)	Williamson	76	Owned	June 1979
	Total licensed beds at December 31, 2011	10,330		

(1) As of December 31, 2011, this hospital is partially owned by local physicians and/or other health care entities; however, we continue to own the majority equity interest in such hospital and manage its day-to-day operations. Subsequent to December 31, 2011, we repurchased all of the minority equity interests in respect of Poplar Bluff Regional Medical Center.

(2) De novo hospital that we opened on February 5, 2007.

(3) We are contractually obligated to build a replacement hospital at this location no later than December 31, 2012. Construction is underway and the new hospital is expected to open during the quarter ending June 30, 2012.

(4) Madison River Oaks Medical Center is a newly constructed hospital that we opened in May 2011 to replace our predecessor hospital in Canton, Mississippi.

(5) We have applied to the Mississippi State Department of Health for a certificate of need that would allow us to transfer these licensed beds to a hospital that we would build in the Biloxi, Mississippi marketplace.

(6) Poplar Bluff Regional Medical Center consists of a north campus (a 213-bed building that we lease) and a south campus (a 210-bed building that we own). We are currently building a new general acute care hospital in Poplar Bluff, Missouri that will ultimately replace our south campus facility. We expect that the new 250-bed hospital will open during the quarter ending March 31, 2013.

(7) The number of licensed beds includes ancillary facilities.

(8) The lease agreement at this hospital expires in May 2012 and will not be renewed or otherwise modified.

As indicated in the above table, we currently lease certain facilities pursuant to long-term leases that provide us with the exclusive right to use and control each hospital's operations. The facilities we lease and the corresponding year of lease expiration are as follows: Highlands Regional Medical Center (2025), Biloxi Regional Medical Center (2040), Summit Medical Center (2028), Northwest Mississippi Regional Medical Center (2035), Midwest Regional Medical Center (2035), Crossgates River Oaks Hospital (2026), Brooksville Regional Hospital/Spring Hill Regional Hospital (2043), Central Mississippi Medical Center (2040), Lower Keys Medical Center (2029), Chester Regional Medical Center (2034), Santa Rosa Medical Center (2045), Stringfellow Memorial Hospital (2048), Shands Lake Shore Regional Medical Center (2040), Jefferson Memorial Hospital (2021), LaFollette Medical Center (2015) and the north campus at Poplar Bluff Regional Medical Center (2014).

Our home office is in an office building complex in Naples, Florida that we own. We use approximately 36% of the complex and lease the remaining space. We have engaged an outside property management company to manage the office complex on our behalf.

As discussed at Note 10 to the Consolidated Financial Statements in Item 8 of Part II, we (i) closed the Woman's Center at Dallas Regional Medical Center in Mesquite, Texas on June 1, 2008 and (ii) acquired the Riverside hospital campus, which is a shuttered facility in Knoxville, Tennessee, as part of a transaction with Mercy Health Partners, Inc. that we completed on September 30, 2011. We are currently evaluating various disposal alternatives for these idle facilities; however, the timing of such divestitures has not yet been determined. Additionally, we lease a building in Canton, Mississippi where our hospital was previously located and we are currently considering several alternatives for this lease arrangement that expires in 2042.

As discussed at Note 2 to the Consolidated Financial Statements in Item 8 of Part II, our senior secured credit facilities with a syndicate of banks, 6.125% Senior Notes due 2016 and a $10.0 million secured demand promissory note with a bank are all secured by a significant portion of our real property.

We believe that our facilities are suitable and adequate for our needs.

Item 3. Legal Proceedings.

We operate in a highly regulated and litigious industry. As a result, we have been, and expect to continue to be, subject to various claims, lawsuits, government investigations and regulatory proceedings. The ultimate resolution of these matters, individually or in the aggregate, could have a materially adverse effect on our business, financial condition, results of operations and/or cash flows. We are currently a party to a number of legal and regulatory proceedings, including those described below.

Ascension Health Lawsuit. On February 14, 2006, Health Management Associates, Inc. (referred to as "Health Management" for the remainder of this Item 3) announced the termination of non-binding negotiations with Ascension Health ("Ascension") and the withdrawal of a non-binding offer to acquire Ascension's St. Joseph Hospital, a general acute care hospital in Augusta, Georgia. On June 8, 2007, certain Ascension subsidiaries filed a lawsuit against Health Management, entitled *St. Joseph Hospital, Augusta, Georgia, Inc. et al. v. Health Management Associates, Inc.*, in Georgia Superior/State Court of Richmond County claiming that Health Management (i) breached an agreement to purchase St. Joseph Hospital and (ii) violated a confidentiality agreement. The plaintiffs claim at least $40 million in damages. Health Management removed the case to the U.S. District Court for the Southern District of Georgia, Augusta Division (No. 1:07-CV-00104). On July 13, 2010, the plaintiffs filed a motion for partial summary judgment and Health Management filed a motion for summary judgment. On March 30, 2011, Health Management's motion for summary judgment was granted as to all of plaintiffs' claims, except for the breach of confidentiality claim, and plaintiffs' motion for partial summary judgment was denied. On June 15, 2011, the case was stayed pending resolution of the appellate process. On July 8, 2011, the plaintiffs filed a notice of appeal to the United States Court of Appeals for the Eleventh Circuit (Case Number: 11-13069). Oral argument is scheduled for the week of April 30, 2012.

We do not believe there was a binding acquisition contract with Ascension or any of its subsidiaries and we do not believe Health Management breached a confidentiality agreement. Accordingly, we will continue to vigorously defend Health Management against the allegations, including the pending appeal. We do not believe that the final outcome of this matter will be material.

Medicare/Medicaid Billing Lawsuits. On January 11, 2010, Health Management and one of its subsidiaries were named in a qui tam lawsuit entitled *United States of America ex rel. J. Michael Mastej v. Health Management Associates, Inc. et al.* in the U.S. District Court for the Middle District of Florida, Tampa Division. The plaintiff's complaint alleged that, among other things, the defendants erroneously submitted claims to Medicare and that those claims were falsely certified to be in compliance with Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law") and the Anti-Kickback Statute. The plaintiff's complaint further alleged that the defendants' conduct violated the federal False Claims Act of 1863 (the "False Claims Act"). The plaintiff seeks recovery of all Medicare and Medicaid reimbursement that the defendants received as a result of the alleged false

certifications and treble damages under the False Claims Act, as well as a civil penalty for each Medicare and Medicaid claim supported by such alleged false certifications. On August 18, 2010, the plaintiff filed a first amended complaint that was similar to the original complaint. On September 27, 2010, the defendants moved to dismiss the first amended complaint for failure to state a claim with the particularity required by Rule 9(b) of the Federal Rules of Civil Procedure and failure to state a claim upon which relief can be granted pursuant to Rule 12(b)(6) of those federal rules. On November 11, 2010, the plaintiff filed a memorandum of law in opposition to the defendants' motion to dismiss. On February 23, 2011, the case was transferred to the U.S. District Court for the Middle District of Florida, Fort Myers Division (No. 2:11-cv-00089-JES-DNF). On May 5, 2011, the plaintiff filed a second amended complaint, which was similar to the first amended complaint. On May 17, 2011, the defendants moved to dismiss the second amended complaint on the same bases set forth in their earlier motion to dismiss. On February 16, 2012, the court granted the defendants' motion to dismiss, without prejudice. The court's order permits the plaintiff to file an amended complaint within 21 days. If the plaintiff amends the complaint, we will vigorously defend Health Management and its subsidiary against the allegations. We do not believe that the final outcome of this matter will be material.

On December 13, 2011, the U.S. District Court for the Middle District of Tennessee ordered that a qui tam lawsuit entitled *United States ex rel. Kevin Dennis, et al. v. Health Management Associates, Inc. et al.* (Case No. 3:09-cv-00484) be partially unsealed and served on the defendants and that certain other contents of the court's file remain under seal. To date, we have not been served with the complaint. The complaint was filed under seal on or about May 27, 2009 and alleges that, among other things, the defendants erroneously submitted claims to Medicare and other health care programs funded by the federal government and the State of Tennessee and that those claims were falsely certified to be in compliance with the Stark law, the Anti-Kickback Statute and the analogous laws of the State of Tennessee. The plaintiffs' complaint further alleges that the defendants' conduct violated the False Claims Act and the Tennessee Medicaid False Claims Act. The plaintiff seeks recovery in the amount of triple the amount of the actual damages that the United States and the State of Tennessee have sustained as a result of the defendants' alleged fraudulent and illegal recruitment and billing practices, a civil penalty for each alleged false claim that the defendants presented or caused to be presented to the United States or the State of Tennessee, and a civil penalty for each of the defendants' acts that allegedly violated the Tennessee Medicaid False Claims Act, as well as unspecified compensatory and punitive damages. On December 7, 2011, the State of Tennessee notified the court of its decision not to intervene in the action and, on December 8, 2011, the United States notified the court that it was also declining to intervene. We intend to vigorously defend Health Management and its subsidiary against the allegations in this matter. We do not believe that the final outcome of this matter will be material.

Governmental Matters. Several Health Management hospitals received letters during the second half of 2009 requesting information in connection with a U.S. Department of Justice ("DOJ") investigation relating to kyphoplasty procedures. Kyphoplasty is a minimally invasive spinal procedure used to treat vertebral compression fractures. The DOJ is currently investigating hospitals and hospital operators in multiple states to determine whether certain Medicare claims for kyphoplasty were incorrect when billed as an inpatient service rather than as an outpatient service. We believe that the DOJ's investigation originated with a False Claims Act lawsuit against Kyphon, Inc., the company that developed the kyphoplasty procedure. The requested information has been provided to the DOJ and we are cooperating with the investigation. To date, the DOJ has not asserted any monetary or other claims against the Health Management hospitals in this matter. Based on the aggregate billings for inpatient kyphoplasty procedures during the period under review that were performed at the Health Management hospitals subject to the DOJ's inquiry, we do not believe that the final outcome of this matter will be material.

During September 2010, Health Management received a letter from the DOJ indicating that an investigation was being conducted to determine whether certain Health Management hospitals improperly submitted claims for the implantation of implantable cardioverter defibrillators ("ICDs"). The DOJ's investigation covers the period commencing with Medicare's expansion of coverage for ICDs in 2003 to the present. The letter from the DOJ further indicates that the claims submitted by Health Management's hospitals for ICDs and related services need to be reviewed to determine if Medicare coverage and payment was appropriate. During 2010, the DOJ sent similar letters and other requests to a large number of unrelated hospitals and hospital operators across the country as part of a nation-wide review of ICD billing under the Medicare program. We have, and will continue to, cooperate with the DOJ in its ongoing investigation, which could potentially give rise to claims against Health Management and/or certain of its subsidiary hospitals under the False Claims Act or other statutes, regulations or laws. Additionally, we recently commenced an internal review of hospital medical records related to ICDs that are the subject of the DOJ investigation. To date, the DOJ has not asserted any monetary or other claims against Health Management or its hospitals in this matter and, at this time, we are unable to determine the potential impact, if any, that will result from the final resolution of the investigation.

The U.S. Department of Health and Human Services, Office of Inspector General ("HHS-OIG") and the DOJ, including the Civil Division and U.S. Attorney's Offices in the Eastern District of Pennsylvania, the Middle District of Florida, the Eastern District of Oklahoma, the Middle District of Tennessee, the Western District of North

Carolina, the District of South Carolina and the Middle District of Georgia, are currently investigating Health Management and certain of its subsidiaries (HHS-OIG and the DOJ are collectively referred to as "Government Representatives"). We believe that such investigations relate to the Anti-Kickback Statute, the Stark law and the False Claims Act and are focused on: (i) physician referrals, including financial arrangements with our whole-hospital physician joint ventures; (ii) the medical necessity of emergency room tests and patient admissions, including whether Pro-Med software has led to any medically unnecessary tests or admissions; and (iii) the medical necessity of certain surgical procedures. We further believe that the investigations may have originated as a result of qui tam lawsuits filed on behalf of the United States. In connection with the investigations, HHS-OIG served subpoenas on Health Management on May 16, 2011 and July 21, 2011 requesting records. Additionally, Government Representatives have interviewed both our current and former employees. We are conducting internal investigations and have met with Government Representatives on numerous occasions to respond to their inquiries. We believe that the HHS-OIG subpoenas, which apply system-wide, may have been served pursuant to the authority of HHS-OIG to investigate health care fraud.

On February 22, 2012 and February 24, 2012, HHS-OIG served subpoenas on certain Health Management hospitals relating to those hospitals' relationships with Allegiance Health Management, Inc. ("Allegiance"). Allegiance, which is unrelated to Health Management, is a post acute health care management company that provides intensive outpatient psychiatric ("IOP") services to patients. The Health Management hospitals that were served subpoenas were: (i) Central Mississippi Medical Center in Jackson, Mississippi; (ii) Crossgates River Oaks Hospital in Brandon, Mississippi; (iii) Davis Regional Medical Center in Statesville, North Carolina; (iv) Lake Norman Regional Medical Center in Mooresville, North Carolina; (v) the Medical Center of Southeastern Oklahoma in Durant, Oklahoma; and (vi) Natchez Community Hospital in Natchez, Mississippi. Each of those hospitals has or had a contract with Allegiance. Among other things, the subpoenas seek: (i) documents related to the hospitals' financial relationships with Allegiance; (ii) documents related to patients who received IOP services from Allegiance at the Health Management hospitals, including their patient medical records; (iii) documents relating to complaints or concerns regarding Allegiance's IOP services at the Health Management hospitals; (iv) documents relating to employees, physicians and therapists who were involved in the provision of IOP services provided by Allegiance at the Health Management hospitals; and (v) other documents related to Allegiance including leases, contracts, policies and procedures, training documents, budgets and financial analyses. The period of time covered by the subpoenas is January 1, 2008 through the date of subpoena compliance. We believe that HHS-OIG has served similar subpoenas on other non-Health Management hospitals that had contracts with Allegiance. We intend to comply with the investigations. At this time, we are unable to determine the potential impact, if any, that will result from the final resolution of these investigations.

In addition to the abovementioned subpoenas and investigations, certain of our hospitals have received other requests for information from state and federal agencies. We are cooperating with all of the ongoing investigations by collecting and producing the requested materials. Because a large portion of our government investigations are in their early stages, we are unable to evaluate the outcome of such matters or determine the potential impact, if any, that could result from their final resolution.

Class Action Lawsuits. On or about January 25, 2012, Health Management, certain of its executive officers and one of its directors were named as defendants in an action entitled *Miklen Sapssov v. Health Management Associates, Inc. et al.*, which was filed in the U. S. District Court for the Middle District of Florida (No. 2:12-CV-00046). This action purports to be brought on behalf of stockholders who purchased our common stock during the period July 27, 2009 through January 9, 2012. The plaintiff alleges, among other things, that Health Management and the other defendants violated Section 10(b) of the Securities Exchange Act of 1934 by making allegedly false and misleading statements in certain public disclosures regarding our business and financial results. The plaintiff alleges that our financial performance was based, in part, on improper billing practices. The plaintiff seeks unspecified damages. A substantially similar purported class action lawsuit, entitled *Norfolk County Retirement System v. Health Management Associates, Inc., et al.*, was filed against the same defendants on or about February 2, 2012 in the U. S. District Court for the Middle District of Florida (No. 8:12-CV-00228). We intend to vigorously defend Health Management against the allegations in these matters. Because the abovementioned lawsuits are in their early stages, we are unable to evaluate their outcome or determine the potential impact, if any, that could result from their final resolution.

Wrongful Termination Lawsuit. On or about October 19, 2011, a wrongful termination action was commenced against us by Paul Meyer, our former Director of Compliance. That litigation, entitled *Meyer v. Health Management Associates, Inc.*, was commenced in the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida (Case No. 11-25334(09)). The plaintiff seeks unspecified compensatory and punitive damages. On November 18, 2011, we removed the case to the United States District Court, Southern District of Florida, Fort Lauderdale Division (Case No. 0:11-cv-62479-RNS). On January 20, 2012, the case was remanded to the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida. Mr. Meyer was terminated after insubordinately refusing to cooperate with our efforts to comply with our obligations under a

government subpoena by refusing to return documents belonging to us that were in his possession. Moreover, Mr. Meyer's failure to cooperate with us in response to a subpoena was contrary to both the intent and purpose of our compliance department and our company-wide compliance program. We have filed a counterclaim against Mr. Meyer for breach of contract, conversion and breach of duty of loyalty. We intend to vigorously defend against the wrongful termination allegations made by Mr. Meyer and we do not believe that the final outcome of this matter will be material.

Other. We are also a party to various other legal actions arising out of the normal course of our business. Due to the inherent uncertainties of litigation and dispute resolution, we are unable to estimate the ultimate losses, if any, relating to each of our outstanding legal actions and other loss contingencies.

Also see "Critical Accounting Policies and Estimates – Professional Liability Risks" in Item 7 of Part II and Note 13 to the Consolidated Financial Statements in Item 8 of Part II.

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

The common stock of Health Management Associates, Inc. (together with its subsidiaries hereinafter referred to as "we," "our" or "us") is listed on the New York Stock Exchange under the symbol "HMA." As of February 17, 2012, there were 254,435,258 shares of our common stock held by approximately 900 record holders. The table below sets forth the high and low sales prices per share of our common stock on the New York Stock Exchange for each of the quarters during the years ended December 31, 2011 and 2010.

	High	Low
Year ended December 31, 2011:		
First quarter	$ 11.07	$ 8.86
Second quarter	11.74	9.82
Third quarter	11.26	6.43
Fourth quarter	9.26	6.06
Year ended December 31, 2010:		
First quarter	$ 9.12	$ 6.49
Second quarter	9.81	7.72
Third quarter	7.93	6.13
Fourth quarter	9.88	7.19

The debt agreements that we entered into as part of a long-term debt restructuring that was completed on November 18, 2011 (the "2011 Debt Restructuring") and the indentures for certain of our other debt agreements restrict our ability to pay cash dividends. Further discussion of the 2011 Debt Restructuring and our long-term debt arrangements can be found at Note 2 to the Consolidated Financial Statements in Item 8.

At December 31, 2011, we had reserved a sufficient number of shares to satisfy the potential conversion of our convertible senior subordinated notes, which are discussed at Note 2(c) to the Consolidated Financial Statements in Item 8.

The table below summarizes the number of shares of our common stock that were withheld to satisfy the tax withholding obligations for our stock-based compensation awards that vested during the three months ended December 31, 2011.

Month Ended	Total Number of Shares Purchased	Average Price Per Share
October 31, 2011	-	$ -
November 30, 2011	-	-
December 31, 2011	18,969	8.27
Total	18,969	

Item 6. Selected Financial Data.

The table on the following page summarizes certain of our selected financial data and should be read in conjunction with the Consolidated Financial Statements and accompanying notes in Item 8. Certain amounts in the table have been reclassified in the prior years to conform to the current year presentation. Such reclassifications related to discontinued operations, which are discussed at Note 10 to the Consolidated Financial Statements.

HEALTH MANAGEMENT ASSOCIATES, INC.
FIVE YEAR SUMMARY OF SELECTED FINANCIAL DATA
(in thousands, except per share amounts)

	Years Ended December 31,				
	2011	2010	2009	2008	2007
Net revenue (1)	$ 5,804,451	$ 5,092,166	$ 4,536,106	$ 4,278,604	$ 4,103,404
Income from continuing operations (1) (2) (3)	206,334	185,774	161,303	210,515	117,438
Income (loss) from discontinued operations, net of income taxes (3) (4)	(2,409)	(13,526)	2,638	(26,358)	396
Net income attributable to Health Management Associates, Inc. (2) (4)	178,710	150,069	138,182	168,149	117,508
Income from continuing operations attributable to Health Management Associates, Inc. common stockholders (per share-diluted)	$ 0.71	$ 0.65	$ 0.55	$ 0.80	$ 0.48
Weighted average number of shares outstanding - diluted	255,037	251,106	246,965	244,671	245,119
Cash dividends per common share (5)	$ -	$ -	$ -	$ -	$ 10.00

	December 31,				
	2011	2010	2009	2008	2007
Total assets	$ 6,004,189	$ 4,910,085	$ 4,604,099	$ 4,554,232	$ 4,633,512
Long-term debt and capital lease obligations (5)	3,574,998	3,018,464	3,040,661	3,206,834	3,770,057
Redeemable equity securities	200,643	201,487	182,473	48,868	19,306
Stockholders' equity, including noncontrolling interests (5)	785,116	533,486	361,620	285,811	71,836

(1) Amounts exclude our discontinued operations, which are identified at Note 10 to the Consolidated Financial Statements in Item 8.

(2) In connection with the 2011 Debt Restructuring, income from continuing operations for the year ended December 31, 2011 included (i) approximately $24.6 million of write-offs of deferred debt issuance costs and related other and (ii) $16.4 million of amortization and net fair value adjustment expense that is attributable to our interest rate swap contract. See Note 2 to the Consolidated Financial Statements in Item 8 for information regarding the 2011 Debt Restructuring and our long-term debt arrangements. Also included in income from continuing operations during 2011 were: (i) a $40.0 million first time benefit from the meaningful use measurement standard under various Medicare and Medicaid Healthcare Information Technology ("HCIT") incentive programs; (ii) $12.9 million of expenses attributable to restructuring activities at Tennova Healthcare; and (iii) $9.5 million of costs for acquisitions and government investigations. See Notes 4 and 13 to the Consolidated Financial Statements in Item 8 for more information about certain of these matters. Income from continuing operations for the year ended December 31, 2008 included a gain of $161.4 million from the sale of a noncontrolling interest in our joint venture with Novant Health, Inc. and one or more of its affiliates (collectively, "Novant"). Additionally, income from continuing operations for the years ended December 31, 2009 and 2008 included net gains on the early extinguishment of debt of $16.2 million and $15.2 million, respectively.

(3) Income from continuing operations for the years ended December 31, 2011, 2010, 2009, 2008 and 2007 included amounts attributable to noncontrolling interests of approximately $25.2 million, $22.2 million $25.0 million, $16.1 million and $0.8 million, respectively. The corresponding amounts for discontinued operations were not material to the years presented.

(4) The loss from discontinued operations for the year ended December 31, 2011 included a goodwill impairment charge of approximately $3.6 million from the termination of a lease agreement in respect of our hospital in Marathon, Florida. The loss from discontinued operations for the year ended December 31, 2010 included (i) a loss of $12.1 million from the sale of our general acute care hospital in Meridian, Mississippi and its related health care operations and (ii) a long-lived asset impairment charge of $8.4 million. Income from discontinued operations for the year ended December 31, 2009 included (i) a gain of $10.4 million from the restructuring of our joint venture with Novant and (ii) long-lived asset impairment charges of $4.6 million. See Notes 4 and 10 to the Consolidated Financial Statements in Item 8 for information regarding Novant and our discontinued operations, respectively. The loss from discontinued operations for the year ended December 31, 2008 included: (i) long-lived asset and goodwill impairment charges of $38.0 million; (ii) a gain of $42.0 million from the sale of a noncontrolling interest in our joint venture with Novant; and (iii) a charge of $7.9 million for the estimated cost of partially subsidizing certain third party physician practice losses. Income from discontinued operations for the year ended December 31, 2007 included a gain of $21.8 million from the sale of two Virginia-based general acute care hospitals and certain affiliated health care entities.

(5) The 2011 Debt Restructuring, which is discussed at Note 2 to the Consolidated Financial Statements in Item 8, was completed on November 18, 2011. In connection with a recapitalization of our balance sheet, a special cash dividend of $10.00 per common share was paid during the year ended December 31, 2007. The special cash dividend, which aggregated approximately $2.43 billion, was financed through borrowings under our former credit facilities.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

Forward-Looking Statements

Certain statements contained in this Annual Report on Form 10-K, including, without limitation, statements containing the words "believe," "anticipate," "intend," "expect," "may," "could," "plan," "continue," "should," "project," "estimate" and words of similar import, constitute "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. These statements may include projections of revenue, provisions for doubtful accounts, income or loss, capital expenditures, debt structure, principal payments on debt, capital structure, the amount and timing of funds under the meaningful use measurement standard of various Healthcare Information Technology ("HCIT") incentive programs, other financial items and operating statistics, statements regarding our plans and objectives for future operations, acquisitions, acquisition financing, divestitures and other transactions, statements of future economic performance, statements regarding our legal proceedings and other loss contingencies, statements regarding market risk exposures, statements regarding the effects and/or interpretations of recently enacted or future health care laws and regulations, statements of the assumptions underlying or relating to any of the foregoing statements, and statements that are other than statements of historical fact.

Forward-looking statements are based on our current plans and expectations and involve known and unknown risks, uncertainties and other factors that may cause our actual results, performance, achievements or industry results to be materially different from any future results, performance or achievements expressed or implied by our forward-looking statements. Such factors include, among other things, the risks and uncertainties identified by us under the heading "Risk Factors" in Item 1A of Part I. Furthermore, we operate in a continually changing business and regulatory environment and new risk factors emerge from time to time. We cannot predict what these new risk factors may be, nor can we assess the impact, if any, of such new risk factors on our business or results of operations, or the extent to which any factor or combination of factors may cause our actual results to differ materially from those expressed or implied by any of our forward-looking statements.

Undue reliance should not be placed on our forward-looking statements. Except as required by law, we disclaim any obligation to update our risk factors or to publicly announce updates to the forward-looking statements contained in this Annual Report on Form 10-K to reflect new information, future events or other developments.

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. We consider the following critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our consolidated financial statements.

Net Revenue

We derive a significant portion of our net revenue from Medicare, Medicaid and managed care health plans. Payments for services rendered to patients covered by these programs are generally less than billed charges. For Medicare and Medicaid, provisions for contractual adjustments are made to reduce patient charges to the estimated cash receipts based on each program's principles of payment/reimbursement (i.e., either prospectively determined or retrospectively determined costs). Final settlements under these programs are subject to administrative review and audit and, accordingly, we periodically provide reserves for the adjustments that may ultimately result therefrom. Estimates for contractual allowances under managed care health plans are primarily based on the payment terms of contractual arrangements, such as predetermined rates per diagnosis, per diem rates or discounted fee for service rates. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to ensure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payors may be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% from our estimated percentage, we project that our net accounts receivable and consolidated net income as of and for the year ended December 31, 2011 would have changed by approximately $28.4 million and $17.4 million, respectively.

In the ordinary course of business, we provide services to patients who are financially unable to pay for their care. Accounts characterized as charity and indigent care are not recognized in net revenue. We maintain a uniform policy whereby patient account balances are characterized as charity and indigent care only if the patient meets certain percentages of the federal poverty level guidelines. Local hospital personnel and our collection agencies pursue payments on accounts receivable from patients who do not meet such criteria. We monitor the levels of charity and indigent care provided by our hospitals and other health care facilities and the procedures employed to identify and account for those patients.

Provision for Doubtful Accounts

Our hospitals and other health care facilities provide services to patients with health care coverage, as well as to those without health care coverage. Those patients with health care coverage are often responsible for a portion of their bill referred to as the co-payment or deductible. This portion of the bill is determined by the patient's individual health care or insurance plan. Patients without health care coverage are evaluated at the time of service, or shortly thereafter, for their ability to pay based on federal and state poverty guidelines, qualification for Medicaid or other state assistance programs, as well as our policies for indigent and charity care. After payment, if any, is received from a third party, statements are sent to patients indicating the outstanding balances on their accounts. If an account is still outstanding after a period of time, it is referred to a primary collection agency for assistance in collecting the amount due. The primary collection agency begins the process of debt collection by contacting the patient via mail and phone. The accounts that are sent to these agencies are often difficult to collect and require more focused, dedicated attention than might be available in one of our business offices. We believe that the primary collection agencies have been very successful in collecting the accounts that we send to them. A secondary collection agency is used when accounts are returned from the primary collection agency as uncollectible. These accounts are written off as uncollectible shortly after they are returned to us from the primary collection agency. In certain circumstances, we may sell a portfolio of outstanding accounts receivable to an unrelated third party.

An account is typically sent to the primary collection agency automatically via electronic transfer of data at the end of the statement cycle although, if deemed necessary or appropriate, the account can be sent to the primary collection agency at any time. Accounts that are identified as self-pay accounts with balances less than $9.99 are automatically written off on the 20th day of each month. All accounts that have been placed with a primary collection agency that are less than $25.00 are also written off.

When considering the adequacy of our allowance for doubtful accounts, accounts receivable balances are routinely reviewed in conjunction with health care industry trends/indicators, historical collection rates by payor, aging reports and other business and economic conditions that might reasonably be expected to affect the collectibility of patient accounts. We believe that our principal risk of collection continues to be uninsured patient accounts and patient accounts for which the primary insurance payor has paid but patient responsibility amounts (generally deductibles and co-payments) remain outstanding. If our actual collection rate changed by 1% from the estimated percentage that we used, we project that our allowance for doubtful accounts and consolidated net income as of and for the year ended December 31, 2011 would have changed by approximately $5.8 million and $3.5 million, respectively.

Although we believe that our existing allowance for doubtful accounts reserve policies for all payor classes are appropriate and responsive to both the current health care environment and the overall economic climate, we will continue to monitor cash collections, accounts receivable agings and related industry trends. Changes in payor mix, general economic conditions or federal and state government health care coverage, including the effects of the Health Care Reform Act, could each have a material adverse effect on our accounts receivable collections, cash flows and results of operations and could result in accounting policy modifications in the future.

Of the accounts receivable identified as due from third party payors at the time of billing, a small percentage may convert to self-pay upon denials from third party payors. Those accounts are closely monitored on a routine basis for potential denial and are reclassified as appropriate. Third party payor and self-pay balances, as a percent of total gross billed accounts receivable, are summarized in the tables below.

	December 31, 2011			
	0-180 days	181-240 days	241-300 days	301 days and over
Medicare	16%	-%	-%	-%
Medicaid	13	1	1	-
Commercial insurance and others	41	2	1	1
Self-pay	13	4	4	3
Totals	83%	7%	6%	4%

	December 31, 2010			
	0-180 days	181-240 days	241-300 days	301 days and over
Medicare	17%	-%	-%	-%
Medicaid	12	1	-	-
Commercial insurance and others	38	2	1	1
Self-pay	15	5	5	3
Totals	82%	8%	6%	4%

Accounts receivable are reserved at increasing percentages as they age. All accounts are reserved 100% when they age 300 days from the date of discharge. In addition to days sales outstanding, which is discussed below under "Liquidity, Capital Resources and Capital Expenditures," we use other factors to analyze the collectibility of our accounts receivable. In that regard, we compare subsequent cash collections to net accounts receivable recorded on our consolidated balance sheet. We also review the provision for doubtful accounts as a percent of net revenue and the allowance for doubtful accounts as a percent of gross accounts receivable. These and other factors are reviewed monthly and are closely monitored for emerging trends in our accounts receivable portfolio.

Impairments of Long-Lived Assets and Goodwill

Long-lived assets. We review our long-lived assets, including amortizable intangible assets, for impairment whenever events or changes in circumstances indicate that the carrying amount of those assets may not be fully recoverable (e.g., advances in technology, deteriorating operating results, excess capacity, obsolescence, etc.). The determination of possible impairment of assets to be held and used is predicated on our estimate of the asset's undiscounted future cash flows. If the estimated future cash flows are less than the carrying value of the asset, an impairment charge is recognized for the difference between the asset's estimated fair value and its carrying value. Long-lived assets to be disposed of, including discontinued operations, are reported at the lower of their carrying amount or estimated fair value, less costs to sell. Estimates of fair value are based on recent sales of similar assets, market analyses, pending disposition transactions and market responses based on discussions with, and offers received from, potential buyers. There were no long-lived asset impairment charges that were material to our continuing operations during the years ended December 31, 2011, 2010 and 2009; however, as discussed at Note 10 to the Consolidated Financial Statements in Item 8, we recognized long-lived asset charges of approximately $8.4 million and $4.6 million in discontinued operations during 2010 and 2009, respectively.

Goodwill. Goodwill is reviewed for impairment on an annual basis (i.e., each October 1) and whenever circumstances indicate that a possible impairment might exist. Our judgment regarding the existence of impairment indicators is based on, among other things, market conditions and operational performance. When performing goodwill impairment tests prior to 2011, we initially compared the estimated fair values of each reporting unit's net assets, including allocated home office net assets, to the corresponding carrying amounts on our consolidated balance sheet. The estimated fair values of our reporting units were determined using a market approach methodology based on net revenue multiples. We also considered a valuation methodology using discounted cash flows and a market approach valuation methodology based on comparable transactions. If the estimated fair value of a reporting unit's net assets was less than the balance sheet carrying amount, we determined the implied fair value of the reporting unit's goodwill, compared such fair value to the corresponding carrying amount and, if necessary, recorded a goodwill impairment charge.

During September 2011, the Financial Accounting Standards Board amended the accounting standards in GAAP as they relate to the annual test for goodwill impairment (the "Goodwill Update"). The Goodwill Update allows, but does not require, an initial assessment of qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for the purpose of determining if detailed quantitative goodwill impairment testing is necessary. We elected to early adopt the Goodwill Update in connection with our annual goodwill impairment testing on October 1, 2011. Our adoption of the Goodwill Update did not have a material impact on our annual goodwill impairment testing or the results therefrom. Specifically, the qualitative factors reviewed by us did not reveal any circumstances whereby detailed quantitative goodwill impairment testing was necessary at the reporting unit level. There were no goodwill impairment charges in continuing operations during the years ended December 31, 2011, 2010 and 2009; however, as discussed at Note 10 to the Consolidated Financial Statements in Item 8, we recognized a goodwill impairment charge of approximately $3.6 million in discontinued operations during 2011. We do not believe that any of our reporting units are currently at risk of incurring a goodwill impairment charge.

Qualitative assessments of our reporting units are based on estimates and assumptions that we believe to be reasonable but are ultimately unpredictable and inherently uncertain. Additionally, we make certain judgments and assumptions when allocating home office assets and liabilities to determine the carrying values of our reporting units. Changes in the estimates, assumptions and other qualitative factors used to conduct goodwill impairment tests, including revenue and profitability projections and market values, could indicate that our goodwill is impaired in future periods and result in a write-off of some or all of our goodwill at that time. Reporting units are one level below the operating segment level (see Note 1(m) to the Consolidated Financial Statements in Item 8). However, after consideration of the relevant GAAP aggregation rules, we determined that our goodwill impairment testing should be performed at the divisional operating level. Goodwill is discretely allocated to our reporting units (i.e., each hospital's goodwill is included as a component of the aggregate reporting unit goodwill being evaluated during the impairment analysis).

Income Taxes

We make estimates to record the provision for income taxes, including conclusions regarding deferred tax assets and deferred tax liabilities, as well as valuation allowances that might be required to offset deferred tax assets. We estimate valuation allowances to reduce deferred tax assets to the amounts that we believe are more likely than not to be realized in future periods. When establishing valuation allowances, we consider all relevant information, including ongoing tax planning strategies. We believe that, other than certain state net operating loss carryforwards, reversals of existing taxable temporary differences, future taxable income and carrybacks will enable us to realize our deferred tax assets and, therefore, we have not recorded any material valuation allowances against our deferred tax assets.

We operate in multiple states with varying tax laws. We are subject to both federal and state audits of our tax filings. Our federal income tax returns have been examined by the Internal Revenue Service through the period ended December 31, 2009. We participate in the Internal Revenue Service's Compliance Assurance Program whereby our federal income tax returns will be audited on a concurrent basis. The Internal Revenue Service is currently auditing our income tax return for the year ended December 31, 2010. We make estimates to record tax reserves that we believe adequately provide for audit adjustments, if any.

Professional Liability Risks

As with most other health care providers, we are subject to claims and legal actions by patients and others in the ordinary course of business. We use our wholly owned captive insurance subsidiary and our risk retention group subsidiary, which are domiciled in the Cayman Islands and South Carolina, respectively, to self-insure a significant portion of our professional liability risks. Those subsidiaries, which are collectively referred to as the "Insurance Subsidiaries," provide (i) claims-made coverage to all of our hospitals and other health care facilities and (ii) occurrence-basis coverage to most of our employed physicians. To mitigate the exposure of the self-insured program covering the hospitals and other health care facilities, the Insurance Subsidiaries buy claims-made reinsurance policies from unrelated third parties for claims above self-retention levels of $10.0 million or $15.0 million, depending on the policy year. The limits of liability provided by the Insurance Subsidiaries for each employed physician located outside of Florida is generally $1 million per claim and $3 million in the aggregate, and the corresponding limits for physicians located in Florida are $250,000 and $750,000, respectively. Our employed physicians not covered by the Insurance Subsidiaries generally maintain claims-made policies with unrelated third party insurance companies.

Our self-insured professional liability reserves reflect estimates of all known indemnity losses, incurred but not reported indemnity losses and related incurred/future loss expenses. As of December 31, 2011 and 2010, such discounted reserves, net of amounts estimated to be recoverable under reinsurance policies, were approximately $215.6 million and $180.9 million, respectively. Included in those amounts were $53.7 million and $61.3 million, respectively, of case reserves on reported claims. Historically, the average lag time between settlement of a claim and payment to the claimant is generally less than one month. Therefore, our total unpaid settled claim amount at the end of any reporting period is not significant. Our expense for professional liability risks includes: (i) an estimate of discounted losses and loss expenses for the current year, including claims incurred but not reported; (ii) changes in estimates for losses and loss expenses from prior years based on actual claim development experience; (iii) interest accretion on discounted reserves; and (iv) cumulative adjustments for changes in the discount rate, if any, during the year. Such expense was $66.3 million, $68.6 million and $60.5 million during the years ended December 31, 2011, 2010 and 2009, including $66.4 million, $52.2 million and $49.9 million, respectively, relating to current year claim activity. The year-over-year increases in our expense for current year claim activity reflect, among other things, organic and acquisition-related growth in our business.

Our reserves for self-insured professional liability risks are determined using actuarially-based techniques and methodologies. The data used to develop such reserves is based, in part, on asserted and unasserted claim information that has been accumulated by our incident reporting system. In the consolidated financial statements, these long-term liabilities are recorded at their estimated present values using a discount rate of 1.00% at both December 31, 2011 and 2010. We select a discount rate that represents a risk-free interest rate correlating to the period when the claims are projected to be paid (i.e., a weighted average payment duration of approximately three years). However, the facts and circumstances of each individual claim can result in an occurrence-to-settlement interval that varies from our payment duration estimate. As of December 31, 2011, a 25 basis point increase or decrease in the discount rate would have changed our professional liability reserve requirements by approximately $1.4 million.

For purposes of estimating case reserves, we use individual claim information, including the nature of the claim, the expected claim amount, payments made on the claim to date, the year in which the claim occurred and the laws of the jurisdiction where the incident occurred. Once case reserves for known claims are determined, the data is stratified by loss layers and retention levels, accident years, reported years, geography and other key attributes. Several actuarial methods are applied to the data by us and our external actuaries on a semi-annual basis to produce estimates of the ultimate indemnity losses and related loss expenses for both known and incurred but not reported claims. Such actuarial methods include: (i) paid and incurred extrapolation methods; (ii) frequency and severity methods to estimate the ultimate average frequency (number of claims) and the ultimate average severity (cost per claim); and (iii) Bornhuetter-Ferguson methods that add expected development to actual paid or incurred experience. Each of these actuarial methods uses our company-specific data, including: historical paid indemnity losses and loss expenses that have been accumulated over a period of fifteen years; current and historical case reserves; actual and projected census data; employed physician information; our professional liability retention levels by policy year; geographic information; trends of loss development factors; trends in the frequency and severity of claims; coverage limits of unrelated third party insurance policies; and other relevant inputs. We also consider pertinent industry data and changes in laws and regulations (e.g., tort reform, settlement caps, etc.) in the jurisdictions where our hospitals and other health care facilities operate. We believe that using the aforementioned company-specific data and other information enables us and our external actuaries to reasonably estimate (i) our ultimate indemnity losses and related loss expenses and (ii) the projected timing of the corresponding payments. Therefore, we further believe that discounting our self-insured professional liability reserves is appropriate.

Given the number of factors used to establish our reserves for self-insured professional liability risks, we believe that there is limited benefit to isolating any individual assumption or parameter from the detail computational process and calculating the impact of changing that single item. Instead, we believe that the sensitivity of the estimates of such reserves is best reflected in the selected actuarial confidence level used in the computations. In our actuarial modeling, we consistently used the central estimate, which generally approximates a confidence level at the 50th percentile. Utilizing a confidence level higher than the central estimate, while not representative of our best estimate, would reflect a reasonably likely outcome for the ultimate resolution of our known and incurred but not reported indemnity claims and related expenses. For example, using a statistical confidence level at the 70th percentile in our actuarial model would increase our discounted net reserves by approximately $23.0 million, or 10.7%.

Our reserves for self-insured professional liability risks are periodically reviewed and adjustments thereto are recorded as more information about claim trends becomes known to us. Although the ultimate settlement of these liabilities may vary from our estimates due to, among other things, their inherently complex, long-term and subjective nature, we believe that the amounts included in the consolidated financial statements are adequate and reasonable. However, if actual losses and loss expenses exceed our projections of claim activity and/or the projected claim payment duration differs from our estimates, our reserves could be materially impacted.

Other Self-Insured Programs

We provide (i) income continuance to, and reimburse certain health care costs of, our disabled employees (collectively, "workers' compensation") and (ii) health and welfare benefits to our employees, their spouses and certain beneficiaries. Such employee benefit programs are primarily self-insured; however, we purchase stop-loss insurance policies from unrelated third parties to mitigate our exposure to catastrophic events and individual years with high levels of benefit claim activity. We record estimated liabilities for both reported and incurred but not reported workers' compensation and health and welfare claims based on historical loss experience and other information provided by our third party administrators. The long-term liabilities for workers' compensation are determined using actuarially-based techniques and methodologies and are discounted to their estimated present values. We select a discount rate that represents a risk-free interest rate correlating to the period when such benefits are projected to be paid. As of December 31, 2011, a 25 basis point increase or decrease in the discount rate would have changed our net workers' compensation liability by approximately $0.5 million (our net liability considers discounted receivables for amounts that are estimated to be recoverable under stop loss insurance policies). Although there can be no assurances, we believe that the net liabilities included in the consolidated financial statements for these self-insured programs are adequate and reasonable. If the actual costs of these programs exceed our projections and/or the projected period over which workers' compensation benefits will be paid differs from our estimates, the net liabilities could be materially adversely affected.

Loss Contingencies

We regularly review the status of our legal and regulatory matters and assess the potential financial exposure thereof. If the potential loss from any claim, lawsuit or regulatory proceeding is considered probable and the amount can be reasonably estimated, we record a reserve. Attorneys' fees and other costs of defending our company in respect of claims, lawsuits and regulatory proceedings are expensed in the period such fees and costs are incurred, except for those amounts relating to our professional liability risks, which are discussed at Note 1(h) to the Consolidated Financial Statements in Item 8. Significant judgment is required when determining probability and whether an exposure is reasonably estimable. Predicting the final resolution of claims, lawsuits and regulatory matters and estimating financial exposure requires consideration of substantial uncertainties and, therefore, the actual costs thereof may vary significantly from our estimates. When making determinations of likely outcomes of legal and regulatory matters and the related financial exposure, we consider many factors, including, but not limited to, the nature of the claim (including unasserted claims), the availability of insurance, our experience with similar types of claims, the jurisdiction where the matter is being adjudicated, input from in-house and external legal counsel, the likelihood of resolution through alternative dispute resolution or other means and the current status of the matter. As additional information becomes available, we reassess our potential liability and we may revise and adjust our estimates at that time. Adjustments to reserves reflect the status of negotiations, settlements, rulings, advice of legal counsel and other relevant information. Changes in our estimates of financial exposure for legal matters and other loss contingencies could have a material impact on our consolidated financial position and results of operations. See Note 13 to the Consolidated Financial Statements in Item 8 for information regarding our material legal matters and other loss contingencies.

Recent Accounting Standards Updates

See Note 1(e) and Note 12 to the Consolidated Financial Statements in Item 8 for a discussion of recent accounting standards updates that we adopted during the year ended December 31, 2011 or that we will adopt during the quarter ending March 31, 2012. We do not believe that such new accounting guidance had or will have a material impact on us.

Results of Operations

2011 Overview

The following discussion and analysis should be read in conjunction with the Consolidated Financial Statements and the accompanying notes in Item 8.

As of December 31, 2011, we operated 66 hospitals by and through our subsidiaries with a total of 10,330 licensed beds in non-urban communities in Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, Missouri, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Washington and West Virginia. See Note 10 to the Consolidated Financial Statements in Item 8 for information about one of our Tennessee-based hospitals with a lease agreement that will expire in May 2012 and will not be renewed. Also, see Note 15 for information about our pending acquisition of an 80% equity interest in each of five Oklahoma-based general acute care hospitals and their related health care operations, which we plan to complete during the quarter ending June 30, 2012. The operating results of hospitals and other ancillary health care businesses that we acquire are included in our consolidated financial statements subsequent to the date of acquisition.

Unless specifically indicated otherwise, the following discussion excludes our discontinued operations, which are identified at Note 10 to the Consolidated Financial Statements in Item 8. Such discontinued operations were not material to our consolidated results of operations during the years presented herein, other than the following items: (i) a 2010 loss of approximately $12.1 million from the sale of Riley Hospital in Meridian, Mississippi and its related health care operations; (ii) 2011, 2010 and 2009 long-lived asset and goodwill impairment charges of $3.6 million, $8.4 million and $4.6 million, respectively; and (iii) a 2009 gain of $10.4 million from the sale of equity interests in a limited liability company that owned and operated two of our general acute care hospitals.

During March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Care Reform Act") were signed into law by President Obama. The primary goals of the Health Care Reform Act are to: (i) provide coverage by January 1, 2014 to an estimated 32 to 34 million Americans who currently do not have health insurance; (ii) reform the health care delivery system to improve quality; and (iii) lower the overall costs of providing health care. To accomplish the goal of expanding coverage, the new legislation mandates that all Americans maintain a minimum level of health care coverage. To that end, the Health Care Reform Act expands Medicaid coverage, provides federal subsidies to assist low-income

individuals when they obtain health insurance and establishes insurance exchanges through which individuals and small employers can purchase health insurance. Health care cost savings under the Health Care Reform Act are expected to come from: (i) reductions in Medicare and Medicaid reimbursement payments to health care providers, including hospital operators; (ii) initiatives to reduce fraud, waste and abuse in government reimbursement programs; and (iii) other reforms to federal and state reimbursement systems. Although certain aspects of the Health Care Reform Act have already become effective, it will be several years before most of the far-reaching and innovative provisions of the new legislation are fully implemented. While we continue to evaluate the provisions of the Health Care Reform Act, its overall effect on our business cannot be reasonably determined at the present time because, among other things, the new legislation is very broad in scope and there exist uncertainties regarding the interpretation and future implementation of many of the regulations mandated under the Health Care Reform Act. Additionally, the Health Care Reform Act remains subject to significant legislative debate, including possible repeal and/or amendment, and there are substantial legal challenges to various aspects of the law that have been made on constitutional grounds, including an appeal currently pending before the United States Supreme Court (a ruling is expected by July 2012). For further discussion of the Health Care Reform Act and its possible impact on our business and results of operations, see "Business – Sources of Revenue" in Item 1 of Part I and "Risk Factors" in Item 1A of Part I.

During the year ended December 31, 2011, which we refer to as the 2011 Calendar Year, we experienced net revenue growth over the year ended December 31, 2010, which we refer to as the 2010 Calendar Year, of approximately 14.0%. Such growth principally resulted from: (i) our acquisition of a 60% equity interest in each of three Florida-based general acute care hospitals with a total of 139 licensed beds and certain related health care operations (collectively, "Shands") in July 2010; (ii) our acquisition of two Florida-based general acute care hospitals with a total of 413 licensed beds and certain related health care operations (collectively, "Wuesthoff") in October 2010; (iii) our acquisition of a 95% equity interest in a Mississippi-based general acute care hospital with a total of 112 licensed beds and certain related health care operations (collectively, "Tri-Lakes") in May 2011; (iv) our acquisition of six Tennessee-based general acute care hospitals and other ancillary health care operations with a total of 882 licensed beds (collectively, the "Mercy Hospitals") on September 30, 2011; (v) increased surgical volume attributable to physician recruitment and market service development (e.g., ambulatory surgical centers, robotic surgical systems, etc.) at certain of our hospitals and other health care facilities; (vi) more emergency room visits, which we believe were attributable, in part, to our dedicated focus on emergency room operations; and (vii) improvements in reimbursement rates that resulted primarily from renegotiated agreements with certain commercial health insurance providers. During the 2011 Calendar Year, we recorded a first time benefit of approximately $40.0 million from the meaningful use measurement standard under various Medicare and Medicaid Healthcare Information Technology incentive programs (collectively, the "HCIT Programs"). Items that adversely affected our profitability during the 2011 Calendar Year included: (i) increases in interest expense and costs for government investigations; (ii) $24.6 million of write-offs of deferred debt issuance costs and related other attributable to a debt restructuring that we completed on November 18, 2011 (the "2011 Debt Restructuring"); and (iii) expenses attributable to our acquisition of the Mercy Hospitals and related restructuring activities. Overall, our income from continuing operations increased during the 2011 Calendar Year by $20.6 million, or 11.1%.

Our strategic operational objectives include increasing patient volume and operating margins, while decreasing uninsured/underinsured patient levels and the provision for doubtful accounts. Our specific plans include, among other things, utilizing experienced local and regional management teams, modifying physician employment agreements, renegotiating payor and vendor contracts and developing action plans responsive to feedback from patient, physician and employee satisfaction surveys. Based on the needs of the communities that we serve, we also seek opportunities for market service development, including establishing ambulatory surgical centers, urgent care centers, cardiac cath labs, angiography suites and orthopedic, cardiology and neurology/neurosurgery centers of excellence. Furthermore, we are investing significant resources in physician recruitment and retention (primary care physicians and specialists), emergency room operations, advanced robotic surgical systems, replacement hospital construction and other capital projects. For example, we continue to implement ER Extra®, which is our signature patient-centered emergency room program that is designed to reduce patient wait times, enhance patient satisfaction and improve the quality and scope of patient assessments. During 2011, we also opened a hospital that we built to replace Madison County Medical Center in Canton, Mississippi and deployed new MAKOplasty® and da Vinci® robotic surgical systems at many of our hospitals. We believe that our strategic initiatives, coupled with appropriate executive management oversight, centralized support and innovative marketing campaigns, will enhance patient, physician and employee satisfaction, improve clinical outcomes and ultimately yield increased surgical volume, emergency room visits and admissions. Additionally, as we consider potential acquisitions, joint ventures and partnerships in 2012 and beyond, we believe that continually improving our existing operations provides us with a fundamentally sound infrastructure upon which we can add hospitals and other ancillary health care businesses.

We have also taken steps that we believe are necessary to achieve industry leadership in clinical quality. Our vision is to be the highest rated health care provider of any hospital system in the country, as measured by Medicare. With our knowledgeable and experienced clinical affairs leadership supporting this critical quality initiative, we measure key performance objectives, maintain accountability for achieving those objectives and recognize the leaders whose quality indicators and clinical outcomes demonstrate improvement. As most recently reported by the Centers for Medicare and Medicaid Services, all four of our core measure care areas have dramatically improved since the commencement of our clinical quality initiatives and we now rank second in core measures amongst for-profit hospital systems. Additionally, The Joint Commission, a leading independent not-for-profit organization that accredits and certifies health care organizations in the United States, recently named nearly 60% of our hospitals as Top Performers on Key Quality Measures, which compares to a nationwide achievement rate of approximately 14%. The Joint Commission aggregated certain evidence-based accountability data from 2010, including core measurement performance data, to determine the top performers.

Outpatient services continue to play an important role in the delivery of health care in our markets, with approximately half of our net revenue generated on an outpatient basis. Recognizing the importance of these services, we have improved many of our health care facilities to accommodate the outpatient needs of the communities that they serve. We have also invested substantial capital in many of our hospitals and physician practices during the past several years, resulting in improvements and enhancements to our diagnostic imaging and ambulatory surgical services.

During the past several years, various economic and other factors have resulted in a large number of uninsured and underinsured patients seeking health care in the United States. Self-pay admissions as a percent of total admissions at our hospitals were approximately 6.7% and 7.1% during the 2011 Calendar Year and the 2010 Calendar Year, respectively. We continue to take various measures to address the impact of uninsured and underinsured patients on our business. Additionally, one of the primary goals of the Health Care Reform Act is to provide health insurance coverage to more Americans. Nevertheless, there can be no assurances that our self-pay admissions will not grow in future periods, especially in light of the prolonged downturn in the economy and correspondingly higher levels of unemployment in many of the markets served by our hospitals. Therefore, we regularly evaluate our self-pay policies and programs and consider changes or modifications as circumstances warrant.

2011 Calendar Year Compared to the 2010 Calendar Year

The tables below summarize our operating results for the 2011 Calendar Year and the 2010 Calendar Year. Hospitals that were owned/leased and operated by us for one year or more as of December 31, 2011 are referred to as same 2011 hospitals. For all year-over-year comparative discussions herein, the operating results of our same 2011 hospitals are only considered to the extent that there was a similar period of operation in both years.

	Years Ended December 31,			
	2011		2010	
	Amount (in thousands)	Percent of Net Revenue	Amount (in thousands)	Percent of Net Revenue
Net revenue	$ 5,804,451	100.0%	$ 5,092,166	100.0%
Salaries and benefits	2,302,844	39.7	2,016,967	39.6
Supplies	776,598	13.4	703,426	13.8
Provision for doubtful accounts	716,856	12.4	624,753	12.3
Rent expense	154,279	2.6	122,983	2.4
Other operating expenses	1,067,980	18.4	892,465	17.5
Medicare and Medicaid HCIT incentive payments	(39,982)	(0.7)	-	-
Depreciation and amortization	267,900	4.6	241,873	4.8
Interest expense	222,747	3.8	211,673	4.2
Write-offs of deferred debt issuance costs and related other	24,595	0.4	-	-
Other	(1,771)	-	(8,797)	(0.2)
	5,492,046	94.6	4,805,343	94.4
Income from continuing operations before income taxes	312,405	5.4	286,823	5.6
Provision for income taxes	(106,071)	(1.8)	(101,049)	(2.0)
Income from continuing operations	$ 206,334	3.6%	$ 185,774	3.6%

2011 Calendar Year Compared to the 2010 Calendar Year (continued)

	Years Ended December 31, 2011	Years Ended December 31, 2010	Change	Percent Change
Same 2011 Hospitals*				
Occupancy	42.1%	43.9%	(180) bps**	n/a
Patient days	1,300,722	1,350,697	(49,975)	(3.7)%
Admissions	311,053	323,917	(12,864)	(4.0)%
Adjusted admissions †	581,056	586,060	(5,004)	(0.9)%
Emergency room visits	1,430,193	1,413,831	16,362	1.2 %
Surgeries	316,298	314,564	1,734	0.6 %
Outpatient revenue percent	51.6%	50.0%	160 bps	n/a
Inpatient revenue percent	48.4%	50.0%	(160) bps	n/a
Total Hospitals				
Occupancy	42.8%	43.9%	(110) bps	n/a
Patient days	1,424,500	1,350,697	73,803	5.5 %
Admissions	338,637	323,917	14,720	4.5 %
Adjusted admissions †	635,934	586,060	49,874	8.5 %
Emergency room visits	1,562,028	1,413,831	148,197	10.5 %
Surgeries	342,421	314,564	27,857	8.9 %
Outpatient revenue percent	51.9%	50.0%	190 bps	n/a
Inpatient revenue percent	48.1%	50.0%	(190) bps	n/a

* Includes acquired hospitals to the extent we operated them for comparable periods

** basis points

† Admissions adjusted for outpatient volume

Net revenue during the 2011 Calendar Year was approximately $5,804.5 million as compared to $5,092.2 million during the 2010 Calendar Year. This change represented an increase of $712.3 million, or 14.0%. Our same 2011 hospitals provided $243.3 million, or 34.2%, of the increase in net revenue as a result of: (i) increased outpatient and surgical volume from, among other things, market service development activities; (ii) an increase in emergency room visits; and (iii) improvements in reimbursement rates. These items were partially offset by a decrease in hospital admissions, which was primarily due to a reduction in admissions of uninsured patients and certain weather-related disruptions. The remaining 2011 net revenue increase of $469.0 million was due to our acquisitions of: (i) Shands in July 2010; (ii) Wuesthoff in October 2010; (iii) Tri-Lakes in May 2011; and (iv) the Mercy Hospitals in September 2011.

Net revenue per adjusted admission increased approximately 5.0% during the 2011 Calendar Year as compared to the 2010 Calendar Year. The factors contributing to such change included higher patient acuity, increased surgical volume and the favorable effects of renegotiated agreements with certain commercial health insurance providers.

Our provision for doubtful accounts during the 2011 Calendar Year increased 10 basis points to 12.4% of net revenue as compared to 12.3% of net revenue during the 2010 Calendar Year. This change was primarily due to amounts considered to be patient responsibility (e.g., deductibles, co-payments, other amounts not covered by insurance, etc.).

Our consistently applied accounting policy is that accounts written off as charity and indigent care are not recognized in net revenue and, accordingly, such amounts have no impact on our provision for doubtful accounts. However, as a measure of our fiscal performance, we routinely aggregate amounts pertaining to our (i) provision for doubtful accounts, (ii) uninsured self-pay patient discounts and (iii) foregone/unrecognized revenue for charity and indigent care and divide the resulting total by the sum of our (i) net revenue, (ii) uninsured self-pay patient discounts and (iii) foregone/unrecognized revenue for charity and indigent care. We believe that this fiscal measure, which we refer to as our Uncompensated Patient Care Percentage, provides us with key information regarding the aggregate level of patient care for which we do not receive remuneration. During the 2011 Calendar Year and the 2010 Calendar Year, our Uncompensated Patient Care Percentage was 25.6% and 25.2%, respectively. This 40 basis point increase during the 2011 Calendar Year primarily reflects greater uninsured self-pay patient revenue discounts, partially offset by a decline in self-pay patients in the mix of patients that we serve.

Salaries and benefits as a percent of net revenue increased to 39.7% during the 2011 Calendar Year from 39.6% during the 2010 Calendar Year. During the 2011 Calendar Year, increased costs for routine salary and wage increases and disproportionately higher salaries and benefits at our recent acquisitions (including restructuring activities at the Mercy Hospitals) were mostly offset by cost containment measures such as flexible staffing and new hire limitations.

Supplies as a percent of net revenue decreased from 13.8% during the 2010 Calendar Year to 13.4% during the 2011 Calendar Year. This decrease was primarily due to improved pricing and greater discounts from our group purchasing agreement and a favorable change in our surgical volume mix during the 2011 Calendar Year.

Rent expense as a percent of net revenue increased during the 2011 Calendar Year as compared to the 2010 Calendar Year while depreciation and amortization expense as a percent of net revenue declined. In recent years, we have entered into more operating lease arrangements. As our use of operating leases has increased, depreciation and amortization expense has declined and rent expense has increased. Additionally, certain of our hospital buildings reached the end of their depreciable lives during 2010, which further reduced depreciation and amortization expense in 2011.

Other operating expenses as a percent of net revenue increased from 17.5% during the 2010 Calendar Year to 18.4% during the 2011 Calendar Year. This increase was primarily due to the costs associated with: (i) the acquisition of the Mercy Hospitals; (ii) restructuring activities at the Mercy Hospitals; and (iii) certain government investigations. See Notes 4 and 13 to the Consolidated Financial Statements in Item 8 for information regarding our recent acquisitions and our ongoing government investigations, respectively. Also contributing to the 2011 increase in other operating expenses were: (i) higher state-mandated provider taxes and increased repairs and maintenance costs during the 2011 Calendar Year; (ii) certain services at our hospitals that have been recently outsourced and/or contracted to third parties; and (iii) disproportionately higher costs at our recent acquisitions.

During the 2011 Calendar Year, we recognized a first time benefit of approximately $40.0 million under the meaningful use measurement standard of the HCIT Programs.

Interest expense increased from approximately $211.7 million during the 2010 Calendar Year to $222.7 million during the 2011 Calendar Year. Such increase was primarily due to non-cash interest expense of $16.4 million attributable to our interest rate swap contract (i.e., accumulated other comprehensive loss amortization and net fair value adjustment expense) that was recognized after the 2011 Debt Restructuring on November 18, 2011. This increase was partially offset by a lower overall effective interest rate on our former $2.75 billion seven-year term loan because less of the outstanding balance thereunder was covered by our interest rate swap contract. We also maintained a lower average outstanding principal balance on such term loan during the 2011 Calendar Year as compared to the 2010 Calendar Year and recorded a greater amount of capitalized interest during the 2011 Calendar Year. See "Liquidity, Capital Resources and Capital Expenditures" below and Note 2 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt arrangements and interest rate swap contract.

As a result of the 2011 Debt Restructuring, we wrote-off approximately $24.0 million of deferred debt issuance costs and incurred $0.6 million of related costs. See Note 2 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt and the 2011 Debt Restructuring.

Our effective income tax rates were approximately 34.0% and 35.2% during the 2011 Calendar Year and the 2010 Calendar Year, respectively. Net income attributable to noncontrolling interests, which is not tax-effected in our consolidated financial statements, reduced our effective income tax rates by approximately 290 basis points and 230 basis points during the 2011 Calendar Year and the 2010 Calendar Year, respectively. Also, see Note 6 to the Consolidated Financial Statements in Item 8 for further information regarding our effective income tax rates.

2010 Calendar Year Compared to the 2009 Calendar Year

The tables below summarize our operating results for the 2010 Calendar Year and the year ended December 31, 2009, which we refer to as the 2009 Calendar Year. Hospitals that were owned/leased and operated by us for one year or more as of December 31, 2010 are referred to as same 2010 hospitals. For all year-over-year comparative discussions herein, the operating results of our same 2010 hospitals are only considered to the extent that there was a similar period of operation in both years.

	Years Ended December 31,			
	2010		2009	
	Amount (in thousands)	Percent of Net Revenue	Amount (in thousands)	Percent of Net Revenue
Net revenue	$ 5,092,166	100.0%	$ 4,536,106	100.0%
Salaries and benefits	2,016,967	39.6	1,779,440	39.2
Supplies	703,426	13.8	637,663	14.1
Provision for doubtful accounts	624,753	12.3	553,639	12.2
Rent expense	122,983	2.4	100,990	2.2
Other operating expenses	892,465	17.5	788,051	17.4
Depreciation and amortization	241,873	4.8	234,883	5.2
Interest expense	211,673	4.2	217,938	4.8
Gains on early extinguishment of debt, net	-	-	(16,202)	(0.4)
Write-offs of deferred debt issuance costs	-	-	444	-
Other	(8,797)	(0.2)	(4,980)	(0.1)
	4,805,343	94.4	4,291,866	94.6
Income from continuing operations before income taxes	286,823	5.6	244,240	5.4
Provision for income taxes	(101,049)	(2.0)	(82,937)	(1.8)
Income from continuing operations	$ 185,774	3.6%	$ 161,303	3.6%

	Years Ended December 31,			
	2010	2009	Change	Percent Change
Same 2010 Hospitals*				
Occupancy	43.6%	45.3%	(170) bps**	n/a
Patient days	1,243,275	1,281,093	(37,818)	(3.0)%
Admissions	301,127	306,184	(5,057)	(1.7)%
Adjusted admissions †	542,628	533,101	9,527	1.8 %
Emergency room visits	1,312,705	1,352,044	(39,339)	(2.9)%
Surgeries	294,999	281,285	13,714	4.9 %
Outpatient revenue percent	50.1%	48.5%	160 bps	n/a
Inpatient revenue percent	49.9%	51.5%	(160) bps	n/a
Total Hospitals				
Occupancy	43.9%	45.3%	(140) bps	n/a
Patient days	1,350,697	1,281,093	69,604	5.4 %
Admissions	323,917	306,184	17,733	5.8 %
Adjusted admissions †	586,060	533,101	52,959	9.9 %
Emergency room visits	1,413,831	1,352,044	61,787	4.6 %
Surgeries	314,564	281,285	33,279	11.8 %
Outpatient revenue percent	50.0%	48.5%	150 bps	n/a
Inpatient revenue percent	50.0%	51.5%	(150) bps	n/a

* Includes acquired hospitals to the extent we operated them for comparable periods

** basis points

† Admissions adjusted for outpatient volume

Net revenue during the 2010 Calendar Year was approximately $5,092.2 million as compared to $4,536.1 million during the 2009 Calendar Year. This change represented an increase of $556.1 million, or 12.3%. Our same 2010 hospitals provided $182.7 million, or 32.9%, of the increase in net revenue as a result of increased surgical volume attributable to physician recruitment and market service development, as well as improvements in reimbursement rates. These items were partially offset by decreases in hospital admissions and emergency room visits, as well as unfavorable movement in our payor mix. Among other things, hospital admissions and emergency room visits declined in 2010 due to (i) fewer births at our hospitals and (ii) a less severe 2010 flu season as compared to 2009 when there was an outbreak of H1N1 influenza ("swine flu") in the United States. The remaining 2010 net revenue increase of $373.4 million was due to our acquisitions of: (i) the 492-bed Sparks Health System ("Sparks") in Fort Smith, Arkansas in December 2009; (ii) Shands in July 2010; and (iii) Wuesthoff in October 2010.

Net revenue per adjusted admission increased approximately 2.1% during the 2010 Calendar Year as compared to the 2009 Calendar Year. The factors contributing to such change included increased patient acuity and the favorable effects of renegotiated agreements with certain commercial health insurance providers, partially offset by the unfavorable movement in our payor mix during the 2010 Calendar Year.

Our provision for doubtful accounts during the 2010 Calendar Year increased 10 basis points to 12.3% of net revenue as compared to 12.2% of net revenue during the 2009 Calendar Year. This change was primarily due to an increase in uninsured patients in the mix of patients that we serve (approximately 7.1% and 7.0% of total hospital admissions during the 2010 Calendar Year and the 2009 Calendar Year, respectively), which can be attributed, in part, to the prolonged downturn in the economy and correspondingly higher levels of unemployment. During the 2010 Calendar Year and the 2009 Calendar Year, our Uncompensated Patient Care Percentage, which is described above under the heading "2011 Calendar Year Compared to the 2010 Calendar Year," was 25.2% and 24.3%, respectively. This 90 basis point increase during the 2010 Calendar Year primarily reflects greater uninsured self-pay patient revenue discounts and unfavorable movement in our payor mix.

Salaries and benefits as a percent of net revenue increased to 39.6% during the 2010 Calendar Year from 39.2% during the 2009 Calendar Year. This increase was primarily due to disproportionately higher salaries and benefits at our 2010 and 2009 acquisitions.

Supplies as a percent of net revenue decreased from 14.1% during the 2009 Calendar Year to 13.8% during the 2010 Calendar Year. This decrease was primarily due to improved pricing and greater discounts from our group purchasing agreement and a favorable change in our surgical volume mix during the 2010 Calendar Year.

Rent expense as a percent of net revenue increased during the 2010 Calendar Year as compared to the 2009 Calendar Year while depreciation and amortization expense as a percent of net revenue declined. See above under the heading "2011 Calendar Year Compared to the 2010 Calendar Year" for the factors contributing to these changes.

Other operating expenses as a percent of net revenue increased from 17.4% during the 2009 Calendar Year to 17.5% during the 2010 Calendar Year. This change was primarily due to an increase in attorneys' fees and disproportionately higher operating expenses at our recent acquisitions.

Interest expense decreased from approximately $217.9 million during the 2009 Calendar Year to $211.7 million during the 2010 Calendar Year. Such decrease was primarily due to a lower overall effective interest rate on our former $2.75 billion seven-year term loan because less of the outstanding balance thereunder was covered by our interest rate swap contract. We also maintained lower average outstanding principal balances on such term loan and our convertible debt securities during the 2010 Calendar Year as compared to the 2009 Calendar Year. These reductions in interest expense were partially offset by a lesser amount of capitalized interest during the 2010 Calendar Year. See Note 2 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt arrangements.

During the 2009 Calendar Year, we repurchased certain of our convertible debt securities, which yielded a net gain on the early extinguishment of debt of approximately $16.2 million. See Note 2(c) to the Consolidated Financial Statements in Item 8 for information regarding our convertible debt repurchases.

Our effective income tax rates were approximately 35.2% and 34.0% during the 2010 Calendar Year and the 2009 Calendar Year, respectively. Net income attributable to noncontrolling interests, which is not tax-effected in our consolidated financial statements, reduced our effective income tax rates by approximately 230 basis points and 380 basis points during the 2010 Calendar Year and the 2009 Calendar Year, respectively. Also, see Note 6 to the Consolidated Financial Statements in Item 8 for further information regarding our effective income tax rates.

Liquidity, Capital Resources and Capital Expenditures

Liquidity

Our cash flows from continuing operating activities provide the primary source of cash for our ongoing business needs. Additionally, at December 31, 2011 approximately $81.7 million of our available-for-sale securities and $400.3 million of borrowing capacity under our new $500.0 million long-term revolving credit facility were available for, among other things, general business purposes and acquisitions. As discussed at Note 15 to the Consolidated Financial Statements in Item 8, we plan to fund the pending acquisition of an 80% equity interest in each of five Oklahoma-based general acute care hospitals and certain related health care operations with available cash balances and proceeds from sales of available-for-sale securities. We believe that our various sources of cash are adequate to meet our foreseeable operating, capital expenditure, business acquisition and debt service needs.

Below is a summary of our recent cash flow activity (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Sources (uses) of cash and cash equivalents:			
Operating activities	$ 544,022	$ 434,691	$ 434,576
Investing activities	(976,011)	(393,653)	(357,253)
Financing activities	401,223	(49,483)	(127,451)
Discontinued operations	(6,903)	4,239	12,532
Net decrease in cash and cash equivalents	$ (37,669)	$ (4,206)	$ (37,596)

2011 Calendar Year Cash Flows Compared to the 2010 Calendar Year Cash Flows

Operating Activities

Our cash flows from continuing operating activities increased approximately $109.3 million, or 25.2%, during the 2011 Calendar Year as compared to the 2010 Calendar Year. This increase primarily related to: (i) improved profitability, including our receipt of $38.3 million under the meaningful use measurement standard of the HCIT Programs; (ii) reductions in both our interest payments and our net federal and state income tax payments during the 2011 Calendar Year when compared to the 2010 Calendar Year; and (iii) increases in our accounts payable, accrued expenses and other liabilities, which were primarily due to our recent acquisitions. Partially offsetting the abovementioned favorable developments during the 2011 Calendar Year was an increase in accounts receivable at the Mercy Hospitals, which we acquired on September 30, 2011.

Prospectively, we believe that our cash flows from continuing operating activities will be adversely impacted through the middle of 2012 by delayed cash collections on accounts receivable at the Mercy Hospitals; however, our new $500.0 million long-term revolving credit facility, which is described under "Capital Resources" below and Note 2 to the Consolidated Financial Statements in Item 8, is available to provide post-acquisition working capital, if necessary, while we await approvals to bill and collect under the Medicare and Medicaid provider numbers that we assumed (see further discussion below under "Days Sales Outstanding"). We also believe that the professional and other costs of our ongoing government investigations, while difficult to predict, will continue and will vary throughout the duration of such investigations. Those costs will be paid with our cash flows from continuing operating activities. See Note 13 to the Consolidated Financial Statements in Item 8 for information regarding such government investigations. Although subject to change due to a variety of factors beyond our control, we project that during the year ending December 31, 2012 (i) we will pay $87.0 million to the counterparties of our interest rate swap contract, which is discussed at Note 2(a) to the Consolidated Financial Statements in Item 8, and (ii) we will receive additional reimbursement under the meaningful use measurement standard of the HCIT Programs ranging from $90 million to $120 million.

Investing Activities

Cash used in investing activities during the 2011 Calendar Year included: (i) approximately $302.0 million of additions to property, plant and equipment, consisting primarily of new medical equipment (including $20.7 million to purchase da Vinci® robotic surgical systems), information technology hardware and software upgrades, renovation and expansion projects at certain of our facilities and replacement hospital construction (including a hospital that opened in May 2011 to replace Madison County Medical Center in Canton, Mississippi and a new 250-

bed hospital that is currently under construction and will ultimately replace our south campus facility at Poplar Bluff Regional Medical Center in Poplar Bluff, Missouri); (ii) $520.0 million to acquire the six Mercy Hospitals; (iii) $38.8 million to acquire a 95% equity interest in a Mississippi-based hospital (Tri-Lakes); (iv) $23.3 million to acquire ten ancillary health care businesses; and (v) a $35.3 million increase in our restricted funds. See Note 4 to the Consolidated Financial Statements in Item 8 for information regarding our recent acquisitions. Excluding the available-for-sale securities in restricted funds, we had a net cash outlay of $64.2 million from buying and selling such securities during the 2011 Calendar Year. These 2011 cash outlays were partially offset by (i) $4.9 million of proceeds from the sales of the remaining real property at Gulf Coast Medical Center, our closed hospital facility in Biloxi, Mississippi, and certain assets at Fishermen's Hospital in Marathon, Florida and (ii) $2.8 million of proceeds from sales of assets and insurance recoveries.

Cash used in investing activities during the 2010 Calendar Year included: (i) approximately $209.1 million of additions to property, plant and equipment, consisting primarily of new medical equipment, information technology hardware and software upgrades, renovation and expansion projects at certain of our facilities and construction of a hospital to replace Madison County Medical Center; (ii) $152.0 million for the acquisition of two Florida-based hospitals (Wuesthoff); (iii) $21.5 million to acquire a 60% equity interest in each of three Florida-based hospitals (Shands); (iv) $18.0 million to acquire six ancillary health care businesses; and (v) a $5.8 million increase in our restricted funds. Excluding the available-for-sale securities in restricted funds, we had a net cash outlay of $16.8 million from buying and selling such securities during the 2010 Calendar Year. These 2010 cash outlays were partially offset by (i) $26.4 million of proceeds from the sale of Riley Hospital in Meridian, Mississippi, which is discussed at Note 10 to the Consolidated Financial Statements in Item 8, and (ii) $3.2 million of proceeds from sales of assets and insurance recoveries.

Financing Activities

During the 2011 Calendar Year, we received approximately $389.2 million of cash proceeds from a syndicate of banks, including $29.2 million under a then existing revolving credit facility to: (i) finance the acquisition of seven Tennessee-based general acute care hospitals and other ancillary health care operations from Catholic Health Partners and its subsidiary Mercy Health Partners, Inc.; (ii) pay certain closing costs of a credit agreement, which is described at Note 2(d) to the Consolidated Financial Statements in Item 8; and (iii) provide start-up working capital to certain of our subsidiaries that are affiliated with the newly acquired hospitals. In connection with the 2011 Debt Restructuring, we received $2,967.8 million of proceeds from new debt arrangements, which was primarily used to repay all of the principal and accrued interest outstanding under certain of our then existing debt agreements. As a result of the 2011 Debt Restructuring and normal recurring activity, our aggregate principal payments on long-term debt and capital lease obligations were $2,869.4 million during the 2011 Calendar Year. We also paid $75.1 million for debt issuance costs related to our new credit agreements and $28.3 million to noncontrolling shareholders primarily for recurring distributions. During the 2011 Calendar Year our cash provided by continuing financing activities also included (i) $14.1 million of cash proceeds from exercises of stock options and (ii) $3.0 million of excess income tax benefits from our stock-based compensation arrangements. See Notes 2 and 3 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt arrangements and capital lease obligations, respectively.

During the 2010 Calendar Year, we made principal payments on long-term debt and capital lease obligations of approximately $40.1 million. We also paid $20.6 million to noncontrolling shareholders primarily for recurring distributions. Partially offsetting these cash outlays were (i) $7.5 million of cash proceeds from exercises of stock options and (ii) $2.5 million that we received from noncontrolling shareholders to acquire minority equity interests in one of our joint ventures.

Discontinued Operations

Cash used by our discontinued operations during the 2011 Calendar Year was approximately $6.9 million, including $12.4 million of purchase price allocated from the abovementioned Mercy Health Partners, Inc. acquisition. The cash provided by our discontinued operations during the 2010 Calendar Year was $4.2 million. We do not believe that the exclusion of such amounts from our consolidated cash flows in future periods will have a material effect on our liquidity or financial position. See Note 10 to the Consolidated Financial Statements in Item 8 for information regarding our discontinued operations.

2010 Calendar Year Cash Flows Compared to the 2009 Calendar Year Cash Flows

Operating Activities

Our cash flows from continuing operating activities were approximately the same amount during the 2010 Calendar Year and the 2009 Calendar Year. However, we experienced increased cash flows during the 2010 Calendar Year from (i) improved operating profitability and (ii) increases in our liabilities during the 2010 Calendar Year that were primarily due to the timing of vendor payments. Offsetting these items were (i) income taxes (i.e., net federal and state income tax payments of $56.7 million and $1.7 million during the 2010 Calendar Year and the 2009 Calendar Year, respectively) and (ii) an increase in accounts receivable from the hospital acquisitions that we completed during 2010.

Investing Activities

Cash used in investing activities during the 2010 Calendar Year included: (i) approximately $209.1 million of additions to property, plant and equipment, consisting primarily of new medical equipment, information technology hardware and software upgrades, renovation and expansion projects at certain of our facilities and construction of a hospital to replace Madison County Medical Center in Canton, Mississippi; (ii) $152.0 million for the acquisition of two Florida-based hospitals (Wuesthoff); (iii) $21.5 million to acquire a 60% equity interest in each of three Florida-based hospitals (Shands); (iv) $18.0 million to acquire six ancillary health care businesses; and (v) a $5.8 million increase in our restricted funds. See Note 4 to the Consolidated Financial Statements in Item 8 for information regarding our recent acquisitions. Excluding the available-for-sale securities in restricted funds, we had a net cash outlay of $16.8 million from buying and selling such securities during the 2010 Calendar Year. These 2010 cash outlays were partially offset by (i) $26.4 million of proceeds from the sale of Riley Hospital in Meridian, Mississippi, which is discussed at Note 10 to the Consolidated Financial Statements in Item 8, and (ii) $3.2 million of proceeds from sales of assets and insurance recoveries.

Cash used in investing activities during the 2009 Calendar Year included (i) approximately $198.9 million of additions to property, plant and equipment, consisting primarily of renovation and expansion projects at certain of our facilities, and (ii) $138.2 million for the acquisition of a health system in Fort Smith, Arkansas (Sparks). Excluding the available-for-sale securities in restricted funds, we had a net cash outlay of $36.5 million from buying and selling such securities during the 2009 Calendar Year. These 2009 cash outlays were partially offset by a decrease in restricted funds of $11.6 million and $5.4 million of proceeds from sales of assets.

Financing Activities

During the 2010 Calendar Year, we made principal payments on long-term debt and capital lease obligations of approximately $40.1 million. We also paid $20.6 million to noncontrolling shareholders primarily for recurring distributions. Partially offsetting these cash outlays were (i) $7.5 million of cash proceeds from exercises of stock options and (ii) $2.5 million that we received from noncontrolling shareholders to acquire minority equity interests in one of our joint ventures. See Notes 2 and 3 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt arrangements and capital lease obligations, respectively.

During the 2009 Calendar Year, we borrowed and repaid $38.0 million under our then existing revolving credit facility to fund the acquisition of Sparks. Furthermore, we made principal payments on our other long-term debt and capital lease obligations of approximately $89.1 million, including mandatory and other prepayments of $43.4 million on certain then existing bank term loan indebtedness. During the 2009 Calendar Year, we also paid (i) $67.7 million to repurchase certain of our 3.75% Convertible Senior Subordinated Notes due 2028 in the open market and (ii) $35.4 million to noncontrolling shareholders, including distributions of $19.6 million from our joint venture in North Carolina and South Carolina and $6.2 million in connection with the restructuring of such joint venture. These 2009 cash outlays were partially offset by $54.8 million that we received from noncontrolling shareholders to acquire minority equity interests in our joint ventures and cash proceeds from exercises of stock options of $9.7 million. See Note 4 to the Consolidated Financial Statements in Item 8 for information regarding our joint venture activity.

Discontinued Operations

Cash provided by our discontinued operations during the 2010 Calendar Year and the 2009 Calendar Year was approximately $4.2 million and $12.5 million, respectively. We do not believe that the exclusion of such amounts from our consolidated cash flows in future periods will have a material effect on our liquidity or financial position. See Note 10 to the Consolidated Financial Statements in Item 8 for information regarding our discontinued operations.

Days Sales Outstanding

To calculate days sales outstanding, or DSO, we initially divide quarterly net revenue by the number of days in the quarter. The result is divided into the net patient accounts receivable balance at the end of the quarter to obtain our DSO. We believe that this statistic is an important measure of collections on our accounts receivable, as well as our liquidity. Our DSO was 51 days at December 31, 2011, which compares to 52 days at September 30, 2011 and 49 days at December 31, 2010.

At December 31, 2011, we were in the process of obtaining the necessary approvals for our Medicare and Medicaid provider numbers for the Mercy Hospitals and their related ancillary health care operations, which we acquired on September 30, 2011. While the necessary approvals are pending, we are unable to bill for the services that we provided at those facilities, which caused our accounts receivable to grow and correspondingly increased our DSO by approximately two days at December 31, 2011. See Note 4 to the Consolidated Financial Statements in Item 8 for information regarding our acquisition of the Mercy Hospitals. Our DSO at December 31, 2011 was also adversely impacted by certain ongoing system and billing conversions that affect our accounts receivable software applications.

Income Taxes

Other than certain state net operating loss carryforwards, we believe that it is more likely than not that reversals of existing taxable temporary differences, future taxable income and carrybacks will allow us to realize the deferred tax assets that are recognized in our consolidated balance sheets.

Effect of Legislative and Regulatory Action on Liquidity

The Medicare and Medicaid reimbursement programs are subject to change as a result of legislative and regulatory actions. Within the statutory framework of those programs, numerous areas are subject to administrative rulings, interpretations and discretion that could affect payments made to us. In the future, federal and/or state governments might (i) reduce the funds available under those programs to close budget gaps or reduce deficit spending or (ii) require more stringent utilization and quality reviews of hospital facilities, either of which could have a material adverse effect on our future revenue and liquidity. Additionally, the implementation of the Health Care Reform Act, which dramatically affects the financing and delivery of health care services in the United States, and/or the continued prevalence of managed care health plans could have an adverse effect on our future revenue and liquidity. For further discussion of the Health Care Reform Act and its possible impact on our business and results of operations, see "Business – Sources of Revenue" in Item 1 of Part I and "Risk Factors" in Item 1A of Part I.

Capital Resources

Senior Secured Credit Facilities. As more fully described at Note 2 to the Consolidated Financial Statements in Item 8, we completed the 2011 Debt Restructuring on November 18, 2011, which included, among other things, new variable rate senior secured credit facilities with a syndicate of banks (the "New Credit Facilities"). The New Credit Facilities consist of: (i) a $500.0 million five-year revolving credit facility (the "New Revolving Credit Agreement"); (ii) a $725.0 million five-year term loan (the "New Term Loan A"); and (iii) a $1.4 billion seven-year term loan (the "New Term Loan B"). We used the net proceeds from the term loans under the New Credit Facilities, together with the net proceeds from the sale of our 7.375% Senior Notes due 2020, to repay all of the principal and accrued interest outstanding under certain of our then existing debt agreements.

We can elect whether interest on borrowings under the New Credit Facilities is calculated using LIBOR or the Prime Rate (as defined in the loan agreement) as its base rate; however, the base rate for the New Term Loan B is subject to a floor of 1.0% when the LIBOR option is selected. The effective interest rate, which fluctuates with changes in the underlying base rates, includes a spread above the base rate that we select. The amount of the interest rate spread is predicated on, among other things, our Consolidated Leverage Ratio (as defined in the loan agreement). We can elect differing interest rates for each of the debt instruments that comprise the New Credit Facilities. Interest is payable in arrears at the end of a calendar quarter or on the date that the selected interest duration period ends.

Beginning on March 31, 2012, the New Term Loan A will be repaid in equal quarterly installments in an aggregate annual amount equal to 7.5% of the principal amount thereof in each of the first two years of such facility, 10.0% in the third year, 15.0% in the fourth year and 60.0% in the fifth year. The New Term Loan B requires quarterly principal payments of $3.5 million, beginning on March 31, 2012, and a balloon payment for the remaining outstanding balance at the end of the facility's seventh year. We have the right to prepay amounts outstanding under the New Credit Facilities at any time without penalty, other than a prepayment of the New Term Loan B, which is subject to a prepayment premium during the first year of the loan agreement. At December 31, 2011, the effective interest rates on the New Term Loan A and the New Term Loan B were 3.2% and 4.5%, respectively. Those rates remained unchanged as of February 17, 2012.

Throughout the New Revolving Credit Agreement's five-year term, we are obligated to pay commitment fees based on the amounts available for borrowing. The New Revolving Credit Agreement provides that we can borrow, on a revolving basis, up to an aggregate of $500.0 million, as adjusted for outstanding standby letters of credit of up to $75.0 million. We did not borrow under the New Revolving Credit Agreement during the period from November 18, 2011 to December 31, 2011. Although there were no amounts outstanding under the New Revolving Credit Agreement on February 17, 2012, standby letters of credit in favor of third parties of approximately $51.9 million reduced the amount available for borrowing thereunder to $448.1 million on such date. Our effective interest rate on the variable rate New Revolving Credit Agreement was approximately 3.2% on February 17, 2012.

The New Credit Facilities are generally subject to mandatory prepayment in amounts equal to: (i) 100% of the net cash proceeds received from certain asset sales, including insurance recoveries and condemnation events, subject to reinvestment provisions and the ratable offer requirements of other pari passu secured debt; (ii) 100% of the net cash proceeds from our issuance of certain new debt; and (iii) 50% of our Excess Cash Flow (as defined in the loan agreement) with step-downs of such percentage based on our Consolidated Leverage Ratio.

We intend to fund the required principal payments under the term loans of the New Credit Facilities and the related interest with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities and, if necessary, borrowings under the New Revolving Credit Agreement.

Demand Promissory Note. We maintain a $10.0 million secured demand promissory note in favor of a bank for use as a working capital line of credit in conjunction with our cash management program. Pursuant to the terms and conditions of the demand promissory note, we may borrow, on a revolving basis, up to the principal face amount of the note. All principal and accrued interest under the demand promissory note will be immediately due and payable upon the bank's written demand. We did not borrow under this credit facility during the 2011 Calendar Year. The demand promissory note's effective interest rate on February 17, 2012 was approximately 2.5%; however, there were no amounts outstanding thereunder on such date.

7.375% Senior Notes due 2020. As more fully described at Note 2(b) to the Consolidated Financial Statements in Item 8, on November 18, 2011 we completed a private placement of $875.0 million in aggregate principal amount of 7.375% Senior Notes due 2020 (the "2020 Senior Notes"). We used the net proceeds from this debt offering, together with the net proceeds from the term loans under the New Credit Facilities, to repay all of the principal and accrued interest outstanding under certain of our then existing debt agreements. The 2020 Senior Notes are senior unsecured debt obligations that bear interest at the rate of 7.375% per annum, payable semi-annually in arrears on January 15 and July 15 of each year, beginning on July 15, 2012. The 2020 Senior Notes mature on January 15, 2020 at which time the entire $875.0 million of principal is due and payable. At any time on or after January 15, 2016, the 2020 Senior Notes are redeemable at our option, in whole or in part, at the redemption prices set forth in the related indenture, plus accrued and unpaid interest. Prior to January 15, 2016, we may redeem the 2020 Senior Notes, in whole or in part, at a redemption price equal to 100% of the principal amount of the notes being redeemed, plus a "make-whole" premium and accrued and unpaid interest. Prior to January 15, 2015, we may also redeem up to 35% of the original principal amount of the 2020 Senior Notes with the proceeds from certain equity offerings at a redemption price of 107.375% of the principal amount of the notes being redeemed, plus accrued and unpaid interest.

We intend to fund the required semi-annual interest payments under the 2020 Senior Notes with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities and, if necessary, borrowings under the New Revolving Credit Agreement.

Debt Covenants

The New Credit Facilities and the indentures governing our convertible debt securities, the 2020 Senior Notes and our 6.125% Senior Notes due 2016 contain covenants that, among other things, require us to maintain compliance with certain financial ratios. At December 31, 2011, we were in compliance with all of the covenants contained in those debt agreements. Although there can be no assurances, we believe that we will continue to be in compliance with all of our debt covenants. Should we fail to comply with one or more of our debt covenants in the future and are unable to remedy the matter, an event of default may result. In that circumstance, we would seek a waiver from our lenders or renegotiate the related debt agreement; however, such renegotiations could, among other things, subject us to higher interest and financing costs on our debt obligations and our credit ratings could be adversely affected.

Dividends

The New Credit Facilities and the indentures for certain of our other debt agreements restrict our ability to pay cash dividends.

Standby Letters of Credit

As of February 17, 2012, we maintained approximately $54.1 million of standby letters of credit in favor of third parties with various expiration dates through February 21, 2013. Should any or all of these letters of credit be drawn upon, we intend to satisfy such obligations with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities and, if necessary, borrowings under the New Revolving Credit Agreement.

Interest Rate Swap Contract

As required by a former credit facility, we entered into a seven-year receive variable/pay fixed interest rate swap contract during February 2007. As part of the 2011 Debt Restructuring, such credit facility was terminated but the interest rate swap contract was not. Although we are exposed to financial risk in the event of nonperformance by one or more of the counterparties to the contract, we do not anticipate nonperformance because our interest rate swap contract is in a liability position and would require us to make settlement payments to the counterparties in the event of a contract termination. The interest rate swap contract provides for us to pay interest at a fixed rate of 6.7445% on the contract's notional amount, which was originally expected to reasonably approximate the declining principal balance of a term loan under the former credit facility. At December 31, 2011, the notional amount of the interest rate swap contract was approximately $2,027.4 million. The estimated fair value of our liability for the interest rate swap contract on such date was $162.3 million and we project that $87.0 million will be payable to the counterparties during the year ending December 31, 2012. However, our aggregate payments through the contract's expiration in February 2014, as well as the specific timing thereof, are subject to change based on, among other things, future LIBOR rates. See Note 5 to the Consolidated Financial Statements in Item 8 for information regarding the estimated fair value of our interest rate swap contract.

Net interest payable or receivable is settled between us and the counterparties at the end of each calendar quarter. We intend to fund any net interest payable to the counterparties with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities and, if necessary, borrowings under the New Revolving Credit Agreement.

Capital Expenditures and Other

We believe that capital expenditures for property, plant and equipment will range from 4.5% to 5.5% of our net revenue (before the provision for doubtful accounts) for the year ending December 31, 2012, which is within the capital expenditure limitations of the New Credit Facilities. As of December 31, 2011, we had started: (i) construction of a 250-bed general acute care hospital to ultimately replace the south campus facility at Poplar Bluff Regional Medical Center in Poplar Bluff, Missouri; (ii) several hospital renovation and expansion projects; and (iii) various information technology hardware and software upgrades. Additionally, we estimate that the remaining cost to build and equip a replacement hospital for Walton Regional Medical Center in Monroe, Georgia will range from $20 million to $25 million. We are currently obligated to complete construction of this replacement hospital no later than December 31, 2012. We do not believe that any of our construction, renovation and/or expansion projects are individually significant or that they represent, in the aggregate, a material commitment of our resources.

Part of our strategic business plan calls for us to acquire hospitals and other ancillary health care businesses in non-urban communities that are aligned with our business model, available at a reasonable price and otherwise meet our strict acquisition criteria. We fund acquisitions, replacement hospital construction and other recurring capital expenditures with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities, amounts available under revolving credit agreements and proceeds from long-term debt issuances, or a combination thereof. Specifically, we plan to fund the acquisition of an 80% equity interest in each of five Oklahoma-based general acute care hospitals and certain related health care operations with available cash balances and proceeds from sales of available-for-sale securities. This pending acquisition, which we expect to close during the quarter ending June 30, 2012, is discussed at Note 15 to the Consolidated Financial Statements in Item 8.

Divestitures of Idle Property and Other

We intend to sell (i) the Woman's Center at Dallas Regional Medical Center, which was a specialty women's hospital in Mesquite, Texas that we closed on June 1, 2008, and (ii) the former Riverside hospital campus that we acquired from Mercy Health Partners, Inc. on September 30, 2011. We are also exploring various alternatives for St. Mary's Medical Center of Scott County wherein the hospital's lease agreement expires in May 2012 and will not be renewed. However, the timing of such divestitures has not yet been determined. We intend to use the proceeds from any transactions involving the abovementioned facilities for general business purposes. See Note 10 to the Consolidated Financial Statements in Item 8 for information about the three facilities that we intend to divest.

Contractual Obligations and Off-Balance Sheet Arrangements

Except as set forth in the table below, we do not have any off-balance sheet arrangements.

As of December 31, 2011, we had recorded approximately (i) $200.6 million for redeemable equity securities and (ii) $39.1 million as a liability for unrecognized income tax benefits and related interest and penalties. We excluded these amounts from the table below due to the uncertainty of the amounts to be paid, if any, as well as the timing of such payments. We also excluded $215.6 million of net professional liability risk reserves (including $40.4 million in current liabilities) from the table below because we do not characterize such reserves as contractual obligations and the unpaid settled claim amount at December 31, 2011 was not significant.

As of December 31, 2011, contractual obligations for each of the next five years ending December 31 and thereafter (including principal and interest) and other commitments are summarized in the table below. Interest rates at December 31, 2011 were used in the table to estimate interest payments on variable rate debt.

	Payments Due by Year Ending December 31,					
Contractual Obligations	**2012**	**2013**	**2014**	**2015**	**2016**	**Thereafter**
	(in thousands)					
Long-term debt (a)	$ 249,435	$ 246,752	$ 350,391	$ 290,579	$ 991,054	$ 2,520,413
Capital leases	22,722	17,468	15,934	15,678	12,013	95,417
Operating leases (b)	125,645	103,195	76,639	59,859	39,470	111,650
Interest rate swap contract	86,975	64,501	10,831	-	-	-
Physician commitments (c)	19,260	10,945	-	-	-	-
Other	200	200	200	200	200	600
Total contractual obligations	$ 504,237	$ 443,061	$ 453,995	$ 366,316	$ 1,042,737	$ 2,728,080

	Commitment Expiration by Year Ending December 31,					
Other Commitments Not Recorded on our Consolidated Balance Sheet	**2012**	**2013**	**2014**	**2015**	**2016**	**Thereafter**
	(in thousands)					
Letters of credit (d)	$ 104,401	$ -	$ -	$ -	$ -	$ -
Physician commitments (c)	26,394	16,357	-	-	-	-
Other (e)	161,191	34,830	2,000	-	-	-
Total commitments	$ 291,986	$ 51,187	$ 2,000	$ -	$ -	$ -

(a) For purposes of the above table, we assumed that we would repurchase our 3.75% Convertible Senior Subordinated Notes due 2028 on May 1, 2014 because the noteholders can unilaterally exercise their contractual right to require us to repurchase some or all of their notes on such date.

(b) Amounts relate to obligations under operating leases for real property, real property master leases and equipment. The real property master leases are leases for buildings near our hospitals for which we guarantee a certain level of rental income to the owners of the property. We sublease space in these buildings to unrelated third parties. Future operating lease obligations are not recorded in our consolidated balance sheets.

(c) See Note 1(e) and Note 13 to the Consolidated Financial Statements in Item 8 for information regarding physician and physician group guarantees and commitments.

(d) Amount relates to outstanding letters of credit that principally serve as security for our workers' compensation self-insurance program and deposits for certain utility companies.

(e) Other includes: (i) construction costs to build replacement hospitals for both Walton Regional Medical Center in Monroe, Georgia and the south campus facility at Poplar Bluff Regional Medical Center in Poplar Bluff, Missouri; (ii) purchase commitments for supplies; and (iii) other miscellaneous commitments.

Impact of Inflation

The health care industry is labor intensive and subject to wage and related employee benefit expense increases, especially during periods of inflation and when there exists a shortage of skilled labor. A skilled nursing staff shortage throughout the health care industry has existed for the past several years and has caused nursing salaries to increase. We have addressed our nursing staff needs by increasing wages, improving hospital working conditions and fostering relationships with local nursing schools. We do not believe that the inflationary trend in nursing salaries or the nursing shortage will have an adverse effect on our results of operations.

Suppliers, utility companies and other vendors pass their cost increases to us in the form of higher prices. We believe that we have been able to partially offset increases in our operating costs by increasing prices, achieving quantity discounts for purchases through our group purchasing agreement and efficiently utilizing our resources. Although we have implemented cost control measures to curb increases in operating costs, we cannot predict our ability to recover or offset future cost increases from our many vendors.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk due to changes in interest rates. To mitigate our exposure to interest rate volatility, a portion of our long-term debt is fixed rate and, if appropriate, we will consider entering into an interest rate swap contract. See Note 2 to the Consolidated Financial Statements in Item 8 for a discussion of our long-term debt. We do not believe that our overall market risk exposures will materially change during 2012.

As of December 31, 2011, the estimated fair value and carrying amount of our fixed rate debt, including capital lease obligations, were approximately $1,529.1 million and $1,463.7 million, respectively. The estimated fair value and carrying amount of our variable rate debt on such date were $2,101.7 million and $2,111.3 million, respectively. A hypothetical 1% increase in interest rates from those that were in effect at December 31, 2011 would impact our annualized interest expense by approximately $14.1 million. Moreover, increases in interest rates would correspondingly increase our interest expense associated with any future borrowings. The table below summarizes principal cash flows and weighted average interest rates by expected maturity dates for our long-term debt and capital lease obligations that were outstanding at December 31, 2011.

	Years Ending December 31,						
	2012	2013	2014	2015	2016	Thereafter	Totals
	(in thousands, except interest rates)						
Fixed rate long-term debt, including capital leases	$ 17,134	$ 12,618	$ 10,843	$ 11,320	$ 408,376	$ 923,385	$ 1,383,676
Weighted average interest rates	6.9%	6.8%	7.0%	7.0%	6.1%	7.4%	7.0%
Fixed rate convertible long-term debt	-	-	$ 91,450 (a)	-	-	-	$ 91,450
Weighted average interest rates	-	-	3.8%	-	-	-	3.8%
Variable rate long-term debt	$ 68,375	$ 68,375	$ 86,500	$ 122,750	$ 449,000	$ 1,330,000	$ 2,125,000
Weighted average interest rates (b)	3.5%	3.5%	3.4%	3.4%	3.3%	4.5%	4.1%

(a) For purposes of the above table, we assumed that we would repurchase our 3.75% Convertible Senior Subordinated Notes due 2028 on May 1, 2014 because the noteholders can unilaterally exercise their contractual right to require us to repurchase some or all of their notes on such date.

(b) For purposes of the above table, we assumed that the interest rates on each of our variable rate long-term debt instruments at December 31, 2011 would remain in effect for the full term of such instruments.

We do not execute transactions or hold derivative financial instruments for trading purposes. However, pursuant to the requirements of the agreements underlying our former credit facilities, we entered into a receive variable/pay fixed interest rate swap contract in February 2007 that provides for us to pay a fixed interest rate of 6.7445% on the notional amount of such contract for its seven-year term. At December 31, 2011, the estimated fair value of the liability for our interest rate swap contract, which is discussed at Note 2(a) to the Consolidated Financial Statements in Item 8, was approximately $162.3 million. A hypothetical 1% change in the LIBOR rate used in the valuation of our interest rate swap contract liability would have changed its estimated fair value by $39.3 million.

We are exposed to market risk related to changes in the values of our available-for-sale securities, including those that are held by our insurance company subsidiaries. As more fully described at Note 5 to the Consolidated Financial Statements in Item 8, those investments have an estimated fair value and cost basis at December 31, 2011 of approximately $246.8 million and $245.5 million, respectively. We are also exposed to risk related to market illiquidity. For example, if one of our insurance subsidiaries requires cash beyond its usual requirements and we are unable to readily access the customary capital markets, we may have difficulty selling our investments in a timely manner or be forced to sell them at prices that are less than what we might have been able to obtain in an active market.

Item 8. Financial Statements and Supplementary Data.

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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)

	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)

	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.

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 Income (Loss), Net	Additional Paid-in Capital	Retained Earnings	Noncontrolling Interests	Total Stockholders' Equity
	Shares	Par Value					
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.

HEALTH MANAGEMENT ASSOCIATES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2011

1. Business and Summary of Significant Accounting Policies

Health Management Associates, Inc. by and through its subsidiaries (collectively, the "Company") provides health care services to patients in hospitals and other health care facilities in non-urban communities located primarily in the southeastern United States. As of December 31, 2011, the Company operated 66 hospitals in fifteen states with a total of 10,330 licensed beds. At such date, twenty-two of the Company's hospitals were located in Florida and ten hospitals were located in each of Mississippi and Tennessee. See Note 10 for information about one of the Company's Tennessee-based hospitals with a lease agreement that will expire in May 2012 and will not be renewed. Also, see Note 15 for acquisition activity subsequent to December 31, 2011.

Unless specifically indicated otherwise, all amounts and percentages presented in the notes below are exclusive of the Company's discontinued operations, which are identified at Note 10.

The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Certain amounts in the consolidated financial statements have been reclassified in prior years to conform to the current year presentation. Such reclassifications primarily related to discontinued operations.

The Company consistently applies the accounting policies described below.

a. Principles of consolidation

The consolidated financial statements include the accounts of the Company and its subsidiaries, all of which are controlled by the Company through majority voting control. All significant intercompany accounts and transactions have been eliminated. The Company uses the equity method of accounting for investments in entities in which it exhibits significant influence, but not control, and has an ownership interest ranging from 20% to 50%.

For consolidation and variable interest entity disclosure purposes, management evaluates circumstances where the Company has ownership, contractual or other financial interests that may result in its (i) ability to direct the activities of an entity that most significantly impact such entity's economic performance and/or (ii) obligation to absorb the losses of, or the right to receive the benefits from, an entity that could potentially be significant to that entity; however, no such arrangements that would be material to the Company's consolidated financial position or results of operations have been identified.

b. Cash and cash equivalents

Cash and cash equivalents include all highly liquid investments with an original maturity of three months or less. The Company's cash equivalents primarily consist of investment grade financial instruments.

c. Available-for-sale securities

The Company's investments in debt securities and shares in publicly traded stocks and mutual funds have been designated by management as available-for-sale securities, as defined by GAAP. The estimated fair values of such securities are based on quoted market prices and pricing valuation models. Changes in temporary unrealized gains and losses are recorded as adjustments to other comprehensive income, net of income taxes. Periodically, management performs an evaluative assessment of individual securities to determine whether declines in fair value are other-than-temporary. Management considers various quantitative, qualitative and judgmental factors when performing its evaluation, including, but not limited to, the nature of the security being analyzed and the length of time and extent to which a security's fair value is below its historical cost. The weighted average cost method is used to calculate the historical cost basis of securities that are sold. Also, see Notes 5 and 11 for more information regarding the Company's available-for-sale securities.

1. Business and Summary of Significant Accounting Policies (continued)

d. Property, plant and equipment

Property, plant and equipment are stated at cost and include major expenditures that extend an asset's useful life. Ordinary repair and maintenance costs (e.g., medical equipment adjustments, painting, cleaning, etc.) are expensed as incurred. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the underlying assets. Estimated useful lives for buildings and improvements range from fifteen to forty years and for equipment range from three to fifteen years. Leasehold improvements, capital lease assets and other assets of a similar nature are amortized on a straight-line basis over the shorter of the term of the respective lease or the useful life of the underlying asset. Depreciation expense was approximately $219.3 million, $207.2 million and $202.8 million during the years ended December 31, 2011, 2010 and 2009, respectively.

e. Deferred debt issuance costs, goodwill and other long-lived assets

Deferred debt issuance costs. Deferred charges and other assets include deferred debt issuance costs that are being amortized over the estimated economic life of the related debt using the effective interest method. A rollforward of the Company's deferred debt issuance costs is presented in the table below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Balances at the beginning of the year	$ 48,515	$ 48,515	$ 50,520
Costs associated with the issuance of long-term debt	75,149	-	-
Write-offs, primarily in connection with a debt refinancing (see Note 2)	(56,463)	-	(444)
Repurchases of convertible debt securities	-	-	(1,561)
Balances at the end of the year	$ 67,201	$ 48,515	$ 48,515

Accumulated amortization of deferred debt issuance costs was approximately $3.1 million and $27.9 million at December 31, 2011 and 2010, respectively. Amortization of deferred debt issuance costs was $7.6 million, $7.1 million and $7.6 million during the years ended December 31, 2011, 2010 and 2009, respectively. Future amortization of deferred debt issuance costs is expected to approximate $11.3 million, $11.0 million, $10.5 million, $9.9 million and $8.4 million during the years ending December 31, 2012, 2013, 2014, 2015 and 2016, respectively.

Goodwill. GAAP calls for goodwill (i.e., the excess of cost over acquired net assets) and intangible assets with indefinite useful lives to be tested for impairment annually and whenever circumstances indicate that a possible impairment might exist. When performing goodwill impairment tests prior to 2011, management initially compared the estimated fair values of each reporting unit's net assets, including allocated home office net assets, to the corresponding carrying amounts on the Company's consolidated balance sheet. The estimated fair values of the Company's reporting units were determined using a market approach methodology based on net revenue multiples. Management also considered a valuation methodology using discounted cash flows and a market approach valuation methodology based on comparable transactions. If the estimated fair value of a reporting unit's net assets was less than the balance sheet carrying amount, management determined the implied fair value of the reporting unit's goodwill, compared such fair value to the corresponding carrying amount and, if necessary, recorded a goodwill impairment charge.

During September 2011, the Financial Accounting Standards Board amended the accounting standards in GAAP as they relate to the annual test for goodwill impairment (the "Goodwill Update"). The Goodwill Update allows, but does not require, an initial assessment of qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for the purpose of determining if detailed quantitative goodwill impairment testing is necessary. Public companies were required to adopt the provisions of the Goodwill Update during interim and annual periods beginning after December 15, 2011; however, early adoption was permitted. Management elected to early adopt the Goodwill Update in connection with the Company's annual goodwill impairment testing on October 1, 2011. The Company's adoption of the Goodwill Update did not have a material impact on its annual goodwill impairment testing or the results therefrom. Specifically, the qualitative factors reviewed by management did not reveal any circumstances whereby detailed quantitative goodwill impairment testing was necessary at the reporting unit level. There were no goodwill impairment charges in continuing operations during the years ended December 31, 2011, 2010 and 2009.

1. Business and Summary of Significant Accounting Policies (continued)

Reporting units are one level below the operating segment level (see Note 1(m)). However, after consideration of the relevant GAAP aggregation rules, management determined that the Company's goodwill impairment testing should be performed at the divisional operating level. Goodwill is discretely allocated to the Company's reporting units (i.e., each hospital's goodwill is included as a component of the aggregate reporting unit goodwill being evaluated during the impairment analysis).

Physician and Physician Group Guarantees. Deferred charges and other assets include estimated physician and physician group guarantee costs, which aggregated approximately $88.0 million and $60.7 million at December 31, 2011 and 2010, respectively. Such amounts are being amortized over the required service periods of the underlying contractual arrangements. The corresponding accumulated amortization was $38.8 million and $30.9 million at December 31, 2011 and 2010, respectively. Amortization expense related to estimated physician and physician group guarantee costs was $29.2 million, $21.7 million and $21.3 million during the years ended December 31, 2011, 2010 and 2009, respectively. Based on the December 31, 2011 balances, future amortization expense is expected to be $37.0 million, $10.0 million and $2.2 million during the years ending December 31, 2012, 2013 and 2014, respectively. See Note 13 for further information regarding physician and physician group guarantees.

Intangible Assets. Included in deferred charges and other assets at December 31, 2011 were intangible assets of approximately $51.2 million relating to contractual rights to operate hospitals and other health care facilities and non-compete arrangements, net of $2.0 million of accumulated amortization. See Note 4 for information about these intangible assets that were acquired during 2011. Future amortization of such assets is expected to approximate $7.9 million, $7.9 million, $7.9 million, $7.1 million and $4.2 million during the years ending December 31, 2012, 2013, 2014, 2015 and 2016, respectively.

Impairment of Long-lived Assets. When events, circumstances or operating results indicate that the carrying values of long-lived assets and/or identifiable intangible assets (excluding goodwill) that are expected to be held and used might be impaired, management prepares projections of the undiscounted future cash flows expected to result from the use of the assets and their eventual disposition. If the projections indicate that the recorded amounts are not expected to be recoverable, such long-lived assets are reduced to their estimated fair values, as determined by management through various discrete valuation analyses, and the Company records an impairment charge. Long-lived assets to be disposed of are reported at the lower of their carrying amount or estimated fair value, less costs to sell. The estimates of fair value are based on recent sales of similar assets, market analyses, pending disposition transactions and market responses based on discussions with, and offers received from, potential buyers.

There were no long-lived asset impairment charges that were material to the Company's continuing operations during the years ended December 31, 2011, 2010 and 2009. During the years ended December 31, 2011, 2010 and 2009, the Company recorded long-lived asset and goodwill impairment charges of approximately $3.6 million, $8.4 million and $4.6 million, respectively, in discontinued operations (see Note 10).

f. Net revenue, cost of revenue and related other

Net Revenue. The Company records gross patient service charges on the accrual basis in the period that the services are rendered. Net revenue represents gross patient service charges less provisions for contractual adjustments. Approximately 40%, 41% and 41% of net revenue during the years ended December 31, 2011, 2010 and 2009, respectively, related to services rendered to patients covered by Medicare and various state Medicaid programs. Payments for services rendered to patients covered by these programs are generally less than billed charges and, therefore, provisions for contractual adjustments are made to reduce patient charges to the estimated cash receipts based on each program's principles of payment/reimbursement (i.e., either prospectively determined or retrospectively determined costs). Final settlements under these programs are subject to administrative review and audit and, accordingly, the Company periodically provides reserves for the adjustments that may ultimately result therefrom. Such adjustments were not material to the Company's consolidated results of operations during the years presented herein. Laws, rules and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, estimates recorded in the consolidated financial statements and disclosed in the accompanying notes may change in the future and such changes in estimates, if any, will be recorded in the Company's operating results in the period they are identified by management. Revenue and receivables from government programs are significant to the Company's operations; however, management does not believe that there are substantive credit risks associated with such programs. There are no other concentrations of revenue or accounts receivable with any individual payor that subject the Company to significant credit or other risks.

1. Business and Summary of Significant Accounting Policies (continued)

Estimates for contractual allowances under managed care health plans are primarily based on the payment terms of contractual arrangements, such as predetermined rates per diagnosis, per diem rates or discounted fee for service rates.

Net revenue is presented net of provisions for contractual adjustments and uninsured patient discounts. The Company's provisions for contractual adjustments were approximately $19,433 million, $15,612 million and $12,589 million during the years ended December 31, 2011, 2010 and 2009, respectively. In the ordinary course of business, the Company provides services to patients who are financially unable to pay for their care. Accounts identified as charity and indigent care are not recognized in net revenue. The Company maintains a uniform policy whereby patient account balances are characterized as charity and indigent care only if the patient meets certain percentages of the federal poverty level guidelines. Local hospital personnel and the Company's collection agencies pursue payments on accounts receivable from patients who do not meet such criteria. Management monitors the levels of charity and indigent care provided by the Company's hospitals and other health care facilities and the procedures employed to identify and account for those patients. Most states include an estimate of charity and indigent care costs in the determination of a hospital's eligibility for Medicaid disproportionate share payments.

See Note 12 for a change in GAAP that will affect the Company's presentation of net revenue in future periods.

Uncompensated Patient Care. To quantify the overall impact of, and trends related to, uninsured accounts, management believes that it is beneficial to view the Company's: (i) foregone/unrecognized revenue for charity and indigent care; (ii) uninsured self-pay patient discounts (i.e., the Company discounts its gross charges to uninsured patients for non-elective procedures by 60% or more); and (iii) provision for doubtful accounts, which is collectively referred to herein as "uncompensated patient care," in combination rather than separately. Management estimates the costs of the Company's uncompensated patient care using a cost-to-charge ratio that is calculated by dividing patient care costs by gross patient charges. Those costs include select direct and indirect costs such as salaries and benefits, supplies, depreciation and amortization, rent and other operating expenses. The table below sets forth the estimated costs of the Company's uncompensated patient care (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Charity and indigent care foregone/unrecognized revenue (based on established rates)	$ 91,927	$ 88,797	$ 79,459
Uninsured self-pay patient discounts	939,763	789,370	641,911
Provision for doubtful accounts	716,856	624,753	553,639
	1,748,546	1,502,920	1,275,009
Cost-to-charge ratio	21.8%	22.3%	22.1%
Estimated costs of uncompensated patient care	$ 381,183	$ 335,151	$ 281,777

Cost of Revenue. The presentation of costs and expenses in the Company's consolidated statements of income does not differentiate between costs of revenue and other costs because substantially all of such costs and expenses are related to providing health care services. Furthermore, management believes that the natural classification of expenses is the most meaningful presentation of the Company's operations. Amounts that could be classified as general and administrative expenses include the costs of the Company's home office, which were approximately $168.8 million, $138.7 million and $117.7 million during the years ended December 2011, 2010 and 2009, respectively.

g. Accounts receivable and allowances for doubtful accounts

The Company grants credit without requiring collateral from its patients, most of whom live near the Company's hospitals and are insured under third party payor agreements. In certain circumstances, the Company charges interest on past due accounts receivable (delinquent accounts are identified by reference to contractual or other payment terms); however, such interest amounts were not material to the years presented herein. The credit risk for non-governmental accounts receivable is limited due to the large number of insurance companies and other payors that provide payment and reimbursement for patient services. Accounts receivable are reported net of estimated allowances for doubtful accounts.

1. Business and Summary of Significant Accounting Policies (continued)

Collection of accounts receivable from third party payors and patients is the Company's primary source of cash and is therefore critical to its successful operating performance. Accordingly, management closely monitors the Company's cash collection trends and the aging of accounts receivable. Collection risks principally relate to uninsured patient accounts and patient accounts for which the primary insurance payor has paid but patient responsibility amounts (generally deductibles and co-payments) remain outstanding. Provisions for doubtful accounts are primarily estimated based on cash collection analyses by payor classification and accounts receivable aging reports. When considering the adequacy of allowances for doubtful accounts, the Company's accounts receivable balances are routinely reviewed in conjunction with historical collection rates, health care industry trends/indicators and other business and economic conditions that might reasonably be expected to affect the collectibility of patient accounts. Accounts receivable are written off after collection efforts have been pursued in accordance with the Company's policies and procedures. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts and subsequent recoveries are netted against the provision for doubtful accounts. Changes in payor mix, general economic conditions or federal and state government health care coverage could each have a material adverse effect on the Company's accounts receivable collections, cash flows and results of operations.

h. Professional liability claims

Reserves for self-insured professional liability indemnity claims and related expenses, including attorneys' fees and other related costs of litigation that have been incurred and will be incurred in the future, are determined using actuarially-based techniques and methodologies. The data used to develop such reserves is based on asserted and unasserted claim information that has been accumulated by the Company's incident reporting system, historical loss payment patterns and industry trends. Such long-term liabilities have been discounted to their estimated present values. Management selects a discount rate that represents a risk-free interest rate correlating to the period when the claims are projected to be paid. The Company's discounted reserves at December 31, 2010 did not include any amounts for estimated losses that were expected to be covered by reinsurance policies; however, see Note 12 for new accounting guidance that the Company adopted effective January 1, 2011.

The reserves for self-insured professional liability claims and expenses are periodically reviewed and adjustments thereto are recorded as more information about claim trends becomes known to management. Adjustments to the reserves are recognized in the Company's operating results in the period that the change in estimate is identified. See Note 13 for further discussion of the Company's professional liability risks and related matters.

i. Self-insured workers' compensation and health and welfare programs

The Company provides (i) income continuance to, and reimburses certain health care costs of, its disabled employees (collectively, "workers' compensation") and (ii) health and welfare benefits to its employees, their spouses and certain beneficiaries. While such employee benefit programs are primarily self-insured, stop-loss insurance policies are maintained in amounts deemed appropriate by management. Nevertheless, there can be no assurances that the amount of stop-loss insurance coverage will be adequate for such Company programs.

The Company records estimated liabilities for both reported and incurred but not reported workers' compensation and health and welfare claims based on historical loss experience and other information provided by the Company's third party administrators. The long-term liabilities for workers' compensation are determined using actuarially-based techniques and methodologies and are discounted to their estimated present values. Management selects a discount rate that represents a risk-free interest rate correlating to the period when such benefits are projected to be paid. The Company's liabilities at December 31, 2010 for workers' compensation and health and welfare benefits did not include any amounts for benefits that were expected to be covered by stop-loss policies; however, see Note 12 for new accounting guidance that the Company adopted effective January 1, 2011. Although there can be no assurances, management believes that the liabilities included in the Company's consolidated financial statements for these self-insured programs are adequate and reasonable. If the actual costs of these programs exceed management's estimates, the liabilities could be materially adversely affected.

1. Business and Summary of Significant Accounting Policies (continued)

j. Fair value of financial instruments

Cash and cash equivalents, net accounts receivable, accounts payable and accrued expenses and other liabilities are reflected in the consolidated balance sheets at their estimated fair values primarily due to their short-term nature. The estimated fair values of long-term debt and available-for-sale securities, which are disclosed at Notes 2 and 5, respectively, were primarily determined by reference to quoted market prices, pricing valuation models and/or bid and ask prices in the relevant market. Additionally, see Note 5 regarding the estimated fair value of the Company's interest rate swap contract, including valuation methods and significant assumptions.

k. Noncontrolling interests in consolidated entities and redeemable equity securities

The consolidated financial statements include all assets, liabilities, revenue and expenses of certain entities that are controlled by the Company but not wholly owned. The Company records noncontrolling interests and redeemable equity securities to reflect the ownership interests and other rights of the noncontrolling shareholders. The sale of a noncontrolling interest, where control of the affected entity is retained, is treated as an equity transaction. Moreover, direct and incremental costs of transactions with noncontrolling shareholders that change the ownership percentage of Health Management Associates, Inc. in a consolidated entity are considered part of the related equity transaction if control is maintained by the parent.

Redeemable equity securities with redemption features that are not solely within the Company's control are classified outside of permanent equity. Those securities are initially recorded at their estimated fair value on the date of issuance. Securities that are currently redeemable or redeemable after the passage of time are adjusted to their redemption value as changes occur. If it is unlikely that a redeemable equity security will ever require redemption (e.g., management does not expect that a triggering contingency will occur, etc.), then subsequent adjustments to the initially recorded amount will only be recognized in the period that a redemption becomes probable. See Note 4 for further information regarding the Company's redeemable equity securities.

l. Income taxes

Deferred income tax assets and liabilities are determined based on differences between financial reporting and tax bases of assets and liabilities and are measured using the enacted tax rates and laws that are expected to apply to taxable income in the periods in which the underlying deferred tax asset or liability is expected to be realized or settled. Management must make estimates when recording the Company's provision for income taxes, including conclusions regarding deferred tax assets and deferred tax liabilities, as well as valuation allowances that might be required to offset deferred tax assets. Management estimates valuation allowances to reduce deferred tax assets to the amounts it believes are more likely than not to be realized in future periods. When establishing valuation allowances, management considers all relevant information, including ongoing tax planning strategies. Management adjusts valuation allowance estimates and records the impact of such changes in the Company's income tax provision in the period that management determines that the probability of deferred tax asset realization has changed.

The Company operates in multiple states with varying tax laws and is subject to both federal and state audits of its tax filings. Management estimates tax reserves to adequately provide for audit adjustments, if any. Actual audit results could vary from the estimates recorded by the Company. Recorded tax reserves and the changes therein were not material to the Company's consolidated financial position or its results of operations during the years presented herein.

See Note 6 for further information regarding income taxes.

m. Segment reporting

GAAP requires that a company with publicly traded debt or equity securities report annual and interim financial and other information about its reportable operating segments. Operating segments are components of an enterprise for which separate financial information is available and such information is evaluated regularly by the chief operating decision maker when deciding how to allocate resources and assess performance. GAAP allows

1. Business and Summary of Significant Accounting Policies (continued)

aggregation of similar operating segments into a single operating segment if the businesses have comparable economic characteristics and are otherwise considered alike. The Company's operating segments, which provide health care services to patients in owned and leased facilities, offer comparable services, have the same types of patients, operate in a consistent manner and have similar economic and regulatory characteristics. Accordingly, such operating segments have been aggregated into a single reportable segment.

n. Discontinued operations

GAAP requires that a component of an entity be reported as discontinued operations if, among other things, such component: (i) has been disposed of or is classified as held for sale; (ii) has operations and cash flows that can be clearly distinguished from the rest of the reporting entity; and (iii) will be eliminated from the ongoing operations of the reporting entity. In the period that a component of the Company meets such criteria, its results of operations and cash flows for current and prior periods are reclassified to discontinued operations and the assets and liabilities of the related disposal group are segregated on the consolidated balance sheet. See Note 10 for information regarding the Company's discontinued operations.

o. Loss contingencies

Management regularly reviews the status of the Company's legal and regulatory matters and assesses the potential financial exposure thereof. If the potential loss from any claim, lawsuit or regulatory proceeding is considered probable and the amount can be reasonably estimated, the Company records a reserve. Significant judgment is required when determining probability and whether an exposure is reasonably estimable. The actual costs resulting from the final resolution of claims, lawsuits and regulatory matters may vary significantly from management's estimates because, among other things, estimating such financial exposure requires consideration of substantial uncertainties. Changes in the estimates of financial exposure for legal matters and other loss contingencies could have a material impact on the Company's consolidated financial position and results of operations. Attorneys' fees and other costs of defending the Company in respect of claims, lawsuits and regulatory proceedings are expensed in the period such fees and costs are incurred, except as noted above at Note 1(h).

See Note 13 for information regarding the Company's material legal matters and other loss contingencies.

2. Long-Term Debt

The table below summarizes the Company's long-term debt and capital lease obligations (in thousands).

	December 31,	
	2011	2010
Revolving credit facilities (a)	$ -	$ -
Bank borrowings (a):		
New Term Loan A	725,000	-
New Term Loan B, net of a discount of approximately $13,742 at December 31, 2011	1,386,258	-
Predecessor Term Loan	-	2,481,434
7.375% Senior Notes due 2020 (b)	875,000	-
6.125% Senior Notes due 2016, net of discounts of approximately $1,584 and $1,953 at December 31, 2011 and 2010, respectively (b)	398,416	398,047
3.75% Convertible Senior Subordinated Notes due 2028, net of discounts of approximately $9,802 and $13,352 at December 31, 2011 and 2010, respectively (c)	81,648	78,098
Installment notes and other unsecured long-term debt at interest rates ranging from 4.2% to 7.5%, payable through 2025	4,264	5,184
Capital lease obligations (see Note 3)	104,412	55,701
Long-term debt and capital lease obligations	3,574,998	3,018,464
Less current maturities	(85,509)	(34,745)
Long-term debt and capital lease obligations, less current maturities	$ 3,489,489	$ 2,983,719

2. Long-Term Debt (continued)

a. Bank Borrowings and Revolving Credit Facilities

New 2011 Bank Borrowings. On November 18, 2011, the Company completed a restructuring of its long-term debt (the "2011 Debt Restructuring"), which included, among other things, new variable rate senior secured credit facilities with a syndicate of banks (the "New Credit Facilities"). The New Credit Facilities consist of: (i) a $500.0 million five-year revolving credit facility (the "New Revolving Credit Agreement"); (ii) a $725.0 million five-year term loan (the "New Term Loan A"); and (iii) a $1.4 billion seven-year term loan (the "New Term Loan B"). The New Term Loan B was subject to an original issue discount of 1.0%. The Company used the net proceeds from the term loans under the New Credit Facilities, together with the net proceeds from the sale of its 7.375% Senior Notes due 2020, to repay all amounts outstanding under the Predecessor Credit Facilities and the Knoxville Credit Agreement (both of which are defined below).

The Company can elect whether interest on borrowings under the New Credit Facilities is calculated using LIBOR or the Prime Rate (as defined in the loan agreement) as its base rate; however, the base rate for the New Term Loan B is subject to a floor of 1.0% when the LIBOR option is selected. The effective interest rate, which fluctuates with changes in the underlying base rates, includes a spread above the base rate selected by the Company. The amount of the interest rate spread is predicated on, among other things, the Company's Consolidated Leverage Ratio (as defined in the loan agreement). The Company can elect differing interest rates for each of the debt instruments that comprise the New Credit Facilities. Interest is payable in arrears at the end of a calendar quarter or on the date that the selected interest duration period ends.

Beginning on March 31, 2012, the New Term Loan A will be repaid in equal quarterly installments in an aggregate annual amount equal to 7.5% of the principal amount thereof in each of the first two years of such facility, 10.0% in the third year, 15.0% in the fourth year and 60.0% in the fifth year. The New Term Loan B requires quarterly principal payments of $3.5 million, beginning on March 31, 2012, and a balloon payment for the remaining outstanding balance at the end of the facility's seventh year. The Company has the right to prepay amounts outstanding under the New Credit Facilities at any time without penalty, other than a prepayment of the New Term Loan B, which is subject to a prepayment premium during the first year of the loan agreement equal to 1.0% of the principal amount prepaid. At December 31, 2011, the effective interest rates on the New Term Loan A and the New Term Loan B were 3.2% and 4.5%, respectively. Those rates remained unchanged as of February 17, 2012.

Throughout the New Revolving Credit Agreement's five-year term, the Company is obligated to pay commitment fees based on the amounts available for borrowing. The New Revolving Credit Agreement provides that the Company can borrow, on a revolving basis, up to an aggregate of $500.0 million, as adjusted for outstanding standby letters of credit of up to $75.0 million. As of February 17, 2012, standby letters of credit in favor of third parties of approximately $51.9 million reduced the amount available for borrowing under the New Revolving Credit Agreement to $448.1 million on such date. Although there were no amounts outstanding on either date, the effective interest rate on the variable rate New Revolving Credit Agreement was approximately 3.3% and 3.2% on December 31, 2011 and February 17, 2012, respectively.

The New Credit Facilities provide for a springing maturity of all amounts then outstanding to the date that is 91 days prior to the maturity date of the 2016 Senior Notes (as defined below) unless (i) the 2016 Senior Notes are first refinanced in full or (ii) the Company has liquidity at a predetermined date equal to $200 million, plus the then outstanding principal amount of the 2016 Senior Notes. The New Credit Facilities are also generally subject to mandatory prepayment in amounts equal to: (i) 100% of the net cash proceeds received from certain asset sales, including insurance recoveries and condemnation events, subject to reinvestment provisions and the ratable offer requirements of other pari passu secured debt; (ii) 100% of the net cash proceeds from the Company's issuance of certain new debt; and (iii) 50% of the Company's Excess Cash Flow (as defined in the loan agreement) with step-downs of such percentage based on the Company's Consolidated Leverage Ratio.

The Company's obligations under the New Credit Facilities are guaranteed on a joint and several basis by all of the Company's material domestic wholly owned subsidiaries (other than certain exempted subsidiaries). As discussed below, the same subsidiaries also provide certain guarantees with respect to the Company's obligations under the 2016 Senior Notes and the 7.375% Senior Notes due 2020. Additionally, the obligations under the New Credit Facilities, as well as those of the 2016 Senior Notes and the Demand Note (as defined below), are secured on a pari passu basis by a substantial portion of the Company's assets (primarily those of the subsidiary guarantors under the New Credit Facilities). As a result, approximately $526.7 million, $92.4 million and $1,957.8 million of the Company's net accounts receivable, supplies, and net property, plant and equipment, respectively, as presented in its consolidated balance sheet at December 31, 2011, collateralize the aforementioned credit facilities.

2. Long-Term Debt (continued)

The agreements underlying the New Credit Facilities contain covenants that, without prior consent of the lenders, limit certain of the Company's activities, including those relating to mergers; consolidations; the ability to secure additional indebtedness; sales, transfers and other dispositions of property and assets; capital expenditures; providing new guarantees; investing in joint ventures; and granting additional security interests. The New Credit Facilities also contain customary events of default and related cure provisions. Additionally, the Company is required to comply with certain financial covenants on a quarterly basis and its ability to pay cash dividends is subject to certain restrictions.

Predecessor Bank Borrowings. On March 1, 2007, the Company completed a recapitalization of its balance sheet, which included, among other things, $3.25 billion in new variable rate senior secured credit facilities with a syndicate of banks (the "Predecessor Credit Facilities") that closed on February 16, 2007. The Predecessor Credit Facilities consisted of a seven-year $2.75 billion term loan (the "Predecessor Term Loan") and a $500.0 million six-year revolving credit facility (the "Predecessor Revolving Credit Agreement"). As part of the 2011 Debt Restructuring, the Company terminated the Predecessor Credit Facilities and repaid all of the principal and accrued interest outstanding thereunder on November 18, 2011.

The Predecessor Term Loan required (i) quarterly principal payments to amortize approximately 1% of the loan's face value during each year of the loan's term and (ii) a balloon payment for the remaining outstanding loan balance at the end of the agreement. The Company was also required to repay principal under the Predecessor Term Loan in an amount that was as much as 50% of its annual Excess Cash Flow, as such term was defined in the Predecessor Credit Facilities' loan agreement. Based on the annual Excess Cash Flow requirements of the Predecessor Credit Facilities, the Company made principal payments under the Predecessor Term Loan of approximately $18.4 million during the year ended December 31, 2009. The Company also prepaid $25.0 million of principal under the Predecessor Term Loan during such year. There were no annual Excess Cash Flow principal payments under the Predecessor Term Loan that were required during the years ended December 31, 2011 and 2010. In connection with the early termination of the Predecessor Credit Facilities and principal payments under the Predecessor Term Loan in advance of their original scheduled maturities, the Company wrote-off deferred debt issuance costs, net of accumulated amortization, of $13.6 million and $0.4 million during the years ended December 31, 2011 and 2009, respectively.

The Company could elect whether interest on the Predecessor Credit Facilities, which was payable quarterly in arrears, was calculated using LIBOR or prime as its base rate. The effective interest rate included a spread above the base rate selected by the Company and was subject to modification in certain circumstances. Additionally, the Company could elect differing base interest rates for the Predecessor Term Loan and the Predecessor Revolving Credit Agreement. Under the Predecessor Revolving Credit Agreement, the Company was also obligated to pay commitment fees based on the amounts available for borrowing. During February 2007, as required by the Predecessor Credit Facilities, the Company entered into a seven-year receive variable/pay fixed interest rate swap contract. The interest rate swap contract was not terminated as part of the 2011 Debt Restructuring. Although the Company is exposed to financial risk in the event of nonperformance by one or more of the counterparties to the contract, management does not anticipate nonperformance because the interest rate swap contract is in a liability position and would require the Company to make settlement payments to the counterparties in the event of a contract termination. The interest rate swap contract provides for the Company to pay interest at a fixed rate of 6.7445% on the contract's notional amount, which was originally expected to reasonably approximate the declining principal balance of the Predecessor Term Loan. At December 31, 2011, the notional amount of the Company's interest rate swap contract was approximately $2,027.4 million. Management projects that $87.0 million will be payable to the counterparties during the year ending December 31, 2012; however, the aggregate payments through the contract's expiration in February 2014, as well as the specific timing thereof, are subject to change based on, among other things, future LIBOR rates. See Note 5 for discussion of the estimated fair value of the Company's interest rate swap contract, including valuation methods and significant assumptions, and Note 11 for the accounting afforded the interest rate swap contract.

Demand Promissory Note. On July 14, 2009, the Company executed a $10.0 million secured demand promissory note in favor of a bank (the "Demand Note"). Pursuant to the terms and conditions of the Demand Note, the Company may borrow, on a revolving basis, up to the principal face amount of the note. Such borrowings, if any, will be secured on a pari passu basis with the New Credit Facilities and the 2016 Senior Notes. All principal and accrued interest under the Demand Note will be immediately due and payable upon the bank's written demand. Interest will be payable monthly and determined using a LIBOR-based rate, plus 2.0%. Although there were no amounts outstanding on December 31, 2011 and February 17, 2012, the effective interest rate on the Demand Note was approximately 2.6% and 2.5%, respectively, on those dates.

2. Long-Term Debt (continued)

b. Senior Debt Securities

2020 Senior Notes. On November 18, 2011, the Company completed a private placement of $875.0 million in aggregate principal amount of 7.375% Senior Notes due 2020 (the "2020 Senior Notes") at an issue price of 100% to qualified institutional buyers under Rule 144A of the Securities Act of 1933 and to persons outside the United States in accordance with Regulation S thereunder. The Company used the net proceeds from this debt offering, together with the net proceeds from the term loans under the New Credit Facilities, to repay all amounts outstanding under the Predecessor Credit Facilities and the Knoxville Credit Agreement (as defined below).

The 2020 Senior Notes are senior unsecured debt obligations that bear interest at the rate of 7.375% per annum, payable semi-annually in arrears on January 15 and July 15 of each year, beginning on July 15, 2012. The 2020 Senior Notes mature on January 15, 2020 at which time the entire $875.0 million of principal is due and payable. At any time on or after January 15, 2016, the 2020 Senior Notes are redeemable at the Company's option, in whole or in part, at the redemption prices set forth in the related indenture, plus accrued and unpaid interest. Prior to January 15, 2016, the Company may redeem the 2020 Senior Notes, in whole or in part, at a redemption price equal to 100% of the principal amount of the notes being redeemed, plus a "make-whole" premium and accrued and unpaid interest. Prior to January 15, 2015, the Company may also redeem up to 35% of the original principal amount of the 2020 Senior Notes with the proceeds from certain equity offerings at a redemption price of 107.375% of the principal amount of the notes being redeemed, plus accrued and unpaid interest.

Among other things, the indenture that governs the 2020 Senior Notes limits and restricts the ability of Health Management Associates, Inc. and certain of its subsidiaries to: (i) incur additional indebtedness; (ii) pay dividends or make other distributions or repurchase or redeem capital stock; (iii) prepay, redeem or repurchase certain debt; (iv) make loans and investments; (v) consolidate, merge or sell all or substantially all of their assets; (vi) incur liens; (vii) enter into transactions with affiliates; and (viii) enter into sale-leaseback transactions. Each of the aforementioned limitations and restrictions are subject to exceptions and qualifications. Upon the occurrence of a change of control, as defined in the indenture, each holder of a 2020 Senior Note will have the right to require the Company to repurchase all or a part of such holder's notes at a purchase price equal to 101% of the principal amount of the notes being repurchased, plus accrued and unpaid interest. Additionally, the Company may be required to use the proceeds from certain asset dispositions to repurchase 2020 Senior Notes at 100% of their principal amount, plus accrued and unpaid interest. The indenture governing the 2020 Senior Notes contains covenants, terms, events of default and related cure provisions that are customary in agreements used in connection with similar transactions.

The 2020 Senior Notes, although unsecured, are guaranteed on a joint and several basis by the same Company subsidiaries that are borrowers and/or guarantors under the New Credit Facilities and the 2016 Senior Notes (as defined below). The 2020 Senior Notes: (i) rank equally in right of payment with all of the Company's and its subsidiary guarantors' existing and future senior unsecured indebtedness; (ii) rank senior in right of payment to all of the Company's and its subsidiary guarantors' existing and future subordinated indebtedness; (iii) are effectively subordinated to all of the Company's and its subsidiary guarantors' existing and future secured indebtedness, to the extent of the value of the pledged assets; and (iv) are structurally subordinated to all of the existing and future liabilities of each of the Company's subsidiaries that do not guarantee the 2020 Senior Notes.

In connection with the sale of the 2020 Senior Notes, the Company entered into a Registration Rights Agreement, pursuant to which it will: (i) file a registration statement with the Securities and Exchange Commission with respect to a registered offer to exchange the 2020 Senior Notes for publicly registered notes of the Company (the "Exchange Notes") that will have terms substantially identical, in all material respects, to the 2020 Senior Notes and (ii) cause such registration statement to be declared effective on or before November 16, 2012. Upon the registration statement being declared effective, the Company will offer the Exchange Notes to holders of the 2020 Senior Notes in exchange for the surrender of their existing notes. In certain instances, the Company may also be required by the Registration Rights Agreement to file a shelf registration statement with the Securities and Exchange Commission for the resale of the 2020 Senior Notes. If the Company fails to meet its obligations under the Registration Rights Agreement, the interest rate on the 2020 Senior Notes will increase by 0.25% per annum for the first 90 day period following such failure and will increase by an additional 0.25% per annum for each subsequent 90 day period that the Company fails to meet its obligations, up to a maximum of 1.00% per annum.

2. Long-Term Debt (continued)

2016 Senior Notes. On April 21, 2006, the Company completed the sale of $400.0 million of 6.125% Senior Notes due 2016 (the "2016 Senior Notes"). The 2016 Senior Notes (i) mature on April 15, 2016 at which time the entire $400.0 million of principal is due and payable and (ii) bear interest at a fixed rate of 6.125% per annum, payable semi-annually in arrears on April 15 and October 15. As a result of the 2011 Debt Restructuring, the 2016 Senior Notes are secured on a pari passu basis with the New Credit Facilities and the Demand Note.

If any of the Company's subsidiaries are required to issue a guaranty in favor of the lenders under any credit facility ranking equal with the 2016 Senior Notes, such subsidiaries are also required, under the terms of the 2016 Senior Notes, to issue a guaranty for the benefit of the holders of the 2016 Senior Notes on substantially the same terms and conditions. As a result of the 2011 Debt Restructuring and the guarantees provided thereunder, the Company's material domestic wholly owned subsidiaries (other than certain exempted subsidiaries) have provided guarantees of payment to the holders of the 2016 Senior Notes on a basis similar to the guarantees provided under the New Credit Facilities.

In connection with the sale of the 2016 Senior Notes, the Company entered into an indenture that governs such notes. The 2016 Senior Notes (and such other debt securities that may be issued from time to time under the indenture) are subject to certain covenants, which include, among other things, limitations and restrictions on: (i) the incurrence of debt secured by liens against the Company and its subsidiaries; (ii) the incurrence of subsidiary debt; (iii) sale lease-back transactions; and (iv) certain consolidations, mergers and transfers of assets. Each of the aforementioned limitations and restrictions are subject to certain contractual exceptions. The indenture governing the 2016 Senior Notes contains covenants, terms, events of default and related cure provisions that are customary in agreements used in connection with similar transactions.

c. Convertible Senior Subordinated Notes

On May 21, 2008, the Company completed a private placement of $250.0 million of its 3.75% Convertible Senior Subordinated Notes due 2028 (the "2028 Notes") to qualified institutional buyers under Rule 144A of the Securities Act of 1933. The 2028 Notes are general unsecured obligations that are subordinated in right of payment to all of the Company's existing and future senior indebtedness. The 2028 Notes mature on May 1, 2028 and bear interest at a fixed rate of 3.75% per annum, payable semi-annually in arrears on May 1 and November 1. The Company can redeem the 2028 Notes for cash at any time on or after May 1, 2014, in whole or in part, at a "Redemption Price" equal to 100% of the principal amount of the notes to be redeemed, plus accrued and unpaid interest. Holders of the 2028 Notes have the right to require the Company to repurchase some or all of their notes for cash at the Redemption Price on May 1, 2014, May 1, 2018 and May 1, 2023. If the Company undergoes a Fundamental Change (as defined in the indenture governing the 2028 Notes) at any time prior to May 1, 2014, holders of the 2028 Notes will have the right to require the Company to repurchase some or all of their notes for cash at the Redemption Price.

Upon the occurrence of certain events, which are described below, the 2028 Notes become convertible into cash and, in select situations, shares of the Company's common stock at a predetermined conversion rate that is subject to mandatory adjustment in some circumstances. The 2028 Notes are convertible at the option of the holders at the applicable "Conversion Rate" on any day prior to the scheduled trading day immediately preceding November 1, 2027 under the following circumstances: (i) if during any fiscal quarter the last reported sales price of the Company's common stock for at least twenty trading days during the period of thirty consecutive trading days ending on the last trading day of the previous fiscal quarter is greater than or equal to 130% of the "Conversion Price" per share of the Company's common stock on each such trading day; (ii) if the Company calls the 2028 Notes for redemption; (iii) if during the five business-day period after any five consecutive trading day period (i.e., the measurement period) in which the trading price per note for each day of the measurement period is less than 98% of the product of the last reported sales price of the Company's common stock and the applicable Conversion Rate on each such day; or (iv) upon the occurrence of specified transactions, including, among other things, certain distributions to the Company's stockholders. The 2028 Notes are also convertible at the option of the noteholders at any time from November 1, 2027 through the third scheduled trading day immediately preceding their maturity date.

2. Long-Term Debt (continued)

Upon the issuance of the 2028 Notes, the Conversion Rate was initially set at 85.034 shares of the Company's common stock per $1,000 principal amount of such notes. The corresponding Conversion Price was initially set at $11.76 per share of the Company's common stock. Both the Conversion Rate and the Conversion Price are subject to mandatory adjustment upon the occurrence of certain events that are identified in the indenture governing the 2028 Notes. Noteholders are entitled to receive additional shares or cash upon the conversion of their notes if (i) the volume-weighted average price of the Company's common stock during an Observation Period (as defined in the indenture governing the 2028 Notes) is greater than the Conversion Price or (ii) certain Fundamental Changes occur prior to May 1, 2014. The indenture governing the 2028 Notes contains covenants, terms, events of default and related cure provisions that are customary in agreements used in connection with similar transactions.

During the year ended December 31, 2009, the Company used cash on hand to repurchase approximately $108.6 million of principal face amount 2028 Notes. Such notes were repurchased in the open market at approximately 62.4% of their principal face amount, plus accrued and unpaid interest. In connection with such 2028 Note repurchases, the Company recorded a net gain on the early extinguishment of debt of $16.2 million. Prior to 2009, the Company repurchased $50.0 million of principal face amount 2028 Notes in the open market.

When the 2028 Notes were originally issued, the Company recorded a debt discount of approximately $58.1 million and an after-tax increase to additional paid-in capital of $34.0 million. The outstanding 2028 Notes at December 31, 2011 (principal face amount of $91.4 million) were recorded net of debt discounts of $9.8 million. The Company is amortizing the debt discount over a remaining period of 2.3 years using an effective interest rate of approximately 8.8%. The Company recorded interest expense of $7.3 million, $7.0 million and $7.8 million on the 2028 Notes during the years ended December 31, 2011, 2010 and 2009, respectively.

d. Acquisition-Related Borrowings

On September 30, 2011, one of the Company's wholly owned subsidiaries, Knoxville HMA Holdings, LLC ("HMA Knoxville"), and certain subsidiaries of HMA Knoxville entered into a credit agreement with a syndicate of banks (the "Knoxville Credit Agreement"). HMA Knoxville entered into the Knoxville Credit Agreement to facilitate its September 30, 2011 acquisition of substantially all of the assets of seven general acute care hospitals and certain related ancillary health care operations in east Tennessee. See Note 4 for information regarding this acquisition. In connection with the 2011 Debt Restructuring, the Knoxville Credit Agreement was terminated on November 18, 2011 and (i) all of the principal and accrued interest outstanding thereunder was repaid and (ii) HMA Knoxville wrote-off deferred debt issuance costs, net of accumulated amortization, of approximately $10.4 million. The Knoxville Credit Agreement consisted of a $360.0 million term loan and a $150.0 million revolving credit facility.

The full amount of the term loan was borrowed by HMA Knoxville on September 30, 2011 and that amount was included as part of the total cash consideration paid to complete the abovementioned acquisition. Borrowings under the revolving credit facility could only be used by HMA Knoxville for its working capital and general corporate purposes. The revolving credit facility allowed HMA Knoxville to borrow, on a revolving basis, up to an aggregate of $150.0 million, as adjusted for outstanding standby letters of credit of up to $5.0 million. HMA Knoxville borrowed approximately $29.2 million under the revolving credit facility through November 18, 2011. Such amount was used to pay closing costs associated with the Knoxville Credit Agreement and provide start-up working capital to HMA Knoxville and its subsidiaries. HMA Knoxville could elect whether interest on the Knoxville Credit Agreement was calculated using LIBOR or prime as its base rate. The effective interest rate included a spread above the base rate selected by HMA Knoxville.

Other. The estimated fair values of the Company's long-term debt instruments, determined by reference to quoted market prices and/or bid and ask prices in the relevant market, are summarized in the table below (in thousands).

	December 31,	
	2011	2010
New Term Loan A	$ 708,688	$ -
New Term Loan B	1,393,000	-
Predecessor Term Loan	-	2,448,211
2016 Senior Notes	416,000	405,000
2020 Senior Notes	910,000	-
2028 Notes	94,391	109,543

2. Long-Term Debt (continued)

The estimated fair values of the Company's other long-term debt instruments reasonably approximate their carrying amounts in the consolidated balance sheets. See Note 1(j) and Note 5 for discussion of the estimated fair values of the Company's other financial instruments, including valuation methods and significant assumptions.

At December 31, 2011, the Company was in compliance with all of the covenants contained in its debt agreements. Moreover, at such date, the Company had reserved a sufficient number of shares of its common stock to satisfy the potential conversion of some or all of the 2028 Notes.

Capitalized interest was approximately $6.0 million, $2.7 million and $4.8 million during the years ended December 31, 2011, 2010 and 2009, respectively.

Scheduled maturities of long-term debt, exclusive of capital lease obligations, for the next five years ending December 31 and thereafter are summarized in the table below (in thousands).

2012	$ 69,522
2013	69,546
2014	178,165
2015	122,967
2016	849,221
Thereafter	2,206,293
	$ 3,495,714

For purposes of the above table, it was assumed that the 2028 Notes will be repurchased on May 1, 2014 because the noteholders can unilaterally exercise their contractual rights to require the Company to repurchase some or all of their notes on such date.

3. Leases

The Company leases real property, equipment and vehicles under cancelable and non-cancelable leases. Certain of the Company's lease agreements provide standard renewal options and recurring escalations of lease payments for, among other things, increases in the lessors' maintenance costs and taxes. Future minimum operating and capital lease payments for the next five years ending December 31 and thereafter, including amounts relating to leased hospitals, are summarized in the table below (in thousands).

	Operating			Capital	
	Real Property	Real Property Master Leases	Equipment	Real Property and Equipment	Totals
2012	$ 37,545	$ 19,252	$ 68,848	$ 22,722	$ 148,367
2013	30,787	17,581	54,827	17,468	120,663
2014	25,755	13,731	37,153	15,934	92,573
2015	21,987	13,219	24,653	15,678	75,537
2016	19,210	11,251	9,009	12,013	51,483
Thereafter	67,539	39,171	4,940	95,417	207,067
Total minimum payments	$ 202,823	$ 114,205	$ 199,430	179,232	$ 695,690
Less amounts representing interest				(74,820)	
Present value of minimum lease payments				$ 104,412	

The Company has entered into several real property master leases with unrelated entities in the ordinary course of business. These leases are for buildings on or near hospital properties that are either subleased to unrelated third parties or used by the local hospital in its daily operations. The Company also owns medical office buildings that are leased to unrelated third parties or used for internal purposes.

Including acquisition transactions, the Company entered into capital leases for real property and equipment of approximately $63.3 million, $12.6 million and $3.0 million during the years ended December 31, 2011, 2010 and 2009, respectively. Amortization expense pertaining to property, plant and equipment under capital lease arrangements is included with depreciation and amortization expense in the consolidated statements of income.

3. Leases (continued)

The table below summarizes the Company's assets under capital lease arrangements and other assets that are directly related to the Company's leasing activities (e.g., leasehold improvements, contractual rights to operate hospitals, etc.), including a non-cash real property addition of approximately $22.5 million at a Company hospital during the year ended December 31, 2010.

	December 31,	
	2011	2010
	(in thousands)	
Property, plant and equipment under capital lease arrangements and other capitalized assets relating to leasing activities	$ 1,265,758	$ 1,124,185
Accumulated depreciation and amortization	(572,111)	(522,432)
Net book value	$ 693,647	$ 601,753

4. Acquisitions, Joint Ventures and Other Activity

Acquisition Activity. The acquisitions described below, as well as the pending acquisition discussed at Note 15, are in furtherance of the part of the Company's business strategy that calls for the acquisition of hospitals and other ancillary health care businesses in non-urban communities. The Company's acquisitions are typically financed using a combination of available cash balances, proceeds from sales of available-for-sale securities, borrowings under revolving credit agreements and other long-term financing arrangements.

2011 Acquisitions. On September 30, 2011, a subsidiary of the Company, Knoxville HMA Holdings, LLC ("HMA Knoxville"), acquired from Catholic Health Partners and its subsidiary Mercy Health Partners, Inc. ("Mercy") substantially all of the assets of Mercy's seven general acute care hospitals in east Tennessee. Those hospitals are as follows:

- Mercy Medical Center St. Mary's in Knoxville (401 licensed beds);
- Mercy Medical Center North in Powell (108 licensed beds);
- Mercy Medical Center West in Knoxville (101 licensed beds);
- St. Mary's Jefferson Memorial Hospital in Jefferson City (58 licensed beds);
- St. Mary's Medical Center of Campbell County in LaFollette (66 licensed beds);
- St. Mary's Medical Center of Scott County in Oneida (25 licensed beds); and
- Baptist Hospital of Cocke County in Newport (74 licensed beds).

HMA Knoxville also acquired (i) substantially all of Mercy's ancillary health care operations that are affiliated with the aforementioned Tennessee-based hospitals (collectively those ancillary facilities are licensed to operate 74 beds) and (ii) Mercy's former Riverside hospital campus (which is licensed to operate 293 beds). The Company's east Tennessee hospital and health care network is now collectively referred to as Tennova Healthcare. See Note 10 for information regarding the Company's treatment of St. Mary's Medical Center of Scott County and the former Riverside hospital campus as discontinued operations on the date of acquisition. The total purchase price for this acquisition was approximately $532.4 million in cash. Additionally, HMA Knoxville assumed certain long-term lease obligations and will make maintenance and capital expenditures at the acquired hospitals. This acquisition was financed with available cash balances, which included the proceeds from sales of available-for-sale securities, and bank financing, which is described at Note 2(d).

Effective May 1, 2011, one of the Company's subsidiaries acquired a 95% equity interest in a company that owns and operates Tri-Lakes Medical Center, a 112-bed general acute care hospital in Batesville, Mississippi, and certain related health care operations. The total purchase price for the Company's 95% equity interest was approximately $38.8 million in cash. During the year ended December 31, 2011, certain of the Company's subsidiaries also acquired ten ancillary health care businesses for aggregate cash consideration of $23.3 million.

2010 Acquisitions. Effective October 1, 2010, certain subsidiaries of the Company acquired from Wuesthoff Health Systems, Inc. the following general acute care hospitals and certain related health care operations: (i) 298-bed Wuesthoff Medical Center in Rockledge, Florida; and (ii) 115-bed Wuesthoff Medical Center in Melbourne, Florida. The total purchase price for this acquisition was approximately $152.0 million in cash.

4. Acquisitions, Joint Ventures and Other Activity (continued)

Effective July 1, 2010, certain subsidiaries of the Company acquired from Shands HealthCare a 60% equity interest in each of the following general acute care hospitals and certain related health care operations: (i) 99-bed Shands Lake Shore hospital in Lake City, Florida; (ii) 15-bed Shands Live Oak hospital in Live Oak, Florida; and (iii) 25-bed Shands Starke hospital in Starke, Florida. Shands HealthCare or one of its affiliates continues to hold a 40% equity interest in each of these hospitals and any related health care operations. The total purchase price for the Company's 60% equity interests in these three hospitals was approximately $21.5 million in cash. One of the Company's subsidiaries also entered into a lease extension for Shands Lake Shore hospital through June 30, 2040. Under the related operating agreements, Shands HealthCare may require the Company to purchase its 40% equity interest in one or more of the three abovementioned hospitals if the Company experiences a change of control. The purchase price in this regard would be set at the fair market value of the equity interests being acquired.

During the year ended December 31, 2010, certain subsidiaries of the Company also acquired six ancillary health care businesses, including one in which the Company held a pre-acquisition minority equity interest, through: (i) the issuance of subsidiary equity securities valued at approximately $3.1 million; (ii) the payment of cash consideration of $18.0 million; and (iii) the assumption of a capital lease agreement.

2009 Acquisitions. Effective December 1, 2009, certain subsidiaries of the Company acquired the Sparks Health System in Fort Smith, Arkansas, which included, among other things, a 492-bed general acute care hospital, physician practices and other related health care operations. The total purchase price for this acquisition was approximately $138.2 million in cash. Additionally, effective September 30, 2009, a subsidiary of the Company issued equity securities valued at approximately $9.2 million to acquire certain ancillary health care businesses.

Other. The Company's acquisitions are accounted for using the purchase method of accounting. The Company uses estimated exit price fair values as of the date of acquisition to (i) allocate the related purchase price to the assets acquired and liabilities assumed and (ii) record noncontrolling interests. Management uses a variety of techniques to estimate exit price fair values, including, but not limited to, valuation methodologies that derive fair values using a market approach based on comparable transactions and an approach based on depreciated replacement cost. The Company recorded incremental goodwill during each of the years ended December 31, 2011, 2010 and 2009 because the final negotiated purchase price in certain completed acquisitions exceeded the fair value of the net tangible and intangible assets acquired. Most of the goodwill that was added in 2011 and 2010 is expected to be tax deductible whereas the goodwill added in 2009 is generally non-deductible.

The Company incurred approximately $5.0 million, $0.9 million and $0.3 million of acquisition-related costs that were included in other operating expenses in the consolidated statements of income during the years ended December 31, 2011, 2010 and 2009, respectively. Amounts paid for acquisition-related costs are included in net cash provided by continuing operating activities in the consolidated statements of cash flows.

The table below summarizes the purchase price allocations for the acquisitions that were completed during the three-year period ended December 31, 2011; however, in some cases, such purchase price allocations are preliminary and remain subject to future refinement as the Company gathers supplemental information.

	Years Ended December 31,		
	2011	2010	2009
		(in thousands)	
Assets acquired:			
Current and other assets	$ 25,762	$ 10,643	$ -
Property, plant and equipment	499,900	190,364	139,645
Intangible and other long-term assets	59,606	-	-
Goodwill	89,910	27,305	7,733
Total assets acquired	675,178	228,312	147,378
Liabilities assumed:			
Current liabilities	(13,725)	(1,395)	-
Capital lease obligations and related other	(61,307)	(11,690)	-
Total liabilities assumed	(75,032)	(13,085)	-
Net assets acquired	$ 600,146	$ 215,227	$ 147,378

During the three months ended December 31, 2011, the Company updated its acquisition accounting for the Mercy acquisition. Among other things, the Company recorded entries during that period to adjust the September 30, 2011 balances to (i) increase property, plant and equipment and other long-term liabilities by approximately $33.6 million and $19.2 million, respectively, and (ii) reduce goodwill by $12.8 million.

4. Acquisitions, Joint Ventures and Other Activity (continued)

The intangible assets that were acquired during 2011 as part of the Company's acquisitions were primarily contractual rights to operate hospitals and other health care facilities (approximately $43.9 million, including $1.1 million allocated to discontinued operations) and non-compete arrangements ($8.4 million). The Company amortizes those intangible assets on a straight-line basis with no residual value over the remaining terms of the related contracts. The weighted average future amortization periods for the intangible assets acquired during the year ended December 31, 2011 are 7.7 years and 4.8 years for the contractual operating rights and non-compete arrangements, respectively.

A rollforward of the Company's goodwill is summarized in the table below (in thousands).

	Years Ended December 31,	
	2011	2010
Balances at the beginning of the year	$ 909,470	$ 881,365
Current year acquisition activity	89,910	27,305
Adjustments for prior period acquisitions, including income tax matters, net	-	800
Balances at the end of the year	$ 999,380	$ 909,470

The operating results of entities acquired by the Company's subsidiaries are included in the Company's consolidated financial statements from the date of acquisition. If an acquired entity was subsequently sold, closed or is being held for sale, its operations are included in discontinued operations, which are discussed at Note 10.

The table below sets forth certain combined pro forma financial information as if the Mercy acquisition had closed on January 1, 2010 (in thousands, except per share data).

	Years Ended December 31,	
	2011	2010
Net revenue	$ 6,294,419	$ 5,708,518
Consolidated net income	207,518	174,679
Net income attributable to Health Management Associates, Inc.	182,303	152,500
Earnings per share attributable to Health Management Associates, Inc. common stockholders:		
Basic	$ 0.72	$ 0.61
Diluted	0.71	0.61

The 2011 pro forma amounts for net income and earnings per share in the above table have been adjusted to exclude approximately $4.8 million of acquisition-related expenses for the abovementioned Mercy acquisition. However, there were no 2011 or 2010 pro forma adjustments made to reflect potential cost reductions or operating efficiencies. Accordingly, the combined pro forma financial information is for comparative purposes only and is not necessarily indicative of the results that the Company would have experienced if the Mercy acquisition had actually occurred on January 1, 2010 or that may occur in the future. During the three months ended December 31, 2011, the Mercy hospitals and their related health care entities (i.e., Tennova Healthcare) contributed $152.5 million and $4.0 million of net revenue to continuing operations and discontinued operations, respectively. During that same period, Tennova Healthcare's losses from continuing operations and discontinued operations were $1.6 million and $1.7 million, respectively. Included in Tennova Healthcare's other operating expenses from continuing operations during the three months ended December 31, 2011 was $12.9 million of restructuring costs, consisting primarily of severance pay and related health and welfare benefits.

Joint Ventures and Redeemable Equity Securities. As of December 31, 2011, the Company had established joint ventures to own/lease and operate 28 of its hospitals. Local physicians and/or other health care entities own minority equity interests in each of the joint ventures and participate in the related hospital's governance. The Company owns a majority of the equity interests in each joint venture and manages the related hospital's day-to-day operations.

4. Acquisitions, Joint Ventures and Other Activity (continued)

Novant Health, Inc. Prior to January 1, 2009, Novant Health, Inc. and one or more of its affiliates (collectively, "Novant") acquired from the Company (i) a 27% equity interest in a limited liability company that then owned/leased and operated the Company's seven general acute care hospitals in North Carolina and South Carolina (the "Carolina Joint Venture") and (ii) certain property, plant and equipment of the physician practices that were affiliated with those hospitals. Novant also assumed full operational and fiscal responsibility for such physician practices; however, the Company was required to partially subsidize the related losses, if any, for a period of up to three years in an amount not to exceed $4.0 million per annum (the "Physician Subsidy"). Effective October 1, 2009, the Carolina Joint Venture was restructured as described below, resulting in a gain of approximately $10.4 million ($0.03 per diluted share) that has been included in discontinued operations under gains (losses) on sales of assets and related other. The portion of the gain attributable to the remeasurement of the Company's retained interest in each of Franklin Regional Medical Center and Upstate Carolina Medical Center was nominal. The realized gain was determined after allocating $14.3 million of goodwill to those hospitals.

(i) all of the equity interests in Davis Regional Medical Center in Statesville, North Carolina, Sandhills Regional Medical Center in Hamlet, North Carolina, Carolina Pines Regional Medical Center in Hartsville, South Carolina and Chester Regional Medical Center in Chester, South Carolina were distributed from the Carolina Joint Venture to the Company;

(ii) Franklin Regional Medical Center in Louisburg, North Carolina and Upstate Carolina Medical Center in Gaffney, South Carolina continue to be owned by the Carolina Joint Venture; however, Novant now manages both hospitals and receives 99% of the net profits, net losses, free cash flow and capital accounts of those hospitals (effectively reducing the Company's interest in each hospital from 73% to 1%);

(iii) Lake Norman Regional Medical Center in Mooresville, North Carolina continues to be owned by the Carolina Joint Venture and managed by the Company (subject to certain management rights expressly delegated to Novant); however, Novant now receives 30% of the net profits, net losses, free cash flow and capital accounts of the hospital (effectively a 3% increase in Novant's interest in the hospital);

(iv) the Company paid Novant approximately $7.6 million, which included the purchase of certain assets used by physicians previously employed by Novant who returned to the Company's employment. Additionally, the Company agreed to make ten annual installment payments of $200,000 to Novant, the first of which was in January 2010;

(v) Novant may require the Company to purchase its 30% interest in Lake Norman Regional Medical Center for the greater of $150.0 million or the fair market value of such interest in the hospital. This right is contingent on a change of control (excluding certain changes of control wherein the Company's senior executive management team is retained); and

(vi) the Company's remaining Physician Subsidy obligation, if any, was cancelled.

As a result of the Carolina Joint Venture restructuring, Franklin Regional Medical Center and Upstate Carolina Medical Center have been included in discontinued operations (see Note 10).

Redeemable Equity Securities and Other. When completing a joint venture transaction, the Company subsidiary that is a party to the joint venture customarily issues equity securities that provide the noncontrolling shareholders with a unilateral right to require the Company's subsidiary to redeem such securities (typically at the lower of the original investment or fair market value). As recorded in the consolidated balance sheets, redeemable equity securities represent (i) the minimum amounts that can be unilaterally redeemed for cash by noncontrolling shareholders in respect of their subsidiary equity holdings and (ii) the initial unadjusted estimated fair values of certain contingent rights held by Novant and Shands HealthCare, which are described above. As of December 31, 2011 and through February 17, 2012, the mandatory redemptions requested by noncontrolling shareholders in respect of their subsidiary equity holdings have been nominal.

4. Acquisitions, Joint Ventures and Other Activity (continued)

A rollforward of the Company's redeemable equity securities is summarized in the table below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Balances at the beginning of the year	$ 201,487	$ 182,473	$ 48,868
Noncontrolling shareholder interests in an acquired business	2,046	-	-
Investments by noncontrolling shareholders	-	5,679	65,063
Purchases of subsidiary shares from and distributions to noncontrolling shareholders	(2,890)	(1,032)	(29)
Estimated fair values of noncontrolling shareholders' contingent rights	-	14,367	68,571
Balances at the end of the year	$ 200,643	$ 201,487	$ 182,473

Management believes it is not probable that the contingent rights of Novant and Shands·HealthCare will vest because there are no circumstances known to management that would trigger the requisite change of control provision with either party. Accordingly, insofar as the contingent rights are concerned, the carrying values of the related redeemable equity securities have not been adjusted since being initially recorded.

The table below presents certain information regarding the changes in the ownership interests of Health Management Associates, Inc. in its consolidated subsidiaries as a result of the abovementioned 2009 joint venture activity (in thousands). No similar disclosures are required for the years ended December 31, 2011 and 2010.

Net income attributable to Health Management Associates, Inc.	$ 138,182
Changes in the additional paid-in capital of Health Management Associates, Inc. due to:	
Sale of subsidiary shares to a noncontrolling shareholder	2,019
Purchase of subsidiary shares from a noncontrolling shareholder	(6,594)
Incremental costs of certain transactions with noncontrolling shareholders	(1,054)
Net transfers to a noncontrolling shareholder and related other	(5,629)
Change from net income attributable to Health Management Associates, Inc., net transfers to a noncontrolling shareholder and related other	$ 132,553

5. Fair Value Measurements, Available-For-Sale Securities and Restricted Funds

General. GAAP defines fair value as the amount that would be received for an asset or paid to transfer a liability (i.e., an exit price) in the principal market for the asset or liability in an orderly transaction between market participants on the measurement date. GAAP also establishes a hierarchy that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. GAAP describes the following three levels of inputs that may be used:

Level 1: Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets and liabilities. The fair value hierarchy gives the highest priority to Level 1 inputs.

Level 2: Observable prices that are based on inputs not quoted on active markets but corroborated by market data.

Level 3: Unobservable inputs when there is little or no market data available, thereby requiring an entity to develop its own assumptions. The fair value hierarchy gives the lowest priority to Level 3 inputs.

Transfers between levels within the fair value hierarchy are recognized by the Company on the date of the change in circumstances that requires such transfer. The table below summarizes the estimated fair values of the Company's financial assets (liabilities) as of December 31, 2011 (in thousands).

	Level 1	Level 2	Level 3	Totals
Available-for-sale securities, including those in restricted funds	$ 216,535	$ 30,275	$ -	$ 246,810
Interest rate swap contract	$ -	$ (162,307)	$ -	$ (162,307)

5. Fair Value Measurements, Available-For-Sale Securities and Restricted Funds (continued)

The estimated fair value of the Company's interest rate swap contract was determined using a model that considers various inputs and assumptions, including LIBOR swap rates, cash flow activity, forward yield curves and other relevant economic measures, all of which are observable market inputs that are classified under Level 2 of the fair value hierarchy. The model also incorporates valuation adjustments for credit risk. The table below summarizes the Company's balance sheet classification of the estimated fair values of its interest rate swap contract liabilities (in thousands).

	December 31,	
	2011	2010
Accrued expenses and other liabilities	$ 86,975	$ -
Other long-term liabilities	75,332	215,473
Totals	$ 162,307	$ 215,473

The Company's Level 2 available-for-sale securities primarily consist of bonds and notes issued by (i) the United States government and its agencies and (ii) domestic and foreign corporations. The estimated fair values of these securities are determined using various valuation techniques, including a multi-dimensional relational model that incorporates standard observable inputs and assumptions such as benchmark yields, reported trades, broker/dealer quotes, issuer spreads, benchmark securities, bids/offers and other pertinent reference data.

See Note 1(j) and Note 2 for discussion of the estimated fair values of the Company's other financial instruments, including valuation methods.

Available-For-Sale Securities (including those in restricted funds). Supplemental information regarding the Company's available-for-sale securities, which consisted of debt securities and shares in publicly traded stocks and mutual funds (all of which had no withdrawal restrictions), is set forth in the table below (in thousands).

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Values
As of December 31, 2011:				
Debt securities and debt-based mutual funds				
Government	$ 125,338	$ 1,164	$ (25)	$ 126,477
Corporate	76,995	356	(708)	76,643
Equity securities and equity-based mutual funds				
Domestic	26,220	2,354	(431)	28,143
International	15,446	304	(1,288)	14,462
Commodity-based fund	1,533	-	(448)	1,085
Totals	$ 245,532	$ 4,178	$ (2,900)	$ 246,810
As of December 31, 2010:				
Debt-based mutual funds				
Government	$ 120,026	$ 326	$ (308)	$ 120,044
Corporate	6,943	457	-	7,400
Equity-based mutual funds				
Domestic	4,840	751	-	5,591
International	8,147	1,190	-	9,337
Totals	$ 139,956	$ 2,724	$ (308)	$ 142,372

5. Fair Value Measurements, Available-For-Sale Securities and Restricted Funds (continued)

As of December 31, 2011 and 2010, investments with aggregate estimated fair values of approximately $67.0 million (294 investments) and $64.5 million (five investments), respectively, generated the gross unrealized losses disclosed in the table on the preceding page. Due to recent declines in the value of such securities and/or the Company's brief holding period (i.e., all such securities have been held for less than one year), as well as the Company's ability to hold the securities for a reasonable period of time sufficient for a projected recovery of fair value, management concluded that other-than-temporary impairment charges were not necessary at either of the balance sheet dates. Management will continue to monitor and evaluate the recoverability of the Company's available-for-sale securities.

As of December 31, 2011, the contractual maturities of debt securities held by the Company, excluding debt-based mutual fund holdings, are set forth in the table below. Expected maturities will differ from contractual maturities because the issuers of the debt securities may have the right to prepay their obligations without prepayment penalties.

	Amortized Cost Basis	Estimated Fair Value
	(in thousands)	
Within 1 year	$ -	$ -
After 1 year and through year 5	6,265	6,209
After 5 years and through year 10	9,036	9,044
After 10 years	14,762	15,022

Gross realized gains and losses on sales of available-for-sale securities and other investment income, which includes interest and dividends, are summarized in the table below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Realized gains	$ 1,694	$ 4,708	$ 1,384
Realized losses	(1,176)	(380)	-
Investment income	6,962	7,132	2,832

Restricted Funds. The Company's restricted funds are held by a wholly owned captive insurance subsidiary that is domiciled in the Cayman Islands. The assets of such subsidiary are effectively limited to use in its proprietary operations. Restricted funds are primarily used to purchase reinsurance policies and pay professional liability indemnity losses and related loss expenses. The current and long-term classification of restricted funds is primarily based on the projected timing of professional liability claim payments. The table below summarizes the estimated fair values of the Company's restricted funds (in thousands).

	December 31,	
	2011	2010
Cash and cash equivalents	$ -	$ 5,706
Available-for-sale securities	124,533	85,045
Totals	$ 124,533	$ 90,751

Supplemental information regarding the available-for-sale securities that are included in restricted funds is set forth in the table below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Proceeds from sales	$ 46,325	$ 17,577	$ 4,600
Purchases	86,057	18,981	$ 72,117

6. Income Taxes

The significant components of the Company's income tax expense (benefit) are summarized in the table below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Federal:			
Current	$ 42,609	$ 54,207	$ (6,946)
Deferred	61,055	27,808	78,900
Total federal	103,664	82,015	71,954
State:			
Current	(15,697)	26,531	(584)
Deferred	18,104	(7,497)	11,567
Total state	2,407	19,034	10,983
Totals	$ 106,071	$ 101,049	$ 82,937

Reconciliations of the federal statutory rate to the Company's effective income tax rates were as follows:

	Years Ended December 31,		
	2011	2010	2009
Federal statutory income tax rate	35.0%	35.0%	35.0%
State income taxes, net of federal benefit	0.5	4.3	2.9
Noncontrolling interests	(2.9)	(2.3)	(3.8)
Tax credits	-	(2.6)	(0.6)
Other	1.4	0.8	0.5
Totals	34.0%	35.2%	34.0%

Net income attributable to noncontrolling interests, which is not tax-effected in the consolidated financial statements, reduces the Company's effective income tax rates.

Tax-effected temporary differences that give rise to federal and state deferred income tax assets and liabilities are summarized in the table below (in thousands).

	December 31,	
	2011	2010
Deferred income tax assets:		
Interest rate swap contract	$ 63,001	$ 82,777
Accrued liabilities	50,001	41,551
Self-insured liabilities	41,843	31,186
State net operating loss and tax credit carryforwards	37,179	37,048
Other	27,788	29,669
Deferred income tax assets, before valuation allowances	219,812	222,231
Valuation allowances	(22,981)	(16,989)
Deferred income tax assets, net	196,831	205,242
Deferred income tax liabilities:		
Property, plant and equipment	(84,587)	(55,021)
Goodwill	(84,101)	(72,494)
Allowance for doubtful accounts	(40,119)	(23,925)
Joint ventures	(234,206)	(201,782)
Deferred gains on the early extinguishment of debt	(13,801)	(13,937)
Convertible debt discount amortization	(3,406)	(4,746)
Deferred revenue	(9,693)	(8,036)
Prepaid expenses	(11,464)	(9,530)
Deferred income tax liabilities	(481,377)	(389,471)
Net deferred income tax liabilities	$ (284,546)	$ (184,229)

6. Income Taxes (continued)

Valuation allowances are the result of state net operating loss carryforwards that management believes may not be fully realized due to uncertainty regarding the Company's ability to generate sufficient future state taxable income. State net operating loss carryforwards aggregated approximately $883 million at December 31, 2011 and have expiration dates through December 31, 2031.

A rollforward of the Company's unrecognized income tax benefits is presented below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Balances at the beginning of the year	$ 36,129	$ 34,910	$ 28,520
Additions for tax positions of the current year	4,434	4,779	7,299
Additions for tax positions of prior years	9,209	3,407	1,736
Reductions for tax positions of prior years	(7,623)	(2,516)	-
Lapses of statutes of limitations	(6,164)	(4,084)	(2,156)
Settlements	(4,470)	(367)	(489)
Balances at the end of the year	$ 31,515	$ 36,129	$ 34,910

Included in the Company's unrecognized income tax benefits at December 31, 2009 was approximately $0.4 million of tax positions for which the ultimate deductibility is highly certain but for which there is uncertainty about the timing of such deductibility. Other than interest and penalties, the disallowance of those deductions in the short-term would not affect the Company's effective income tax rates but would accelerate payments to certain taxing authorities. There were no such unrecognized income tax benefits at December 31, 2011 and 2010.

The Company files numerous consolidated and separate federal and state income tax returns. With a few exceptions, there are no ongoing federal or state income tax examinations for periods before the year ended December 31, 2010. Management does not expect significant changes to the Company's income tax reserves over the next year due to current audits and/or potential statute extensions.

The Company recognizes interest and penalties related to unrecognized income tax benefits in its provision for income taxes. During the years ended December 31, 2010 and 2009, the Company recognized approximately $1.8 million and $1.1 million, respectively, of net interest and penalties expense. The Company recognized a corresponding net benefit of $1.3 million during the year ended December 31, 2011 due to the reversal of certain previously established accrued expense balances. At December 31, 2011 and 2010, the Company had accrued $7.6 million and $8.9 million, respectively, for interest and penalties.

In the normal course of business, there may be differences between the Company's income tax provision for financial reporting purposes and final settlements with taxing authorities. These differences, which principally relate to state income tax matters, are subject to interpretation pursuant to the applicable regulations. Management does not believe that the resolution of these differences will have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

7. Earnings Per Share

Basic earnings per share is computed based on the weighted average number of outstanding common shares. Diluted earnings per share is computed based on the weighted average number of outstanding common shares plus the dilutive effect of common stock equivalents, primarily computed using the treasury stock method.

GAAP requires contingently convertible debt instruments, if dilutive, to be included in diluted earnings per share calculations, regardless of whether or not the market price trigger contained in the convertible debt instrument was met. The 2028 Notes, which are discussed at Note 2(c), were structured so that the common stock underlying those securities are not immediately included in the diluted earnings per share calculations.

7. Earnings Per Share (continued)

The table below sets forth the computations of basic and diluted earnings (loss) per share for the common stockholders of Health Management Associates, Inc. (in thousands, except per share amounts).

	Years Ended December 31,		
	2011	2010	2009
Numerators:			
Income from continuing operations	$ 206,334	$ 185,774	$ 161,303
Income attributable to noncontrolling interests	(25,215)	(22,179)	(24,981)
Income from continuing operations attributable to Health Management Associates, Inc. common stockholders	181,119	163,595	136,322
Income (loss) from discontinued operations	(2,409)	(13,526)	2,638
Income from discontinued operations attributable to noncontrolling interests	-	-	(778)
Income (loss) from discontinued operations attributable to Health Management Associates, Inc. common stockholders	(2,409)	(13,526)	1,860
Net income attributable to Health Management Associates, Inc. common stockholders	$ 178,710	$ 150,069	$ 138,182
Denominators:			
Denominator for basic earnings (loss) per share-weighted average number of outstanding common shares	251,541	248,272	245,381
Dilutive securities: stock-based compensation arrangements	3,496	2,834	1,584
Denominator for diluted earnings (loss) per share	255,037	251,106	246,965
Earnings (loss) per share:			
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
Securities excluded from diluted earnings (loss) per share because they were antidilutive or performance conditions were not met:			
Stock options	4,042	6,673	10,033
Deferred stock and restricted stock	605	682	1,979

8. Stock-Based Compensation

Background. The Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan (the "EICP") permits the Company to grant stock awards to: (i) employees; (ii) independent directors serving on the Company's Board of Directors; and (iii) non-employed physicians and clinicians who provide the Company with bona fide advisory or consulting services. The Company has granted non-qualified stock options and awarded other stock-based compensation to key employees and directors under the EICP or its predecessor plan; however, no stock awards have been granted to non-employed physicians and clinicians. The Health Management Associates, Inc. 2006 Outside Director Restricted Stock Award Plan (the "2006 Director Plan") provided for annual issuances of restricted stock awards to independent directors; however, only a nominal amount of shares remain available for award under such plan. Accordingly, beginning January 1, 2011, annual deferred stock awards have been granted to independent directors under the EICP.

The Company has approximately 43.4 million shares of common stock authorized for stock-based compensation under all of its plans (12.0 million shares remained available for award at December 31, 2011). The Company's policy is to issue new shares of common stock to satisfy stock option exercises and other stock-based compensation arrangements. If an award granted under a stock-based plan is forfeited, expires, terminates or is otherwise satisfied without delivery of shares of common stock to the plan participant, then the underlying shares will become available again for the benefit of employees, directors and non-employed physicians and clinicians.

8. Stock-Based Compensation (continued)

General. GAAP requires that the fair value of all share-based payments to employees and directors be measured on their grant date and either recognized as expense in the income statement over the requisite service period or, if appropriate, capitalized and amortized. Compensation expense for the stock-based arrangements described below, which is recorded in salaries and benefits in the consolidated statements of income, was approximately $25.2 million, $18.4 million and $10.9 million during the years ended December 31, 2011, 2010 and 2009, respectively. Substantially all such expense relates to the Company's deferred stock and restricted stock awards. The Company has not capitalized any stock-based compensation amounts. For awards with service-only vesting conditions, stock-based compensation expense is recognized on a straight-line basis over the requisite service period, which is generally aligned with the underlying stock-based award's vesting period. If an award has either a performance or market vesting condition, stock-based compensation expense is recognized ratably from the service inception date to the vesting date for each tranche of the award. For stock-based arrangements with performance conditions as a prerequisite to vesting, compensation expense is not recognized until it is probable that the corresponding performance condition will be achieved. During the years ended December 31, 2011, 2010 and 2009, stock-based compensation expense yielded income tax benefits of $9.7 million, $7.1 million and $3.9 million, respectively, that have been recognized in the consolidated statements of income.

Cash receipts from all stock-based plans during the years ended December 31, 2011, 2010, and 2009 were approximately $14.1 million, $7.5 million and $9.7 million, respectively. Realized income tax benefits, including those pertaining to deferred stock and restricted stock awards for which the Company receives no cash proceeds upon issuance of the underlying common stock, were $11.0 million, $4.8 million and $3.0 million during the years ended December 31, 2011, 2010 and 2009, respectively.

Deferred Stock and Restricted Stock Awards. Deferred stock is a right to receive shares of common stock upon fulfillment of specified conditions. Historically, the Company's only deferred stock vesting condition has been continuous employment; however, a component of the 2011 and 2010 deferred stock awards to certain key managers also included a performance criterion based on the Company's operating results. The Company provides deferred stock to its key employees through stock incentive awards that generally vest 20% to 25% per annum or 100% on the fourth grant anniversary date. At the completion of the vesting period, common stock is issued to the grantee.

Restricted stock represents shares of common stock that preserve the indicia of ownership for the holder but are subject to restrictions on transfer and risk of forfeiture until fulfillment of specified conditions. In addition to requiring continuous service as an employee, the annual vesting of senior executive officer restricted stock awards requires the satisfaction of certain predetermined performance objectives that are set by the Compensation Committee of the Board of Directors. The independent directors' restricted stock awards and deferred stock awards under the 2006 Director Plan and the EICP, respectively, vest in four equal installments on January 1 of each year following the grant date, provided that the recipient remains an independent director on such dates or certain other conditions are met.

On March 11, 2008, the Compensation Committee approved and implemented a long-term incentive compensation program for certain senior executive officers (the "LTI Program"), which provides long-term incentive compensation in the form of cash payments and equity awards. Annual targeted incentive compensation awards under the LTI Program are expected to be granted as follows: (i) restricted stock that vests based on service; (ii) restricted stock that vests based on the satisfaction of performance criteria; and (iii) cash based on the satisfaction of the same performance criteria. The predetermined performance criterion that will be reviewed annually for vesting purposes is currently an operational fiscal measure of the Company that is defined in the grant award. Full vesting of awards under the LTI Program also requires continuous employment with the Company over a four-year period, with awards vesting 25% per annum. Based on the service and performance criteria under the LTI Program, approximately 715,000 shares of restricted stock vested after December 31, 2011.

8. Stock-Based Compensation (continued)

Deferred stock and restricted stock activity for the Company's stock-based compensation plans, inclusive of participants employed at discontinued operations, is summarized in the table below.

	Shares		Weighted Average Grant Date Fair Values	
	Deferred Stock	Restricted Stock	Deferred Stock	Restricted Stock
	(in thousands)			
Balances at January 1, 2009 (non-vested)	5,008	569	$ 7.02	$ 6.25
Granted	135	1,317	5.64	1.76
Vested	(1,792)	(104)	6.46	7.34
Forfeited	(368)	(32)	7.71	5.27
Balances at December 31, 2009 (non-vested)	2,983	1,750	7.03	2.83
Granted	4,544	824	7.39	7.33
Vested	(879)	(480)	7.25	3.31
Forfeited	(432)	-	7.16	-
Balances at December 31, 2010 (non-vested)	6,216	2,094	7.25	4.45
Granted	4,139	505	9.63	9.67
Vested	(1,992)	(653)	7.67	4.33
Forfeited	(1,334)	-	7.95	-
Balances at December 31, 2011 (non-vested)	7,029	1,946	8.38	5.89

Subsequent to December 31, 2011, approximately 2.4 million shares of deferred stock vested upon completion of the requisite service and attainment of the 2011 performance criterion. The Company also granted new restricted stock awards and deferred stock awards to senior executive officers, key managers and independent directors. Underlying those awards were 7.6 million shares of the Company's common stock that will vest 25% per annum if the individual remains an independent director or employee of the Company, subject to, in some circumstances, the satisfactory achievement of the 2012 LTI Program performance criterion.

The aggregate intrinsic values of deferred stock and restricted stock issued during the years ended December 31, 2011, 2010 and 2009 were approximately $25.6 million, $10.1 million and $5.6 million, respectively. The aggregate grant date fair values of deferred stock and restricted stock awards that vested during such years were $18.1 million, $8.0 million and $12.3 million, respectively.

Compensation expense for deferred stock and restricted stock awards is based on the fair value (i.e., market price) of the underlying stock on the date of grant, except for awards with a market condition (i.e., awards that require the attainment of certain predetermined market prices of the Company's common stock as a vesting requirement). For awards with market conditions, management uses valuation methodologies to estimate their fair values. Because such awards have not been used by the Company in recent years, they had a nominal financial impact on the Company's consolidated operating results during the years presented herein. At December 31, 2011, there was approximately $40.5 million of unrecognized compensation cost attributable to non-vested deferred stock and restricted stock awards. Such cost is expected to be recognized over the remaining requisite service period for each award, the weighted average of which is approximately 2.8 years.

Stock Options. All employee stock options have ten year terms and vest 25% on each grant anniversary date over four years of continuous employment with the Company. Stock options granted to the independent members of the Company's Board of Directors have ten year terms and vest 25% on each grant anniversary date, provided that such individual remains an independent director on the vesting dates.

Stock-based compensation expense for stock options is based on the estimated fair values of the stock option awards on the date of grant as determined by the Black-Scholes option pricing model. At December 31, 2011, there was approximately $0.1 million of unrecognized compensation cost attributable to a non-vested employee stock option award that is expected to be recognized over the award's remaining requisite service period of approximately 0.7 years. The aggregate grant date fair value of stock options that vested during each of the years ended December 31, 2011, 2010 and 2009 was $0.2 million. The aggregate intrinsic values of stock options exercised during the years ended December 31, 2011, 2010 and 2009 were $2.8 million, $2.2 million and $2.6 million, respectively.

8. Stock-Based Compensation (continued)

Stock option activity for the Company's stock-based compensation plans, inclusive of participants employed at discontinued operations, is summarized in the table below.

	Options	Weighted Average Exercise Prices	Weighted Average Remaining Contractual Terms (Years)	Aggregate Intrinsic Values
	(in thousands)			(in thousands)
Outstanding at January 1, 2009	12,977	$ 8.48		
Exercised	(1,632)	5.94		
Terminated	(2,795)	7.29		
Outstanding at December 31, 2009	8,550	9.38		
Exercised	(1,094)	6.82		
Terminated	(281)	10.20		
Outstanding at December 31, 2010	7,175	9.74		
Exercised	(1,563)	9.00		
Terminated	(610)	10.59		
Outstanding at December 31, 2011 (all are expected to vest)	5,002	$ 9.87	2.20	$ 1,310
Exercisable options at December 31, 2011	4,877	$ 10.01	2.10	$ 983

Except for 125,000 stock options with an exercise price of $4.75, all of the Company's outstanding stock options at December 31, 2011 in the table below are currently exercisable.

Exercise Price	Number Outstanding	Weighted Average Remaining Contractual Terms (Years)
	(in thousands)	
$ 4.75	500	6.7
9.22	1,177	1.4
9.91	948	0.4
11.31	2,377	2.4

9. Retirement Plans

The Company maintains defined contribution retirement plans that cover substantially all of its employees. Under those plans, the Company can elect to match a portion of employee contributions. During the period from January 1, 2009 through September 30, 2010, substantially all matching contributions were suspended. The total retirement plan matching contribution expense during the years ended December 31, 2011, 2010 and 2009 was approximately $9.2 million, $2.9 million and $1.2 million, respectively.

Additionally, the Company maintains a supplemental retirement plan for certain executive officers. Generally, that plan provides for annual payments after the attainment of normal retirement age (62) or early retirement age (55) in the case of one participant, if the individuals are still employed by the Company on those dates. Supplemental retirement plan payments generally continue for the remainder of the executive officer's life.

10. Discontinued Operations

The Company's discontinued operations during the years presented herein included: (i) the 172-bed Woman's Center at Dallas Regional Medical Center in Mesquite, Texas; (ii) 189-bed Gulf Coast Medical Center in Biloxi, Mississippi; (iii) 140-bed Riley Hospital in Meridian, Mississippi; (iv) 25-bed Fishermen's Hospital in Marathon, Florida; (v) 70-bed Franklin Regional Medical Center in Louisburg, North Carolina; (vi) 125-bed Upstate Carolina Medical Center in Gaffney, South Carolina; (vii) 25-bed St. Mary's Medical Center of Scott County in Oneida, Tennessee; (viii) a 293-bed idle hospital campus in Knoxville, Tennessee; and (ix) certain other health care operations affiliated with those hospitals. Note 4 discusses the Company's divestiture of Franklin Regional Medical Center and Upstate Carolina Medical Center.

The operating results and cash flows of discontinued operations are included in the Company's consolidated financial statements up to the date of disposition. Additionally, as required by GAAP, the operating results and cash flows of the abovementioned entities have been separately presented as discontinued operations in the Company's consolidated financial statements. Because Fishermen's Hospital became a discontinued operation subsequent to December 31, 2010, the Company's 2010 and 2009 consolidated financial statements have been retroactively adjusted in accordance with GAAP to conform to the current year presentation.

10. Discontinued Operations (continued)

The Company closed Gulf Coast Medical Center ("GCMC") on January 1, 2008. On July 18, 2011, the remaining real property at GCMC was sold for cash consideration of approximately $3.4 million, less selling and other related costs. The resulting gain of $0.6 million has been included in discontinued operations during the year ended December 31, 2011. During the years ended December 31 2010 and 2009, the Company recorded long-lived asset impairment charges in respect of GCMC of $8.4 million and $2.2 million, respectively, to reduce the hospital's assets to their estimated net realizable value.

During May 2011, one of the Company's subsidiaries entered into a lease termination agreement for Fishermen's Hospital that became effective on July 1, 2011. As part of the agreement, the hospital's remaining equipment, as well as certain working capital items, were sold to the Company's former lessor for $1.5 million in cash. The Fishermen's Hospital lease termination resulted in a goodwill impairment charge of $3.6 million during the year ended December 31, 2011. Management decided not to renegotiate a new lease agreement for Fishermen's Hospital, in large part, because recent operating results and future projections were below expectations.

On December 31, 2010, certain of the Company's subsidiaries sold Riley Hospital and its related health care operations (collectively, "Riley Hospital"), which included the hospital's supplies and long-lived assets (primarily property, plant and equipment). The selling price, which was paid in cash, was $24.0 million, plus a working capital adjustment. After allocating approximately $5.9 million of goodwill to the hospital, this divestiture resulted in a loss of $12.1 million during the year ended December 31, 2010. During the year ended December 31, 2011, discontinued operations included a post-closing working capital purchase price adjustment for Riley Hospital of $0.3 million that increased the Company's loss on the sale of such hospital.

The Woman's Center at Dallas Regional Medical Center (the "Woman's Center") was closed on June 1, 2008. Although management is currently evaluating various disposal alternatives for this idle facility, the timing of such divestiture has not yet been determined. Management concluded that the estimated fair value of the hospital's long-lived assets, less costs to sell, was lower than the corresponding net book value of such assets. Accordingly, the Company recorded a long-lived asset impairment charge of approximately $2.4 million during the year ended December 31, 2009 to reduce the hospital's long-lived assets to their estimated net realizable value.

As discussed at Note 4, a subsidiary of the Company acquired St. Mary's Medical Center of Scott County ("SMMC")" and the idle Riverside hospital campus ("Riverside") from Mercy on September 30, 2011. The aggregate allocated purchase price for SMMC and Riverside was approximately $12.4 million and has been included in investing activities under discontinued operations in the Company's consolidated statements of cash flows. SMMC is a leased facility with a lease agreement that expires in May 2012. For the same reason discussed above in respect of Fishermen's Hospital, management does not intend to extend or otherwise modify the SMMC lease. Mercy closed the hospital at the Riverside location prior to the Company's acquisition of the facility. Although management is currently evaluating various disposal alternatives for each of SMMC and Riverside, the timing of such divestitures has not yet been determined.

The table below sets forth the underlying details of the Company's discontinued operations (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Net revenue	$ 17,615	$ 76,845	$ 151,236
Salaries and benefits	6,854	29,742	58,515
Provision for doubtful accounts	3,430	9,958	29,635
Depreciation and amortization	1,624	6,600	10,291
Other operating expenses	6,331	32,105	54,790
Long-lived asset and goodwill impairment charges	3,614	8,410	4,550
(Gains) losses on sales of assets and related other, net (see Note 4)	(304)	12,113	(10,428)
	21,549	98,928	147,353
Income (loss) before income taxes	(3,934)	(22,083)	3,883
Income tax benefit (expense)	1,525	8,557	(1,245)
Income (loss) from discontinued operations	$ (2,409)	$ (13,526)	$ 2,638

10. Discontinued Operations (continued)

The table below summarizes the principal components of the Company's assets of discontinued operations (in thousands).

	December 31, 2011	December 31, 2010
Supplies, prepaid expenses and other assets	$ 569	$ 1,082
Property, plant and equipment, net, and other	13,992	6,688
Goodwill	-	3,614
Total assets of discontinued operations	$ 14,561	$ 11,384

11. Accumulated Other Comprehensive Income (Loss)

GAAP defines comprehensive income as the change in equity of a business enterprise from transactions and other events and circumstances that relate to non-owner sources. A rollforward of the Company's accumulated other comprehensive income (loss) is presented in the table below (in thousands).

	Unrealized Gains (Losses) on Available-for-Sale Securities	Interest Rate Swap Contract	Totals
Balances at January 1, 2009, net of income taxes of $113,836	$ -	$ (169,914)	$ (169,914)
Unrealized gains (losses) on available-for-sale securities, net of income taxes of $735	1,351	-	1,351
Change in fair value of interest rate swap contract, net of income taxes of $37,602	-	48,321	48,321
Balances at December 31, 2009, net of income taxes of $75,499	1,351	(121,593)	(120,242)
Unrealized gains (losses) on available-for-sale securities, net of income taxes of $859	1,614	-	1,614
Adjustments for net (gains) losses reclassified into net income, net of income taxes of $750	(1,393)	-	(1,393)
Change in fair value of interest rate swap contract, net of income taxes of $6,543	-	(11,103)	(11,103)
Balances at December 31, 2010, net of income taxes of $81,933	1,572	(132,696)	(131,124)
Unrealized gains (losses) on available-for-sale securities, net of income taxes of $39	(78)	-	(78)
Adjustments for net (gains) losses reclassified into net income, net of income taxes of $357	(663)	-	(663)
Change in fair value of interest rate swap contract, net of income taxes of $17,662	-	30,073	30,073
Reclassification adjustments for amortization of expense into net income, net of income taxes of $4,032	-	6,352	6,352
Balances at December 31, 2011, net of income taxes of $60,635	$ 831	$ (96,271)	$ (95,440)

Prior to the Company's debt restructuring on November 18, 2011, which is discussed at Note 2, the Company's interest rate swap contract had been a perfectly effective cash flow hedge instrument that was used to manage the risk of variable interest rate fluctuation on certain long-term debt. Changes in its estimated fair value were previously recognized as a component of other comprehensive income (loss). See Note 2(a) and Note 5 for further discussion of the interest rate swap contract. As a result of the Company's debt restructuring, the interest rate swap contract is no longer an effective cash flow hedge instrument. Therefore, subsequent changes in its estimated fair value are no longer included in other comprehensive income (loss) but are recognized in the Company's consolidated statements of income as interest expense. Future amortization of the accumulated other comprehensive loss attributable to the interest rate swap contract is expected to approximate $79.0 million, $70.3 million and $8.1 million during the years ending December 31, 2012, 2013 and 2014, respectively.

12. Recent Accounting Standards Updates

During August 2010, the Financial Accounting Standards Board (the "FASB") approved a change to certain accounting standards. That change prohibits health care entities from netting projected insurance recoveries against the related liabilities and/or reserves in their balance sheets (e.g., professional liability claims and expenses, workers' compensation, health and welfare benefits, etc.). The modified accounting standard, which permitted early adoption, was required to be adopted for fiscal years and interim periods that began after December 15, 2010. Additionally, such accounting standard permitted adoption on either a prospective or retrospective basis. Effective January 1, 2011, the Company adopted the modified accounting standard on a prospective basis. The only impact of such adoption was an increase of approximately $15.4 million in the Company's deferred charges and other assets and a corresponding increase in the related liabilities. That "gross-up" amount was $15.9 million at December 31, 2011. Management does not believe that retrospective application of the modified accounting standard to any period prior to January 1, 2011 would have resulted in a material change to any of the Company's historical interim or annual consolidated financial statements.

During May 2011, the FASB amended and updated the accounting standards in GAAP as they relate to fair value measurement (the "Fair Value Update"). The Fair Value Update (i) expands and enhances GAAP's current disclosures about fair value measurements and (ii) clarifies the FASB's intent about the application of existing fair value measurement requirements in certain circumstances. Public companies were required to adopt the provisions of the Fair Value Update on a prospective basis during interim and annual periods that began after December 15, 2011. Early adoption of the amended accounting guidance was not permitted. There was no material impact from the Company's adoption of the Fair Value Update on January 1, 2012.

During June 2011, the FASB amended and updated the accounting standards in GAAP regarding the presentation of comprehensive income (the "OCI Update"). Among other things, the OCI Update (i) eliminated the option to report total comprehensive income and its components in the statement of changes in stockholders' equity and (ii) required the presentation of net income/loss, items of other comprehensive income and total comprehensive income in one continuous financial statement or two separate but consecutive financial statements. The OCI Update did not change the accounting for any items of other comprehensive income. Public companies were required to adopt the provisions of the OCI Update on a retrospective basis during interim and annual periods beginning after December 15, 2011. Early adoption of the OCI Update was permitted. The Company adopted the OCI Update, which only affects the presentation of the consolidated financial statements, during the year ended December 31, 2011.

During July 2011, the FASB amended and updated the accounting standards in GAAP regarding the income statement presentation and related disclosures of net revenue for health care entities (the "Net Revenue Update"). Among other things, the Net Revenue Update requires health care entities to (i) present the provision for doubtful accounts as a reduction of net patient service revenue in the income statement if the entity does not assess a patient's ability to pay prior to rendering services or determine that collection of the related revenue is reasonably assured and (ii) provide enhanced disclosures about major sources of revenue by payor and the activity in the allowance for doubtful accounts. The Net Revenue Update does not otherwise change the revenue recognition criteria for health care entities. Public companies were required to adopt the provisions of the Net Revenue Update during interim and annual periods beginning after December 15, 2011. The income statement presentation change must be adopted on a retrospective basis but the enhanced disclosures may be adopted either retrospectively or prospectively. Early adoption of the Net Revenue Update was permitted. The Net Revenue Update, which only affects the presentation of the consolidated income statement and certain related disclosures, was adopted by the Company on January 1, 2012. The required changes will be reflected in the interim condensed consolidated financial statements to be included in the Company's Quarterly Report on Form 10-Q for the three months ending March 31, 2012.

13. Commitments and Contingencies

Renovation and Expansion Projects. As of December 31, 2011, the Company had started: (i) construction of a 250-bed general acute care hospital to ultimately replace the south campus facility at its Poplar Bluff Regional Medical Center in Poplar Bluff, Missouri; (ii) several hospital renovation and expansion projects; and (iii) various information technology hardware and software upgrades. Additionally, management estimates that the remaining cost to build and equip a replacement hospital for Walton Regional Medical Center in Monroe, Georgia will range from $20 million to $25 million. The Company is currently obligated to complete construction of this replacement hospital no later than December 31, 2012. Management does not believe that any of the Company's construction, renovation and/or expansion projects are individually significant or that they represent, in the aggregate, a material commitment of the Company's resources.

13. Commitments and Contingencies (continued)

Standby Letters of Credit. At December 31, 2011, the Company maintained approximately $104.4 million of standby letters of credit in favor of third parties with various expiration dates through February 21, 2013; however, such amount was reduced to $54.1 million on February 17, 2012. The December 31, 2011 balance reflected a transitional period after completion of the 2011 Debt Restructuring.

Physician and Physician Group Guarantees. The Company is committed to providing financial assistance to physicians and physician groups practicing in the communities that its hospitals serve through certain recruiting arrangements and professional services agreements. At December 31, 2011, the Company was committed to non-cancelable guarantees of approximately $73.0 million under such arrangements. The actual amounts advanced will depend on the financial results of each physician's and physician group's private practice during the related contractual measurement period, which generally approximates one to two years. Amounts advanced under these agreements are considered to be loans. Provided that the physician or physician group continues to practice in the community served by the Company's hospital, the loan is generally forgiven on a pro rata basis over a period of 12 to 24 months. Management believes that the recorded liabilities for physician and physician group guarantees of $30.2 million and $10.3 million at December 31, 2011 and 2010, respectively, are adequate and reasonable; however, there can be no assurances that the ultimate liability will not exceed management's estimates. Estimated guarantee liabilities and the related intangible assets are predicated on historical payment patterns and an evaluation of the facts and circumstances germane to the specific contract under review. If the costs of these arrangements exceed management's estimates, the liabilities could materially increase.

Professional Liability Risks. The Company uses its wholly owned captive insurance subsidiary and its risk retention group subsidiary, which are domiciled in the Cayman Islands and South Carolina, respectively, to self-insure a significant portion of its professional liability risks. Those subsidiaries, which are collectively referred to as the "Insurance Subsidiaries," provide (i) claims-made coverage to all of the Company's hospitals and other health care facilities and (ii) occurrence-basis coverage to most of the Company's employed physicians. The employed physicians not covered by the Insurance Subsidiaries generally maintain claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the program covering the Company's hospitals and other health care facilities, the Insurance Subsidiaries buy claims-made reinsurance policies from unrelated third parties for claims above certain self-retention levels.

The Company's discounted reserves for indemnity losses and related loss expenses, net of amounts estimated to be recoverable under reinsurance policies, were approximately $215.6 million and $180.9 million at December 31, 2011 and 2010, respectively. Such amounts were derived using a discount rate of 1.00% and a weighted average payment duration of approximately three years. A 50 basis point reduction in the discount rate during the year ended December 31, 2010, which was reflective of changes in market conditions, increased the Company's net reserves by $2.4 million at December 31, 2010. See Note 12 for a change in GAAP that affected the Company's balance sheet presentation of its discounted reserves for indemnity losses and related loss expenses. The Company's undiscounted reserves for professional liability risks, net of amounts estimated to be recoverable under reinsurance policies, were $221.4 million and $185.8 million at December 31, 2011 and 2010, respectively. The Company included $40.4 million and $53.4 million in accrued expenses and other liabilities in the consolidated balance sheets at December 31, 2011 and 2010, respectively, to reflect the estimated loss and loss expense payments that are projected to be satisfied within one year of those balance sheet dates. The Company recorded total expenses for its professional liability risks of $66.3 million, $68.6 million and $60.5 million during the years ended December 31, 2011, 2010 and 2009, respectively. Such expenses, which include indemnity losses, related loss expenses, interest accretion on discounted reserves and cumulative adjustments for changes in the discount rate, were determined using actuarially-based techniques and methodologies and have been included in other operating expenses in the Company's consolidated statements of income.

Considerable subjectivity, variability and judgment are inherent in professional liability risk estimates. Although management believes that the amounts included in the Company's consolidated financial statements are adequate and reasonable, there can be no assurances that the ultimate liability for professional liability matters will not exceed management's estimates. If actual indemnity losses and loss expenses exceed management's projections of claim activity and/or the projected claim payment duration differs from management's estimates, the Company's reserves could be materially adversely affected. Additionally, there can be no assurances that the reinsurance policies procured by the Insurance Subsidiaries will be adequate for the Company's professional liability profile.

13. Commitments and Contingencies (continued)

Ascension Health Lawsuit. On February 14, 2006, Health Management Associates, Inc. (referred to as "Health Management" for the remainder of this Note 13) announced the termination of non-binding negotiations with Ascension Health ("Ascension") and the withdrawal of a non-binding offer to acquire Ascension's St. Joseph Hospital, a general acute care hospital in Augusta, Georgia. On June 8, 2007, certain Ascension subsidiaries filed a lawsuit against Health Management, entitled *St. Joseph Hospital, Augusta, Georgia, Inc. et al. v. Health Management Associates, Inc.*, in Georgia Superior/State Court of Richmond County claiming that Health Management (i) breached an agreement to purchase St. Joseph Hospital and (ii) violated a confidentiality agreement. The plaintiffs claim at least $40 million in damages. Health Management removed the case to the U.S. District Court for the Southern District of Georgia, Augusta Division (No. 1:07-CV-00104). On July 13, 2010, the plaintiffs filed a motion for partial summary judgment and Health Management filed a motion for summary judgment. On March 30, 2011, Health Management's motion for summary judgment was granted as to all of plaintiffs' claims, except for the breach of confidentiality claim, and plaintiffs' motion for partial summary judgment was denied. On June 15, 2011, the case was stayed pending resolution of the appellate process. On July 8, 2011, the plaintiffs filed a notice of appeal to the United States Court of Appeals for the Eleventh Circuit (Case Number: 11-13069). Oral argument is scheduled for the week of April 30, 2012.

Management does not believe there was a binding acquisition contract with Ascension or any of its subsidiaries and does not believe Health Management breached a confidentiality agreement. Accordingly, management will continue to vigorously defend Health Management against the allegations, including the pending appeal. Management does not believe that the final outcome of this matter will be material.

Medicare Billing Lawsuit. On January 11, 2010, Health Management and one of its subsidiaries were named in a qui tam lawsuit entitled *United States of America ex rel. J. Michael Mastej v. Health Management Associates, Inc. et al.* in the U.S. District Court for the Middle District of Florida, Tampa Division. The plaintiff's complaint alleged that, among other things, the defendants erroneously submitted claims to Medicare and that those claims were falsely certified to be in compliance with Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law") and the Anti-Kickback Statute. The plaintiff's complaint further alleged that the defendants' conduct violated the federal False Claims Act of 1863 (the "False Claims Act"). The plaintiff seeks recovery of all Medicare and Medicaid reimbursement that the defendants received as a result of the alleged false certifications and treble damages under the False Claims Act, as well as a civil penalty for each Medicare and Medicaid claim supported by such alleged false certifications. On August 18, 2010, the plaintiff filed a first amended complaint that was similar to the original complaint. On September 27, 2010, the defendants moved to dismiss the first amended complaint for failure to state a claim with the particularity required by Rule 9(b) of the Federal Rules of Civil Procedure and failure to state a claim upon which relief can be granted pursuant to Rule 12(b)(6) of those federal rules. On November 11, 2010, the plaintiff filed a memorandum of law in opposition to the defendants' motion to dismiss. On February 23, 2011, the case was transferred to the U.S. District Court for the Middle District of Florida, Fort Myers Division (No. 2:11-cv-00089-JES-DNF). On May 5, 2011, the plaintiff filed a second amended complaint, which was similar to the first amended complaint. On May 17, 2011, the defendants moved to dismiss the second amended complaint on the same bases set forth in their earlier motion to dismiss. On February 16, 2012, the court granted the defendants' motion to dismiss, without prejudice. The court's order permits the plaintiff to file an amended complaint within 21 days. If the plaintiff amends the complaint, management will vigorously defend Health Management and its subsidiary against the allegations. Management does not believe that the final outcome of this matter will be material.

Governmental Matters. Several Health Management hospitals received letters during the second half of 2009 requesting information in connection with a U.S. Department of Justice ("DOJ") investigation relating to kyphoplasty procedures. Kyphoplasty is a minimally invasive spinal procedure used to treat vertebral compression fractures. The DOJ is currently investigating hospitals and hospital operators in multiple states to determine whether certain Medicare claims for kyphoplasty were incorrect when billed as an inpatient service rather than as an outpatient service. Management believes that the DOJ's investigation originated with a False Claims Act lawsuit against Kyphon, Inc., the company that developed the kyphoplasty procedure. The requested information has been provided to the DOJ and management is cooperating with the investigation. To date, the DOJ has not asserted any monetary or other claims against the Health Management hospitals in this matter. Based on the aggregate billings for inpatient kyphoplasty procedures during the period under review that were performed at the Health Management hospitals subject to the DOJ's inquiry, management does not believe that the final outcome of this matter will be material.

13. Commitments and Contingencies (continued)

During September 2010, Health Management received a letter from the DOJ indicating that an investigation was being conducted to determine whether certain Health Management hospitals improperly submitted claims for the implantation of implantable cardioverter defibrillators ("ICDs"). The DOJ's investigation covers the period commencing with Medicare's expansion of coverage for ICDs in 2003 to the present. The letter from the DOJ further indicates that the claims submitted by Health Management's hospitals for ICDs and related services need to be reviewed to determine if Medicare coverage and payment was appropriate. During 2010, the DOJ sent similar letters and other requests to a large number of unrelated hospitals and hospital operators across the country as part of a nation-wide review of ICD billing under the Medicare program. Management has, and will continue to, cooperate with the DOJ in its ongoing investigation, which could potentially give rise to claims against Health Management and/or certain of its subsidiary hospitals under the False Claims Act or other statutes, regulations or laws. Additionally, management recently commenced an internal review of hospital medical records related to ICDs that are the subject of the DOJ investigation. To date, the DOJ has not asserted any monetary or other claims against Health Management or its hospitals in this matter and, at this time, management is unable to determine the potential impact, if any, that will result from the final resolution of the investigation.

The U.S. Department of Health and Human Services, Office of Inspector General ("HHS-OIG") and the DOJ, including the Civil Division and U.S. Attorney's Offices in the Eastern District of Pennsylvania, the Middle District of Florida, the Eastern District of Oklahoma, the Middle District of Tennessee, the Western District of North Carolina, the District of South Carolina and the Middle District of Georgia, are currently investigating Health Management and certain of its subsidiaries (HHS-OIG and the DOJ are collectively referred to as "Government Representatives"). Management believes that such investigations relate to the Anti-Kickback Statute, the Stark law and the False Claims Act and are focused on: (i) physician referrals, including financial arrangements with Health Management's whole-hospital physician joint ventures; (ii) the medical necessity of emergency room tests and patient admissions, including whether Pro-Med software has led to any medically unnecessary tests or admissions; and (iii) the medical necessity of certain surgical procedures. Management further believes that the investigations may have originated as a result of qui tam lawsuits filed on behalf of the United States. In connection with the investigations, HHS-OIG served subpoenas on Health Management on May 16, 2011 and July 21, 2011 requesting records. Additionally, Government Representatives have interviewed both current and former employees of Health Management and its subsidiaries. Health Management is conducting internal investigations and has met with Government Representatives on numerous occasions to respond to their inquiries. Management believes that the HHS-OIG subpoenas, which apply system-wide, may have been served pursuant to the authority of HHS-OIG to investigate health care fraud.

On February 22, 2012 and February 24, 2012, HHS-OIG served subpoenas on certain Health Management hospitals relating to those hospitals' relationships with Allegiance Health Management, Inc. ("Allegiance"). Allegiance, which is unrelated to Health Management, is a post acute health care management company that provides intensive outpatient psychiatric ("IOP") services to patients. The Health Management hospitals that were served subpoenas were: (i) Central Mississippi Medical Center in Jackson, Mississippi; (ii) Crossgates River Oaks Hospital in Brandon, Mississippi; (iii) Davis Regional Medical Center in Statesville, North Carolina; (iv) Lake Norman Regional Medical Center in Mooresville, North Carolina; (v) the Medical Center of Southeastern Oklahoma in Durant, Oklahoma; and (vi) Natchez Community Hospital in Natchez, Mississippi. Each of those hospitals has or had a contract with Allegiance. Among other things, the subpoenas seek: (i) documents related to the hospitals' financial relationships with Allegiance; (ii) documents related to patients who received IOP services from Allegiance at the Health Management hospitals, including their patient medical records; (iii) documents relating to complaints or concerns regarding Allegiance's IOP services at the Health Management hospitals; (iv) documents relating to employees, physicians and therapists who were involved in the provision of IOP services provided by Allegiance at the Health Management hospitals; and (v) other documents related to Allegiance including leases, contracts, policies and procedures, training documents, budgets and financial analyses. The period of time covered by the subpoenas is January 1, 2008 through the date of subpoena compliance. Management believes that HHS-OIG has served similar subpoenas on other non-Health Management hospitals that had contracts with Allegiance. Management intends to comply with the investigations. At this time, management is unable to determine the potential impact, if any, that will result from the final resolution of these investigations.

In addition to the abovementioned subpoenas and investigations, certain Health Management hospitals have received other requests for information from state and federal agencies. Management is cooperating with all of the ongoing investigations by collecting and producing the requested materials. Because a large portion of the abovementioned government investigations are in their early stages, management is unable to evaluate the outcome of such matters or determine the potential impact, if any, that could result from their final resolution.

13. Commitments and Contingencies (continued)

Class Action Lawsuits. On or about January 25, 2012, Health Management, certain of its executive officers and one of its directors were named as defendants in an action entitled *Miklen Sapssov v. Health Management Associates, Inc. et al.*, which was filed in the U. S. District Court for the Middle District of Florida (No. 2:12-CV-00046). This action purports to be brought on behalf of stockholders who purchased Health Management's common stock during the period July 27, 2009 through January 9, 2012. The plaintiff alleges, among other things, that Health Management and the other defendants violated Section 10(b) of the Securities Exchange Act of 1934 by making allegedly false and misleading statements in certain public disclosures regarding Health Management's business and financial results. The plaintiff alleges that Health Management's financial performance was based, in part, on improper billing practices. The plaintiff seeks unspecified damages. A substantially similar purported class action lawsuit, entitled *Norfolk County Retirement System v. Health Management Associates, Inc., et al.*, was filed against the same defendants on or about February 2, 2012 in the U. S. District Court for the Middle District of Florida (No. 8:12-CV-00228). Management intends to vigorously defend Health Management against the allegations in these matters. Because the abovementioned lawsuits are in their early stages, management is unable to evaluate their outcome or determine the potential impact, if any, that could result from their final resolution.

Other. The Company is also a party to various other legal actions arising out of the normal course of its business. Due to the inherent uncertainties of litigation and dispute resolution, management is unable to estimate the ultimate losses, if any, relating to each of the Company's outstanding legal actions and other loss contingencies. Should an unfavorable outcome occur in some or all of its legal and other related matters, there could be a material adverse effect on the Company's financial position, results of operations and liquidity.

14. Quarterly Data (unaudited)

The tables below summarize certain unaudited financial information for each of the quarters in the two-year period ended December 31, 2011.

	Quarters During the Year Ended December 31, 2011 (1)			
	First	Second (2)	Third (3)	Fourth (4)
	(in thousands, except per share amounts)			
Net revenue	$ 1,426,829	$ 1,395,353	$ 1,398,495	$ 1,583,774
Income from continuing operations	61,966	56,916	49,704	37,748
Income (loss) from discontinued operations	146	(1,583)	255	(1,227)
Consolidated net income	62,112	55,333	49,959	36,521
Net income attributable to Health Management Associates, Inc.	55,524	48,611	43,728	30,847
Earnings (loss) per share attributable to Health Management Associates, Inc. common stockholders:				
Basic				
Continuing operations	$ 0.22	$ 0.20	$ 0.17	$ 0.13
Discontinued operations	-	(0.01)	-	-
Net income	$ 0.22	$ 0.19	$ 0.17	$ 0.13
Diluted				
Continuing operations (5)	$ 0.22	$ 0.20	$ 0.17	$ 0.13
Discontinued operations	-	(0.01)	-	-
Net income (5)	$ 0.22	$ 0.19	$ 0.17	$ 0.13
Weighted average number of shares outstanding:				
Basic	250,038	251,765	252,157	252,175
Diluted	253,727	255,235	255,124	256,032

14. Quarterly Data (unaudited) (continued)

	Quarters During the Year Ended December 31, 2010 (1)			
	First	Second	Third	Fourth (6)
	(in thousands, except per share amounts)			
Net revenue	$ 1,265,154	$ 1,230,101	$ 1,250,362	$ 1,346,549
Income from continuing operations	53,488	46,068	40,006	46,212
Income (loss) from discontinued operations	(69)	(355)	(126)	(12,976)
Consolidated net income	53,419	45,713	39,880	33,236
Net income attributable to Health Management Associates, Inc.	46,940	39,657	35,293	28,179
Earnings (loss) per share attributable to Health Management Associates, Inc. common stockholders:				
Basic				
Continuing operations	$ 0.19	$ 0.16	$ 0.14	$ 0.17
Discontinued operations	-	-	-	(0.05)
Net income	$ 0.19	$ 0.16	$ 0.14	$ 0.12
Diluted				
Continuing operations	$ 0.19	$ 0.16	$ 0.14	$ 0.16
Discontinued operations	-	-	-	(0.05)
Net income	$ 0.19	$ 0.16	$ 0.14	$ 0.11
Weighted average number of shares outstanding:				
Basic	247,555	248,390	248,526	248,600
Diluted	249,867	251,198	250,972	252,372

(1) Net revenue, income from continuing operations and income (loss) from discontinued operations have been reclassified for all quarters to conform to the current year consolidated statement of income presentation. Such reclassifications primarily related to discontinued operations, which are discussed at Note 10.

(2) As more fully discussed at Note 10, the loss from discontinued operations during the quarter ended June 30, 2011 included a goodwill impairment charge of approximately $3.6 million.

(3) During the quarter ended September 30, 2011, the Company recorded approximately $9.3 million of costs for acquisitions and government investigations. See Notes 4 and 13 for discussion of these matters.

(4) As more fully discussed at Note 2, the Company restructured its long-term debt on November 18, 2011. As a result, the quarter ended December 31, 2011 includes (i) approximately $24.6 million of write-offs of deferred debt issuance costs and related other and (ii) $16.4 million of accumulated other comprehensive loss amortization and net fair value adjustment expense that is attributable to the Company's interest rate swap contract. During such quarter, the Company also: (i) recognized $38.2 million of benefit from the meaningful use measurement standard under various Medicare and Medicaid Healthcare Information Technology ("HCIT") incentive programs and (ii) recorded $12.9 million of expense attributable to restructuring activities at Tennova Healthcare (see Note 4).

(5) Due to rounding, the sum of the four quarters does not agree to the total for the year ended December 31, 2011.

(6) As more fully discussed at Note 10, the loss from discontinued operations during the quarter ended December 31, 2010 included (i) a loss of approximately $12.1 million on the sale of Riley Hospital and its related health care operations and (ii) a long-lived asset impairment charge of $8.4 million.

15. Subsequent Event

On February 3, 2012, one of the Company's subsidiaries signed a definitive agreement with a subsidiary of INTEGRIS Health, Inc. ("INTEGRIS") to acquire an 80% equity interest in each of five Oklahoma-based general acute care hospitals and certain related health care operations. A subsidiary of INTEGRIS will retain a 20% equity interest in such entities. The hospitals to be acquired are as follows:

- Blackwell Regional Hospital in Blackwell (53 licensed beds);
- Clinton Regional Hospital in Clinton (64 licensed beds);
- Marshall County Medical Center in Madill (25 licensed beds);
- Mayes County Medical Center in Pryor (52 licensed beds); and
- Seminole Medical Center in Seminole (32 licensed beds).

Pursuant to the definitive acquisition agreement, the total purchase price for the 80% equity interests in these five hospitals will be $60.0 million in cash. Additionally, the Company's subsidiary will assume certain long-term lease obligations. The acquired assets and assumed liabilities will include, among other things, supply inventories, property, plant and equipment and certain long-term lease obligations. Subject to regulatory approvals and other conditions customary to closing, management anticipates that this acquisition will close during the quarter ending June 30, 2012.

The abovementioned acquisition is in furtherance of that part of the Company's business strategy that calls for the acquisition of hospitals and other ancillary health care businesses in non-urban communities. Management plans to fund this acquisition with available cash balances and proceeds from sales of available-for-sale securities.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

Not applicable.

Item 9A. Controls and Procedures.

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

Our President and Chief Executive Officer (principal executive officer) and our Executive Vice President and Chief Financial Officer (principal financial officer) evaluated our disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) as of the end of the period covered by this Form 10-K. Based on this evaluation, our President and Chief Executive Officer and our Executive Vice President and Chief Financial Officer concluded that our disclosure controls and procedures were effective as of such date.

Changes in Internal Control Over Financial Reporting

There has been no change in our internal control over financial reporting that occurred during the fourth quarter of the fiscal year covered by this Form 10-K that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Management's Annual Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining effective internal control over financial reporting, as such term is defined in Exchange Act Rule 13a-15(f). Our internal control system was designed under the supervision of our President and Chief Executive Officer and our Executive Vice President and Chief Financial Officer and with the participation of management in order to provide reasonable assurance regarding the reliability of our financial reporting and our preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles.

All internal control systems, no matter how well designed and tested, have inherent limitations, including, among other things, the possibility of human error, circumvention or disregard. Therefore, even those systems of internal control that have been determined to be effective can provide only reasonable assurance that the objectives of the control system are met and may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Under the supervision of our President and Chief Executive Officer and our Executive Vice President and Chief Financial Officer and with the participation of management, we conducted an assessment of the effectiveness of our internal control over financial reporting based on the criteria set forth in "Internal Control-Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on an assessment of such criteria, management concluded that, as of December 31, 2011, we maintained effective internal control over financial reporting.

As more fully described under the heading "Acquisition Activity – 2011 Acquisitions" at Note 4 to the Consolidated Financial Statements in Item 8, we acquired seven general acute care hospitals and other ancillary health care operations from Catholic Health Partners and its subsidiary Mercy Health Partners, Inc. on September 30, 2011. The acquired facilities are now known collectively as "Tennova Healthcare." We excluded Tennova Healthcare from our 2011 assessment of the effectiveness of our internal control over financial reporting. Tennova Healthcare accounted for approximately $630.0 million of our total assets at December 31, 2011 and $152.5 million and $4.0 million of our net revenue from continuing operations and discontinued operations, respectively, during the year then ended. We expect that our internal control system will be fully implemented at Tennova Healthcare during 2012 and correspondingly evaluated by us for effectiveness.

An assessment of the effectiveness of our internal control over financial reporting as of December 31, 2011 has been performed by Ernst & Young LLP, an independent registered public accounting firm. The attestation report of Ernst & Young LLP is included on the following page.

Attestation Report of the Independent Registered Public Accounting Firm

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders
Health Management Associates, Inc.

We have audited 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 (the COSO criteria). Health Management Associates, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Annual Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit 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 effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Annual Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Tennova Healthcare, which are included in the 2011 consolidated financial statements of Health Management Associates, Inc. and constituted approximately $630.0 million and $521.3 million of total and net assets, respectively, as of December 31, 2011 and $152.5 million and $4.0 million of net revenue from continuing operations and discontinued operations, respectively, during the year then ended. Our audit of internal control over financial reporting of Health Management Associates, Inc. also did not include an evaluation of the internal control over financial reporting of Tennova Healthcare.

In our opinion, Health Management Associates, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the 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 of Health Management Associates, Inc. and our report dated February 27, 2012 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Certified Public Accountants
Miami, Florida
February 27, 2012

Item 9B. Other Information.

Not applicable.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Except as set forth below, the information required by this Item 10 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the headings "Election of Directors," "Corporate Governance" and "Section 16(a) Beneficial Ownership Reporting Compliance," which proxy statement will be filed not later than 120 days after December 31, 2011.

Executive Officers

Below is information regarding those persons who served as our executive officers during the year ended December 31, 2011, as well as Kerrin E. Gillespie and Linda A. Epstein, who became executive officers effective January 1, 2012 and January 7, 2012, respectively.

Gary D. Newsome, age 54, became our President and Chief Executive Officer and a director on September 13, 2008. From early 1998 until September 12, 2008, Mr. Newsome was employed by Community Health Systems, Inc. ("Community"). He started at Community as a Group Vice President and by the end of his tenure with the company he was a Division President with responsibility for hospitals in Illinois, New Jersey, Pennsylvania, Tennessee and West Virginia. Mr. Newsome previously held management positions with us from June 1993 to March 1998, including Divisional Vice President, Assistant Vice President/Operations and Group Operations Vice President. Mr. Newsome is a member of the American College of Healthcare Executives. Mr. Newsome received a Bachelor of Science degree from Bluefield State College in West Virginia and a Masters in Business Administration from Butler University in Indianapolis.

Kelly E. Curry, age 57, has served as our Executive Vice President since July 1, 2007 and, effective January 12, 2010, he also became our Chief Financial Officer. Mr. Curry also served as our Chief Administrative Officer from September 13, 2008 until January 12, 2010 and Chief Operating Officer from July 1, 2007 until September 12, 2008. Before such time, he served as a consultant to us on hospital operations from October 2006 to June 2007. Mr. Curry, who is a Certified Public Accountant, previously held management positions with us from March 1982 to October 1994, including the position of Chief Financial Officer from April 1987 to October 1994. Since 1995, Mr. Curry has served as Chairman and President of Foundation in Christ Ministries, Ltd. in Ireland. Mr. Curry also serves on the board of the United States affiliate of Grain of Wheat International and its Swiss-based parent charity corporation.

Robert E. Farnham, age 56, has served as our Senior Vice President - Finance since March 2001. From March 2001 until January 12, 2010, Mr. Farnham also served as our Chief Financial Officer. He joined us in 1985 and previously served as our Senior Vice President and Controller. Prior to joining us, Mr. Farnham, who is a Certified Public Accountant, was employed by the accounting firm of PricewaterhouseCoopers LLP, formerly known as Coopers & Lybrand LLP.

Timothy R. Parry, age 57, served as our Senior Vice President, General Counsel and Corporate Secretary during 2011 and through January 5, 2012, at which time he resigned as our General Counsel and Corporate Secretary. Additionally, effective March 2, 2012, he will retire. Mr. Parry joined us in February 1996 as our Vice President and Assistant General Counsel after twelve years with the law firm of Harter Secrest & Emery LLP, the last seven years as a partner. Mr. Parry became our General Counsel in 1997. Prior to joining Harter Secrest & Emery LLP, he was an Ohio Assistant Attorney General for two years and a law clerk for the U.S. District Court for the Southern District of Ohio. Mr. Parry is an adjunct professor of law at Ave Maria Law School in Naples, Florida and he was appointed to the school's faculty during 2009. He also previously served as a member of the Board of the Federation of American Hospitals.

Joseph C. Meek, age 56, has served as our Vice President and Treasurer since July 9, 2007. Prior to joining us, Mr. Meek held corporate treasury and investor relations positions of increasing responsibility with SSM Health Care, Spectrum Brands and Peabody Energy, all in St. Louis, Missouri, between 1998 and 2007. Mr. Meek also held banking positions with Industrial Bank of Japan, Yasuda Trust and Union Bank of Switzerland, all in Chicago, Illinois, between 1984 and 1998. On December 5, 2011, the Corporate Governance and Nominating Committee of our Board of Directors determined that Mr. Meek would no longer be considered an executive officer of our company; however, he continues to serve as our Vice President and Treasurer.

Kerrin ("Kerry") E. Gillespie, age 53, has served as our Executive Vice President of Operations Finance since January 1, 2012. Mr. Gillespie also served as our Senior Vice President and Divisional Chief Financial Officer from May 23, 2011 to December 31, 2011. From March 2010 until May 2011, he served as Senior Vice President and Chief Financial Officer of Radiation Therapy Services Holdings, Inc. Before joining Radiation Therapy Services Holdings, Inc., Mr. Gillespie served as Chief Financial Officer of Ardent Health Services, LLC from March

2007 to March 2010. During the period from April 1998 to February 2007, Mr. Gillespie was Vice President of Group Operations at Community Health Systems, Inc. Mr. Gillespie previously held financial and operational positions with us from June 1991 to April 1998, including Assistant Corporate Controller, Manager of Operations Finance and executive officer positions at certain of our hospitals. Mr. Gillespie, who is a Certified Public Accountant, is a member of the American Institute of Certified Public Accountants and the Financial Executives Institute, as well as a fellow of the Healthcare Financial Management Association.

Linda A. Epstein, age 52, has served as our acting General Counsel since January 7, 2012. She has also served as our Vice President and Associate General Counsel of Litigation and Risk Management since July 29, 2008. Prior to joining us, Ms. Epstein was a partner at the law firm of Wicker, Smith, O'Hara, McCoy & Ford, P.A., from May 2000 to July 2008, other than the period from May 2002 to September 2003 when she was a partner at the law firm of Ennis, Paige & Epstein, P.A. In addition to a law degree, Ms. Epstein also has a Bachelors in Science and Nursing degree. Ms. Epstein is currently a member of the Florida Bar Association, Collier County Bar Association, and American Health Lawyers Association.

Code of Ethics

We have adopted a Code of Business Conduct and Ethics that applies to our principal executive officer, principal financial officer, principal accounting officer or controller or persons performing similar functions. Our Code of Business Conduct and Ethics also applies to all of our other employees and, as set forth therein, to our directors. On February 20, 2012, the Audit Committee of our Board of Directors amended the Code of Business Conduct and Ethics. None of the revised or expanded provisions represents a material change to our existing standards, policies or practices. Rather, the changes and enhancements were designed to both incorporate the principles of our "Getting to Great" initiative and provide additional formal guidance regarding the ethical behavior that we expect from our directors, officers and all of our other employees. The amended Code of Business Conduct and Ethics also incorporates and references certain of our internal resources that are designed to enhance adherence by such persons to the highest ethical standards and further support compliance with all applicable laws.

Our Code of Business Conduct and Ethics is posted on our website at www.hma.com under Investor Relations. We intend to satisfy any disclosure requirements pursuant to Item 5.05 of Form 8-K regarding any amendment to, or a waiver from, certain provisions of our Code of Business Conduct and Ethics by posting such information on our website under Investor Relations.

Item 11. Executive Compensation.

The information required by this Item 11 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation," which proxy statement will be filed not later than 120 days after December 31, 2011.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

Except as set forth below, the information required by this Item 12 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the heading "Security Ownership of Certain Beneficial Owners and Management," which proxy statement will be filed not later than 120 days after December 31, 2011.

Securities Authorized for Issuance under Equity Compensation Plans as of December 31, 2011

Equity Compensation Plan Information			
Plan category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders[1]	12,031,482	$ 4.10	12,015,626
Equity compensation plans not approved by security holders	-	-	-
Totals	12,031,482	$ 4.10	12,015,626

(1) Includes, among other things, deferred stock awards granted to independent directors, officers and management staff pursuant to the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan. See Note 8 to the Consolidated Financial Statements in Item 8 of Part II for more information about our stock-based compensation plans.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The information required by this Item 13 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the headings "Certain Transactions" and "Corporate Governance," which proxy statement will be filed not later than 120 days after December 31, 2011.

Item 14. Principal Accountant Fees and Services.

The information required by this Item 14 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the heading "Selection of Independent Registered Public Accounting Firm," which proxy statement will be filed not later than 120 days after December 31, 2011.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

We filed our consolidated financial statements in Item 8 of Part II. Additionally, the financial statement schedule entitled "Schedule II - Valuation and Qualifying Accounts" is filed as part of this Form 10-K under this Item 15.

All other schedules have been omitted since the required information is not present or is not present in amounts sufficient to require submission of the schedule or because the information required is included in the consolidated financial statements and notes thereto.

The exhibits filed as part of this Form 10-K are listed in the Index to Exhibits immediately following the signature page of this Form 10-K.

HEALTH MANAGEMENT ASSOCIATES, INC.
SCHEDULE II - VALUATION AND QUALIFYING ACCOUNTS
(in thousands)

Description	Balances at Beginning of Period	Acquisitions and Dispositions	Charged to Operations (a)	Charged to Other Accounts	Deductions (b)	Balances at End of Period
Allowance for Doubtful Accounts (c)						
Year ended December 31, 2011	$ 495,486	$ -	$ 746,450	$ -	$ (662,964)	$ 578,972
Year ended December 31, 2010	455,705	291	662,239	-	(622,749)	495,486
Year ended December 31, 2009	449,031	(12,975)	606,812	-	(587,163)	455,705

(a) Charges to operations include amounts related to provisions for doubtful accounts, before recoveries of accounts receivable that were previously written off.

(b) Accounts receivable written off as uncollectible.

(c) This table includes the activity of discontinued operations, as identified at Note 10 to the Consolidated Financial Statements in Item 8 of Part II.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

HEALTH MANAGEMENT ASSOCIATES, INC.

By: /s/ Gary D. Newsome Gary D. Newsome	President and Chief Executive Officer	February 21, 2012

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

/s/ William J. Schoen William J. Schoen	Chairman of the Board of Directors	February 21, 2012
/s/ Gary D. Newsome Gary D. Newsome	President, Chief Executive Officer and Director (Principal Executive Officer)	February 21, 2012
/s/ Kelly E. Curry Kelly E. Curry	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 21, 2012
/s/ Gary S. Bryant Gary S. Bryant	Vice President and Controller (Principal Accounting Officer)	February 21, 2012
/s/ Kent P. Dauten Kent P. Dauten	Director	February 21, 2012
/s/ Pascal J. Goldschmidt Pascal J. Goldschmidt, M.D.	Director	February 21, 2012
/s/ Donald E. Kiernan Donald E. Kiernan	Director	February 21, 2012
/s/ Robert A. Knox Robert A. Knox	Director	February 21, 2012
/s/ Vicki A. O'Meara Vicki A. O'Meara	Director	February 21, 2012
/s/ William C. Steere, Jr. William C. Steere, Jr.	Director	February 21, 2012
/s/ Randolph W. Westerfield Randolph W. Westerfield, Ph.D.	Director	February 21, 2012

INDEX TO EXHIBITS

(2) Plan of acquisition, reorganization, arrangement, liquidation or succession

Not applicable.

(3) (i) Articles of Incorporation

3.1 Fifth Restated Certificate of Incorporation, previously filed and included as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1995 (SEC File No. 000-18799), is incorporated herein by reference.

3.2 Certificate of Amendment to Fifth Restated Certificate of Incorporation, previously filed and included as Exhibit 3.2 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 1999, is incorporated herein by reference.

(ii) By-laws

3.3 By-laws, as amended and restated, previously filed and included as Exhibit 3.1 to the Company's Current Report on Form 8-K dated December 7, 2010, are incorporated herein by reference.

(4) Instruments defining the rights of security holders, including indentures

4.1 Specimen Stock Certificate, previously filed and included as Exhibit 4.11 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 1992 (SEC File No. 000-18799), is incorporated herein by reference.

4.2 Indenture, dated as of April 21, 2006, between the Company and U.S. Bank National Association pertaining to the Company's 6.125% Senior Notes due 2016, previously filed and included as Exhibit 4.1 to the Company's Current Report on Form 8-K dated April 18, 2006, is incorporated herein by reference.

4.3 Form of Global Note for the Company's 6.125% Senior Notes due 2016, previously filed and included as part of Exhibit 4.1 to the Company's Current Report on Form 8-K dated April 18, 2006, is incorporated herein by reference.

4.4 Supplemental Indenture, dated as of February 28, 2007, between the Company and U.S. Bank National Association pertaining to the Company's 6.125% Senior Notes due 2016, previously filed and included as Exhibit 4.7 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009, is incorporated herein by reference.

4.5 Credit Agreement dated as of February 16, 2007 among the Company; Bank of America, N.A., as Lender, Administrative Agent, Swing Line Lender and Letter of Credit ("L/C") Issuer; Wachovia Bank, National Association, as Lender, Syndication Agent and L/C Issuer; Citicorp USA Inc., JPMorgan Chase Bank, N.A. and SunTrust Bank, as Lenders and Co-Documentation Agents; and certain other lenders that are parties thereto (includes form of Term B Note, form of Revolving Credit Note, form of Guaranty and form of Security Agreement), previously filed on July 8, 2009 and included as Exhibit 99.1 to the Company's Current Report on Form 8-K/A dated February 16, 2007, is incorporated herein by reference.

4.6 Indenture, dated as of May 21, 2008, between the Company and U.S. Bank, National Association pertaining to the Company's 3.75% Convertible Senior Subordinated Notes due 2028 issued by the Company, previously filed and included as Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, is incorporated herein by reference.

4.7 Form of 3.75% Convertible Senior Subordinated Note due 2028 issued by the Company, previously filed and included as part of Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, is incorporated herein by reference.

4.8 Credit Agreement, dated as of September 30, 2011, among Knoxville HMA Holdings, LLC and certain of its subsidiaries, SunTrust Bank, as Administrative Agent, Lender, Swingline Lender and Issuing Bank, and Deutsche Bank Trust Company Americas, The Royal Bank of Scotland PLC, Wells Fargo Bank, N.A., Bank of America, N.A. and Barclays Bank PLC, as Lenders (includes the form of the notes evidencing the term loan facility and the revolving credit facility), previously filed on January 12, 2012 and included as Exhibit 4.1 to the Company's Current Report on Form 8-K/A (Amendment No. 1) dated November 18, 2011, is incorporated herein by reference.

4.9 Security Agreement, dated as of September 30, 2011, by Knoxville HMA Holdings, LLC and certain of its subsidiaries in favor of SunTrust Bank, as Administrative Agent under the Credit Agreement with a syndicate of banks, dated as of September 30, 2011, previously filed and included as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011, is incorporated herein by reference.

4.10 Indenture, dated as of November 18, 2011, among the Company, each of the subsidiary guarantors party thereto and U.S. Bank, National Association pertaining to the Company's 7.375% Senior Notes due 2020 (includes the form of the related notes).

4.11 Registration Rights Agreement, dated as of November 18, 2011, among the Company, the guarantors party thereto, Deutsche Bank Securities Inc. and Wells Fargo Securities, LLC pertaining to the Company's 7.375% Senior Notes due 2020.

4.12 Credit Agreement, dated as of November 18, 2011, among the Company, Wells Fargo Bank, National Association, as Administrative Agent, Swing Line Lender and Letter of Credit Issuer, Wells Fargo Securities, LLC, as Joint Lead Arranger and Joint Bookrunner, Deutsche Bank Securities, Inc., as Joint Lead Arranger, Joint Bookrunner and Syndication Agent, Citigroup Global Markets Inc., as Joint Bookrunner, Citibank, N.A., as Co-Documentation Agent, SunTrust Robinson Humphrey, Inc., as Joint Bookrunner, SunTrust Bank, as Co-Documentation Agent, Barclays Capital, as Joint Bookrunner, Barclays Bank PLC, as Co-Documentation Agent, and each of RBS Securities Inc., J.P. Morgan Securities LLC and Morgan Stanley Senior Funding, Inc., as Managing Agents, and certain other lenders thereto (includes the form of the related notes).

4.13 Security Agreement, dated as of November 18, 2011, among the Company, the guarantors party thereto and Wells Fargo Bank, National Association, as Collateral Agent, pertaining to the Company's Credit Agreement, dated as of November 18, 2011.

(9) Voting trust agreement

Not applicable.

(10) Material contracts

Exhibits 4.2 through 4.13 referenced under (4) of this Index to Exhibits are incorporated herein by reference.

10.1 Registration Agreement dated September 2, 1988 between HMA Holding Corp., First Chicago Investment Corporation, Madison Dearborn Partners IV, Prudential Venture Partners, Prudential Venture Partners II, William J. Schoen, Kelly E. Curry, Stephen M. Ray, Robb L. Smith, George A. Taylor and Earl P. Holland, previously filed and included as Exhibit 10.23 to the Company's Registration Statement on Form S-1 (Registration No. 33-36406), is incorporated herein by reference.

†10.2 Restructuring Agreement, dated as of September 30, 2009, among Health Management Associates, Inc., Carolinas Holdings, LLC, Carolinas JV Holdings, L.P., Novant Health, Inc. and Foundation Health Systems Corp., previously filed and included as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2009, is incorporated herein by reference.

10.3 Asset Purchase Agreement, dated June 30, 2011, between Health Management Associates, Inc., Knoxville HMA Holdings, LLC, Catholic Health Partners and Mercy Health Partners, Inc., previously filed on October 27, 2011 and included as Exhibit 2.1 to the Company's Current Report on Form 8-K/A (Amendment No. 2) dated June 30, 2011, is incorporated herein by reference.

*10.4 Health Management Associates, Inc. Stock Option Plan for Outside Directors, previously filed and included as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1995 (SEC File No. 000-18799), is incorporated herein by reference.

*10.5 Amendment No. 1 to the Health Management Associates, Inc. Stock Option Plan for Outside Directors, previously filed and included as Exhibit 10.59 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 1995 (SEC File No. 000-18799), is incorporated herein by reference.

*10.6 Form of Director Stock Option Agreement under the Health Management Associates, Inc. Stock Option Plan for Outside Directors, as amended, previously filed and included as Exhibit 10.35 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 2004, is incorporated herein by reference.

*10.7 Health Management Associates, Inc. 2006 Outside Director Restricted Stock Award Plan, previously filed and included as Appendix A to the Company's definitive Proxy Statement filed on January 19, 2006, is incorporated herein by reference.

*10.8 Amendment to the Health Management Associates, Inc. 2006 Outside Director Restricted Stock Award Plan, previously filed and included as Exhibit 10.25 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009, is incorporated herein by reference.

*10.9 Form of Restricted Stock Award Plan Notice under the Health Management Associates, Inc. 2006 Outside Director Restricted Stock Award Plan, previously filed and included as Exhibit 99.1 to the Company's Current Report on Form 8-K dated February 21, 2006, is incorporated herein by reference.

*10.10 First Amendment to Employment Agreement between the Company and William J. Schoen, dated February 6, 2007, previously filed and included as Exhibit 99.1 to the Company's Current Report on Form 8-K dated February 6, 2007, is incorporated herein by reference; and Employment Agreement for William J. Schoen made as of January 2, 2001, previously filed and included as Exhibit 99.2 to the Company's Registration Statement on Form S-8 (Registration No. 333-53602), is incorporated herein by reference.

*10.11 Fourth Amendment and Restatement of the Health Management Associates, Inc. Supplemental Executive Retirement Plan, previously filed and included as Exhibit 99.1 to the Company's Current Report on Form 8-K dated December 2, 2008, is incorporated herein by reference.

*10.12 The Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit A to the Company's definitive Proxy Statement filed on March 31, 2008, is incorporated herein by reference.

*10.13 Amendment No. 1 to the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.24 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009, is incorporated herein by reference.

*10.14 Amendment No. 2 to the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit A to the Company's definitive Proxy Statement filed on April 5, 2010, is incorporated herein by reference.

*10.15 Form of Stock Option Agreement under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.36 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 2004, is incorporated herein by reference.

*10.16 Form of Contingent Stock Award under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.32 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007, is incorporated herein by reference.

*10.17 Form of Deferred Stock Award under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.33 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007, is incorporated herein by reference.

*10.18 Form of Deferred Stock Award under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan for independent directors serving on the Company's Board of Directors, previously filed and included as Exhibit 10.19 to the Company's Annual Report on Form 10-K for the year ended December 31, 2010, is incorporated herein by reference.

*10.19 Form of Restricted Stock Award and Cash Performance Award for the year ended December 31, 2008 under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.26 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008, is incorporated herein by reference.

*10.20 Stock Option Award granted to Gary D. Newsome under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008, is incorporated herein by reference.

*10.21 The forms of Restricted Stock Award and Cash Performance Award for the years ended December 31, 2010 and 2009 under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan are the same, in all material respects, as the form of award previously filed and included as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009, which exhibit is incorporated herein by reference.

*10.22 The form of Restricted Stock Award and Cash Performance Award for the year ended December 31, 2011 under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.23 to the Company's Annual Report on Form 10-K for the year ended December 31, 2010, is incorporated herein by reference.

*10.23 Certain executive officer compensation information, including stock-based compensation under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed on the Company's Current Report on Form 8-K dated February 15, 2011, is incorporated herein by reference.

*10.24 Certain executive officer compensation information, previously filed and included in Item 5 of Part II of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011, is incorporated herein by reference.

*10.25 Agreement and Release, dated as of January 19, 2012, between Hospital Management Services of Florida, Inc. and Timothy R. Parry, previously filed and included as Exhibit 99.1 to the Company's Current Report on Form 8-K dated January 17, 2012, is incorporated herein by reference.

*10.26 Cash Performance Award granted to Joseph C. Meek under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010, is incorporated herein by reference.

*10.27 Deferred Stock Award granted to Joseph C. Meek under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010, is incorporated herein by reference.

*10.28 The form of Deferred Stock Award granted to Joseph C. Meek for the year ended December 31, 2011 under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2010, is incorporated herein by reference.

*10.29 Certain executive officer compensation information, including stock-based compensation under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed on the Company's Current Report on Form 8-K dated February 21, 2012, is incorporated herein by reference.

(11) Statement re computation of per share earnings

Not applicable.

(12) Statements re computation of ratios

Not applicable.

(13) Annual report to security holders, Form 10-Q or quarterly report to security holders

Not applicable.

(14) Code of Ethics

Not applicable.

(16) Letter re change in certifying accountant

Not applicable.

(18) Letter re change in accounting principles

Not applicable.

(21) Subsidiaries of the registrant

21.1 Subsidiaries of the registrant.

(22) Published report regarding matters submitted to vote of security holders

Not applicable.

(23) Consents of experts and counsel

23.1 Consent of Ernst & Young LLP.

(24) Power of attorney

Not applicable.

(31) Rule 13a-14(a)/15d-14(a) Certifications

31.1 Rule 13a-14(a)/15d-14(a) Certification of Principal Executive Officer.
31.2 Rule 13a-14(a)/15d-14(a) Certification of Principal Financial Officer.

(32) Section 1350 Certifications

32.1 Section 1350 Certifications.

(99) Additional exhibits

Not applicable.

(101) Interactive data files

**101.INS XBRL Instance Document
**101.SCH XBRL Taxonomy Extension Schema Document
**101.CAL XBRL Taxonomy Extension Calculation Linkbase Document
**101.DEF XBRL Taxonomy Extension Definition Linkbase Document
**101.LAB XBRL Taxonomy Extension Label Linkbase Document
**101.PRE XBRL Taxonomy Extension Presentation Linkbase Document

* Management contract or compensatory plan or arrangement.

** Pursuant to Rule 406T of Regulation S-T, the information in this exhibit shall not be deemed to be "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, or otherwise subject to the liability of that section, and shall not be incorporated by reference into any registration statement, prospectus or other document filed under the Securities Act of 1933, or the Securities Exchange Act of 1934, except as shall be expressly set forth by specific reference in such filings.

† Health Management Associates, Inc. requested confidential treatment of certain information contained in this exhibit. Such information was filed separately with the Securities and Exchange Commission pursuant to an application for confidential treatment under 17 C.F.R. §§ 200.80(b)(4) and 240.24b-2. On November 18, 2009, the Securities and Exchange Commission approved the request pursuant to an Order Granting Confidential Treatment.

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HOME OFFICE
5811 Pelican Bay Boulevard, Suite 500
Naples, Florida 34108-2710
239-598-3131

INTERNET ADDRESS
www.hma.com

ANNUAL REPORT TO THE SEC
Health Management's Annual Report on Form 10-K, filed with the Securities and Exchange Commission (SEC), and other filings made by Health Management with the SEC may be obtained by writing to Health Management at its address listed above. Such information filed by Health Management with the SEC is also available by accessing Health Management's website at www.hma.com.

NYSE SYMBOL
HMA

INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM
Ernst & Young LLP
Miami, Florida

ANNUAL MEETING
Stockholders are cordially invited to attend the 2012 Annual Meeting of Stockholders, which will be held at 1:30 p.m., local time, on Tuesday, May 22, 2012, at the Ritz-Carlton Golf Resort Naples, 2600 Tiburón Drive, Naples, FL, 34109.

Management urges all stockholders to vote their proxies and thus participate in the decisions that will be made at the Annual Meeting.

TRANSFER AGENT
American Stock Transfer & Trust Company
59 Maiden Lane, Plaza Level
New York, New York 10038
(800) 937-5449
www.amstock.com

For a change of name, address, or to replace lost stock certificates, write or call the Transfer Agent's Securities Transfer Division.

SECURITIES ANALYST CONTACT
John C. Merriwether
Vice President – Financial Relations
239-598-3131

2012 NOV 14 AM 10:05

ANALYST COVERAGE
Argus Research Company
Auriga USA
Bank of America / Merrill Lynch
Barclays Capital
BMO Capital
Cantor Fitzgerald
Citigroup
Credit Suisse
CRT Capital Group
Deutsche Bank
Jefferies & Co.
Lazard Capital
Leerink Swann & Company
Mizuho Securities
Morgan Stanley
Oppenheimer
Raymond James
RBC Capital Markets
Robert W. Baird & Company
Suntrust
Susquehanna Financial Group
UBS
Wells Fargo

FORWARD-LOOKING STATEMENTS
Certain statements contained in this Annual Report, including, without limitation, statements containing the words "believe," "anticipate," "intend," "expect," "may," "could," "plan," "continue," "should," "project," "estimate" and words of similar import, constitute "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. Forward-looking statements may include projections of revenue, provisions for doubtful accounts, income or loss, capital expenditures, debt structure, principal payments on debt, capital structure, the amount and timing of funds under the meaningful use measurement standard of various Healthcare Information Technology ("HCIT") incentive programs, other financial items and operating statistics, statements regarding our plans and objectives for future operations, acquisitions, acquisition financing, divestitures and other transactions, statements of future economic performance, statements regarding our legal proceedings and other loss contingencies, statements regarding market risk exposures, statements regarding the effects and/or interpretations of recently enacted or future health care laws and regulations, statements of the assumptions underlying or relating to any of the foregoing statements, and statements that are other than statements of historical fact.

Forward-looking statements are based on our current plans and expectations and involve known and unknown risks, uncertainties and other factors that may cause our actual results, performance, achievements or industry results to be materially different from any future results, performance or achievements expressed or implied by our forward-looking statements. Such factors include, among other things, the risks and uncertainties identified by us that are more fully described in the accompanying 2011 Annual Report on Form 10-K under the heading "Risk Factors" in Item 1A of Part I. Furthermore, we operate in a continually changing business and regulatory environment and new risk factors emerge from time to time. We cannot predict what these new risk factors may be, nor can we assess the impact, if any, of such new risk factors on our business or results of operations or the extent to which any factor or combination of factors may cause our actual results to differ materially from those expressed or implied by any of our forward-looking statements.

Undue reliance should not be placed on our forward-looking statements. Except as required by law, we disclaim any obligation to update our risk factors or to publicly announce updates to the forward-looking statements contained in this Annual Report to reflect new information, future events or other developments.

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

December 3, 2012

Jeffrey D. Potter, Sr. Vice President
Tennova Healthcare
200 E. Blount Ave., Suite 600
Knoxville, TN 37920

RE: Certificate of Need Application -- Metro Knoxville HMA, LLC d/b/a Tennova Healthcare, North Knoxville Medical Center - CN1211-056

Dear Mr. Potter:

This is to acknowledge the November 29, 2012 receipt of supplemental information to your application for a Certificate of Need for the initiation of diagnostic cardiac catheterization services. The project involves construction and equipping of shell space within the hospital to serve as a dual cardiac catheterization/vascular lab, support areas for the lab, expanded waiting room, and additional pre-operative and post-operative space. No inpatient beds are involved in this project. The project cost is $4,377,421.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on December 1, 2012. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on February 27, 2013.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

MMH:MAB

cc: Tere Hendricks, Director, Division of Health Statistics

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

MEMORANDUM

TO: Tere Hendricks, Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 Fifth Avenue North
Nashville, Tennessee 37247

FROM: Melanie M. Hill
Executive Director

DATE: December 3, 2012

RE: Certificate of Need Application
Metro Knoxville HMA, LLC d/b/a Tennova Healthcare, North Knoxville Medical Center - CN1211-056

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on December 1, 2012 and end on February 1, 2013.

Should there be any questions regarding this application or the review cycle, please contact this office.

MMH:MAB

Enclosure

cc: Jeffrey D. Potter, Sr. Vice President

2012 NOV -9 AM 10: 39

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the **Knoxville News Sentinel** which is a newspaper
(Name of Newspaper)
of general circulation in **Knox County**, Tennessee, on or before **November 9, 2012**, for one day.
(County) (Month / day)(Year)

==========

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, North Knoxville Medical Center, Hospital**
(Name of Applicant) (Facility Type-Existing)

owned by: **Metro Knoxville HMA Holdings, LLC, d/b/a Tennova Healthcare** with an ownership type of **Limited Liability Corporation** and to be managed by: **Metro Knoxville HMA Holdings, LLC, d/b/a Tennova Healthcare** intends to file an application for a Certificate of Need

for: **the initiation of diagnostic cardiac catheterization services, to be located on the Tennova Healthcare – North Knoxville Medical Center campus, 7565 Dannaher Drive, Powell, TN 37849. The project involves construction and equipping of shell space within the hospital to serve as a dual cardiac catheterization/vascular lab, support areas for the lab, expanded waiting room, and additional pre-operative and post-operative space. No inpatient beds are involved in this project. The anticipated total cost of the project is $4,377,421.**

The anticipated date of filing the application is: **November 14, 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 Ave., Suite 600** (Address)

Knoxville (City) **Tennessee** (State) **37920** (Zip Code) **865 / 632-5605** (Area Code / Phone Number)

(Signature) **November 8, 2012** (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

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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.

==========

Copy

Supplemental #1

Tennova Healthcare

CN1211-056

SUPPLEMENTAL- # 1
November 28, 2012
11:05am

2012 NOV 28 AM 11 05

November 27, 2012

Jeffrey D. Potter
Senior Vice President
Tennova Healthcare.
200 E. Blount Street, Suite 600
Knoxville, TN 37920

RE: Certificate of Need Application CN1211-056
Metro Knoxville HMA, LLC d/b/a Tennova Healthcare - North Knoxville Medical Center

Dear Mr. Potter:

This will acknowledge our November 14, 2012 receipt of your application for a Certificate of Need for the initiation of diagnostic cardiac catheterization services to be located at North Knoxville Medical Center Campus, 7565 Dannaher Drive, 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, Wednesday, November 28, 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.

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1. **Section A, Item 4**

   Please provide documentation from the Tennessee Secretary of State web-site that Metro Knoxville HMA, LLC d/b/a Tennova Healthcare-North Knoxville Medical Center is an active LLC.

   Documentation is attached as Attachment 1, demonstrating that Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – North Knoxville Medical Center is an active LLC.

2. **Section A, Item 9 (Bed Complement Chart)**

The applicant has placed a N/A in the name of the management/operating entity (if applicable). The historical data chart reflects the applicant paid $8,737,825 in management fees to affiliates in 2011. Please clarify.

The response was meant to indicate that there is no outside management company outside the Health Management Associates' family of companies. Health Management Associates, Inc. is the parent company of the entity, "Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – North Knoxville Medical Center". Health Management Associates provides centralized support services to North Knoxville Medical Center, such as information technology, legal, managed care, and human resources services.

3. **Section B, Project Description, Item II. C. (Applicant's Need)**

The applicant states cardiac catheterization was approved as part of the Original CON to build what was then known as St. Mary's Medical Center North approximately 5 years ago. Where have the patients that were projected to receive services during this time gone for cardiac catheterization services? Also, please address the marketing and education efforts that will be made by the applicant to attract patients for cardiac catheterization services in Year One and Year Two.

Because cardiac catheterization services have not been available to this point at North Knoxville Medical Center, patients who want to be treated by East Tennessee Heart Consultants have received those services at Physicians Regional Medical Center or Turkey Creek Medical Center. Some patients also received services at other Knox County hospitals, or in Anderson County at Methodist Medical Center of Oak Ridge.

Primary marketing efforts to attract patients for cardiac catheterization services will be focused on the physicians who refer patients to East Tennessee Heart Consultants, to ensure that they know diagnostic cardiac catheterization services are available at North Knoxville Medical Center. Those physicians are primary care doctors who serve the 11 county service area for this project, with the heaviest focus being on those physicians in north Knox county, eastern Anderson county, and Campbell, Claiborne, Scott, and Union counties. There will also be outreach and education for EMS providers, so that they are aware of the new service being offered.

The applicant mentions an affiliated organization named Turkey Creek Medical Center later in the application. Please indicate the distance Turkey Creek is from the applicant and the type of services available there that is similar to those being proposed in this application.

Turkey Creek Medical Center is located 19 miles away, in far west Knox County. Turkey Creek Medical Center provides both diagnostic and therapeutic cardiac catheterization services, as well as an open heart surgery program.

4. **Section B, Project Description, Item II. E.1.a and b. (Mobile Major Medical Equipment and proposed schedule of operations)**

The applicant is proposing to schedule vascular surgery one day per week and diagnostic catheterizations two days per week starting at 7 am each day of surgery. Please complete the following table for Year Two of the proposed project.

	Monday (Hours of Operation)	Tuesday (Hours of Operation)	Wednesday (Hours of Operation)	Thursday (Hours of Operation)	Friday (Hours of Operation)
Vascular Surgery	7:00 a.m. – 3:00 p.m.				
Cardiac Catheterizations		7:00 a.m. – 3:00 p.m.	7:00 a.m. – 3:00 p.m.		

The applicant states when necessary patients will be transferred to its tertiary medical hospital, Physicians Regional Medical Center. Please provide possible scenarios when a transfer may occur. Also, please indicate if the services that may be needed at Physicians Regional Medical Center will be available during the proposed hours of operation that will be listed in the table above.

Possible scenarios requiring a transfer are:

- ***During the course of an outpatient, diagnostic cardiac catheterization procedure, a high grade of stenosis is found. If the patient is very symptomatic or a high-risk patient, it would be appropriate to transfer the patient for a therapeutic procedure as opposed to discharging the patient.***
- ***If, during the course of a diagnostic cardiac catheterization procedure the patient becomes very unstable and cannot be stabilized, a transfer would be required.***
- ***If an inpatient becomes highly symptomatic with triple vessel disease, it would be appropriate to transfer that inpatient for surgery.***

Because Physicians Regional Medical Center is a tertiary hospital, emergency cardiac catheterization and open heart surgery services are available 24 hours a day, 7 days per week.

The type of equipment being proposed is the Phillips Allura Xper LD20. However, the equipment quote and FDA documentation is for an Allura Xper FD20. What is the difference in the equipment? Please clarify.

This was a typographical error in the application. The name of the equipment being proposed is the Philips Allura Xper FD20.

Please provide a brief general description of vascular surgery and cardiac catheterization.

Vascular surgery of the type that will be performed in the lab proposed in this application is known as peripheral vascular catheterization. Peripheral vascular catheterization is an invasive medical procedure that may be performed within a cardiac catheterization laboratory. The procedure involves the insertion of a catheter in a peripheral artery or vein for diagnostic or therapeutic purposes. This procedure is used to evaluate the presence of plaque build-up (Atherosclerosis) in the peripheral arteries – meaning the arteries to the lower abdomen, kidneys, arms, legs, head, neck and feet.

Cardiac catheterization is an invasive medical procedure performed within a cardiac catheterization laboratory and used as a diagnostic or therapeutic tool for heart and circulatory conditions. During a catheterization procedure a catheter is inserted into a blood vessel and is manipulated by a physician to travel along the course of the vessel in the chambers or vessels of the heart. Imaging equipment is used as an aid in placing the catheter tip in the desired position. Once in place the physicians is able to perform various diagnostic and/or therapeutic procedures. Cardiac catheterization services include diagnostic cardiac catheterizations, therapeutic cardiac catheterizations, and electrophysiological (EP) studies, both diagnostic and therapeutic. However, this application only proposes performing diagnostic cardiac catheterization procedures.

5. **Section B, Project Description Item III.A.(Plot Plan)**

As required for all projects, a Plot Plan must provide the size of the site (in acres), location of the structure on the site and the location of the proposed construction. Please also include slightly larger, more legible labels for the plot plan. Please provide a new Plot Plan with all the requested information.

An updated Plot Plan for the site is attached as Attachment 5.

6. **Section B, Project Description, Item IV (Floor Plan)**

The proposed floor plans are noted. Please indicate the purpose of shell space in Area 1.

The shell space in Area 1 is for the purpose of possible future growth. It is much more cost-effective to build out the shell space while the construction process is underway, rather than to go back at a later time to finish out that space if it is needed at some point in the future for a second cardiac catheterization / vascular lab.

7. **Section C Need Item 1- Principles of the State Health Plan**

The Five Principles to Achieving Better Health in the State Health Plan is noted. Only two of the five appears to be addressed. Please discuss how the project addresses the remaining three Principles; healthy lives, economic efficiencies and healthcare workforce. Please list each principle and summarize underneath how each will be achieved.

This application contributes to the remaining three Principles to Achieving Better Health in the State Health Plan in the following ways:

- ***Healthy Lives.*** ***In the State Health Plan, it is noted that Tennesseans see heart disease, stroke, and high blood pressure as having the greatest impact on the health of state residents. In this section it is also noted that health starts "where we live, work, and learn." This application is focused on providing a needed healthcare service to a highly at-risk population, in a location that is accessible to patients who are currently underserved.***

- ***Economic Efficiencies.*** ***The State Health Plan identifies one of the key elements in providing economically efficient healthcare as "balancing***

competitive markets, health systems, and economic efficiencies." In order for North Knoxville Medical Center to continue to be a competitive hospital provider, it needs to expand the services offered to include more acute services, such as cardiac catheterization and vascular surgery. In addition, the service is expected to be profitable in the second year, even at the minimal volumes projected. As volumes grow, the service will become even more profitable and economically efficient for the hospital.

- ***Healthcare Workforce. One of the stated strategies in the State Health Plan around the Healthcare Workforce is to "assure the health care workforce is trained to provide high quality and culturally competent care." The model of utilizing existing cardiac catheterization lab staff from Physicians Regional Medical Center to provide staffing for the North Knoxville lab, while also training others in the skills necessary to support cardiac catheterization procedures as volumes grow, is an efficient way to ensure high quality for a new service line, as well as to provide professional development for both the staff doing the training and the staff receiving the training.***

8. Section C Need Item 1 (Specific Criteria for Cardiac Catheterization Services Item A.2.)

Please provide documentation the applicant is accredited by The Joint Commission.

A copy of North Knoxville Medical Center's Joint Commission accreditation certificate is attached as Attachment 8. Please note that it has not been re-issued since the change in ownership from Mercy Health Partners to Tennova Healthcare, and that North Knoxville Medical Center is a satellite hospital of Physicians Regional Medical Center. The hospital license and provider number is the same, and this certificate is still in effect. Upon the hospital's next Joint Commission survey inspection, a certificate will be issued reflecting the name change.

9. Section C Need Item 1 (Specific Criteria for Cardiac Catheterization Services Item A.3.)

The intra-facility emergency transfer policy is noted. Does the applicant have a transfer policy to an alternate facility, if needed? Also, is it the policy of the applicant to only transfer to facilities that are affiliated with Tennnova?

While it is not the policy of the applicant to only transfer to facilities that are affiliated with Tennova, patients who are utilizing Tennova services have chosen the health system and generally want the high quality of services or specific physicians that are part of the Tennova Healthcare system. That being said, the applicant does maintain transfer agreements with every hospital in Knox County. Because Tennova Healthcare has a tertiary medical center at Physicians Regional Medical Center, most medical needs can be met through a transfer within the Tennova Healthcare system. However, if there is a medical need that Tennova Healthcare cannot adequately meet, or if a patient requests a transfer, it is Tennova Healthcare's policy to transfer to whichever hospital is in the patients' best interest. Trauma patients who present to a Tennova Healthcare hospital are immediately transferred to the University of Tennessee Medical Center.

How will the transfer policy be reviewed/tested on a regular (quarterly basis)?

Because North Knoxville Medical Center already receives some volume of patients presenting to the emergency department with cardiac issues, as well as occasional inpatients who experience a significant cardiac issue, transfers are already occurring almost daily (200-225 patients per year over the past three years). In fact, the hospital's quality team already measures the time it takes from a patient experiencing chest pain or other symptoms that would indicate the need for some type of cardiac procedure to the time when the patient receives percutaneous coronary intervention following a transfer to Physicians Regional Medical Center. Therefore, the transfer policy is being tested almost daily. Clinical policies and procedures such as the transfer policy also undergo an annual review to ensure that policy and practice are in synch.

Please clarify if Physician's Regional Medical Center is the closest facility that has open heart surgery capabilities.

Located eight miles North Knoxville Medical Center, Physicians Regional Medical Center is the closest facility that has open heart surgery capabilities.

10. Section C Need Item 1 (Specific Criteria for Cardiac Catheterization Services Item 10.b.)

Please complete the following chart for the number of deaths from diseases of the heart with rates per 100,000 population using the latest data from the Tennessee Department of Health.

County/State	Number of Deaths	Rate
State	14,489	228.3
Anderson	206	274.2
Campbell	135	331.6
Claiborne	104	322.9
Cocke	125	350.5
Grainger	56	247.2
Hamblen	172	275.0
Jefferson	133	258.7
Knox	903	208.9
Scott	56	251.9
Sevier	253	281.5
Union	37	193.6

11. Section C, Need, Item 4.b. (Special Needs of the Service area Population)

The applicant states 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 in the service area. Please briefly define the Affordable Care Act and the methodology used by the applicant to determine how the uninsured in the service area will go from 19% to 8%.

The Affordable Care Act contemplates the reduction in the uninsured through expansion of Medicaid eligibility, allowing young people to stay on their parents' health insurance until age 26, and subsidizing the purchase of health insurance on the new private exchange starting in 2014. People expected to benefit from the private exchange subsidies are working people whose employers do not offer health care benefits, or who are lower wage earners for whom purchasing health care insurance is currently cost prohibitive. It is projected by Thomson Reuters, the source used to provide the insurance coverage estimated included in this application, that the number of uninsured Americans will drop by 50% because of expanded coverage under the Affordable Care Act.

12. Section C. Need, Item 5

The utilization of trends of similar institutions in the service area with cath labs using 2012 JAR data is noted. However, please apply the same chart for adult cardiac catheterization utilization for each provider in the proposed service area using the most recent three years of data available.

An updated utilization chart reflecting the most recent three years of utilization data available is attached as Attachment 12.

13. Section C. Need, Item 6 (Applicant's Projected Utilization)

Your response is noted. The Project Forecast Chart indicates the initiation of service is 12/2013. What is the projected utilization in Year 1 (2014) and Year 2 (2015)? Please break out the projected utilization between diagnostic and therapeutic catheterizations.

The Project Forecast Chart was completed assuming that the first full year of service will be 2014. According to the Project Completion Forecast Chart, the cardiac catheterization / vascular lab will be ready for service in December, 2013. December, 2013 will be a start-up month with the expectation of very low volumes. Beginning in January, 2014, the application assumes that 285 cardiac catheterization procedures will be completed in calendar year 2014, and 306 completed in calendar year 2015. All projected utilization reflects diagnostic catheterizations only, since approval to provide therapeutic services has not been requested as part of this application.

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

There are no architectural and engineering fees in the Project Costs Chart although the Project Forecast Chart lists an architectural/engineering contract. Please clarify.

The architectural work was completed two years ago when the application, then Mercy Health Partners, considered applying for this same project. There are, therefore, no additional architectural and engineering fees to be incurred.

Please indicate if the equipment cost includes taxes, fees, and installation costs.

The equipment cost is inclusive of taxes, fees, and installation.

Please list all moveable equipment over $50,000.

A full list of moveable equipment was included as Attachment B.I.Project Description.2. A listing of only the moveable equipment over $50,000 is attached to these supplemental responses as Attachment 14.

15. Section C. Economic Feasibility Item 5

Please recheck the calculations for average gross charge, average deduction from operating revenue, and average net charge.

The average gross charge, average deduction from operating revenue, and average net charge should be amended to:

Average gross charge per procedure: $16,239
Average deduction from operating revenue: $12,623
Average net charge: $3,616

16. Section C, Economic Feasibility, Item 4. (Historic Data Chart)

There appears to be an error in the calculation in Year 2 of net operating income. If needed, please revise.

An updated Historical Data Chart is attached, as Attachment 16.

Please clarify the reason why there are management fees to affiliates in the amount of $8,737,825 assigned in 2011, but not in 2009 and 2010.

During 2009 and 2010, Tennova Healthcare was under different ownership. At that time, Catholic Health Partners owned the health system then known as Mercy Health Partners. Catholic Health Partners did not reflect management fees to affiliates in the same way that Health Management Associates' hospital organizations do. There is no accurate way for the applicant to provide more detailed information on past financials.

17. Section C. Economic Feasibility Item 4. (Projected Data Chart)

Management fees are not included in the 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.

There are no management fees included in the Projected Data Chart, because there are no management fees being paid to non-affiliates as part of this project.

Management fees to affiliates are not allocated out to specific service lines, but rather are allocated out at the whole hospital level and are related to support services such as information technology, legal, managed care, and human resources services.

Are salaries/wages in the amount of $55,012 in Year One and 466,014 in Year Two understated while there are four FTEs employed by the proposed project?

No, salaries/wages are not understated, since the FTEs will be shared between North Knoxville Medical Center and Physicians Regional Medical Center, allowing for maximum efficiency and cost effectiveness.

On page 39, Orderly Development, Item 3, it indicates there will be one (1) full-time physician employed. The projected data chart does not have a salary assigned the Physician's Salaries and Wages. Please clarify.

Actually, the application indicates that there will be one (1) physician working within the cardiac catheterization lab when it is operational, not that the physician will be employed by Tennova Healthcare. The physician practice will bill for the professional fees related to providing the surgical service, and his or her salary will be paid from the physician practice, not the hospital.

Why is there a sharp increase in contractual adjustments in the amount of $3,494,333 in Year One to $4,193,200 in Year Two? Please clarify.

The percentage off of gross revenue that is anticipated for contractual adjustments is consistent between Years One and Two. In both cases, it is projected that approximately 75.5% of charges will be deducted as contractual adjustments. The increase in the dollar amount of the contractual adjustments year over year is a product of anticipated increased volumes and charges per procedure.

Please clarify why there is retirement of principal of $4,337,421 in Year One, but not any assigned in Year Two.

The Projected Data Chart form indicates that Capital Expenditures should be noted in section F. This project does require capital, but that capital comes from North Knoxville Medical Center's parent organization, Health Management Associates. North Knoxville Medical Center will not have its financials adjusted for the use of the project capital, other than reflecting an appropriate depreciation amount annually for the equipment. An amended Projected Data Chart has been included as Attachment 17, removing the "retirement of principal" from the project's financial projections.

18. Section C. Economic Feasibility Item 6.B

The comparison of the proposed project charges to other providers affiliated with Tennova is noted. Please compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code (s).

A chart showing the proposed project charges compared to the current Medicare allowable fee schedule by CPT is attached. Please note that for those CPT codes for which the Medicare allowable fee is listed as "packaged," those CPT codes must be coded under a DRG package and cannot be broken out separately for the purposes of Medicare billing.

19. Section C. Economic Feasibility Item 8

The applicant projects to lose $3,914,357 in Year One of the proposed project. The hospital's historical data chart reflects net operating income of $5,460,163 in Year 2011. Please discuss how the financial viability of Metro Knoxville HMA, LLC d/b/a Tennova Healthcare - North Knoxville Medical Center and the initiation of diagnostic cardiac catheterization services will be achieved simultaneously.

The Projected Data Chart form indicates that Capital Expenditures should be noted in section F. This project does require capital, but that capital comes from North Knoxville Medical Center's parent organization, Health Management Associates. North Knoxville Medical Center will not have its financials adjusted for the use of the project capital, other than reflecting an appropriate depreciation amount annually for the equipment. An amended Projected Data Chart has been included as Attachment 17, removing the "retirement of principal" from the project's financial projections.

20. Section C, Contribution to Orderly Development, Item 7

A) Please provide a copy of the hospital's license.
B) Please provide a copy of the applicant's JCAHO accreditation certificate.
C) Please provide a copy of the most recent JCAHO survey report and the facility's responses.

Although a copy of each of the documents listed above was included with the original application, another set has been included as Attachment 20 with this response for the purpose of clarity.

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 January 18, 2013. 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. э 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

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List of Attachments

Attachment 1	Certificate of Existence
Attachment 5	Updated Plot Plan
Attachment 8	Joint Commission Accreditation Certificate
Attachment 12	Updated Utilization Chart
Attachment 14	List of Moveable Equipment over $50,000
Attachment 16	Updated Historical Data Chart
Attachment 17	Updated Projected Data Chart
Attachment 18	Medicare Allowable Fees by CPT Code
Attachment 20	Hospital License
	Joint Commission Accreditation Certificate
	Most Recent Joint Commission Survey Report and Hospital Response

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Attachment 1

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2012 NOV 28 AM 11 05

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

Filing Information

Name: **Metro Knoxville HMA, LLC**

General Information

SOS Control # :	**660505**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	06/10/2011
Filing Date:	06/10/2011 2:52 PM	Fiscal Year Close	12
Status:	Active	Member Count:	2
Duration Term:	Perpetual		
Managed By:	Member Managed		

Registered Agent Address
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Principal Address
STE 600
200 E BLOUNT AVE
KNOXVILLE, TN 37920-1611

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
10/19/2012	Assumed Name Cancellation	7108-0749
	Name Status Changed From: Active (Tennova Healthcare) To: Inactive - Name Cancelled (Tennova Healthcare)	
07/19/2012	Assumed Name	7078-0166
	New Assumed Name Changed From: No Value To: Tennova Women's Care	
07/19/2012	Assumed Name	7078-0168
	New Assumed Name Changed From: No Value To: Tennova South Imaging Center	
03/26/2012	2011 Annual Report	A0111-2700
	Principal Address 1 Changed From: 5811 PELICAN BAY BLVD SUITE 500 To: 200 E BLOUNT AVE	
	Principal Address 2 Changed From: No value To: STE 600	
	Principal City Changed From: NAPLES To: KNOXVILLE	
	Principal State Changed From: FL To: TN	
	Principal Postal Code Changed From: 34108 To: 37920-1611	
	Principal County Changed From: No value To: KNOX COUNTY	
	Member Count Changed From: 1 To: 2	
09/08/2011	Assumed Name	6936-2860
	New Assumed Name Changed From: No Value To: Tennova Sleep Center North	

Filing Information

Name: **Metro Knoxville HMA, LLC**

09/08/2011 Assumed Name 6936-2861

New Assumed Name Changed From: No Value To: Tennova Sleep Center South

09/08/2011 Assumed Name 6936-2862

New Assumed Name Changed From: No Value To: Tennova Sleep Center West

09/08/2011 Assumed Name 6936-2863

New Assumed Name Changed From: No Value To: Tennova Physical Therapy and Sports Medicine North

09/08/2011 Assumed Name 6936-2864

New Assumed Name Changed From: No Value To: Tennova Surgery Center West

09/08/2011 Assumed Name 6936-2865

New Assumed Name Changed From: No Value To: Tennova Ambulatory Care Center South

09/08/2011 Assumed Name 6936-2866

New Assumed Name Changed From: No Value To: Tennova Pain Management Center North

09/08/2011 Assumed Name 6936-2867

New Assumed Name Changed From: No Value To: Tennova Pain Management Center Northshore

09/08/2011 Assumed Name 6936-2868

New Assumed Name Changed From: No Value To: Tennova Cardiac Rehab Services East Towne

09/08/2011 Assumed Name 6936-2870

New Assumed Name Changed From: No Value To: Tennova Diabetes Management Center

09/08/2011 Assumed Name 6936-2871

New Assumed Name Changed From: No Value To: Tennova Rehab Care Center

09/08/2011 Assumed Name 6936-2872

New Assumed Name Changed From: No Value To: Tennova Women's Pavillion

09/08/2011 Assumed Name 6936-2873

New Assumed Name Changed From: No Value To: Tennova Pain Management Center

09/08/2011 Assumed Name 6936-2874

New Assumed Name Changed From: No Value To: Tennova Transitional Care Unit

09/08/2011 Assumed Name 6936-2875

New Assumed Name Changed From: No Value To: Tennova Wound Healing Center

09/08/2011 Assumed Name 6936-2876

New Assumed Name Changed From: No Value To: Tennova Physical Therapy

09/08/2011 Assumed Name 6936-2877

New Assumed Name Changed From: No Value To: Tennova Behavioral Services

09/02/2011 Assumed Name 6934-3116

New Assumed Name Changed From: No Value To: Tennova Healthcare

09/02/2011 Assumed Name 6934-3117

New Assumed Name Changed From: No Value To: Tennova Healthcare - Physcians Regional Medical Center

Filing Information

Name: **Metro Knoxville HMA, LLC**

09/02/2011 Assumed Name 6934-3118

New Assumed Name Changed From: No Value To: Tennova Healthcare - Turkey Creek Medical Center

09/02/2011 Assumed Name 6934-3119

New Assumed Name Changed From: No Value To: Tennova Healthcare - North Knoxville Medical Center

06/10/2011 Initial Filing 6903-0364

Active Assumed Names (if any)	Date	Expires
Tennova South Imaging Center	07/19/2012	07/19/2017
Tennova Women's Care	07/19/2012	07/19/2017
Tennova Behavioral Services	09/09/2011	09/08/2016
Tennova Physical Therapy	09/09/2011	09/08/2016
Tennova Wound Healing Center	09/09/2011	09/08/2016
Tennova Transitional Care Unit	09/09/2011	09/08/2016
Tennova Pain Management Center	09/09/2011	09/08/2016
Tennova Women's Pavillion	09/09/2011	09/08/2016
Tennova Rehab Care Center	09/09/2011	09/08/2016
Tennova Diabetes Management Center	09/09/2011	09/08/2016
Tennova Cardiac Rehab Services East Towne	09/09/2011	09/08/2016
Tennova Pain Management Center Northshore	09/09/2011	09/08/2016
Tennova Pain Management Center North	09/09/2011	09/08/2016
Tennova Ambulatory Care Center South	09/09/2011	09/08/2016
Tennova Surgery Center West	09/09/2011	09/08/2016
Tennova Physical Therapy and Sports Medicine North	09/09/2011	09/08/2016
Tennova Sleep Center West	09/09/2011	09/08/2016
Tennova Sleep Center South	09/09/2011	09/08/2016
Tennova Sleep Center North	09/09/2011	09/08/2016
Tennova Healthcare - North Knoxville Medical Center	09/02/2011	09/02/2016
Tennova Healthcare - Turkey Creek Medical Center	09/02/2011	09/02/2016
Tennova Healthcare - Physcians Regional Medical Center	09/02/2011	09/02/2016

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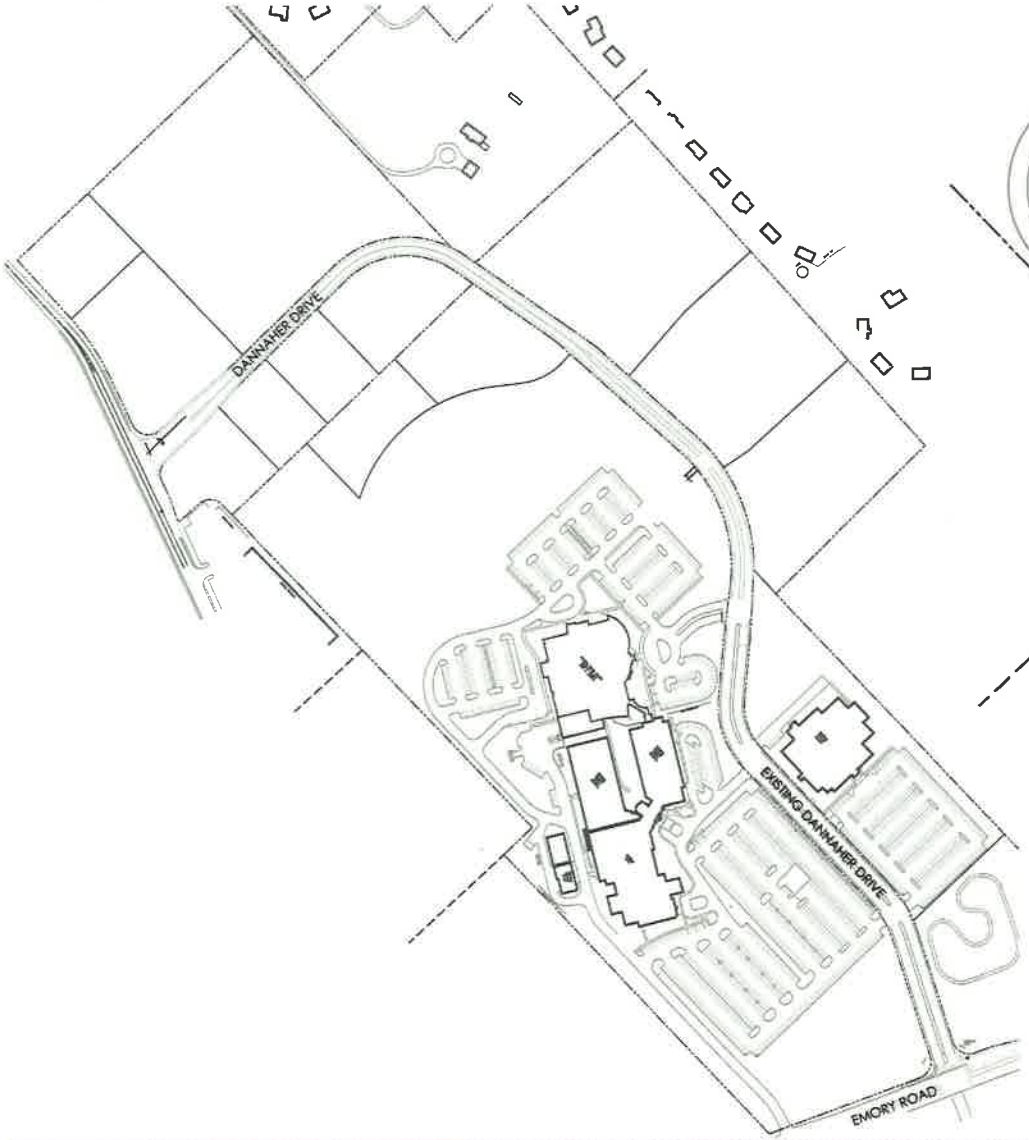
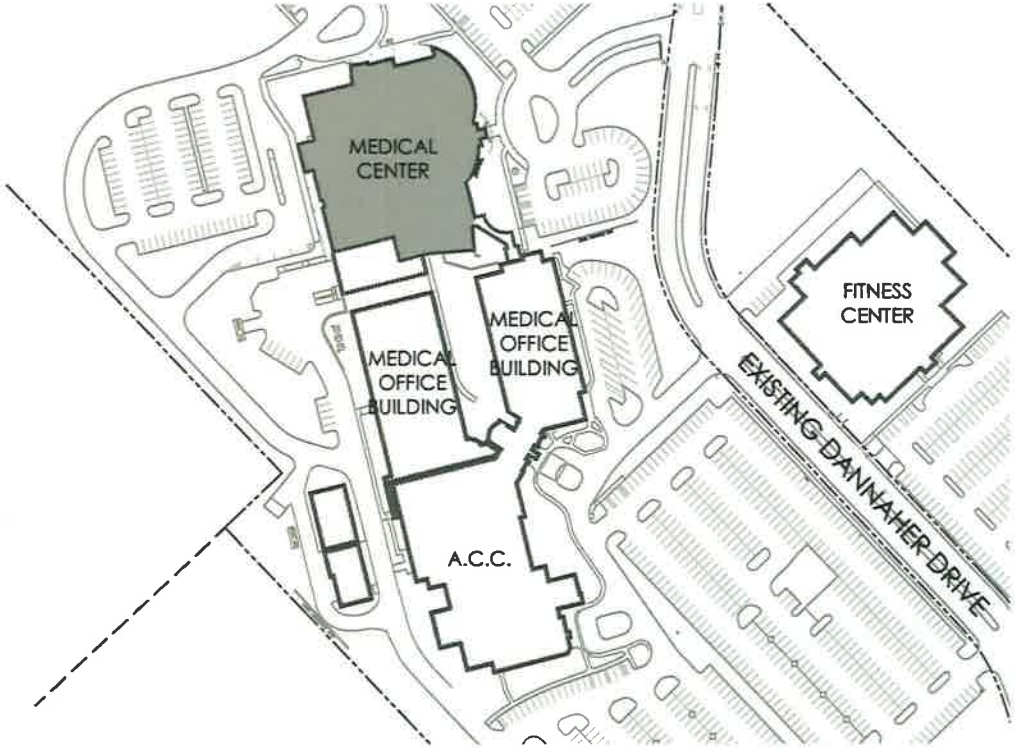
Attachment 5





27NOV2012

1 PLOT PLAN | 37.14 ACRES
CATH LAB RENOVATION C.O.N.
TENNOVA NORTH KNOXVILLE MEDICAL CENTER

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Attachment 8

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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.

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Attachment 12

Cardiac Catheterization Lab Utilization Data - 2009 - 2011

Facility	# of Cath Labs	2009 Total Procedures	2010 Total Procedures	2011 Total Procedures	Total Procedures - Annual Average	Procedures Per Lab - Annual Average	% of Capacity, 2009 - 2011
Physicians Regional	4	6,633	7,505	5,858	6,665	1,666	83.3%
Turkey Creek	2	2,580	3,394	2,748	2,907	1,454	72.7%
Ft. Sanders Regional	4	6,404	5,590	4,449	5,481	1,370	68.5%
Parkwest	5	13,741	13,399	12,800	13,313	2,663	133.1%
Methodist of Oak Ridge	2	3,286	3,061	3,184	3,177	1,589	79.4%
Morristown Hamblen	2	2,849	3,286	3,345	3,160	1,580	79.0%
LeConte	1	160	170	484	271	271	13.6%
UTMC	4	6,679	7,050	6,191	6,640	1,660	83.0%
Totals and Ave. Utilization	**24**	**42,332**	**43,455**	**39,059**	**41,615**	**1,734**	**86.7%**

*Note - Only adult patients considered. No pediatric patients included.
Source - 2010 - 2012 JARs

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Attachment 14

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North Knoxville Medical Center Cardiac Catheterization / Vascular Lab Project
Moveable Equipment Over $50,000

Catalog #	Catalog Item/Desciption	QTY	Unit Price	Total Price
ALL1302	MONITORS	1	$ 162,681.00	$ 162,681.00
ALL1953	SYSTEMS, NURSE CALL	1	$ 68,000.00	$ 68,000.00
MON1652	MONITOR, PHYSIOLOGICAL, ECG/NIBP/SAO2	6	$ 11,750.00	$ 70,500.00
MON4201	MONITOR, PHYSIOLOGICAL, CARDIAC CATH	1	$ 165,000.00	$ 165,000.00
PAC1801	PAC'S IMAGING SYS, READING STATION	1	$ 175,000.00	$ 175,000.00
PAC2350	PAC'S IMAGING SYS, WORK STATION	3	$ 30,000.00	$ 90,000.00

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Attachment 16

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HISTORICAL DATA CHART

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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 (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**	**$8,994,782**	**$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**

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HISTORICAL DATA CHART-OTHER EXPENSES

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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**

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Attachment 17

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PROJECTED DATA CHART

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

		Year 1	Year 2
A.	Utilization Data (Procedures – Cardiac Catheterizations)	285	306
B.	Revenue from Services to Patients		
	1. Inpatient Services	$1,157,064	$1,388,477
	2. Outpatient Services	$3,471,192	$4,165,430
	3. Emergency Services	0	0
	4. Other Operating Revenue (Specify)_____	0	0
	Gross Operating Revenue	**$4,628,256**	**$5,553,907**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$3,494,333	$4,193,200
	2. Provision for Charity Care	41,275	45,220
	3. Provisions for Bad Debt	61,912	67,830
	Total Deductions	**$3,597,520**	**$4,306,250**
NET OPERATING REVENUE		**$1,030,736**	**$1,247,657**
D.	Operating Expenses		
	1. Salaries and Wages	$ 55,012	$66,014
	2. Physician's Salaries and Wages	0	0
	3. Supplies	111,000	133,200
	4. Taxes	8,918	10,702
	5. Depreciation	432,742	432,742
	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	0	0
	Total Operating Expenses	**$607,672**	**$642,658**
E.	Other Revenue (Expenses) -- Net (Specify)_____	$0	$0
NET OPERATING INCOME (LOSS)		**$423,064**	**$604,999**
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	**$423,064**	**$604,999**

SUPPLEMENTAL- # 1
November 28, 2012
11:05am

Attachment 18

SUPPLEMENTAL- # 1
November 28, 2012
11:05am

Charge Schedule - Diagnostic Cardiac Catheterization

CPT Code	DESCRIPTION	CHARGE	Medicare Allowable
75625	AORTOGRAM ABDOMINAL	$ 5,202.35	$ 1,936.69
75630	AORTOGRAM ABDOMINAL W/ RUNOFF	$ 5,202.35	$ 1,936.69
75605	AORTOGRAM THORACIC SERIAL S&I	$ 5,202.35	$ 1,936.69
92960	CARDIOVERSION ELECTIVE EXT T	$ 932.15	$ 346.42
93455	CORONARY ART/GRFT ANGIO S&I	$ 9,174.25	$ 2,523.10
93454	CORONARY ARTERY ANGIO S&I	$ 8,516.75	$ 2,523.10
93463	DRUG ADMIN & HEMODYNAMIC MEAS	$ 803.75	packaged
93005	EKG	$ 242.25	$ 24.82
G0278	ILIAC ANGIO W/ CARDIAC CATH	$ 1,714.00	packaged
93568	INJECT PULM ART HRT CATH	$ 1,714.00	packaged
36013	INTRO CATH MAIN PULMON ARTERY	$ 2,021.00	packaged
36010	INTRO CATH SUP/INF VENA CAVA	$ 1,950.00	packaged
96374	IV PUSH ONE/FIRST DRUG	$ 290.00	$ 32.32
93459	L HRT ART/GRFT ANGIO	$ 11,112.75	$ 2,523.10
93458	L HRT ARTERY/VENTRICLE ANGIO	$ 10,455.00	$ 2,523.10
93622	LEFT VENTRICULAR RECORDING 02	$ 10,632.00	packaged
33010	PERICARDIOCENTESIS; INITIAL	$ 2,625.00	$ 357.62
93457	R HRT AR/GRFT ANGIO	$ 16,099.25	$ 2,523.10
93456	R HRT CORONARY ARTERY ANGIO	$ 15,441.75	$ 2,523.10
93461	R&L HRT ART/VENT GRFT ANGIO	$ 11,950.00	$ 2,523.10
93460	R&L HRT ART/VENTRICLE ANGIO	$ 11,249.50	$ 2,523.10
93453	R&L HRT CATH W/ VENTRICLGRPHY	$ 9,638.25	$ 2,523.10
75724	RENAL ANGIO BILAT	$ 2,937.75	packaged
G0275	RENAL ANGIO W/ CARDIAC CATH	$ 1,447.00	packaged
93451	RIGHT HEART CATH	$ 7,248.50	$ 2,523.10
93503	SWAN GANZ INSERT	$ 2,680.00	$ 1,065.46

SUPPLEMENTAL- # 1
November 28, 2012
11:05am

Attachment 20

SUPPLEMENTAL- # 1
November 28, 2012
11:05am

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.

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

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

By [illegible]
COMMISSIONER

SUPPLEMENTAL- # 1
November 28, 2012
11:05am

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

SUPPLEMENTAL- # 1

November 28, 2012
11:05am

FORM APPROVED
OMB NO. 0938-0391

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 _____ 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 000	INITIAL COMMENTS 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. 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 [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: 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. The findings included: Building A Review of facility policy titled "Restraints" dated	A 167	A 167: Patient Rights/Restraints: 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 CEO - Tennova (X6) DATE

/ 'eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that c 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

STATEMENT OF DEFICIENCIES / 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 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 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..." Patient #16 was admitted to the facility on December 20, 2012, with diagnoses including Respiratory Failure. 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. 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. Building C Patient #35 was admitted to the facility on December 22, 2011 with diagnoses to include Myocardial Infarction, Respiratory Failure, and Acute Renal Failure. 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.	

SUPPLEMENTAL- # 1

November 28, 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES 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: 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 tubes and catheters. Continued review revealed no documentation regarding the time limit for use of the restraint. 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 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. 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. The findings included: Building A. 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. 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 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.	

SUPPLEMENTAL- # 1

November 28, 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES 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 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 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". 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." 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. 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 All patient medical record entries must be legible, complete, dated, timed, and authenticated in	A 450		

SUPPLEMENTAL- # 1

November 28, 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES 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 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 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: Building A 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. The findings included: Building A 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..." 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 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. 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.	

SUPPLEMENTAL- # 1

November 28, 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

(X1) STATEMENT OF DEFICIENCIES A. 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 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. 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. 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 (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. (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 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	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

TEMENT OF DEFICIENCIES 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 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 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: 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. The findings included: Building A Patient #7 was admitted to the facility on January 9, 2012, for a Discectomy. 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. Patient #8 was admitted to the facility on January 9, 2012, for an ACD&F (Anterior Cervical Discectomy and Fusion). 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 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	

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A 454	Continued From page 7 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. 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. 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..." 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 [All records must document the following, as appropriate:] 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 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	

SUPPLEMENTAL- # 1

November 28, 2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 466	Continued From page 8 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. The findings included: Building A Patient #2 was admitted to the facility on January 8, 2012, with diagnoses including Respiratory Failure, Congestive Heart Failure, and Osteomyelitis. 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. 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. 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..." 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	

SUPPLEMENTAL- # 1

November 28, 2012
11:05am

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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 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. 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. The findings included: Building A 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. 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 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. 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.	

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A 503	Continued From page 10 biologicals must be locked or stored in a locked storage room...all drugs and biologicals must be secure..." 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 Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to remove expired drugs from patient use. The findings included: Building B 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. Review of facility policy titled, "Storage:General", last revised June 24, 2009, revealed,	A 505	A 505: Unusable Drugs 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. 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	

SUPPLEMENTAL- # 1

November 28, 2012
11:05am

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A 505	Continued From page 11 "Medications shall be stored under proper conditions of sanitation..." 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 Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure supplies were not avaliable beyond the expiration date in the Interventional Radiology department. The findings included: Building A 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. 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. 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.	

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A 724	Continued From page 12 of June, 2009 and four #11 Scalpel Blades with an expiration date of May, 2006 in the cabinet and were expired. 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 The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: 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 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. 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	

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A 749	Continued From page 13 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. The findings included: Building A 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. 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. 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. 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. 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	

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A 749	Continued From page 14 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. 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..." 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). Medical record review of a physician's progress note dated January 5, 2012, revealed, "...MRSA facial abcess." 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. 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. 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. 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	

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A 749	Continued From page 15 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. 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. 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. 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. 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. 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. 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. 7. Emesis basins were immediately removed from nursing work areas on	

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A 749	Continued From page 16 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. 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. 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..." Building C 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.	

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(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. 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. 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..." 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. 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. 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		

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	440120		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

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A 749	Continued From page 18 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). Continued medical record review revealed no order to discontinue the Neutropenic Precautions. 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. 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. 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. 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		

SUPPLEMENTAL- # 1

November 28, 2012
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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	

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A 749	Continued From page 19 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 Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: 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. The findings included: Building A 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 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.	

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A 951	Continued From page 20 earlier) on two trays. 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. 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. 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		

SUPPLEMENTAL- # 1

November 28, 2012

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STATEMENT OF DEFICIENCIES / 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	

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A 951	Continued From page 21 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..." 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		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 440120	(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	

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K 020	NFPA 101 LIFE SAFETY CODE STANDARD 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.	K 020		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor vertical shafts were maintained. The findings include: 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.		[redacted] DUMBWAITER SHAFT PERMANENTLY SEALED AND RATED 1-20-12 [illegible]	
K 025	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 025	[redacted]	
	This STANDARD is not met as evidenced by:			

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

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	440120	A. BUILDING 01 - MAIN 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

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K 025	Continued From page 1 Based on observation and interview, the facility failed to assure smoke barrier fire ratings are maintained. The findings include: 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 BM	
K 045	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: 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). The findings include: 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.	K 045	New multi-lamp fixture installed 1-12-12 BM	
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant	K 072		

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	440120	A. BUILDING 01 - MAIN B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY MEDICAL CENTER	800 EAST OAK HILL AVENUE KNOXVILLE, TN 37917

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K 072	Continued From page 2 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	K 072		
	This STANDARD is not met as evidenced by: 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.) The findings include: 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).		Furniture removed day of survey 1-10-12 [illegible]	
K 075	NFPA 101 LIFE SAFETY CODE STANDARD 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]	

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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 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
K 075	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure combustible decorations were fire retardant (NFPA 110, 19.7.5.4). The findings include: 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 BM	
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure electrical junction boxes had their covers installed. (NFPA 70, 314.28 (C). The findings include: 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 Pavilion 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 BM	

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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 B. WING _____	01/12/2012

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
K 000	INITIAL COMMENTS 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

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SUPPLEMENTAL- # 1
November 28, 2012
11:05am

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 B. WING	01/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY MEDICAL CENTER	900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917

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K 000	INITIAL COMMENTS 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

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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		

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H 001	1200-8-1 Initial This Rule is not met as evidenced by: 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. 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 (1) Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 4. The competency of all staff is evaluated at least annually; and This Rule is not met as evidenced by: Based on review of employee records the facility failed to ensure employees received annual competency testing for one (#7) of fifteen	H 605		

SUPPLEMENTAL- # 1
November 28, 2012
11:05am

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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		

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H 605	Continued From page 1 employees reviewed. The findings included: Building A Review of the record of employee #7 revealed no documentation of completion of annual unit-based competency testing for 2011. 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...". 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		

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November 28, 2012
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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
P 002	1200-8-30 No Deficiencies 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. 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. 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

TITLE (X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

SUPPLEMENTAL- # 1
November 28, 2012
11:05am

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 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

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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 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

TITLE (X6) DATE

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Division of Health Care Facilities

2012 NOV 28 AM 11 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - TURKEY CREEK MEDICAL 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		

(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 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