HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
MARCH 26, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	Shelby County Health Care Corporation d/b/a Regional One Health f/k/a the Regional Medical Center at Memphis (The MED)
PROJECT NUMBER:	CN1311-044
ADDRESS:	877 Jefferson Avenue Memphis (Shelby County), Tennessee 38103
LEGAL OWNER:	Shelby County Health Care Corporation 877 Jefferson Avenue Memphis (Shelby County), Tennessee 38103
OPERATING ENTITY:	NA
CONTACT PERSON:	E. Graham Baker, Jr. (615) 370-3380
DATE FILED:	November 15, 2013
PROJECT COST:	$300,000
FINANCING:	Cash Reserves
REASON FOR FILING:	The establishment of a twenty (20) bed nursing home that is dually certified for Medicare/Medicaid. ***The twenty (20) nursing home beds are subject to the 125 bed Nursing Home Bed Pool for the July 2013 to June 2014 state fiscal year period.***

DESCRIPTION:

Shelby County Health Care Corporation d/b/a Regional One Health is seeking approval to establish a twenty (20) bed nursing home that will operate as a department of the hospital. The beds will be dually certified for Medicare/Medicaid. At the time the application was filed, the applicant had

been operating under the d/b/a of The Regional Medical Center at Memphis more commonly referred to as The MED. According to Monica Wharton, Chief Legal Officer and General Counsel, the 20-bed nursing home, if approved, will most likely be referred to as the Transitional Care Unit.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW:

NURSING HOME SERVICES

A. Need

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

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

See step 2 below for the Nursing Home Bed Need calculation.

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

Based on the 2016 projected population for Shelby County and using the above formula, the need calculation is 5,094 nursing home beds for the applicant's declared service area, Shelby County.

It appears that this criterion has been met.

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

According to the Tennessee Department of Health's website, there currently are 3,976 nursing home beds in Shelby County. There are also 198 outstanding CON-approved but unimplemented beds in Shelby County for a current inventory of 4,174 nursing home beds. By

subtracting the 4,174 nursing home bed inventory from the 5,094 nursing home beds needed, the result is a net need for 920 nursing home beds in Shelby County.

It appears the application meets this criterion.

Note to Agency Members Regarding Bed Need Formula: The formula was included in a 1996 amendment to the statute governing the development of new nursing home beds. The formula was based upon a population-based methodology that did not consider levels of care (skilled or non-skilled) or payment sources (Medicare, Medicaid, 3rd party). Institutional care was the norm and there were limited, if any, home and community-based care options. The Long-Term Care Community Care Community Choices Act of 2008 (CHOICES) and the 2012 changes in Nursing Facility Level of Care Criteria for TennCare recipients have impacted nursing home occupancies in TN. According to TCA § 68-11-1622, the Agency shall issue no certificates of need for new nursing home beds other than the one hundred twenty-five beds included per fiscal year (commonly referred to as the 125-bed pool). These beds must be certified to participate in the Medicare skilled program. This does not preclude a nursing home from dually certifying beds for both Medicare and Medicaid. This applicant has requested Medicare/Medicaid certified beds.

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

   The applicant states the project's proposed service area is Shelby County. The applicant indicates that 88.5% of ROH's patients reside in Shelby County.

   It appears that this criterion has been met.

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

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

It appears that this criterion is not applicable since the twenty (20) proposed nursing home beds are not in excess of the need standard of the 1990s formula.

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

It appears that this criterion is not applicable since the twenty (20) proposed nursing home beds are not in excess of the need standard of the 1990s formula.

B. Occupancy and Size Standards:

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

The applicant projects 6,178 patient days during the second year of operation which equates to an 84.6% occupancy rate. The applicant expects to attain 90% occupancy by the third year of operation

Since the applicant does not project to attain 90% occupancy by the second year of operation, it appears that this criterion has not been met.

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

According to the Department of Health Report, there were 26 nursing homes in 2012 with more than 50 beds. Six of those 26 nursing homes had occupancy rates greater than 95%.

It appears that this criterion has not been met.

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

   Since this application is for the establishment of a nursing home, it appears that this criterion is not applicable.

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

   This applicant is requesting twenty (20) nursing home beds. This project is not in a rural area nor part of a continuing care retirement center.

   It appears that this criterion has not been met.

STAFF SUMMARY

Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italics.

The applicant describes this project as a twenty (20) bed skilled nursing unit licensed as nursing home beds that will operate as a unit of the hospital. The beds will be certified for both Medicare and Medicaid. The applicant expects that all admissions will be referred from ROH.

The applicant expects to open the skilled nursing home in June 2014.

125 Bed Nursing Home Bed Pool

- The applicant is requesting 20 new beds which will come from the Nursing Home 125 bed pool for the July 2013 to June 2014 state fiscal year period.
- There are currently 45 nursing home beds available in the July 2013 to June 2014 bed pool. Including this application there are currently two applications pending requesting a total of 50 beds. Both applications are in Shelby County.
- A copy of the 125 bed pool bed stats is located at the end of this summary.

Ownership/Management

- The proposed 20 bed nursing home will be owned by Shelby County Health Care Corporation d/b/a Regional One Health.
- ROH is self-managed; however the applicant is considering the possibility of hiring a management entity that specializes in managing skilled nursing facilities. A decision on a management contract has not been made; however the applicant included an annual expense of $90,000 in the Projected Data Chart for a management fee in case a management contract is executed.

Facility Information

The applicant proposes to place the 20 bed skilled nursing home in the Adams Building on the hospital campus. The skilled beds will be placed on the third floor where a twenty (20) bed inpatient rehabilitation unit is currently housed. The rehabilitation unit will be moved to the Turner Tower on the hospital campus as part of a previously approved but unimplemented CON (CN1208-037A).

Note to Agency members: The Adams Building was constructed in 1945. The applicant was asked by HSDA staff to discuss the placement of a skilled nursing home into a facility that was almost 70 years old. The applicant provided a letter from an architect that included the following statement "To the best of our knowledge based on visual observation and review of existing construction documents of the proposed location, it appears that the evacuated inpatient rehabilitation, meets the standards and guidelines for a nursing home."

According to the floor plan in addition to the space for eight private rooms and six semi-private rooms, the unit will have space available for a gym, dining room, treatment rooms, and offices. The new space will just need to be painted and new furnishings such as beds, tables, and chairs will be brought into the space. The size of the space is 16,910 gross square feet.

Project Need

The applicant provided the following justification:

- The current bed need formula identified a net need for 920 nursing home beds in Shelby County.
- The actual "need" for nursing home beds is of little consequence for this project, since ROH currently provides care for skilled nursing patients within existing hospital beds, which is more costly. It is anticipated that all of the patients in the proposed skilled nursing unit will be referred by ROH. Moving skilled nursing patients to a skilled nursing unit on campus will result in a cost savings to the hospital.
- The applicant performed an internal study based on discharges over a twelve month period and the applicant's highest discharge ZIP Codes demonstrated a need for 20 skilled beds and for all discharges was 35 beds.
- Existing nursing homes are reluctant to accept referral of patients who have little or no ability to pay for such care. The implementation of this

new SNF unit by the applicant will have no negative impact on area skilled nursing facilities.

Note to Agency members: While the applicant projects 50% of the patients will be uninsured, the applicant projects that the other 50% of the patients will be Medicare. The reduction of referring Medicare patients to area skilled nursing facilities may have a negative impact.

Service Area Demographics

ROH's declared primary service area is Shelby County. The following review of demographic data will be for Shelby County.

- The total population of Shelby County is estimated at 943,812 residents in calendar year (CY) 2014 increasing by approximately 0.6% to 949,178 residents in CY 2016.
- The overall statewide population is projected to grow by 1.8% from 2014 to 2016.
- The Shelby County population cohort of age 65 and older presently accounts for approximately 11.5% of the total population compared to a state-wide average of 14.9% in CY 2014.
- The 65 and older population will increase from 11.5% of the general population in 2014 to 12.3% in 2016. The statewide 65 and older population will increase from 14.9% in 2014 of the general population to 15.5% in 2016.
- The 65 and older population will increase 7.5% between 2014 and 2016 in Shelby County. The statewide 65 and older population will increase 6.1% during the same timeframe.
- The proportion of TennCare enrollees of the total county population is 24.3%, compared with the state-wide average of 18.4%.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Historical Utilization

- The applicant is proposing the establishment of a 20 bed nursing home so that there is no historical utilization to report for the applicant.
- The individual nursing home utilization trend table for Shelby County at the end of this summary reflects the following: Shelby County nursing

homes reported 1,300,573 patient days in 2010, which have decreased by 22,440 or 1.7% in 2012.

- Even though patient days experienced a decline between 2010 and 2012 area wide nursing home occupancy increased form 83.7% in 2010 to 87.1% in 2012. This trend was impacted by the fact that there were 4,261 licensed nursing home beds in 2010, reducing to 4,169 in 2011, and reducing further to 4,020 in 2012. The occupancy ranges for the 31 nursing homes reporting in 2012 was as follows:
    - 6 nursing homes reported occupancy of greater than 95%.
    - 7 nursing homes reported occupancy in the 90% - 95% range
    - 13 nursing homes reported occupancy in the 80% - 89% range
    - 4 nursing homes reported occupancy in the 70% - 79% range
    - 1 nursing homes reported occupancy below 70%
- According to 2012 Final JAR data, of the 4,020 nursing home beds in Shelby County during 2012, 3,465 or 86.2% were Medicare certified skilled nursing beds. Review of the 2012 Nursing Home JAR indicated that the Medicare skilled average daily census was 652. This indicates that the skilled nursing home beds in Shelby County were utilized by Medicare skilled patients approximately 18.8% of the time. The details of skilled vs. non skilled utilization by nursing home in Shelby County are presented in a table at the end of this summary.

Note to Agency Members: Declining patient days are most likely attributed to the implementation of the 2008 CHOICES Act and the 2012 changes to the TennCare Level of Care Criteria. Occupancy rates most likely increased because most nursing homes de-license excess beds to avoid the $2,225 per bed nursing home annual assessment (bed tax) fee. This assessment fee is in addition to annual licensure fees. All nursing homes pay this fee whether they have certified beds or not. These fees and any federal matching fees made relative to the nursing home annual assessment are used solely by TennCare to provide payments to nursing homes.

Projected Utilization

Regional One Health (20 Bed Skilled Nursing Unit)

Year	Licensed Beds	*Medicare-certified beds	SNF Medicare ADC	SNF Medicaid ADC	SNF All other Payors	Non-Skilled ADC	Total ADC	Licensed Occupancy
1	20	20	8	0	8	0	16	80%
2	20	20	8.5	0	8.5	0	17	85%

* Includes dually-certified beds

- The above table projects that occupancy will be 80% in the first full year of operation and increase to 85% by the second year of operation.
- In Year 2, on average the 20 Medicare/Medicaid skilled beds will contain 8.5 Medicare skilled patients and 8.5 other payor (Uninsured) skilled patients.

Note to Agency Members: The applicant is planning for the 20 SNF beds to be both certified for Medicare and Medicaid. The applicant indicates in the second supplemental response that "a TennCare patient may wind up in our SNF" but goes on to state that "However we believe such possibility is (1) remote, and (2) will be for such a short period of time that we have no financial or other projections for that to happen. We will continue to try to transfer hospital patients who need nursing facility care and who are TennCare-eligible to area facilities."

The applicant goes on to state that "The number of TennCare patients eligible for SNF care who are admitted at The MED was negligible. Most of our TennCare patients are either OB patients or children. They are not eligible for SNF care. The remaining patients who would normally be eligible for TennCare who require SNF care are also eligible for Medicare."

The applicant also stated that "we do not plan to accept patients from other hospitals or other admission sources. With that said we will not refuse to accept a patient for which we can provide care." The applicant provides further rationale for this project on page 6 of the supplemental response.

Staff is concerned that the projection of zero TennCare utilization is an unrealistic assumption because the facility has indicated it will seek dual certification for Medicare and Medicaid. All certified facilities must comply with federal regulations

governing admission, transfer, and discharge rights (CFR 483.12) regardless of payor source. Additionally, since this facility is seeking Medicaid certification, it would be subject to the Linton Consent Decree which is explained in more detail below. An explanation of Linton follows:

A legal precedent was established in the Linton Ruling, a Tennessee lawsuit settled in 1990. Mildred Lea Linton, a nursing home resident, represented a class of plaintiffs who alleged that Tennessee's nursing home bed certification policy, in which fewer than all beds within a particular wing or floor could be available for Medicaid recipients, violated the Medicaid Act. Ms. Linton's nursing home apportioned only 40 of its 87 intermediate care facility beds as Medicaid beds. When Medicaid officials reduced Ms. Linton's care eligibility from skilled to intermediate, Ms. Linton's nursing home informed her that it was decertifying her Medicaid bed and would not likely have available any Medicaid beds. The District Court found that Tennessee's "limited bed policy" violated the Medicaid Act, and the state was instructed to submit a remedial plan, which, among other provisions, required Medicaid providers to certify all available, licensed nursing home beds within their facilities and to admit residents on a first-come, first-serve basis."

Agency members may want to ask the applicant to further explain the rationale behind the proposed payor mix of the facility and how it will handle potential Medicaid (TennCare) admissions.

Project Cost

The total estimated project cost is $300,000.

Major costs are:

- Moveable Equipment (beds, tables, chairs, etc.)-$209,872 or 70% of total cost
- Construction (Renovation-Painting)-$37,128 or 12.4% of total cost

For other details on Project Cost, see the Project Cost Chart in the original application.

The construction cost is $2.20 per square foot. As reflected in the table below, the renovated construction cost is approximately $17/square foot below the 1st quartile of $19.30/square foot of statewide nursing home renovated construction projects from 2010 to 2012.

Statewide
Nursing Home Construction Cost Per Square Foot
2010-2012

	Renovated Construction	New Construction	Total construction
1st Quartile	$19.30/sq. ft.	$164.57/sq. ft.	$73.23/sq. ft.
Median	$35.76/sq. ft.	$167.31/sq. ft.	$166.57/sq. ft.
3rd Quartile	$55.00/sq. ft.	$181.72/sq. ft.	$167.61/sq. ft.

Source: HSDA Applicant's Toolbox

Note to Agency Members: It is unknown how the proposed space can be renovated to meet nursing home standards with a stated construction cost of only $37,128 which would suggest minor renovations and upgrades. A previous application filed by this applicant in 2012, CN1208-037A, noted that all inpatient services were being relocated from the Adams Building which was built in 1945. That application noted that only two buildings on campus, Turner Tower and Medplex, met seismic safety standards at the time they were built. That application also noted the Adams Building was well beyond its lifespan and cited the following concerns: lack of energy efficient mechanical and electrical systems, antiquated physical plant, and prohibitive cost of attempting to upgrade the building to current hospital codes. Since this application is for a newly licensed nursing home, it will have to meet current codes so Agency members may want to inquire how that can be accomplished.

Historical Data Chart
ROH reported net operating income of $5,532,000 in 2010, $74,433,000 in 2011, and $51,184,000 2012.

Projected Data Chart
The applicant projects $1,268,398 in total gross revenue on 5,815 patient days during the first year of operation of the 20 bed skilled nursing unit and $1,388,043 on 6,178 patient days in Year Two (approximately $224.68 per day). The Projected Data Chart reflects the following:

- Net operating income less capital expenditures for the applicant will equal ($1,175,088) in Year One and ($1,372,283) in Year Two and ($1,323,643) in Year Three. The applicant acknowledges the trend of projected net operating losses. This is due to 50% of the patients expected to be uninsured and non-paying. The applicant explains that it is less costly to place an uninsured patient in a SNF bed than an acute hospital bed. The

applicant goes on to state that even though the SNF unit will lose $1,323,645 in Year 3, the overall hospital savings will be $2,811,960 by placing SNF-eligible patients in a SNF bed rather than an acute hospital bed.

Note to Agency members: Since the applicant is expecting Medicare revenue of $634,199 and no other revenue from uninsured patients, it is unclear how the applicant expects to obtain net revenues in excess of $1.2 million. With net revenues of $634,199 projected losses could be greater than reported in the Projected Data Chart. Agency members may want to inquire about the applicant's projected revenue and operating losses.

Charges

In Year One of the proposed project, the average patient daily charges are as follows:

- The proposed average per diem charge is $218.13/day in Year 1.
- The average bad debt reduction $6.54/day, producing an average net per diem charge of $211.59/day.

Payor Mix

- Medicare- Net charges will equal $634,199 in Year One representing 50% of total net revenue.
- Even though the applicant plans for the skilled nursing unit to be Medicaid certified, other than the potential for uninsured patients to qualify for Medicaid, the applicant is not projecting any Medicaid utilization or revenue.
- The applicant expects that 50% of the unit will be occupied by uninsured patients, which means zero revenue.

Note to Agency members: As noted previously, staff questions whether zero Medicaid utilization is a realistic projection.

TennCare reimburses nursing homes for two distinct levels of care provided to Medicaid eligible recipients, Level 1 and Level 2. Level 1 reimbursement is for non-skilled care while Level 2 is for skilled services requiring nursing care and/or rehabilitation therapies. In 2012, TennCare further refined its Level of Care criteria with a weighted scale that measures acuity in several areas: functional areas such as activities of daily living, clinical needs such as the need for skilled nursing or rehabilitation services, and other factors that help determine whether an individual can live safely and independently.

Even though many patients Age 65+ will qualify for Medicare, the applicant is projecting that half the patients will be under Age 65 and be uninsured. If any of these patients do qualify for TennCare, the applicant states that projected losses will be reduced.

Financing

The applicant has stated that the project will be funded through cash reserves. A November 14, 2013 letter in the original application from Senior Executive Vice-President & CFO J. Richard Wagers, Jr. indicated that ROH has sufficient cash reserves to fund this $300,000 project.

Shelby County Health Care Corporation's audited financial statements for the period ending June 30, 2013 indicates $15,471,067 in cash and cash equivalents, total current assets of $194,419,642, total current liabilities of $39,561,383 and a current ratio of 4.91:1.

Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Staffing

The applicant states that existing hospital staff will be transferred to the facility so that no additional staff will need to be hired. The direct patient care proposed staffing for the 20 bed SNF unit in Year 1 is presented in the table below:

Position	Year 1 FTEs
RNs	5.0
LPNs	4.0
CNA	5.0
Resp. Therapists	3.0
*Physical Therapy	1.5
*Occupational Therapy	1.0
*Speech Therapy	0.5
MDS Coordinator	1.0
Activity Coordinator	0.5

**Contractual*

Licensure/Accreditation

- The nursing home at RHO will seek licensure from the Tennessee Department of Health and certification by Medicare and Medicaid
- RHO is accredited by the Joint Commission and CARF.

Corporate documentation, draft management agreement, real estate deed, and policy manuals are on file at the Agency office and will be available at the Agency meeting.

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

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

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

Outstanding Certificates of Need

Shelby County Health Care Corporation d/b/a The Regional Medical Center at Memphis, CN1208-037A, has an outstanding Certificate of Need that will expire on January 1, 2016. It was approved at the November 14, 2012 Agency meeting to convert ten (10) medical surgical beds to ten (10) inpatient rehabilitation beds, add three operating rooms (ORs) dedicated to outpatient surgery in the Turner Tower, and renovate and relocate medical surgical beds to the Turner Tower, one of the newer buildings on the MED campus built in 1992. The estimated project cost is **$28,400,000.00. Project Status:** *A representative of the applicant reported in a 3/10/14 email that the Turner Tower project is 99% complete. The rehabilitation unit and the surgery center are occupied. The second floor has not opened yet but is structurally complete. All areas have received final licensure inspection. The applicant is awaiting final approval from licensure.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no Letters of Intent or denied applications for other similar providers in the service area.

Pending Application

Ave Maria Home, CN1312-048, has a pending application that is scheduled to be heard at the April 23, 2014 Agency meeting. The application is for the replacement of thirty-five (35) of the current seventy-five (75) skilled nursing facility (SNF) beds at 2805 Charles Bryan Road, Bartlett (Shelby County) and the addition of thirty (30)* Medicare certified SNF beds at 2840 Charles Bryan Road, Bartlett (Shelby County). If approved, the nursing home will have a total of one hundred five (105) licensed beds. The estimated project cost is **$7,982,000.00**
**These beds are subject to the 2013-2014 Nursing Home Bed Pool.*

Outstanding Certificates of Need

The Farms at Bailey Station, CN1311-045A, has an outstanding Certificate of Need that will expire on April 1, 2017. It was approved at the February 26, 2014 Agency meeting for the establishment of a thirty (30)* SNF bed nursing home certified for Medicare participation to be part of a continuing care retirement community. The estimated project cost is **$7,301,961.00. Project Status:** *The applicant plans to combine this outstanding CON with previously approved but unimplemented CN1303-008 for 30 SNF beds for the development of a 60 bed nursing home.*

The Village at Germantown, CN1310-039A, has an outstanding Certificate of Need that will expire on March 1, 2016. It was approved at the January 22, 2014 Agency meeting for the addition of twenty (20) Medicare-certified skilled beds to its existing thirty (30) Medicare skilled bed nursing home. The estimated project cost is **$5,654,232.00. Project Status:** *Recently approved.*

The Farms at Bailey Station, CN1303-008A, has an outstanding Certificate of Need that will expire on August 1, 2016. It was approved at the June 26, 2013 Agency meeting for the establishment of a thirty (30)* SNF bed nursing home certified for Medicare participation to be part of a continuing care retirement community. The estimated project cost is **$7,301,961.00. Project Status:** *The applicant will combine this outstanding but unimplemented CON with outstanding CN1311-045 for an additional 30 SNF beds for the development of a 60 bed nursing home.*

Collins Chapel Health & Rehabilitation Center, CN1202-011A, has an outstanding Certificate of Need which will expire on August 1, 2015. The CON was approved at the June 27, 2012 Agency meeting for the establishment of a

nursing home with twenty-eight (28) Medicare SNF beds and to provide skilled nursing services facility services. The estimated project cost is **$1,626,331.** *Project Status Update: The applicant received approval at the February 26, 2014 Agency meeting for a one year extension until August 1, 2015. When requesting the extension the applicant noted that its architects has filed plans with the Tennessee Department of Health for approval. Because of certain needs for architectural plan redesign, the initiation of the filing of the final plans had to be delayed until January 2014. Given the unexpected delay in plan completion, the extension request was filed.*

Christian Care Center of Memphis f/k/a Americare Health and Rehabilitation, CN0908-045A has an outstanding Certificate of Need which will expire on January 1, 2016. The CON was approved at the November 18, 2009 for the partial relocation and replacement of a health care facility (in accordance with TCA 68-11-1629): relocation of ninety (90) of two hundred and thirty seven (237) nursing home beds from 3391 Old Getwell Road in Memphis (Shelby County), TN to a 3.15 acre parcel of land at the northwest corner of Kirby Parkway and Kirby Gate Blvd in Memphis (Shelby County), TN. The estimated cost is **$10,473,976.** *Project Status Update: The applicant received approval at the October 23, 2013 Agency meeting for a $1,853,976 project cost increase and a two year extension of the expiration date from January 1, 2014 to January 1, 2016. In the Annual Progress Report dated December 20, 2013 the applicant reported that the City of Memphis issued its building permit on December 18, 2013, and the project is currently staffed with an on-site full time project manager from the contractor. Grading and fill work has begun on the project site along with temporary placement of electrical power. The contractor anticipates work to begin on the foundation of the building in the next 45-60 days.*

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

MAF 3/13/2014

NURSING HOME BED POOL STATS

July 1, 2013 – June 30, 2014

125 BED POOL

NH BEDS APPROVED	80 NURSING HOME BEDS
NH BEDS PENDING	50 NURSING HOME BEDS
SWING BEDS APPROVED	0 SWING BEDS
SWING BEDS PENDING	0 SWING BEDS
TOTAL BEDS DENIED/WITHDRAWN	0 BEDS
SUBTOTAL-- BEDS REQUESTED	130 BEDS
TOTAL BEDS AVAILABLE FROM POOL	**45 BEDS**
(TOTAL PENDING BEDS)	(50 BEDS)

COUNTY	PROJECT NUMBER	FACILITY	PROJECT DISPOSITION	MEETING DATE	DESCRIPTION
Knox	CN1307-024	Shannondale Rehabilitation Center	APPROVED	10/23/2013	The establishment of a new thirty (30)* bed Medicare skilled nursing home to be known as Shannondale Rehabilitation Center. The facility will be located on the campus of Shannondale Continuing Care Retirement Community at 7510 and 7522 Middlebrook Pike, Knoxville (Knox County), TN. The estimated project cost is $6,609,488.00.
Shelby	CN1310-039	The Village at Germantown Skilled Nursing Facility	APPROVED	1/22/2014	The addition of twenty (20) Medicare-certified skilled beds to its existing thirty (30) Medicare skilled bed nursing home. The estimated project cost is $5,641,539.00.

Shelby	CN1311-044	Shelby County Health Corporation, d/b/a The Regional Medical Center at Memphis	**PENDING**	3/26/2014	The establishment of a twenty (20) bed nursing home certified for Medicare/Medicaid that will operate as a department of The MED. The estimated project cost is $300,000.00.
Shelby	CN1311-045	The Farms at Bailey Station	**APPROVED**	2/26/2014	The addition of thirty (30) Medicare-certified skilled beds to be part of the thirty (30) Bed SNF approved by CN1303-008A for a total of 60 SNF beds. The estimated project cost is $6,306,575.00.
Shelby	CN1312-048	Ave Maria Home	**PENDING**	4/23/2014	The replacement of thirty-five (35) of the current seventy-five (75) beds and the addition of thirty (30) Medicare-certified skilled beds for a total of one hundred five (105) licensed nursing home beds. The estimated project cost is $7,999,960.00.

SHELBY COUNY NURSING HOME UTILIZATION TRENDS, 2010-2012

Nursing Home	2012 Beds	2010 Pat. Days	2011 Pat. Days	2012 Pat. Days	10-'12 % Chg.	'10 % Occ.	'11 % Occ.	'12 % Occ.
Allen Morgan Health and Rehab Center	104	29,053	27,178	32,094	10.5%	76.5%	71.6%	84.5%
Allenbrook Nursing & Rehab Center	180	61,632	62,846	62,784	1.9%	93.8%	95.7%	95.6%
*Americare Health & Rehab Center	0	52,472	52,210	0	-100.0%	60.7%	97.3%	0.0%
Applingwood Healthcare Cntr.	78	27,076	24,486	26,651	-1.6%	95.1%	86.0%	93.6%
Ashton Place Health & Rehab Center	211	72,619	65,464	68,410	-5.8%	94.3%	85.0%	88.8%
Ave Maria Home	75	26,796	25,652	24,507	-8.5%	97.9%	93.7%	89.5%
Baptist Mem. Hospital-Memphis SNF	35	10,378	10,590	10,561	1.8%	81.2%	82.9%	82.7%
Baptist Skilled Rehab Unit-Germantown	18	324	5,123	5,423	1573.8%	4.9%	78.0%	82.5%
**Bright Glade Health and Rehab Center	77	25,709	25,451	25,867	0.6%	87.0%	86.1%	92.0%
Dove Health & Rehab of Collierville	114	27,733	34,996	35,754	28.9%	66.6%	84.1%	85.9%
Grace Healthcare of Cordova	284	86,103	74,167	72,642	-15.6%	83.1%	71.5%	70.1%
Graceland Nursing Center	240	82,117	76,445	75,843	-7.6%	93.7%	87.3%	86.6%
Harbor View f/k/a Court Manor	120	23,637	34,815	36,457	54.2%	54.0%	79.5%	83.2%
Primacy Healthcare & Rehab f/k/a Kindred	120	41,826	31,637	32,196	-23.0%	95.5%	72.2%	73.5%
Kirby Pines Manor	120	40,578	42,160	42,722	5.3%	92.6%	96.3%	97.5%
Memphis Jewish Home	160	48,726	44,394	42,920	-11.9%	83.4%	76.0%	73.5%
Methodist Healthcare SNF	44	5,472	5,370	6,623	21.0%	34.1%	33.4%	41.2%
MidSouth Health & Rehab.	155	17,147	29,172	49,201	186.9%	30.3%	51.6%	87.0%
Millington Healthcare Center	85	29,170	28,410	28,917	-0.9%	94.0%	91.6%	93.2%
Poplar Point f/k/a Overton Park	169	53,543	47,604	51,074	-4.6%	86.8%	77.2%	82.8%
Parkway Health and Rehab	120	36,359	42,549	42,102	15.8%	83.0%	97.1%	96.1%

Nursing Home	2012 Beds	2010 Pat. Days	2011 Pat. Days	2012 Pat. Days	10-'12 % Chg.	'10 % Occ.	'11 % Occ.	'12 % Occ.
Quality Care Center of Memphis	48	13,026	12,244	12,535	-3.8%	74.3%	69.9%	71.5%
Quince Nursing and Rehab Center	188	65,719	66,343	65,776	0.1%	95.8%	96.7%	95.9%
***Rainbow Health & Rehab of Memphis	115	38,767	39,763	39,641	2.3%	94.8%	94.7%	94.4%
Signature Healthcare St. Francis	197	72,715	62,807	61,821	-15.0%	101.1%	87.3%	86.0%
Signature Healthcare-St. Peter Villa	180	56,578	54,445	60,560	7.0%	86.1%	82.9%	92.2%
Signature Healthcare Memphis	140	49,005	48,440	49,467	0.9%	95.9%	94.8%	96.8%
Spring Gate Rehab and Healthcare	233	73,826	78,591	78,439	6.2%	86.8%	92.4%	92.2%
The Highlands of Memphis Health & Rehab	180	53,561	55,265	60,143	12.3%	81.5%	84.1%	91.5%
King's Daughters and Sons Home	108	38,768	37,908	38,653	-0.3%	98.3%	96.2%	98.1%
The Village at Germantown	30	10,002	9,371	9,462	-5.4%	91.3%	85.6%	86.4%
Whitehaven Community Living Center	92	30,136	30,268	28,888	-4.1%	89.7%	90.1%	86.0%
TOTAL	**4,020**	**1,300,573**	**1,286,164**	**1,278,133**	**-1.7%**	**83.7%**	**84.6%**	**87.1%**

**Americare was a 237 bed nursing home in 2010. In compliance with TCA 68-11-1629 and approval of CN0908-045A for partial relocation of 90 beds, Americare became a 147 bed nursing home in 2011. In 2012 Americare closed*
***Licensed for 81 beds in 2010 and 2011*
****Added 3 beds in 2011per approval of CN1003-012A*

Shelby County Nursing Home Skilled/Non-Skilled Utilization

Nursing Home	Licensed Beds	SNF Beds-Medicare	SNF/NF Beds-Dually Certified	NF Beds-Medicaid	Licensed Only Non Certified Beds	NF-ADC (Medicaid/ Level I Only)	SNF Medicare Level II ADC	NF-ADC
Allen Morgan Health and Rehabilitation Center	104	24	0	0	80	0	18	69
Allenbrooke Nursing and Rehabilitation Center, LLC	180	0	180	0	0	128	15	139
Applingwood Health Care Center	78	0	78	0	0	43	18	55
Ashton Place Health and Rehab Center	211	0	211	0	0	134	22	139
Ave Maria Home	75	0	75	0	0	22	9	58
Baptist Memorial Hospital - Memphis Skilled Nursing Facility	35	35	0	0	0	0	23	0
Baptist Skilled Rehabilitation Unit – Germantown	18	18	0	0	0	0	13	0
Bright Glade Health and Rehabilitation	77	0	77	0	0	43	14	56
Dove Health & Rehab of Collierville, LLC	114	0	114	0	0	64	16	75
Grace Healthcare of Cordova	284	0	284	0	0	129	22	149
Graceland Nursing Center	240	120	0	120	0	148	14	154
Harbor View Nursing and Rehabilitation Center, Inc.	120	0	120	0	0	72	19	80
Highlands of Memphis Health & Rehab	180	0	180	0	0	106	21	131
Kindred Transitional Care and Rehabilitation Center-Primacy	120	120	0	0	0	0	53	29
Kirby Pines Manor	120	30	0	0	90	0	23	89
Memphis Jewish Home	160	0	160	0	0	60	29	60
Methodist Healthcare Skilled Nursing Facility	44	44	0	0	0	0	15	0
MidSouth Health and Rehabilitation Center	155	0	155	0	0	92	15	113
Millington Healthcare Center	85	19	66	0	0	47	20	57
Parkway Health and Rehabilitation Center	120	0	120	0	0	66	24	74
Poplar Point Health and Rehabilitation	169	0	54	115	0	0	24	0
Quality Care Center of Memphis	48	0	48	0	0	34	0	34
Quince Nursing and Rehabilitation Center	188	0	188	0	0	108	28	134
Rainbow Health & Rehab of Memphis, LLC	115	0	115	0	0	70	26	78

Nursing Home	Licensed Beds	SNF Beds-Medicare	SNF/NF Beds-Dually Certified	NF Beds-Medicaid	Licensed Only Non Certified	NF-ADC (Medicaid/ Level I Only)	SNF Medicare Level II ADC	NF-ADC
Signature Healthcare at St. Francis	**197**	**84**	**113**	**0**	**0**	**76**	**51**	**94**
Signature Healthcare at St. Peter Villa	180	0	120	60	0	94	26	112
Signature Healthcare of Memphis	140	0	140	0	0	101	24	109
Spring Gate Nursing and Rehabilitation Center	233	0	143	90	0	144	22	158
The King's Daughters and Sons Home	108	0	108	0	0	60	16	79
The Village at Germantown	30	30	0	0	0	0	21	5
Whitehaven Community Living Center	92	0	92	0	0	63	11	64
Total	**4020**	**524**	**2941**	**385**	**170**	**1,903**	**652**	**2399**

Source: *Joint Annual Report of Nursing Homes 2012 (Final)*, Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics

LETTER OF INTENT

25

NOV 7 '13 PM12:35

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the *Commercial Appeal* (Name of Newspaper) which is a newspaper of general circulation in Shelby County (County), Tennessee, on or before November 10, 2013 (Month / day) (Year) for one day.

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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 Shelby County Health Care Corporation, d/b/a The Regional Medical Center at Memphis, 877 Jefferson Avenue, Memphis (Shelby County), Tennessee 38103 ("Applicant" or "The MED"), owned and managed by itself, is applying for a Certificate of Need for the establishment of a twenty (20) skilled bed nursing unit to be licensed as nursing home beds and operated as a department of The MED. The requested beds are subject to the FY 2013-2014 pool of nursing home beds authorized by T.C.A. § 68-11-1622. Due to the Linton Rule, all beds will be certified for both Medicare and Medicaid. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that the Applicant will serve Medicare, Medicaid, commercially insured, and private-pay patients, and the Applicant will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $300,000.00, plus filing fee.

The anticipated date of filing the application is: November 15, 2013.

The contact person for this project is E. Graham Baker, Jr. (Contact Name) Attorney (Title)

who may be reached at: his office at (Company Name) 2021 Richard Jones Road, Suite 350 (Address)

Nashville	TN	37215	615/ 370-3380
(City)	(State)	(Zip Code)	(Area Code / Phone Number)

E Graham Baker, Jr (Signature) 11/07/13 (Date) graham@grahambaker.net (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
502 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

==========

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

HF0051 (Revised 7/02 – all forms prior to this date are obsolete)

ORIGINAL APPLICATION

NOV 15 '13 PM 1:04

CERTIFICATE OF NEED APPLICATION

For

ESTABLISHMENT OF A 20 SKILLED BED NURSING UNIT

by

Shelby County Health Care Corporation,
d/b/a Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis (Shelby County), Tennessee 38103

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
502 Deaderick Street
9th Floor
Nashville, Tennessee 37243
615/741-2364

FILING DATE: November 15, 2013

NOV 15 '13 PM 1:04

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency or Institution

Shelby County Health Care Corporation	901/545-7928
Name	Phone Number
877 Jefferson Avenue	Shelby
Street or Route	County

Memphis,	TN	38103
City	State	Zip Code

2. Contact Person Available for Responses to Questions

E. Graham Baker, Jr.	Attorney
Name	Title
Weeks and Anderson	graham@grahambaker.net
Company Name	e-mail address

2021 Richard Jones Road, Suite 350	Nashville,	TN	37215
Street or Route	City	State	Zip Code
Attorney	615/370-3380		615/221-0080
Association with Owner	Phone Number		Fax Number

3. Owner of the Facility, Agency, or Institution

Shelby County Health Care Corporation	901/545-7928
Name	Phone Number
877 Jefferson Avenue	Shelby
Street or Route	County

Memphis,	TN	38103
City	State	Zip Code

4. Type of Ownership of Control (Check One)

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

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. See *Attachment A.4.*

SECTION A:

APPLICANT PROFILE

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

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

Response: The Applicant is Shelby County Health Care Corporation, d/b/a, Regional Medical Center at Memphis, 877 Jefferson Avenue, Memphis (Shelby County), Tennessee 38103, filing this application for a Certificate of Need for the establishment of a twenty (20) skilled bed nursing unit. This SNF unit will be operated as a department of the hospital.

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

Response: The requested documents for the Applicant are included in the application as *Attachment A.4*.

Section A, Item 4: Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, §68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

Response: The Applicant is Shelby County Health Care Corporation, d/b/a, Regional Medical Center at Memphis, 877 Jefferson Avenue, Memphis (Shelby County), Tennessee 38103, filing this application for a Certificate of Need for the establishment of a twenty (20) skilled bed nursing unit. This SNF unit will be operated as a department within the hospital.

See the following chart:

Shelby County Health Care Corporation, d/b/a Regional Medical Center at Memphis

Section A, Item 5: For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract

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

Response: The Applicant, also doing business as The MED, is self-managed. However, it is considering the possibility of hiring a management entity for the SNF unit. Discussions have taken place between The MED and outside management entities that specialize in managing such units. However, no decisions have been made either to have an outside management company, or if so, which one. With that said, The MED is furnishing a draft management contract as *Attachment A.5*, which contract would serve as a basis for developing such a contract in the future, if necessary. In addition, the Projected Data Chart for the SNF unit includes an expense of $90,000, which is thought to be a reasonable amount for such a contract if executed. Obviously, if The MED decides to self-manage the SNF unit, this expense would be deleted.

Section A, Item 6: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the tide/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.

Response: The Applicant is located on an 18.55 acre site in downtown Memphis. The original lease between the Applicant and Shelby County began in 1981, and is for 50 years. Appropriate documents are included as *Attachment A.6*.

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

Please see note on Page 5
Name

Street or Route County

City State Zip Code

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. Please see *Attachment A.5.*

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

A.	Ownership	____	D.	Option to Lease	____
B.	Option to Purchase	____	E.	Other (Specify)	
C.	Lease of 50 Years	X		_____	____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. See *Attachment A.6.*

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

A.	Hospital	X	I.	Nursing Home (add SNF unit to hosp)	X
B.	Ambulatory Surgical Treatment Center (Multi-Specialty)	____	J.	Outpatient Diagnostic Center	____
C.	ASTC	____	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) add SNF unit	X

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

A.	New Institution	____	H.	Change In Bed Complement (Please note the type of change by underlining the appropriate response: Increase, Decrease Designation, Distribution, Conversion, Relocation)	X
B.	Replacement/Existing Facility	____			
C.	Modification/Existing Facility	____			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4)				
E.	Specify add SNF unit to hospital	X	I.	Change of Location	____
F.	Discontinuance of OB Services	____	J.	Other (Specify) add 20 bed SNF unit as department of hospital	X
G.	Acquisition of Equipment	____			____

9. Bed Complement Data

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

Response:

	Current Beds Licensed	Current Beds CON*	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A. Medical	420		124		420
B. Surgical (Orthopedic)	6		6		6
C. Long-Term Care Hospital					
D. Obstetrical	45		45		45
E. ICU/CCU	61		61		61
F. Neonatal	69		69		69
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolescent Psychiatric					
K. Rehabilitation	20	10	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)				20	20
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child & Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	621	10	335	20	651**

* CON Beds approved but not yet in service

*** The Applicant will be licensed for 631 hospital bed as soon as the approved additional 10 rehab beds are licensed, which should be prior to the hearing on this project, and that number will not change. The addition of 20 SNF beds will increase total licensed beds at The MED to 651. Also, due to the Linton Rule, all 20 SNF beds will be certified as both Medicare and Medicaid.*

10. Medicare Provider Number will be applied for
Certification Type Nursing Home

Medicare Provider Number 440152
Certification Type Hospital

11. Medicaid Provider Number will be applied for
Certification Type Nursing Home – Level II

Medicaid Provider Number NPI # 1144213117
Certification Type Hospital

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

Response: This is an existing hospital, but the facility will be adding a new SNF unit to be operated as a department of the hospital. While this is the initiation of a new service at the hospital, the Applicant will continue to provide care for both Medicare and Medicaid patients, and certification will be sought for both Medicare and Medicaid for this 20 bed SNF unit. All SNF beds will be skilled beds, and due to the Linton Rule, all SNF beds will be dually-certified. It is anticipated that 50% of the SNF patients will be Medicare, and the remaining 50% will be uninsured patients. If some of the uninsured patients later become eligible for Medicaid, they will be certified as such.

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

Response: We have TennCare contracts with UHC/AmeriChoice, Blue Care and TennCare Select. These contracts will not change as a result of this project.

The Applicant will contract with any new MCOs that provide services in the area.

Please see *Attachment A.13* for a map showing which MCOs are available in the State.

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

SECTION B: PROJECT DESCRIPTION

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

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

Response: Shelby County Health Care Corporation, d/b/a The Regional Medical Center at Memphis, 877 Jefferson Avenue, Memphis (Shelby County), Tennessee 38103 ("Applicant" or "The MED"), owned and managed by itself, is applying for a Certificate of Need for the establishment of a twenty (20) skilled bed nursing unit to be licensed as nursing home beds and operated as a department of The MED. The requested beds are subject to the FY 2013-2014 pool of nursing home beds authorized by T.C.A. §68-11-1622. Due to the Linton Rule, all beds will be certified for both Medicare and Medicaid. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that the Applicant will serve Medicare, Medicaid, commercially insured, and private-pay patients, and the Applicant will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $300,000.00, including filing fee.

It is proposed that the Applicant will renovate an existing twenty (20) bed unit in the Adams Building on the hospital campus. This unit is now being utilized as a twenty (20) bed rehab unit, which will soon move to Turner Tower as approved under CN1208-037A. This existing space currently meets all licensure requirements for nursing home care, and will be painted to freshen up the space, and some new moveable equipment (beds, tables and chairs) will be purchased.

The Applicant's primary service area is Shelby County. Approximately 88.5% of the Applicant's patients who originate in Tennessee were from Shelby County in 2011, according to the JAR for that year. The MED provided 68,095 inpatient days to Tennessee residents in 2011, with 60,247 originating from Shelby County. With that said, the Applicant also provided care to patients from 31 total counties in Tennessee in 2011, and patients from at least 10 other states came to the Applicant for care in 2011. In addition to the 68,095 patient days provided to Tennessee residents, 22,677 inpatient days were provided to residents of other states, bringing the total inpatient days to 90,772. While this data emphasizes the "regional" nature of the Applicant's service area, for Tennessee purposes, Shelby County is our primary service area.

Population Estimates for Shelby County and State of Tennessee
(Total and Aged Population)

State/County	2013 Population	2015 Population	2013-2015 Change	2013Pop. % 65+	2015 Pop. % 65+	2013-2015 Change
Shelby	956,126	970,591	1.5%	10.8%	11.3%	6.1%
Tennessee	6,414,297	6,530,459	1.8%	14.10%	14.70%	5.8%

Source: Population Estimates and Projections, Tennessee Counties and the State, 2010-2020, Office of Health Statistics, Bureau of Health Informatics, Tennessee Department of Health.

In addition, please note other population characteristics of Shelby County, as compared to the State of Tennessee, in the chart below:

Selected Population Estimates for Shelby County and State of Tennessee

State/County	2010 Pop. % Below Poverty Level	2010 Pop. Per Capita Income	2010 Pop. Median Household Income
Shelby	20.1%	$25,470	$46,102
Tennessee	16.9%	$24,197	$43,989

Source: State and County QuickFacts, U.S. Bureau of Census (See Attachment B.II.B for more data).

As reported on Joint Annual Reports for existing county facilities, nursing homes in Shelby County have operated 82.6%, 83.8%, and 84.5% for 2009 through 2011, respectively. At least two facilities have decreased facility bed counts since the filing of the 2011 JARs, and one facility has surrendered its license. Civic Health and Rehab Center was licensed for 147 beds, and its license expired on July 1, 2013. Bright Glade Health and Rehab Center decreased its bed count from 81 to 77 beds on July 1, 2013, and Grace Healthcare of Cordova decreased its bed count from 284 to 240 beds on July 1, 2013. Taking these bed losses into consideration, the occupancy rate for Shelby County Nursing Homes would increase from 84.5% to 88.7% for 2011. With these decreases, there currently exist 3,974 nursing home beds in Shelby County, with a need for 5,094 beds by 2016.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis.

We project having 16, 17, and 18 patients in Years 1 through 3, respectively.

In addition, the statutory 125 nursing home bed "pool" has not been overutilized during the past ten years. While 1,250 new beds have been authorized (10 years x 125 beds), only 734 have been approved. Note that at the time of submission of this application, 20 beds are pending in an application that has been submitted but not yet heard by the HSDA. Therefore, even if the additional 20 beds are approved, there remain ample beds (a total of 75 beds) from the pool to approve this project.

See following chart:

Statutory Nursing Home Bed Pool

Fiscal Year	Approved
2013-2014	30*
2012-2013	90
2011-2012	68
2010-2011	92
2009-2010	21
2008-2009	76
2007-2008	125
2006-2007	85
2005-2006	64
2004-2005	83
Total	734

**additional 20 beds pending at time of writing*

Source: HSDA Website

This is a clear indication that facilities are applying for these beds only when it is felt the beds are needed – not just because the beds are available. Such is the case with this particular application.

Finally, the approval of this project should not impact existing facilities in the County. First, the requested beds (20) would result in an increase of only 0.5% of the total beds in the County. Second, the patients we will serve are our own hospital patients who cannot be placed in existing facilities. Third, the

overall bed need in Shelby County is for 5,094 beds by 2016, and there are only 3,934 beds available at the present time. Fourth, by converting an existing patient area at our hospital, we are able to modify the physical plant for limited funds, making the transition to nursing home very feasible from a financial standpoint. And fifth, the ability of the Applicant to transfer skilled patients into skilled beds will result in an overall savings to the hospital by decreasing the cost of care for these patients.

Funding for the project will be through cash reserves. The implementation of this project is financially feasible, since the only implementation costs involve relatively minor administrative costs, painting an existing 20 bed unit, and purchasing new moveable equipment (beds, tables, chairs). The cost of this project compares very favorably to recent nursing home applications that have been filed with the HSDA. A chart prepared by the HSDA and provided later in this application indicates that the median construction cost per nursing home bed (new construction) in 2009 through 2011 was approximately $167.31 per GSF, and total construction was approximately $165.00 per GSF.

The total cost per bed for our project is approximately $15,000, most of which is equipment costs. The total cost per square foot is $17.75 (16,910 GSF divided by total implementation cost of $300,000).

It is anticipated that 50% of the SNF patients will be Medicare, and the remaining 50% will be uninsured patients. If some of the uninsured patients later become eligible for Medicaid, they will be certified as such.

Nursing staffing is readily available, as all nurses are currently on staff. This project will merely shift skilled patients (and nursing staff) from hospital beds into a separate SNF unit.

Attachment B.III.A.1 shows that The MED is bounded by Jefferson Avenue, N. Pauline Street, Madison Avenue, and N. Dunlap Avenue. The site is downtown Memphis, close to I-240 and is readily accessible to patients, family members, and other health care providers. Public transportation is available.

Plot Plan and proposed footprints are included as *Attachments B.III.A.1 and B.IV.*

Increasingly, the Applicant is unable to place med/surg patients into appropriate SNF facilities. Existing nursing facilities are reluctant to accept referrals of patients who have little or no ability to pay for such care. As a result, the implementation of this new SNF unit by the Applicant will have no negative impact on area SNFs.

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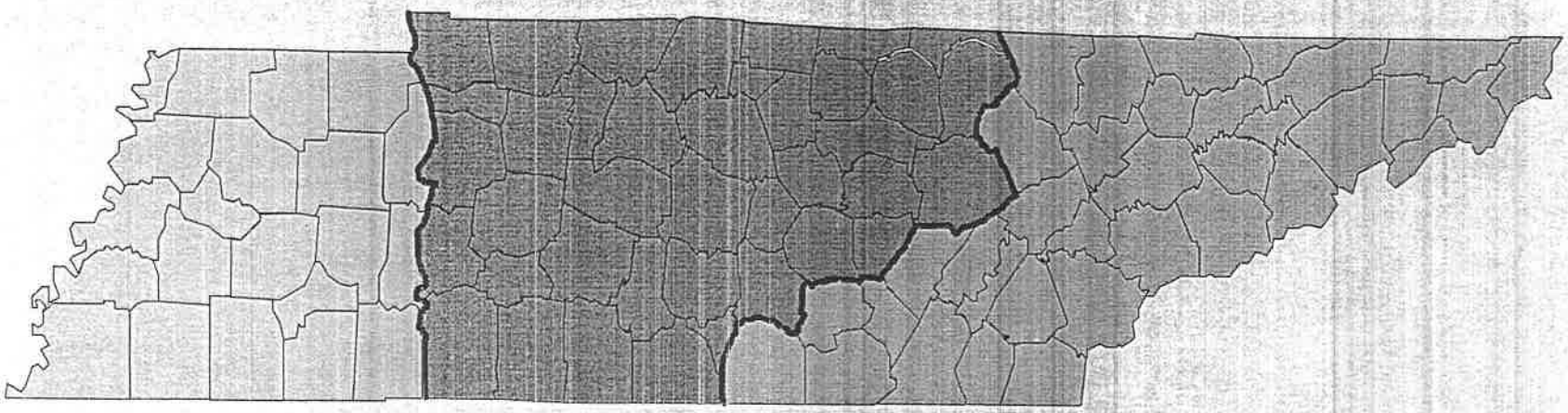
Grand Regions by MCO



West

Middle

East

TENNCARE

Grand Regions by MCO

West Tennessee	Counties
UHC Community Plan	Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, Weakley
BlueCare	
TennCare Select	

Middle Tennessee	Counties
UHC Community Plan	Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, Wilson
AmeriGroup	
TennCare Select	

East Tennessee	Counties
UHC Community Plan	Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, Washington
BlueCare	
TennCare Select	

TENNCARE

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

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

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

Response: This project involves the implementation of a 20 bed SNF unit, to be operated as a unit of the hospital. The hospital currently operates a 20 bed rehab unit in the Adams Building, and that unit is scheduled to move to the Turner Tower very shortly. It is anticipated that the rehab unit will have moved prior to the hearing on this SNF project. The rehab space will be renovated to accommodate the SNF unit.

There is no construction for this project. The existing space will merely be painted, and new beds, tables and chairs brought into the space.

Funding for the project will be through cash reserves. The implementation of this project is financially feasible, since the only implementation costs involve relatively minor administrative costs, painting an existing 20 bed unit, and purchasing new moveable equipment (beds, tables, chairs). The cost of this project compares very favorably to recent nursing home applications that have been filed with the HSDA. A chart prepared by the HSDA and provided later in this application indicates that the median construction cost per nursing home bed (new construction) in 2009 through 2011 was approximately $167.31 per GSF, and total construction was approximately $165.00 per GSF.

The total cost per bed for our project is approximately $15,000, most of which is equipment costs. The total cost per square foot is $17.75 (16,910 GSF divided by total implementation cost of $300,000).

Attachment B.IV shows the footprint of the space where the SNF unit will be located.

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

Response: It is proposed that the Applicant will renovate an existing twenty (20) bed unit in the Adams Building on the hospital campus. This unit is now being utilized as a twenty (20) bed rehab unit, which will soon move to Turner Tower as approved under CN1208-037A. This existing space currently meets all licensure requirements for nursing home care, and will be painted to freshen up the space, and some new moveable equipment (beds, tables and chairs) will be purchased.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis.

We project having 16, 17, and 18 patients in Years 1 through 3, respectively.

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

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

Response: N/A, as no new services will be provided.

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

Response: N/A.

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

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

a. Describe the new equipment, including:

1. Total cost; (As defined by Agency Rule).
2. Expected useful life;
3. List of clinical applications to be provided; and
4. Documentation of FDA approval.

b. Provide current and proposed schedules of operations.

Response: N/A.

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

Response: N/A.

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

Response: N/A.

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

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

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

Response:

1. The size of the medical complex approximates 18.55 Acres. Please see attached plot plan (*Attachment B.III.A.1*).

2. Please see *Attachment B.III.A.1*. This attachment indicates the location of the existing buildings on the site. The existing 20 bed rehab unit is located in Adams Building, but rehab will soon move to Turner Tower, and the vacated space will be utilized for the 20 bed SNF unit.

3. There is no proposed construction, as normally intimated by this question, as the space already exists. There will be minor renovation costs (painting the space), and purchase of moveable medical equipment (beds, tables, chairs).

4. *Attachment B.III.A.1* shows that The MED is bounded by Jefferson Avenue, N. Pauline Street, Madison Avenue, and N. Dunlap Avenue. The site is downtown Memphis and is readily accessible to patients, family members, and other health care providers. Other hospitals are located nearby. This attachment also shows that other providers even own plots of land located within this block.

(B) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: *Attachment B.III.A.1* shows that The MED is bounded by Jefferson Avenue, N. Pauline Street, Madison Avenue, and N. Dunlap Avenue. The site is downtown Memphis, close to I-240 and is readily accessible to patients, family members, and other health care providers. Public transportation is available.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

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

Response: Please see *Attachment B.IV* for a footprint of the proposed facility. This facility can accommodate 20 SNF patients. It is anticipated that there will be 8 private rooms and 6 semi-private rooms in this unit.

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

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

Response: N/A.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

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

QUESTIONS

NEED

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

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

Response: Please see *Attachment Specific Criteria.*

Further, the State Health Plan lists the following Five Principles for Achieving Better Health, and are based on the Division's enacting legislation:

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

The MED has been serving patients since 1936, and continues to this day. Many changes have been made at the hospital, and more are planned, including this project. The MED's goals are consistent with the State Health Plan, and this project will improve the health of Tennesseans.

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

The MED accepts all patients who present for care, irrespective of their ability to pay.

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

The development of services at The MED has always been the result of attempts to meet the needs of Tennesseans. In today's competitive market, patients are drawn to more modern facilities. This project will result in improvement of both services and the physical plant in which to provide those services. Therefore, the approval of this application will enhance the "development" of health care services in the proposed service area.

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

Tennessee is fortunate to have an excellent licensing division of the Department of Health. The Board of Licensing Health Care Facilities provides standards for and monitoring of licensed health care providers. This Applicant is fully licensed by the Department of Health and is certified by Medicare, Medicaid (TennCare), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, most recent survey 06/08/2011), and the Commission on Accreditation of Rehabilitation Facilities (CARF, most recent survey 11/01/2009).

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

The Applicant is committed to providing safe working conditions for its staff and continuing education to its staff. The MED serves as a clinical rotation site for the UT Schools of Medicine and Nursing and other Allied Health Professional Schools. The MED is a member of THA, AHA, TNPath, and NAPH.

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

Response: N/A.

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

Response: From a historical point of view, the Applicant has not enjoyed financial success in the past as other hospitals in Memphis improved their respective campuses and added services. Following a brief period of time when a management company was brought in, a new senior administration was hired recently (2010) to oversee the improvement of both the physical plant and to enhance patient services at the facility. Both the management company and new senior management have been able to cut expenses, streamline processes, rework contracts, enhance the quality of services, and improve the financial viability of The MED. A CON was recently approved for a major renovation of Turner Tower, including the addition of operating rooms dedicated to outpatient surgery. The hospital's burn unit is under renovation, and another CON application was approved for the establishment of a long term acute care hospital to be located on campus. This CON project is the next phase of planned improvements to the campus in an effort to further improve both the quality of services being provided to our patients, and our physical plant. At present, there is no formally-adopted long range plan, but several areas of the campus continue to be studied by senior leadership, key department heads, and the Board of Directors.

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

Response: The Applicant's primary service area is Shelby County. Approximately 88.5% of the Applicant's patients who originate in Tennessee were from Shelby County in 2011, according to the JAR for that year. The MED provided 68,095 inpatient days to Tennessee residents in 2011, with 60,247 originating from Shelby County. With that said, the Applicant also provided care to patients from 31 total counties in Tennessee in 2011, and patients from at least 10 other states came to the Applicant for care in 2011. In addition to the 68,095 patient days provided to Tennessee residents, 22,677 inpatient days were provided to residents of other states, bringing the total inpatient days to 90,772. While this data emphasizes the "regional" nature of the Applicant's service area, for Tennessee purposes, Shelby County is our primary service area.

Please see *Attachment C.Need.3* for a map of the service area.

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

Response: Our proposed service area is Shelby County. The projected population for the next 4 years, according to the TN Department of Health, is as follows:

2013	956,126
2014	963,097
2015	970,591
2016	976,726

In addition, U.S. Census Bureau data for the U.S., State and Shelby County is supplied as *Attachment B.II.B.* This attachment shows that whereas 14.2% of the 2012 Tennessee population was over 65, only 10.8% of Shelby County population was aged. Per capita annual income in Shelby County was $25,470 from 2007 - 2011, whereas Tennessee had an average per capita income of $24,197 for the same reporting period. Median household income for 2007 – 2011 for Shelby County totaled $46,102, and comparable income for the State was $43,989. Finally, 16.9% of Tennesseans live below the poverty level, whereas 20.1% of Shelby County residents live below the poverty level.

See chart below:

Selected Demographic Estimates for Shelby County/Tennessee
(Source: U.S. Census Quickfacts)

Demographics	Shelby Co.	Tennessee	U.S.
65+	10.8%	14.2%	13.0%
Per Capita $	$25,470	$24,197	$27,334
Household $	$46,102	$43,989	$51,914
Below Pov. Lvl	20.1%	16.9%	13.8%
Pop/Sq. Mile	1,216	154	87.4
Home Owners	60.8%	69.0%	66.6%
White	42.9%	79.3%	72.4%
Black	52.8%	17.0%	12.6%

Population Estimates for Shelby County and State of Tennessee
(Total and Aged Population)

State/County	2013 Population	2015 Population	2013-2015 Change	2013Pop. % 65+	2015 Pop. % 65+	2013-2015 Change
Shelby	956,126	970,591	1.5%	10.8%	11.3%	6.1%
Tennessee	6,414,297	6,530,459	1.8%	14.10%	14.70%	5.8%

Source: Population Estimates and Projections, Tennessee Counties and the State, 2010-2020, Office of Health Statistics, Bureau of Health Informatics, Tennessee Department of Health.

In addition, please note other population characteristics of Shelby County, as compared to the State of Tennessee, in the chart below:

Selected Population Estimates for Shelby County and State of Tennessee

State/County	2010 Pop. % Below Poverty Level	2010 Pop. Per Capita Income	2010 Pop. Median Household Income
Shelby	20.1%	$25,470	$46,102
Tennessee	16.9%	$24,197	$43,989

Source: State and County QuickFacts, U.S. Bureau of Census (See Attachment B.II.B for more data).

The statistical bed need data, especially combined with the growing elderly population, points to a growing need for nursing home beds in Shelby County.

In addition, several items of interest were selected from the U.S. Census Bureau Fact Sheets available on the internet for the chart below:

Percentage of Population, Years	Shelby	TN
High School Graduate 2007-2011	85.5%	83.2%
Bachelor's Degree or Higher 2007-2011	28.3%	23.0%
Foreign Born 2077-2011	6.0%	4.5%

Source: U.S. Census Bureau, Fact Sheets

The Applicant does not and will not discriminate in any way, whether regarding admissions or in hiring practices, at its facility.

Finally, please note the following chart regarding the demographics of the service area:

Demographic /Geographic Area	Shelby County	State of TN
Total Population-Current Year -2013	956,126	6,414,297
Total Population-Projected Year -2015	970,591	6,530,459
Total Population-% change	1.5%	1.8%
Age 65+ Population – 2013	103,296	904,587
Age 65+ Population – 2015	109,969	960,158
Age 65+ Population - % change	6.1%	5.8%
Age 65+ Population as % of Total Population (2015)	11.3%	14.7%
TennCare Enrollees (2013)	227,649	1,193,721
TennCare Enrollees as % of Total Population (2013)	23.8%	18.7%
Median Age (2011)	34	38
Median Household Income (2011)	46,102	43,989
Persons Below Poverty Level as % (2011)	20.1%	16.9%

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

Response: Shelby County is our primary service area. The total population of Shelby County is projected to increase only about 1.5% from now until 2015, yet the aged population (65+) is projected to increase about 6.1% in those same two years. The State of Tennessee total population is projected to increase only 1.8% between 2013 and 2015, yet the State's elderly population is projected to increase 5.8%. Therefore, the elderly population of Shelby County is anticipated to grow about 4 times faster than the general population of Shelby County, while the elderly population of the State is anticipated to grow only about 3.5 times as fast as the general population of the State. This means that the elderly population of Shelby County is increasing much faster than the State. See the following chart:

Population Estimates for Shelby County and State of Tennessee
(Total and Aged Population)

State/County	2013 Population	2015 Population	2013-2015 Change	2013Pop. % 65+	2015 Pop. % 65+	2013-2015 Change
Shelby	956,126	970,591	1.5%	10.8%	11.3%	6.1%
Tennessee	6,414,297	6,530,459	1.8%	14.10%	14.70%	5.8%

Source: Population Estimates and Projections, Tennessee Counties and the State, 2010-2020, Office of Health Statistics, Bureau of Health Informatics, Tennessee Department of Health.

In addition, please note other population characteristics of Shelby County, as compared to the State of Tennessee, in the chart below:

Selected Population Estimates for Shelby County and State of Tennessee

State/County	**2010 Pop. % Below Poverty Level**	**2010 Pop. Per Capita Income**	**2010 Pop. Median Household Income**
Shelby	20.1%	$25,470	$46,102
Tennessee	16.9%	$24,197	$43,989

Source: State and County QuickFacts, U.S. Bureau of Census (See Attachment B.II.B for more data).

In addition, several items of interest were selected from the U.S. Census Bureau Fact Sheets available on the internet for the chart below:

Percentage of Population, Years	Shelby	TN
High School Graduate 2007-2011	85.5%	83.2%
Bachelor's Degree or Higher 2007-2011	28.3%	23.0%
Foreign Born 2077-2011	6.0%	4.5%

Source: U.S. Census Bureau, Fact Sheets

The Applicant does not and will not discriminate in any way, whether regarding admissions or in hiring practices, at its facility.

Also, please note that there are Medically Underserved Areas in Shelby County, which this project should help alleviate to some extent. See Attachment C.Need.4.B.

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

Response: It is proposed that the Applicant will renovate an existing twenty (20) bed unit in the Adams Building on the hospital campus. This unit is now being utilized as a twenty (20) bed rehab unit, which will soon move to Turner Tower as approved under CN1208-037A. This existing space currently meets all licensure requirements for nursing home care, and will be painted to freshen up the space, and some new moveable equipment (beds, tables and chairs) will be purchased.

The Applicant's primary service area is Shelby County. Approximately 88.5% of the Applicant's patients who originate in Tennessee were from Shelby County in 2011, according to the JAR for that year (Note: 2012 JARs are Provisional). The MED provided 68,095 inpatient days to Tennessee residents in 2011, with 60,247 originating from Shelby County. With that said, the Applicant also provided care to patients from 31 total counties in Tennessee in 2011, and patients from at least 10 other states came to the Applicant for care in 2011. In addition to the 68,095 patient days provided to Tennessee residents, 22,677 inpatient days were provided to residents of other states, bringing the total inpatient days to 90,772. While this data emphasizes the "regional" nature of the Applicant's service area, for Tennessee purposes, Shelby County is our primary service area.

As reported on Joint Annual Reports for existing county facilities, nursing homes in Shelby County have operated 82.6%, 83.8%, and 84.5% for 2009 through 2011, respectively. At least two facilities have decreased facility bed counts since the filing of the 2011 JARs, and one facility has surrendered its license. Civic Health and Rehab Center was licensed for 147 beds, and its license expired on July 1, 2013. Bright Glade Health and Rehab Center decreased its bed count from 81 to 77 beds on July 1, 2013, and Grace Healthcare of Cordova decreased its bed count from 284 to 240 beds on July 1, 2013. Taking these bed losses into consideration, the occupancy rate for Shelby County Nursing Homes would increase from 84.5% to 88.7% for 2011. With these decreases, there currently exist 3,974 nursing home beds in Shelby County, with a need for 5,094 beds by 2016.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study

showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis.

Attachment C.N.5 shows certain Shelby County Nursing Home Utilization for 2009 – 2011.

Also, please see the following chart for existing nursing home utilization in another format:

Shelby County Nursing Home UtilizationTrends-2009-2011

Nursing Home	Beds	Pt days '09	Pt days '10	Pt days '11	% change '09-'11	Occ. '09	Occ. '10	Occ. '11
Allen Morgan Health and Rehab Cntr	104	28,443	29,053	27,178	-4.4%	74.9%	76.5%	71.6%
Allenbrooke Nursing and Rehab Cntr, LLC	180	61,566	61,632	62,846	2.1%	93.7%	93.8%	95.7%
Civic Health and Rehab Cntr	147	52,630	52,472	52,210	-0.8%	98.1%	97.8%	97.3%
Applingwood Health Care Center	78	25,959	27,076	24,486	-5.7%	91.2%	95.1%	86.0%
Ashton Place Health and Rehab Center	211	72,948	72,619	65,464	-10.3%	94.7%	94.3%	85.0%
Ave Maria Home	75	26,917	26,796	25,652	-4.7%	98.3%	97.9%	93.7%
Baptist Memorial Hospital - Memphis SNF	35	8,647	10,378	10,590	22.5%	67.7%	81.2%	82.9%
Baptist Skilled Rehab Unit - Germantown	18	*	324	5,123		*	4.9%	78.0%
Bright Glade Health and Rehabilitation	81	26,264	25,709	25,451	-3.1%	88.8%	87.0%	86.1%
Harbor View Nursing and Rehab Cntr, Inc.	120	24,682	23,637	34,815	41.1%	56.4%	54.0%	79.5%
Dove Health & Rehab of Collierville, LLC	114	11,038	27,733	34,996	217.1%	26.5%	66.6%	84.1%
Grace Healthcare of Cordova	284	80,505	86,103	74,167	-7.9%	77.7%	83.1%	71.5%
Graceland Nursing Center	240	83,676	82,117	76,445	-8.6%	95.5%	93.7%	87.3%
Kirby Pines Manor	120	41,741	40,578	42,160	1.0%	95.3%	92.6%	96.3%
Memphis Jewish Home	160	54,271	48,726	44,394	-18.2%	92.9%	83.4%	76.0%
Methodist Healthcare SNF	44	6,128	5,472	5,370	-12.4%	38.2%	34.1%	33.4%
MidSouth Health and Rehab Cntr	155	52,466	17,147	29,172	-44.4%	92.7%	30.3%	51.6%
Millington Healthcare Center	85	27,186	29,170	28,410	4.5%	87.6%	94.0%	91.6%
Poplar Point Health and Rehabilitation	169	51,418	53,543	47,604	-7.4%	83.4%	86.8%	77.2%
Parkway Health and Rehabilitation Center	120	42,590	36,359	42,549	-0.1%	97.2%	83.0%	97.1%
Kindred Trans. Care & Rehab Cntr-Primacy	120	40,117	41,826	31,637	-21.1%	91.6%	95.5%	72.2%
Quality Care Center of Memphis	48	13,288	13,026	12,244	-7.9%	75.8%	74.3%	69.9%
Quince Nursing and Rehabilitation Center	188	66,004	65,719	66,343	0.5%	96.2%	95.8%	96.7%
Rainbow Health & Rehab of Memphis, LLC	115	30,269	38,767	39,763	31.4%	72.1%	92.4%	94.7%
Signature Health of Memphis	140	47,157	49,005	48,440	2.7%	92.3%	95.9%	94.8%
Spring Gate Nursing and Rehab Cntr	231	71,473	73,826	78,591	10.0%	84.8%	87.6%	93.2%
Signature HealthCare at St. Francis	197	28,965	72,715	62,807	116.8%	40.3%	101.1%	87.3%
Signature Healthcare at St. Peter Villa	180	62,792	56,578	54,445	-13.3%	95.6%	86.1%	82.9%
The King's Daughters and Sons Home	108	38,873	38,768	37,908	-2.5%	98.6%	98.3%	96.2%
The Village at Germantown	30	10,011	10,002	9,371	-6.4%	91.4%	91.3%	85.6%
Highlands of Memphis Health & Rehab	180	53,824	53,561	55,265	2.7%	81.9%	81.5%	84.1%
Whitehaven Community Living Center	92	29,249	30,136	30,268	3.5%	87.1%	89.7%	90.1%
TOTAL	4,169	1,271,097	1,300,573	1,286,164	1.2%	83.5%	85.5%	84.5%

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: There is no historic utilization since this application is for a new facility.

As reported on Joint Annual Reports for existing county facilities, nursing homes in Shelby County have operated 82.6%, 83.8%, and 84.5% for 2009 through 2011, respectively. At least two facilities have decreased facility bed counts since the filing of the 2011 JARs, and one facility has surrendered its license. Civic Health and Rehab Center was licensed for 147 beds, and its license expired on July 1, 2013. Bright Glade Health and Rehab Center decreased its bed count from 81 to 77 beds on July 1, 2013, and Grace Healthcare of Cordova decreased its bed count from 284 to 240 beds on July 1, 2013. Taking these bed losses into consideration, the occupancy rate for Shelby County Nursing Homes would increase from 84.5% to 88.7% for 2011. With these decreases, there currently exist 3,974 nursing home beds in Shelby County, with a need for 5,094 beds by 2016.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis.

We project having 16, 17, and 18 patients in Years 1 through 3, respectively.

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

-- **All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)**

-- **The cost of any lease should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater.**

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

-- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

Response: The Project Costs Chart is completed. This project involves approximately 16,910 GSF which will be renovated at a cost of $37,128, for an average construction (renovation) cost per GSF of approximately $2.20. The total project would approximate $17.75 per GSF. There is no construction. Renovation costs are for painting the existing space.

The chart below, prepared by the HSDA, indicates construction costs for recent nursing home applications. A review of these average costs indicate this particular project is financially feasible.

Nursing Home Construction Cost Per Square Foot

Years: 2010 - 2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$19.30/sq ft	$164.57/sq ft	$73.23/sq ft
Median	$35.76/sq ft	$167.31/sq ft	$164.57/sq ft
3rd Quartile	$55.00/sq ft	$181.72/sq ft	$167.61/sq ft

Source: CON approved applications for years 2010 through 2012

Due to insufficient sample size, Renovated Construction is not available.

PROJECT COSTS CHART

NOV 15 '13 PM 1:05

A. Construction and equipment acquired by purchase.

1.	Architectural and Engineering Fees	$
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant	50,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Construction Costs (renovation – painting)	37,128
6.	Contingency Fund	
7.	Fixed Equipment (Not included in Construction Contract)(Generator, Nurse Call)	
8.	Moveable Equipment (List all equipment over $50,000)*	209,872
9.	Other (Specify)	
	Subsection A Total	**297,000**

B. Acquisition by gift, donation, or lease.

1.	Facility (Inclusive of Building and Land)	
2.	Building Only	
3.	Land Only	
4.	Equipment (Specify)	
5.	Other (Specify)	
	Subsection B Total	**0**

C. Financing costs and fees

1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	
	Subsection C Total	**0**

D.	Estimated Project Cost (A + B + C)		**$ 297,000**
E.	CON Filing Fee		**$ 3,000**
F.	Total Estimated Project Cost (D + E)	TOTAL	**$ 300,000**

2. **Identify the funding sources for this project.**

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

___ **A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**

___ **B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**

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

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

X__ **E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

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

Response: This project will be financed by cash reserves. The financials of the Applicant indicate that funds are available. In addition, J. Richard Wagers, Jr., The MED's Sr. Executive Vice President and CFO has furnished a letter attesting that The MED has sufficient assets to implement this project (see *Attachment C.EF.2*).

SUPPLEMENTAL # 1
December 17, 2013
1:30pm

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

Response: The Project Costs Chart is completed. This project involves approximately 16,910 GSF which will be renovated at a cost of $37,128, for an average construction (renovation) cost per GSF of approximately $2.20. The total project would approximate $17.75 per GSF. There is no construction. Renovation costs are for painting the existing space.

The chart below, prepared by the HSDA, indicates construction costs for recent nursing home applications. A review of these average costs indicate this particular project is financially feasible.

Nursing Home Construction Cost Per Square Foot

Years: 2010 - 2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$19.30/sq ft	$164.57/sq ft	$73.23/sq ft
Median	$35.76/sq ft	$167.31/sq ft	$164.57/sq ft
3rd Quartile	$55.00/sq ft	$181.72/sq ft	$167.61/sq ft

Source: CON approved applications for years 2010 through 2012

Due to insufficient sample size, Renovated Construction is not available.

4. **Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the Proposal Only (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).**

Response: Historical and Projected Data Charts are completed.

Historical Data Chart: As a new SNF unit of the hospital, there is no historical data.

Projected Data Chart: Completed.

Please note that there are no contractual adjustments. The financial analysis utilized net charges as inpatient revenue. Therefore, the funds stated on Line B.1 are the net charges.

Charity Care is estimated to be an additional 3% of the total. As approximately 50% of the patients are anticipated to be uninsured (no payment mechanism), in reality, Charity Care will be much greater. The lack of revenue from anticipated uninsured patients is reflected in the lower amount of net charges reported on Line B.1.

In the past, the HSDA has requested 3 years of Projected Data if one of the first 2 years indicated negative cash flow. This project, as explained, will have negative cash flow all of the first 3 years, and perhaps some time after that. However, even though the SNF unit is projected to have negative cash flow, the overall savings to The MED is such that increased income for the hospital more than offsets the loss of this new department.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (month).

Response: Note: Dollar Amounts in Thousands.

		2012	2011	2010
A.	Utilization/Occupancy Rate	90,277	90,772	94,450
B.	Revenue from Services to Patients			
	1. Inpatient Services	866,217	847,128	833,753
	2. Outpatient Services	148,251	125,519	111,855
	3. Emergency Services	203,953	157,181	140,071
	4. Other Operating Revenue (Specify)_____	89,737	107,096	53,402
	Gross Operating Revenue	**1,308,158**	**1,236,923**	**1,139,081**
C.	Deductions from Operating Revenue			
	1. Contractual Adjustments	589,199	556,790	518,316
	2. Provision for Charity Care	297,219	257,038	250,673
	3. Provision for Bad Debt	87,459	85,606	105,585
	Total Deductions	**973,877**	**899,434**	**874,575**
	NET OPERATING REVENUE	**334,281**	**337,488**	**264,506**
D.	Operating Expenses			
	1. Salaries and Wages	147,984	137,301	132,453
	2. Physician's Salaries and Wages	24,231	23,365	22,845
	3. Supplies	52,985	49,878	47,149
	4. Taxes			
	5. Depreciation	11,392	11,029	11,754
	6. Rent			
	7. Interest, other than Capital		104	364
	8. Management Fees:			
	a. Fees to Affiliates			
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify) _____	75,298	68,703	68,444
	Total Operating Expenses	**311,890**	**290,379**	**283,010**
E.	Other Revenue (Expenses)-Net (Specify)_____	28,793	27,324	24,035
	NET OPERATING INCOME (LOSS)	**51,184**	**74,433**	**5,532**
F.	Capital Expenditures			
	1. Retirement of Principal			
	2. Interest			
	Total Capital Expenditure	**0**	**0**	**0**
	NET OPERATING INCOME (LOSS) LESSCAPITAL EXPENDITURES	**51,184**	**74,433**	**5,532**

SUPPLEMENTAL #2
December 30, 2013
3:03 pm

PROJECTED DATA CHART

Give information for the three (3) years following the completion of this project. The fiscal year begins in July (month).

	Yr-1	Yr-2	Yr-3
A. Utilization/Occupancy	16	17	18
B. Revenue from Services to Patients			
1. Inpatient Services	$1,268,398	$1,388,043	$1,512,565
2. Outpatient Services			
3. Emergency Services			
4. Other Operating Revenue (Specify)			
Gross Operating Revenue	**$1,268,398**	**$1,388,043**	**$1,512,565**
C. Deductions from Operating Revenue			
1. Contractual Adjustments			
2. Provision for Charity Care			
3. Provision for Bad Debt	$38,051	$41,642	$45,379
Total Deductions	**$38,051**	**$41,642**	**$45,379**
NET OPERATING REVENUE	**$1,230,347**	**$1,346,401**	**$1,467,186**
D. Operating Expenses			
1. Salaries and Wages	$1,213,572	$1,345,212	$1,432,308
2.Physician's Salaries and Wages (Contracted)	$24,996	$25,752	$26,520
3. Supplies	$436,125	$477,251	$520,232
4. Taxes			
5. Depreciation	$30,000	$30,000	$30,000
6. Rent	$225,000	$231,756	$238,656
7. Interest, other than Capital			
8. Management Fees:			
a. Fees to Affiliates			
b. Fees to Non-Affiliates	90,000	90,000	90,000
9. Other Expenses (Specify) Contract Services, Marketing, Laundry, & Dietary	$385,742	$518,713	$453,113
Total Operating Expenses	**$2,405,435**	**$2,718,684**	**$2,790,829**
E. Other Revenue (Expenses)-Net (Specify)			
NET OPERATING INCOME (LOSS)	**-$1,175,088**	**-$1,372,283**	**-$1,323,643**
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest (on Letter of Credit)			
Total Capital Expenditure			
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**-$1,175,088**	**-$1,372,283**	**-$1,323,643**

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

Response: Please note that there are no contractual adjustments. The financial analysis utilized net charges as inpatient revenue. Therefore, the funds stated on Line B.1 are the net charges.

Net charges are anticipated to be $217.20 per day (total net of $1,268,398 divided by 5,840 patient days).

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

Response: There are no current charges.

Net charges are anticipated to be $217.20 per day (total net of $1,268,398 divided by 5,840 patient days).

Our projections will not be altered as a result of implementation of the proposal.

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

Response: Patient charges are listed on *Attachment C.EF.6.B.* Our net charges are anticipated to be $217.20 per day, which compares very favorably to net charges at existing nursing homes in Shelby County.

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

Response: The Projected Data Chart indicates negative cash flow for the new SNF unit at The MED.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

It is projected that the overall cost savings to The MED will approximate in excess of $2,500,000 per year. This figure resulted from comparing the overall per patient day costs for a hospital bed, as compared to the projected per patient day costs for a SNF bed. This projection was based on the first year of 5,840 patient days. As the SNF utilization grows, overall savings should increase.

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

Response: The Projected Data Chart indicates negative cash flow for the new SNF unit at The MED.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

It is projected that the overall cost savings to The MED will approximate in excess of $2,500,000 per year. This figure resulted from comparing the overall per patient day costs for a hospital bed, as compared to the projected per patient day costs for a SNF bed. This projection was based on the first year of 5,840 patient days. As the SNF utilization grows, overall savings should increase.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response: The nursing home will participate in both the Medicare and Medicaid programs.

We anticipate that 50% of our patients will be Medicare patients and 50% of our patients will be uninsured (no payment whatsoever).

Assuming net revenue of $1,268,398 the first year, approximately $634,199 will be reimbursed by Medicare (Net Revenue of $1,268,398 x 50% Medicare).

We are not projecting any Medicaid patients at present, but assume the remaining 50% of patients will be free care. If some of these uninsured patients eventually qualify for Medicaid/TennCare, such patients will be certified as such and any reimbursement from Medicaid/TennCare will diminish our projected losses in the SNF unit, and increase our overall hospital savings with the implementation of this unit.

Further, in case uninsured patients qualify for Medicaid/TennCare, this unit will already be certified as such.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response: As noted in *Attachment C.EF.10,* sufficient funds are available in order to pay for this project with cash reserves.

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

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response: There are no less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by this project. The Applicant receives all patients who present for health care service, irrespective of the patient's ability or inability to pay for such services. Many of the patients we serve are uninsured. When such patients require SNF care, existing facilities are reluctant to accept the referral. Therefore, the hospital has to provide SNF services to these patients in a hospital setting, which is much more costly than providing the same services in a licensed SNF unit. Therefore, even though the SNF unit will have negative cash flow, the overall savings to the Applicant will more than offset any losses projected in this application for that SNF unit.

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

Response: There are no less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by this project. The Applicant receives all patients who present for health care service, irrespective of the patient's ability or inability to pay for such services. Many of the patients we serve are uninsured. When such patients require SNF care, existing facilities are reluctant to accept the referral. Therefore, the hospital has to provide SNF services to these patients in a hospital setting, which is much more costly than providing the same services in a licensed SNF unit. Therefore, even though the SNF unit will have negative cash flow, the overall savings to the Applicant will more than offset any losses projected in this application for that SNF unit.

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.**

We have TennCare contracts with UHC/Americhoice, Blue Care and TNCare Select. These contracts will not change as a result of this project. The Applicant will contract with any new MCOs that provide services in the area.

The MED and its predecessors have provided acute medical services for citizens of Shelby County and the surrounding area for generations, beginning in 1936. Today, it is a regional referral facility for a wide catchment area. While Shelby County residents remain its main reason for existence, the hospital provides a wide assortment of tertiary health care services for people from surrounding areas. As stated earlier, its 2011 JAR shows that its patients originated from 31 Tennessee counties plus 10 additional states. As such, The MED has a plethora of contractual and working relationships.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response: The nursing home bed utilization data supplied by the State indicates that there are currently 3,974 existing nursing home beds in Hamilton County (2011 JARs minus bed closures since the filing of those documents). To best knowledge of the Applicant, no new beds have been approved that are not yet in service in Shelby County. There is a statistical need of 5,094 beds by 2016. This means that there is a need for 1,120 nursing home beds in the County. Approval of this application will help satisfy that need.

Since we will be transferring existing hospital patients within our facility to our SNF unit, the transfer of these patients through the approval of this project will have no impact on existing skilled nursing providers. In effect, the patients we will refer to our SNF unit are patients that would not be leaving our hospital, anyway.

To conclude, the approval of this project should not impact existing facilities in the County. First, the requested beds (20) would result in an increase of only 0.5% of the total beds in the County. Second, the patients we will serve are our own hospital patients who cannot be placed in existing facilities. Third, the overall bed need in Shelby County is for 5,094 beds by 2016, and there are only 3,934 beds available at the present time. Fourth, by converting an existing patient area at our hospital, we are able to modify the physical plant for limited funds, making the transition to nursing home very feasible from a financial standpoint. And fifth, the ability of the Applicant to transfer skilled patients into skilled beds will result in an overall savings to the hospital by decreasing the cost of care for these patients.

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

Response: No additional staff will need to be hired. As the SNF patients transfer to the SNF unit, nursing and other personnel will be reassigned to continue caring for these patients.

Existing and Year 1 Nursing and Respiratory Therapist personnel and salary ranges are given below:

Nursing and Respiratory Therapist Personnel

Position	Year 1	Salary Range
RN	5	$55,000 – 65,000/yr
LPN	4	$38,000 – 42,000/yr
CAN	5	$22,000 – 26,000/yr
RT	3	$46,000 – 50,000/yr

In addition, please see *Attachment C.OD.3* for prevailing wage patterns in the area.

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

Response: No additional staff will need to be hired. As the SNF patients transfer to the SNF unit, nursing and other personnel will be reassigned to continue caring for these patients.

Existing and Year 1 Nursing and Respiratory Therapist personnel and salary ranges are given below:

Nursing and Respiratory Therapist Personnel

Position	Year 1	Salary Range
RN	5	$55,000 – 65,000/yr
LPN	4	$38,000 – 42,000/yr
CAN	5	$22,000 – 26,000/yr
RT	3	$46,000 – 50,000/yr

As stated, we believe that adequate additional staff are readily available to provide appropriate care to all patients in our proposed 20 bed SNF unit. In the future, we will be able to add staff if any need arises by interviewing prospective personnel already contained in our HR files and by interviewing recent graduates of local schools. The University of Tennessee in Memphis maintains programs in both physical and occupational therapies, and the University of Memphis has a nursing school from which to draw future staff.

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

Response: The Applicant is familiar with all licensing certification requirements 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.).**

Response: The Applicant has clinical affiliation relationships with UT School of Medicine and the University of Memphis School of Nursing.

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

Response: The Applicant is familiar with all licensure requirements of the regulatory agencies of the State.

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

Response:

Licensure:	Tennessee Department of Health
Accreditation:	Medicare, Medicaid/TennCare, JCAHO, CARF

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

Response: Please see *Attachment C.OD.7.c* for copies of The MED's hospital license, JCAHO accreditation letter, and CARF accreditation.

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

Response: Please see *Attachment C.OD.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.**

Response: There have been no final orders or judgments as are contemplated by this question.

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

Response: There have been no final orders or judgments as are contemplated by this question.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

Response: The Applicant will provide all data contemplated by this question.

PROOF OF PUBLICATION

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

Response: If the requested documentation is not attached, it will be submitted once received.

DEVELOPMENT SCHEDULE

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

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

Form HF0004
Revised 05/03/04
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): 02/2014.

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

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced **(renovation)**	10	05/2014
7. Construction 40% complete	4	05/2014
8. Construction 80% complete	4	05/2014
9. Construction 100% complete (approved for occupancy (renovation)	2	05/2014
10. *Issuance of license	30	06/2014
11. *Initiation of service	5	06/2014
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)	30	07/2014

*** 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

NOV 15 '13 PM 1:07

STATE OF TENNESSEE

COUNTY OF DAVIDSON

E. Graham Baker, Jr., 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 to the best of his/her knowledge.

E. Graham Baker, Jr., ATTORNEY
SIGNATURE/TITLE

Sworn to and subscribed before me this 15th day of November, 2013 (month) (year), a Notary Public in and for the County/State of Davidson/Tennessee.

Nadean E. Poteet
NOTARY PUBLIC

NADEAN E. POTEET STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY

My commission expires July 3rd (Month/Day), 2017 (Year).

NURSING HOME SERVICES

A. Need

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

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

Response: Shelby County Health Care Corporation, d/b/a The Regional Medical Center at Memphis, 877 Jefferson Avenue, Memphis (Shelby County), Tennessee 38103 ("Applicant" or "The MED"), owned and managed by itself, is applying for a Certificate of Need for the establishment of a twenty (20) skilled bed nursing unit to be licensed as nursing home beds and operated as a department of The MED. The requested beds are subject to the FY 2013-2014 pool of nursing home beds authorized by T.C.A. §68-11-1622. Due to the Linton Rule, all beds will be certified for both Medicare and Medicaid.

As reported on Joint Annual Reports for existing county facilities, nursing homes in Shelby County have operated 82.6%, 83.8%, and 84.5% for 2009 through 2011, respectively. At least two facilities have decreased facility bed counts since the filing of the 2011 JARs, and one facility has surrendered its license. Civic Health and Rehab Center was licensed for 147 beds, and its license expired on July 1, 2013. Bright Glade Health and Rehab Center decreased its bed count from 81 to 77 beds on July 1, 2013, and Grace Healthcare of Cordova decreased its bed count from 284 to 240 beds on July 1, 2013. Taking these bed losses into consideration, the occupancy rate for Shelby County Nursing Homes would increase from 84.5% to 88.7% for 2011. With these decreases, there currently exist 3,974 nursing home beds in Shelby County, with a need for 5,094 beds by 2016.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip

codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis.

We project having 16, 17, and 18 patients in Years 1 through 3, respectively.

Finally, the approval of this project should not impact existing facilities in the County. First, the requested beds (20) would result in an increase of only 0.5% of the total beds in the County. Second, the patients we will serve are our own hospital patients who cannot be placed in existing facilities. Third, the overall bed need in Shelby County is for 5,094 beds by 2016, and there are only 3,934 beds available at the present time. Fourth, by converting an existing patient area at our hospital, we are able to modify the physical plant for limited funds, making the transition to nursing home very feasible from a financial standpoint. And fifth, the ability of the Applicant to transfer skilled patients into skilled beds will result in an overall savings to the hospital by decreasing the cost of care for these patients.

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

Response: According to the Tennessee Department of Health, there is a need for 5,094 beds in Shelby County by 2016.

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

Response: Please see *Attachment C.N.5* for the most recent supply and utilization of licensed and CON approved nursing home beds in the service area:

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

Response: The Applicant's primary service area is Shelby County. Approximately 88.5% of the Applicant's patients who originate in Tennessee were from Shelby County in 2011, according to the JAR for that year. The MED provided 68,095 inpatient days to Tennessee residents in 2011, with 60,247 originating from Shelby County. With that said, the Applicant also provided care to patients from 31 total counties in Tennessee in 2011, and patients from at least 10 other states came to the Applicant for care in 2011. In addition to the 68,095 patient days provided to Tennessee residents, 22,677 inpatient days were provided to residents of other states, bringing the total inpatient days to 90,772. While this data emphasizes the "regional" nature of the Applicant's service area, for Tennessee purposes, Shelby County is our primary service area.

Please see *Attachment C.Need.3* for a map of the service area.

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

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

Response: To the knowledge of the Applicant, there are no outstanding nursing home beds in Shelby County.

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

Response: As reported on Joint Annual Reports for existing county facilities, nursing homes in Shelby County have operated 82.6%, 83.8%, and 84.5% for 2009 through 2011, respectively. At least two facilities have decreased facility bed counts since the filing of the 2011 JARs, and one facility has surrendered its license. Civic Health and Rehab Center was licensed for 147 beds, and its license expired on July 1, 2013. Bright Glade Health and Rehab Center decreased its bed count from 81 to 77 beds on July 1, 2013, and Grace Healthcare of Cordova decreased its bed count from 284 to 240 beds on July 1, 2013. Taking these bed losses into consideration, the occupancy rate for Shelby County Nursing Homes would increase from 84.5% to 88.7% for 2011. With these decreases, there currently exist 3,974 nursing home beds in Shelby County, with a need for 5,094 beds by 2016.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis.

We project having 16, 17, and 18 patients in Years 1 through 3, respectively.

In addition, the statutory 125 nursing home bed "pool" has not been overutilized during the past ten years. While 1,250 new beds have been authorized (10 years x 125 beds), only 734 have been approved. Note that at the time of submission of this application, 20 beds are pending in an application that has been submitted but not yet heard by the HSDA. Therefore, even if the additional 20 beds are approved, there remain ample beds (a total of 75 beds) from the pool to approve this project.

See following chart:

Statutory Nursing Home Bed Pool

Fiscal Year	Approved
2013-2014	30*
2012-2013	90
2011-2012	68
2010-2011	92
2009-2010	21
2008-2009	76
2007-2008	125
2006-2007	85
2005-2006	64
2004-2005	83
Total	734

**additional 20 beds pending at time of writing*

Source: HSDA Website

This is a clear indication that facilities are applying for these beds only when it is felt the beds are needed – not just because the beds are available. Such is the case with this particular application.

Finally, the approval of this project should not impact existing facilities in the County. First, the requested beds (20) would result in an increase of only 0.5% of the total beds in the County. Second, the patients we will serve are our own hospital patients who cannot be placed in existing facilities. Third, the overall bed need in Shelby County is for 5,094 beds by 2016, and there are only 3,934 beds available at the present time. Fourth, by converting an existing patient area at our hospital, we are able to modify the physical plant for limited funds, making the transition to nursing home very feasible from a financial standpoint. And fifth, the ability of the Applicant to transfer skilled patients into skilled beds will result in an overall savings to the hospital by decreasing the cost of care for these patients.

B. Occupancy and Size Standards:

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

Response: We project having 16, 17, and 18 patients in Years 1 through 3, respectively. Therefore, our projection indicates we will have 90% occupancy after two years of operation.

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

Response: This criteria will not be met.

The actual "need" for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly. It is anticipated that all of the patients in this new SNF unit will be referred by the hospital. Moving skilled patients into a SNF unit on campus will result in a cost savings to the hospital, even though the SNF unit, itself, may well experience higher expenses than revenue. As such, the Applicant will experience a positive cash flow with the implementation of these SNF beds, even though the SNF unit itself may experience a negative cash flow. *Attachment B.I.A* is a letter explaining why we need to transfer SNF patients from hospital beds to SNF beds.

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

Response: N/A, as this is a new facility.

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

Response: N/A, as this is not a free-standing facility.

Attachment B.I.A

Regional Medical Center at Memphis

To: Health Services and Development Agency

From: Johnie Shipp, RN
Director Case Management/Patient Access

Subject: Skill Nursing Facility

Date: November 14, 2013

The Regional Medical Center averages 13,000 admissions annually. 29.2% of the organizations admissions are uninsured. Transitioning our patient population to a post-acute care setting is a challenge due to the limited availability of resources. With the increased changes of the health care environment and reimbursement, the hospital must organize its services to promote more efficient and cost effective services.

Current transition to a skilled nursing facility is not an option for an uninsured patient without requiring an approval process with the state that can exceed seven to 14 days. Although the skilled nursing facility (SNF) will possibly operate at a loss, a skilled nursing facility option will allow services to be provided to our patients at a lower cost.

Benefits to our patients include: specialized care, reduction in acute care length of stay, 24 hour continued medical services and a reduction in cost without compromising quality of patient care. Having a skilled nursing facility as an option will allow our organization to better manage its resources at a reduced cost without delaying a patient's need for transition to next level of care.

877 Jefferson Avenue Memphis, TN 38103 901.545.7100

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Attachment B.II.B

U.S. Department of Commerce

Home Blogs About Us Index A to Z Glossary FAQs

People Business Geography Data Research Newsroom Search

State & County QuickFacts

Shelby County, Tennessee

People QuickFacts	Shelby County	Tennessee
Population, 2012 estimate	940,704	6,456,243
Population, 2010 (April 1) estimates base	927,640	6,346,113
Population, percent change, April 1, 2010 to July 1, 2012	1.4%	1.7%
Population, 2010	927,644	6,346,105
Persons under 5 years, percent, 2012	7.3%	6.3%
Persons under 18 years, percent, 2012	25.8%	23.1%
Persons 65 years and over, percent, 2012	10.8%	14.2%
Female persons, percent, 2012	52.3%	51.2%
White alone, percent, 2012 (a)	42.9%	79.3%
Black or African American alone, percent, 2012 (a)	52.8%	17.0%
American Indian and Alaska Native alone, percent, 2012 (a)	0.3%	0.4%
Asian alone, percent, 2012 (a)	2.5%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2012 (a)	0.1%	0.1%
Two or More Races, percent, 2012	1.4%	1.6%
Hispanic or Latino, percent, 2012 (b)	5.9%	4.8%
White alone, not Hispanic or Latino, percent, 2012	37.9%	75.1%
Living in same house 1 year & over, percent, 2007-2011	82.0%	84.1%
Foreign born persons, percent, 2007-2011	6.0%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	8.6%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	85.5%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	28.3%	23.0%
Veterans, 2007-2011	61,732	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	22.3	24.0
Housing units, 2011	397,976	2,829,025
Homeownership rate, 2007-2011	60.8%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	27.7%	18.1%
Median value of owner-occupied housing units, 2007-2011	$136,200	$137,200
Households, 2007-2011	340,394	2,457,997
Persons per household, 2007-2011	2.66	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$25,470	$24,197
Median household income, 2007-2011	$46,102	$43,989
Persons below poverty level, percent, 2007-2011	20.1%	16.9%

Business QuickFacts	Shelby County	Tennessee
Private nonfarm establishments, 2011	19,487	129,489[1]
Private nonfarm employment, 2011	418,711	2,300,542[1]
Private nonfarm employment, percent change, 2010-2011	-0.2%	1.6%[1]
Nonemployer establishments, 2011	80,869	473,451
Total number of firms, 2007	76,350	545,348
Black-owned firms, percent, 2007	30.9%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.3%	0.5%
Asian-owned firms, percent, 2007	3.4%	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	0.1%	0.1%
Hispanic-owned firms, percent, 2007	1.7%	1.6%
Women-owned firms, percent, 2007	30.8%	25.9%
Manufacturers shipments, 2007 ($1000)	17,969,681	140,447,760

Merchant wholesaler sales, 2007 ($1000)	29,636,012	80,116,528
Retail sales, 2007 ($1000)	11,932,863	77,547,291
Retail sales per capita, 2007	$12,971	$12,563
Accommodation and food services sales, 2007 ($1000)	1,787,964	10,626,759
Building permits, 2012	2,325	20,147

Geography QuickFacts	Shelby County	Tennessee
Land area in square miles, 2010	763.17	41,234.90
Persons per square mile, 2010	1,215.5	153.9
FIPS Code	157	47
Metropolitan or Micropolitan Statistical Area	Memphis, TN-MS-AR Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 25 firms
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

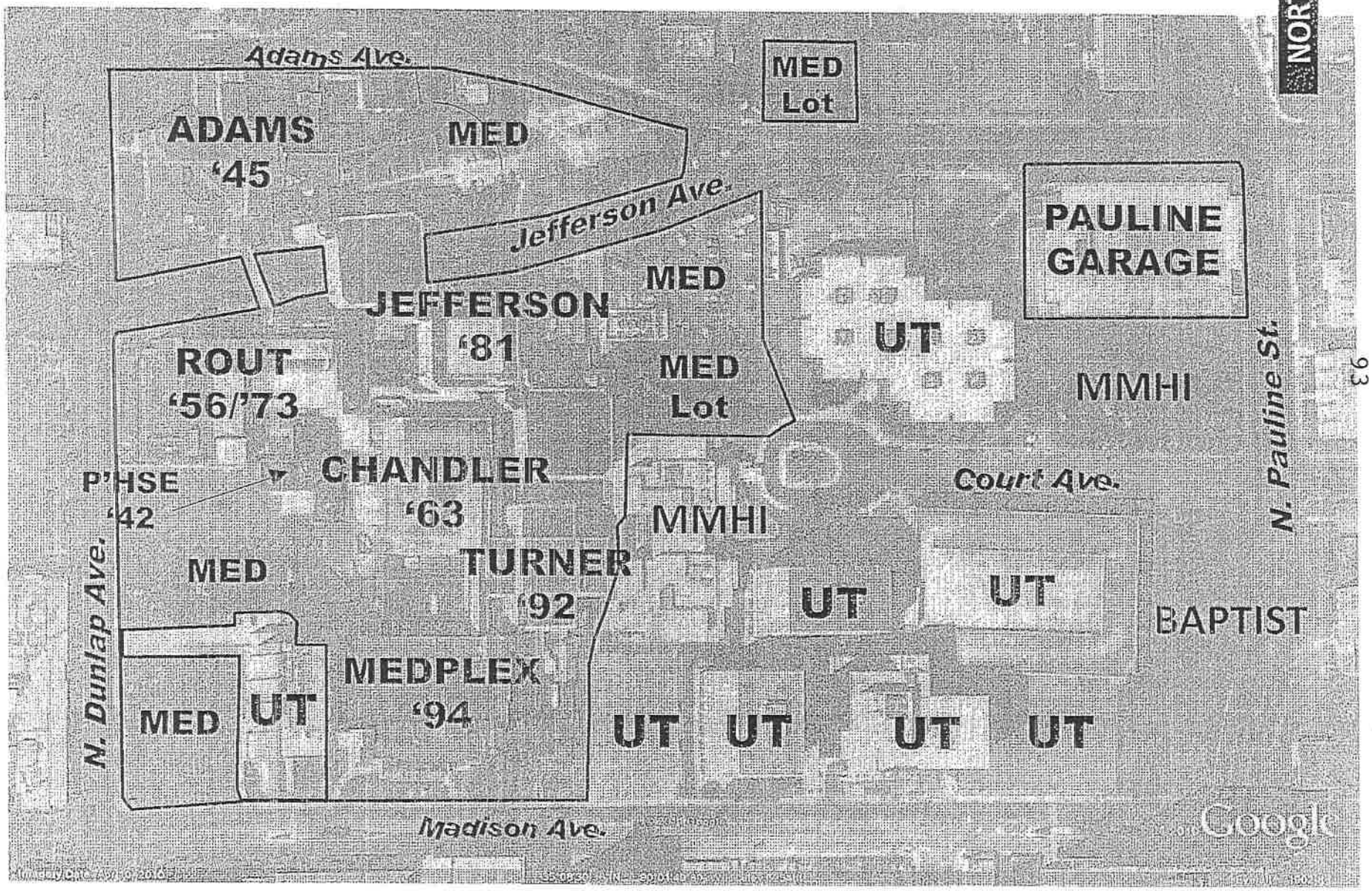
Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits
Last Revised: Thursday, 27-Jun-2013 14:31:49 EDT

The Regional Medical Center at Memphis
Property Map

Parcel ID #	Description	Acres
018051-00051	Hospital	7.94
018050-00001	Adams Pavilion	3.92
018051-00043	Valet Parking Lot - Dunlap	0.70
018051-00042	Chandler Parking Lot - Dunlap	0.34
018051-00052	Outpatient Center Parking Lot - Dunlap	0.92
018051-00041	Outpatient Center Parking Lot - Dunlap	0.14
018051-00055	ED Parking Lot & Grass Lot - Jefferson	1.73
18051-00040	Hospital Drive	0.63
18063-00002	Pauline Garage	1.81
18049-00009C	Vacant Lot - Adams	0.42
	Total Acreage	18.55

Regional Medical Center at Memphis +/- 18.55Acres

Satellite View



Adams Avenue
Dunlop Street
University of Tennessee
Jefferson Avenue
Dunlop Street
County of Shelby
County of Shelby
County of Shelby
City of Memphis
State of TN
City of Memphis
State of TN
Madison Avenue

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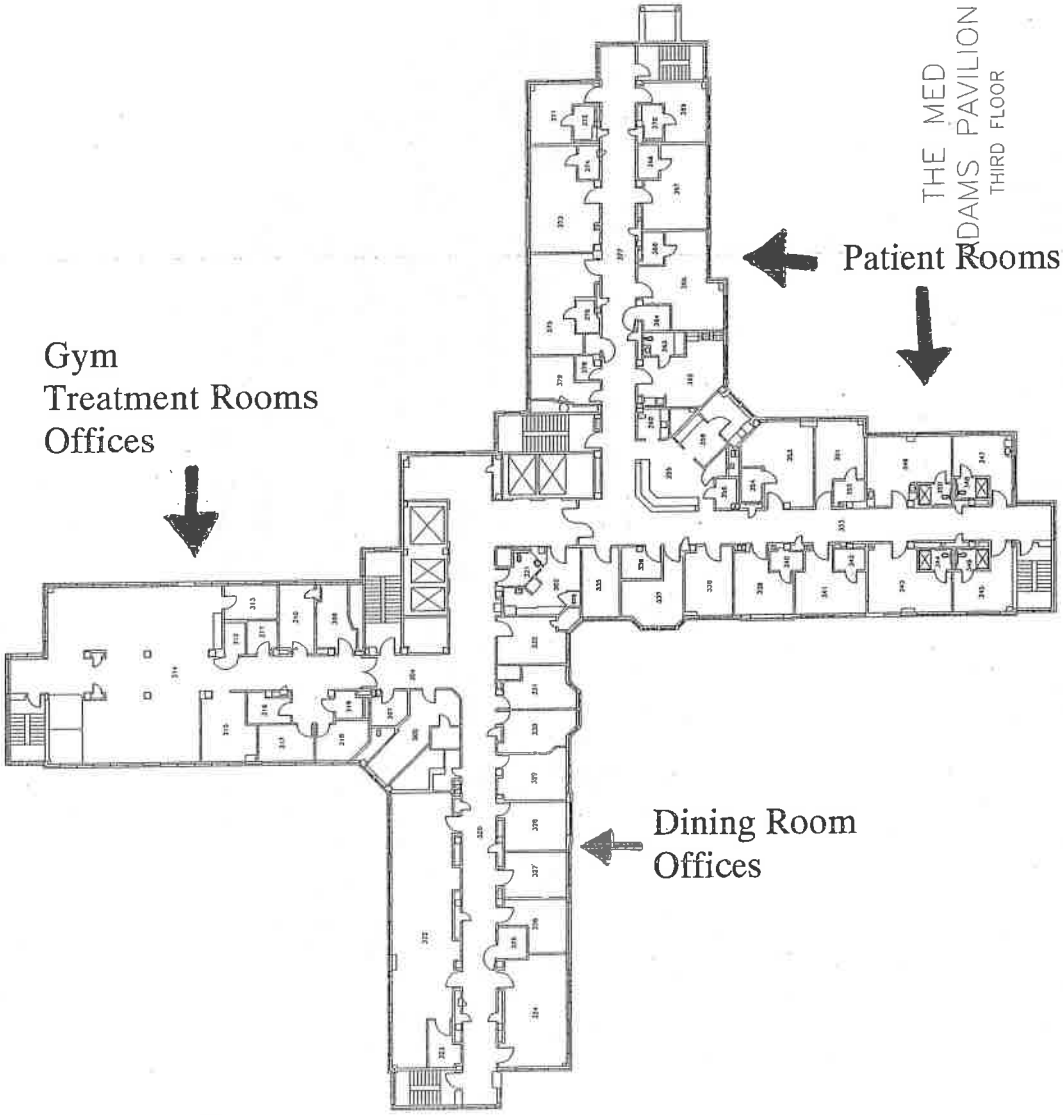
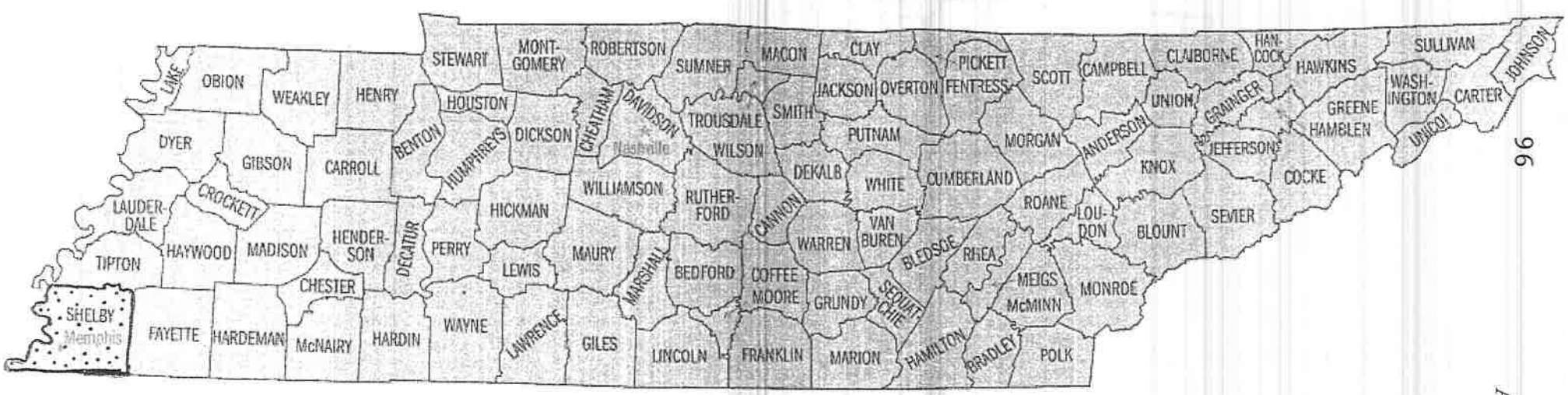
Attachment B.IV



Tennessee County Map



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Health Resources and Services Administration

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Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Shelby County
ID #: All

Results: 59 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Shelby County					
Shelby Service Area	03249	MUA	56.50	1994/07/12	
CT 0201.01					
CT 0201.02					
CT 0202.10					
CT 0205.12					
Shelby Service Area	03250	MUA	51.00	1994/07/12	
CT 0216.20					
CT 0219.00					
CT 0220.22					
CT 0220.23					
CT 0220.24					
CT 0221.11					
CT 0221.12					
CT 0222.10					
CT 0222.20					
CT 0223.10					
CT 0223.21					
CT 0223.30					
CT 0224.10					
CT 0225.00					
CT 0227.00					
Nw Memphis Service Area	07469	MUA	56.00	2005/04/06	
CT 0002.00					
CT 0003.00					
CT 0004.00					
CT 0006.00					
CT 0007.00					
CT 0008.00					
CT 0009.00					
CT 0011.00					
CT 0012.00					
CT 0013.00					
CT 0014.00					
CT 0015.00					
CT 0017.00					
CT 0019.00					
CT 0020.00					
CT 0021.00					
CT 0024.00					
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CT 0027.00					
CT 0028.00					
CT 0030.00					
CT 0036.00					
CT 0089.00					
CT 0099.01					
CT 0099.02					
CT 0100.00					
CT 0101.10					
CT 0101.20					
CT 0102.10					
CT 0102.20					
CT 0103.00					
CT 0111.00					
CT 0112.00					
CT 0113.00					
CT 0205.21					
CT 0205.23					
CT 0205.24					

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U.S. Department of Health & Human Services

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HRSA U.S. Department of Health and Human Services
Health Resources and Services Administration

Enter Keywords SEARCH

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Find Shortage Areas: HPSA by State & County

- Shortage Designation Home
- Find Shortage Areas
- HPSA & MUA/P by Address
- HPSA Eligible for the Medicare Physician Bonus Payment
- MUA/P by State & County

Criteria:

State: Tennessee
County: Shelby County
ID: All
Date of Last Update: All Dates
HPSA Score (lower limit): 0

Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All

Results: 106 records found.
(Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.)

HPSA Name	ID	Type	FTE	# Short	Score
157 - Shelby County					
Low Income - N.W. Memphis-Frayser	1479994706	Population Group	20	6	15
C.T. 0002.00		Census Tract			
C.T. 0003.00		Census Tract			
C.T. 0004.00		Census Tract			
C.T. 0006.00		Census Tract			
C.T. 0007.00		Census Tract			
C.T. 0008.00		Census Tract			
C.T. 0009.00		Census Tract			
C.T. 0011.00		Census Tract			
C.T. 0012.00		Census Tract			
C.T. 0013.00		Census Tract			
C.T. 0014.00		Census Tract			
C.T. 0015.00		Census Tract			
C.T. 0017.00		Census Tract			
C.T. 0019.00		Census Tract			
C.T. 0020.00		Census Tract			
C.T. 0021.00		Census Tract			
C.T. 0024.00		Census Tract			
C.T. 0025.00		Census Tract			
C.T. 0027.00		Census Tract			
C.T. 0028.00		Census Tract			
C.T. 0030.00		Census Tract			
C.T. 0036.00		Census Tract			
C.T. 0089.00		Census Tract			
C.T. 0099.01		Census Tract			
C.T. 0099.02		Census Tract			
C.T. 0100.00		Census Tract			
C.T. 0101.10		Census Tract			
C.T. 0101.20		Census Tract			
C.T. 0102.10		Census Tract			
C.T. 0102.20		Census Tract			
C.T. 0103.00		Census Tract			
C.T. 0111.00		Census Tract			
C.T. 0112.00		Census Tract			
C.T. 0113.00		Census Tract			
C.T. 0205.11		Census Tract			
C.T. 0205.12		Census Tract			
C.T. 0205.21		Census Tract			
C.T. 0205.23		Census Tract			
C.T. 0205.24		Census Tract			
Low Income - Southwest Memphis	1479994707	Population Group	40	2	8
C.T. 0037.00		Census Tract			
C.T. 0038.00		Census Tract			
C.T. 0039.00		Census Tract			
C.T. 0045.00		Census Tract			
C.T. 0046.00		Census Tract			
C.T. 0050.00		Census Tract			
C.T. 0053.00		Census Tract			
C.T. 0055.00		Census Tract			
C.T. 0056.00		Census Tract			
C.T. 0057.00		Census Tract			
C.T. 0058.00		Census Tract			
C.T. 0059.00		Census Tract			
C.T. 0060.00		Census Tract			
C.T. 0062.00		Census Tract			
C.T. 0063.00		Census Tract			
C.T. 0064.00		Census Tract			
C.T. 0065.00		Census Tract			
C.T. 0066.00		Census Tract			
C.T. 0067.00		Census Tract			
C.T. 0068.00		Census Tract			
C.T. 0069.00		Census Tract			
C.T. 0070.00		Census Tract			
C.T. 0073.00		Census Tract			
C.T. 0074.00		Census Tract			
C.T. 0075.00		Census Tract			
C.T. 0078.10		Census Tract			
C.T. 0078.21		Census Tract			
C.T. 0078.22		Census Tract			
C.T. 0079.00		Census Tract			
C.T. 0080.00		Census Tract			
C.T. 0081.10		Census Tract			
C.T. 0081.20		Census Tract			
C.T. 0082.00		Census Tract			
C.T. 0105.00		Census Tract			
C.T. 0106.10		Census Tract			
C.T. 0106.20		Census Tract			
C.T. 0106.30		Census Tract			
C.T. 0108.10		Census Tract			

C.T. 0110.10		Census Tract			
C.T. 0110.20		Census Tract			
C.T. 0114.00		Census Tract			
C.T. 0115.00		Census Tract			
C.T. 0116.00		Census Tract			
C.T. 0117.00		Census Tract			
C.T. 0118.00		Census Tract			
C.T. 0217.31		Census Tract			
C.T. 0220.22		Census Tract			
C.T. 0220.23		Census Tract			
C.T. 0220.24		Census Tract			
C.T. 0221.11		Census Tract			
C.T. 0221.12		Census Tract			
C.T. 0222.10		Census Tract			
C.T. 0222.20		Census Tract			
C.T. 0223.10		Census Tract			
C.T. 0223.21		Census Tract			
C.T. 0223.22		Census Tract			
C.T. 0223.30		Census Tract			
C.T. 0224.10		Census Tract			
C.T. 0225.00		Census Tract			
C.T. 0226.00		Census Tract			
C.T. 0227.00		Census Tract			
C.T. 9801.00		Census Tract			
Federal Correctional Institution - Memphis	1479994730	Correctional Facility	0	1	12
Christ Community Health Services, Inc.	1479994793	Comprehensive Health Center		0	18
Memphis Health Center, Inc.	1479994795	Comprehensive Health Center		0	17

Data as of: 11/7/2013

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Shelby County Nursing Home Bed Utilization
2009

State ID #	Nursing Home	Beds	Occ.	Total TNCare	TNCare	Total Level I	Level I	Total Level II	Level II	Pt days	Adm's
793062	Allen Morgan Health and Rehabilitation Center	104	74.9%	0	0.0%	25,098	88.2%	3,345	11.8%	28,443	165
793662	Allenbrooke Nursing and Rehabilitation Center, LLC	180	93.7%	0	0.0%	47,467	77.1%	14,099	22.9%	61,566	469
792962	Americare Health and Rehab Cntr	237	60.8%	90	0.2%	39,465	75.0%	13,165	25.0%	52,630	162
794962	Applingwood Health Care Center	78	91.2%	0	0.0%	20,949	80.7%	5,010	19.3%	25,959	99
792162	Ashton Place Health and Rehab Center	211	94.7%	0	0.0%	58,598	80.3%	14,350	19.7%	72,948	426
790162	Ave Maria Home	75	98.3%	0	0.0%	23,348	86.7%	2,569	9.5%	26,917	48
794862	Baptist Memorial Hospital - Memphis SNF	35	67.7%	0	0.0%	0	0.0%	8,647	100.0%	8,647	502
795162	Baptist Skilled Rehabilitation Unit - Germantown	*	*	*	*	*	*	*	*	*	*
790262	Bright Glade Health and Rehabilitation	81	88.8%	0	0.0%	20,336	77.4%	5,928	22.6%	26,264	171
791762	Cort Manor Nursing Cntr	98	69.0%	0	0.0%	21,832	88.5%	2,850	11.5%	24,682	116
790462	Dove Health & Rehab of Collierville, LLC	114	26.5%	0	0.0%	2,521	22.8%	8,517	77.2%	11,038	61
793162	Grace Healthcare of Cordova	284	77.7%	0	0.0%	54,178	67.3%	26,327	32.7%	80,505	721
794462	Graceland Nursing Center	240	95.5%	0	0.0%	53,671	64.1%	30,005	35.9%	83,676	380
793962	Kirby Pines Manor	120	95.3%	0	0.0%	35,815	85.8%	5,926	14.2%	41,741	200
794262	Memphis Jewish Home	160	92.9%	0	0.0%	29,878	55.1%	24,393	44.9%	54,271	295
794062	Methodist Healthcare Skilled Nursing Facility	44	38.2%	4,884	79.7%	0	0.0%	6,128	100.0%	6,128	489
791462	MidSouth Health and Rehabilitation Center	155	92.7%	0	0.0%	35,910	68.4%	16,556	31.6%	52,466	127
794362	Millington Healthcare Center	85	87.6%	0	0.0%	18,977	69.8%	8,209	30.2%	27,186	328
794162	Poplar Point Health and Rehabilitation	169	83.4%	0	0.0%	35,060	68.2%	16,358	31.8%	51,418	408
794662	Parkway Health and Rehabilitation Center	120	97.2%	855	2.0%	20,768	48.8%	21,822	51.2%	42,590	240
793362	Primacy Healthcare and Rehab Cntr	120	91.6%	0	0.0%	23,045	57.4%	17,072	42.6%	40,117	544
790962	Quality Care Center of Memphis	48	75.8%	0	0.0%	13,288	100.0%	0	0.0%	13,288	45
793262	Quince Nursing and Rehabilitation Center	188	96.2%	0	0.0%	47,969	72.7%	18,035	27.3%	66,004	492
790562	Rainbow Health & Rehab of Memphis, LLC	112	74.0%	0	0.0%	14,667	48.5%	15,602	51.5%	30,269	172
791562	Signature Health of Memphis	140	92.3%	33,032	70.0%	34,911	74.0%	12,246	26.0%	47,157	351
792862	Spring Gate Nursing and Rehabilitation Center	233	84.0%	0	0.0%	53,142	74.4%	18,331	25.6%	71,473	870
793762	Signature HealthCare at St. Francis	197	40.3%	0	0.0%	24,898	86.0%	4,067	14.0%	28,965	539
793462	Signature Healthcare at St. Peter Villa	180	95.6%	0	0.0%	42,521	67.7%	20,271	32.3%	62,792	317
790762	The King's Daughters and Sons Home	108	98.6%	0	0.0%	29,912	76.9%	8,961	23.1%	38,873	73
795062	The Village at Germantown	30	91.4%	0	0.0%	4,382	43.8%	5,629	56.2%	10,011	125
792662	Highlands of Memphis Health & Rehab	180	81.9%	0	0.0%	16,938	31.5%	36,886	68.5%	53,824	151
792262	Whitehaven Community Living Center	92	87.1%	0	0.0%	20,153	68.9%	9,096	31.1%	29,249	180
	TOTAL	4,218	82.6%		3.1%		68.4%		31.5%		

Source: JAR for Nursing Homes, 2009
** No JAR*

NOV 15 '10 PM 1:0

Attachment C.N.5

Shelby County Nursing Home Bed Utilization
2010

State ID #	Nursing Home	Beds	Occ.	Total TNCare	TNCare	Total Level I	Level I	Total Level II	Level II	Pt days	Adm's
793062	Allen Morgan Health and Rehabilitation Center	104	76.5%	0	0.0%	24,557	84.5%	4,496	15.5%	29,053	220
793662	Allenbrooke Nursing and Rehabilitation Center, LLC	180	93.8%	0	0.0%	49,461	80.3%	12,171	19.7%	61,632	402
792962	Americare Health and Rehab Cntr	237	60.7%	0	0.0%	39,392	75.1%	13,080	24.9%	52,472	157
794962	Applingwood Health Care Center	78	95.1%	0	0.0%	22,388	82.7%	4,688	17.3%	27,076	115
792162	Ashton Place Health and Rehab Center	211	94.3%	23,225	32.0%	50,339	69.3%	22,280	30.7%	72,619	491
790162	Ave Maria Home	75	97.9%	0	0.0%	24,037	89.7%	2,759	10.3%	26,796	71
794862	Baptist Memorial Hospital - Memphis SNF	35	81.2%	0	0.0%	0	0.0%	10,378	100.0%	10,378	583
795162	Baptist Skilled Rehabilitation Unit - Germantown	18	4.9%	0	0.0%	0	0.0%	324	100.0%	324	37
790262	Bright Glade Health and Rehabilitation	81	87.0%	0	0.0%	19,848	77.2%	5,861	22.8%	25,709	200
791762	Harbor View Nursing and Rehabiliation Center, Inc.	120	54.0%	0	0.0%	18,528	78.4%	5,109	21.6%	23,637	186
790462	Dove Health & Rehab of Collierville, LLC	114	66.6%	0	0.0%	18,726	67.5%	9,007	32.5%	27,733	192
793162	Grace Healthcare of Cordova	284	83.1%	0	0.0%	15,701	18.2%	70,402	81.8%	86,103	266
794462	Graceland Nursing Center	240	93.7%	30,334	36.9%	55,505	67.6%	26,612	32.4%	82,117	339
793962	Kirby Pines Manor	120	92.6%	0	0.0%	30,615	75.4%	9,963	24.6%	40,578	201
794262	Memphis Jewish Home	160	83.4%	0	0.0%	26,384	54.1%	22,342	45.9%	48,726	399
794062	Methodist Healthcare Skilled Nursing Facility	44	34.1%	0	0.0%	0	0.0%	5,472	100.0%	5,472	471
791462	MidSouth Health and Rehabilitation Center	155	30.3%	1,891	11.0%	12,631	73.7%	4,516	26.3%	17,147	47
794362	Millington Healthcare Center	85	94.0%	15,195	52.1%	20,513	70.3%	8,657	29.7%	29,170	329
794162	Poplar Point Health and Rehabilitation	169	86.8%	20,511	38.3%	39,858	74.4%	13,685	25.6%	53,543	377
794662	Parkway Health and Rehabilitation Center	120	83.0%	12,717	35.0%	23,593	64.9%	12,766	35.1%	36,359	308
793362	Primacy Healthcare and Rehab Cntr	120	95.5%	0	0.0%	20,586	49.2%	21,240	50.8%	41,826	684
790962	Quality Care Center of Memphis	48	74.3%	11,582	88.9%	12,833	98.5%	193	1.5%	13,026	39
793262	Quince Nursing and Rehabilitation Center	188	95.8%	0	0.0%	49,672	75.6%	16,047	24.4%	65,719	392
790562	Rainbow Health & Rehab of Memphis, LLC	112	94.8%	25,965	67.0%	22,835	58.9%	15,932	41.1%	38,767	158
791562	Signature Health of Memphis	140	95.9%	35,460	72.4%	34,474	70.3%	14,531	29.7%	49,005	247
792862	Spring Gate Nursing and Rehabilitation Center	233	86.8%	0	0.0%	54,002	73.1%	19,824	26.9%	73,826	901
793762	Signature HealthCare at St. Francis	197	101.1%	15,817	21.8%	33,345	45.9%	39,370	54.1%	72,715	777
793462	Signature Healthcare at St. Peter Villa	180	86.1%	0	0.0%	37,734	66.7%	18,844	33.3%	56,578	312
790762	The King's Daughters and Sons Home	108	98.3%	0	0.0%	28,881	74.5%	9,887	25.5%	38,768	108
795062	The Village at Germantown	30	91.3%	0	0.0%	0	0.0%	10,002	100.0%	10,002	187
792662	Highlands of Memphis Health & Rehab	180	81.5%	18,893	35.3%	43,301	80.8%	10,260	19.2%	53,561	123
792262	Whitehaven Community Living Center	88	93.8%	0	0.0%	23,743	78.8%	6,393	21.2%	30,136	138
	TOTAL	4,254	83.8%		16.3%		65.6%		34.4%		

Source: JAR for Nursing Homes, 2010

Shelby County Nursing Home Bed Utilization
2011

State ID #	Nursing Home	Beds	Occ.	Total TNCare	TNCare	Total Level I	Level I	Total Level II	Level II	Pt days	Adm's
793062	Allen Morgan Health and Rehabilitation Center	104	71.6%	0	0.0%	22,636	83.3%	4,542	16.7%	27,178	281
793662	Allenbrooke Nursing and Rehabilitation Center, LLC	180	95.7%	0	0.0%	51,066	81.3%	11,780	18.7%	62,846	267
792962	Civic Health and Rehabilitation Center	147	97.3%	0	0.0%	39,162	75.0%	13,048	25.0%	52,210	96
794962	Applingwood Health Care Center	78	86.0%	14,257	58.2%	18,728	76.5%	5,758	23.5%	24,486	151
792162	Ashton Place Health and Rehab Center	211	85.0%	54,495	83.2%	47,931	73.2%	17,533	26.8%	65,464	484
790162	Ave Maria Home	75	93.7%	8,647	33.7%	24,181	94.3%	1,471	5.7%	25,652	47
794862	Baptist Memorial Hospital - Memphis SNF	35	82.9%	0	0.0%	0	0.0%	10,590	100.0%	10,590	572
795162	Baptist Skilled Rehabilitation Unit - Germantown	18	78.0%	0	0.0%	0	0.0%	5,123	100.0%	5,123	424
790262	Bright Glade Health and Rehabilitation	81	86.1%	0	0.0%	19,091	75.0%	6,360	25.0%	25,451	148
791762	Harbor View Nursing and Rehabiliation Center, Inc.	120	79.5%	0	0.0%	26,129	75.1%	8,686	24.9%	34,815	257
790462	Dove Health & Rehab of Collierville, LLC	114	84.1%	23,489	67.1%	26,313	75.2%	8,683	24.8%	34,996	202
793162	Grace Healthcare of Cordova	284	71.5%	0	0.0%	55,248	74.5%	18,919	25.5%	74,167	261
794462	Graceland Nursing Center	240	87.3%	28,486	37.3%	53,307	69.7%	23,138	30.3%	76,445	258
793962	Kirby Pines Manor	120	96.3%	0	0.0%	32,304	76.6%	9,856	23.4%	42,160	237
794262	Memphis Jewish Home	160	76.0%	0	0.0%	28,178	63.5%	16,216	36.5%	44,394	491
794062	Methodist Healthcare Skilled Nursing Facility	44	33.4%	0	0.0%	0	0.0%	5,370	100.0%	5,370	438
791462	MidSouth Health and Rehabilitation Center	155	51.6%	0	0.0%	21,790	74.7%	7,382	25.3%	29,172	224
794362	Millington Healthcare Center	85	91.6%	0	0.0%	21,146	74.4%	7,264	25.6%	28,410	227
794162	Poplar Point Health and Rehabilitation	169	77.2%	42,184	88.6%	37,044	77.8%	10,560	22.2%	47,604	152
794662	Parkway Health and Rehabilitation Center	120	97.1%	0	0.0%	27,792	65.3%	14,757	34.7%	42,549	295
793362	Kindred Transitional Care and Rehab Cntr-Primacy	120	72.2%	0	0.0%	10,067	31.8%	21,570	68.2%	31,637	646
790962	Quality Care Center of Memphis	48	69.9%	11,628	95.0%	12,057	98.5%	187	1.5%	12,244	26
793262	Quince Nursing and Rehabilitation Center	188	96.7%	0	0.0%	50,492	76.1%	15,851	23.9%	66,343	408
790562	Rainbow Health & Rehab of Memphis, LLC	115	94.7%	28,056	70.6%	28,507	71.7%	11,256	28.3%	39,763	161
791562	Signature Health of Memphis	140	94.8%	35,791	73.9%	36,505	75.4%	11,935	24.6%	48,440	247
792862	Spring Gate Nursing and Rehabilitation Center	231	93.2%	0	0.0%	56,796	72.3%	21,795	27.7%	78,591	952
793762	Signature HealthCare at St. Francis	197	87.3%	30,648	48.8%	33,752	53.7%	29,055	46.3%	62,807	849
793462	Signature Healthcare at St. Peter Villa	180	82.9%	37,068	68.1%	37,142	68.2%	17,303	31.8%	54,445	324
790762	The King's Daughters and Sons Home	108	96.2%	21,150	55.8%	28,033	74.0%	9,875	26.0%	37,908	139
795062	The Village at Germantown	30	85.6%	0	0.0%	0	0.0%	9,371	100.0%	9,371	235
792662	Highlands of Memphis Health & Rehab	180	84.1%	40,320	73.0%	42,965	77.7%	12,300	22.3%	55,265	216
792262	Whitehaven Community Living Center	92	90.1%	26,331	87.0%	24,769	81.8%	5,499	18.2%	30,268	220
	TOTAL	4,169	84.5%		31.3%		71.0%		29.0%		

Source: JAR for Nursing Homes, 2011

NOTES: Civic Health and Rehab Center's license expired on July 1, 2013
Bright Glade Health and Rehab Center decreased bed count to 77 beds on April 1, 2011
Grace Healthcare of Cordova decreased bed count to 240 beds on July 1, 2013
Spring Gate Nursing and Rehab Center is licensed for 233 beds, according to TN DoH

Attachment C.EF.2

Regional Medical Center at Memphis

November 14, 2013

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

Re: 20 Bed SNF Unit

Mrs. Hill,

I am the Chief Financial Officer for Regional Medical Center. Our latest financials, submitted with our Certificate of Need application, indicate that we have sufficient cash reserves to fund this $300,000.00 project.

This is to notify you that our cash reserves are available for this project.

Please contact me if you have any questions.

Sincerely,

J. Richard Wagers Jr.

J. Richard Wagers, Jr.
Senior Executive Vice President & CFO

877 Jefferson Avenue Memphis, TN 38103 901.545.7100

Shelby County Nursing Homes Patient Charges

2009

Attachment C.EF.6.B.

Nursing Home	Beds	Occ.	Pt days	Avg. Gross	Avg. Deduct	Avg. Net
Allen Morgan Health and Rehab Cntr	104	74.9%	28,443	258.86	83.53	175.33
Allenbrooke Nursing & Rehab Cntr, LLC	180	93.7%	61,566	220.21	19.18	201.03
Americare Health and Rehab Cntr	237	60.8%	52,630	213.31	0.00	213.31
Applingwood Health Care Center	78	91.2%	25,959	230.29	11.48	218.82
Ashton Place Health and Rehab Center	211	94.7%	72,948	235.15	30.64	204.51
Ave Maria Home	75	98.3%	26,917	178.34	5.92	172.41
Baptist Memorial Hospital - Memphis SNF	35	67.7%	8,647	1140.73	779.26	361.48
Baptist Skilled Rehab Unit - Germantown	*	*	*	*	*	*
Bright Glade Health and Rehabilitation	81	88.8%	26,264	225.41	7.90	217.51
Cort Manor Nursing Cntr	98	69.0%	24,682	190.34	7.91	182.44
Dove Health & Rehab of Collierville, LLC	114	26.5%	11,038	315.36	131.53	183.83
Grace Healthcare of Cordova	284	77.7%	80,505	383.35	170.53	212.82
Graceland Nursing Center	240	95.5%	83,676	195.50	15.65	179.85
Kirby Pines Manor	120	95.3%	41,741	234.29	11.69	222.61
Memphis Jewish Home	160	92.9%	54,271	390.98	143.99	246.99
Methodist Healthcare Skilled Nursing Facility	44	38.2%	6,128	1434.97	1001.24	433.73
MidSouth Health and Rehabilitation Center	155	92.7%	52,466	198.13	34.92	163.21
Millington Healthcare Center	85	87.6%	27,186	359.99	139.24	220.75
Poplar Point Health and Rehabilitation	169	83.4%	51,418	219.18	23.51	195.67
Parkway Health and Rehabilitation Center	120	97.2%	42,590	289.40	93.51	195.89
Primacy Healthcare and Rehab Cntr	120	91.6%	40,117	296.46	6.15	290.31
Quality Care Center of Memphis	48	75.8%	13,288	103.94	0.00	103.94
Quince Nursing and Rehabilitation Center	188	96.2%	66,004	250.08	20.94	229.14
Rainbow Health & Rehab of Memphis, LLC	112	74.0%	30,269	373.08	117.10	255.98
Signature Health of Memphis	140	92.3%	47,157	224.95	15.29	209.66
Spring Gate Nursing & Rehab Cntr	233	84.0%	71,473	230.79	0.00	230.79
Signature HealthCare at St. Francis	197	40.3%	28,965	456.44	37.52	418.91
Signature Healthcare at St. Peter Villa	180	95.6%	62,792	245.89	43.55	202.34
The King's Daughters and Sons Home	108	98.6%	38,873	212.67	19.82	192.85
The Village at Germantown	30	91.4%	10,011	276.33	0.00	276.33
Highlands of Memphis Health & Rehab	180	81.9%	53,824	207.65	16.73	190.92
Whitehaven Community Living Center	92	87.1%	29,249	247.94	45.83	202.10

Source: JAR for Nursing Homes, 2009

Notes: Avg. Gross = average gross charge per paient day
Avg. Deduct = average deductions per paient day
Avg. Net = average net charge per paient day

* No JAR

Shelby County Nursing Homes Patient Charges
105
2010

Nursing Home	Beds	Occ.	Pt days	Avg. Gross	Avg. Deduct	Avg. Net
Allen Morgan Health and Rehab Cntr	104	76.5%	29,053	267.03	67.70	199.33
Allenbrooke Nursing and Rehab Cntr, LLC	180	93.8%	61,632	224.67	16.91	207.76
Americare Health and Rehab Cntr	237	60.7%	52,472	210.45	0.00	210.45
Applingwood Health Care Center	78	95.1%	27,076	233.34	14.98	218.37
Ashton Place Health and Rehab Center	211	94.3%	72,619	250.43	22.75	227.68
Ave Maria Home	75	97.9%	26,796	190.77	14.05	176.72
Baptist Memorial Hospital - Memphis SNF	35	81.2%	10,378	910.36	773.36	137.00
Baptist Skilled Rehabilitation Unit - Germantown	18	4.9%	324	1604.18	1185.65	418.53
Bright Glade Health and Rehabilitation	81	87.0%	25,709	247.43	9.83	237.60
Harbor View Nursing & Rehab Cntr, Inc.	120	54.0%	23,637	239.63	12.58	227.05
Dove Health & Rehab of Collierville, LLC	114	66.6%	27,733	335.46	58.91	276.56
Grace Healthcare of Cordova	284	83.1%	86,103	260.59	70.64	189.95
Graceland Nursing Center	240	93.7%	82,117	219.66	31.23	188.43
Kirby Pines Manor	120	92.6%	40,578	308.59	140.58	168.01
Memphis Jewish Home	160	83.4%	48,726	399.06	141.17	257.90
Methodist Healthcare Skilled Nursing Facility	44	34.1%	5,472	1492.97	1102.62	390.35
MidSouth Health and Rehabilitation Center	155	30.3%	17,147	221.17	34.71	186.46
Millington Healthcare Center	85	94.0%	29,170	362.33	131.34	230.99
Poplar Point Health and Rehabilitation	169	86.8%	53,543	206.32	8.37	197.95
Parkway Health and Rehabilitation Center	120	83.0%	36,359	349.85	111.41	238.43
Primacy Healthcare and Rehab Cntr	120	95.5%	41,826	300.64	5.52	295.12
Quality Care Center of Memphis	48	74.3%	13,026	114.12	0.00	114.12
Quince Nursing and Rehabilitation Center	188	95.8%	65,719	250.52	19.28	231.24
Rainbow Health & Rehab of Memphis, LLC	112	94.8%	38,767	371.85	123.44	248.41
Signature Health of Memphis	140	95.9%	49,005	225.78	71.58	154.20
Spring Gate Nursing and Rehabilitation Center	233	86.8%	73,826	238.97	0.00	238.97
Signature HealthCare at St. Francis	197	101.1%	72,715	233.80	757.84	158.01
Signature Healthcare at St. Peter Villa	180	86.1%	56,578	20.50	5.64	14.86
The King's Daughters and Sons Home	108	98.3%	38,768	215.97	17.32	198.66
The Village at Germantown	30	91.3%	10,002	402.72	0.00	402.72
Highlands of Memphis Health & Rehab	180	81.5%	53,561	285.30	22.90	262.39
Whitehaven Community Living Center	88	93.8%	30,136	231.83	34.02	197.81

Source: JAR for Nursing Homes, 2010

Notes: Avg. Gross = average gross charge per paient day
Avg. Deduct = average deductions per paient day
Avg. Net = average net charge per paient day

Shelby County Nursing Homes Patient Charges
106
2011

Nursing Home	Beds	Occ.	Pt days	Avg. Gross	Avg. Deduct	Avg. Net
Allen Morgan Health and Rehab Cntr	104	71.6%	27,178	293.81	47.11	246.70
Allenbrooke Nursing and Rehab Cntr, LLC	180	95.7%	62,846	221.42	13.13	208.28
Civic Health and Rehab Cntr	147	97.3%	52,210	0.00	0.00	0.00
Applingwood Health Care Center	78	86.0%	24,486	270.16	16.10	254.06
Ashton Place Health and Rehab Center	211	85.0%	65,464	229.50	5.08	224.42
Ave Maria Home	75	93.7%	25,652	227.62	20.70	206.91
Baptist Memorial Hospital - Memphis SNF	35	82.9%	10,590	983.09	817.95	165.14
Baptist Skilled Rehab Unit - Germantown	18	78.0%	5,123	1810.77	1270.46	540.31
Bright Glade Health and Rehabilitation	81	86.1%	25,451	269.85	9.31	260.55
Harbor View Nursing and Rehab Cntr, Inc.	120	79.5%	34,815	269.10	18.54	250.56
Dove Health & Rehab of Collierville, LLC	114	84.1%	34,996	310.38	47.91	262.47
Grace Healthcare of Cordova	284	71.5%	74,167	285.52	92.31	193.21
Graceland Nursing Center	240	87.3%	76,445	230.19	32.82	197.37
Kirby Pines Manor	120	96.3%	42,160	316.75	151.48	165.27
Memphis Jewish Home	160	76.0%	44,394	412.40	129.03	283.36
Methodist Healthcare SNF	44	33.4%	5,370	1667.91	1314.51	353.40
MidSouth Health and Rehab Cntr	155	51.6%	29,172	285.88	17.62	268.26
Millington Healthcare Center	85	91.6%	28,410	311.37	59.51	251.86
Poplar Point Health and Rehabilitation	169	77.2%	47,604	211.50	3.49	208.01
Parkway Health and Rehabilitation Center	120	97.1%	42,549	269.02	52.72	216.30
Kindred Transitional Care & Rehab Cntr-Primacy	120	72.2%	31,637	362.77	4.48	358.29
Quality Care Center of Memphis	48	69.9%	12,244	120.80	0.00	120.80
Quince Nursing and Rehabilitation Center	188	96.7%	66,343	256.10	17.27	238.82
Rainbow Health & Rehab of Memphis, LLC	115	94.7%	39,763	274.52	38.05	236.47
Signature Health of Memphis	140	94.8%	48,440	201.38	31.02	170.36
Spring Gate Nursing and Rehabilitation Center	231	93.2%	78,591	235.57	0.00	235.57
Signature HealthCare at St. Francis	197	87.3%	62,807	211.61	20.05	191.57
Signature Healthcare at St. Peter Villa	180	82.9%	54,445	231.79	48.43	183.36
The King's Daughters and Sons Home	108	96.2%	37,908	226.09	17.32	208.77
The Village at Germantown	30	85.6%	9,371	418.16	0.00	418.16
Highlands of Memphis Health & Rehab	180	84.1%	55,265	333.45	52.32	281.13
Whitehaven Community Living Center	92	90.1%	30,268	229.36	34.35	195.01

Source: JAR for Nursing Homes, 2011

Notes: Avg. Gross = average gross charge per paient day
Avg. Deduct = average deductions per paient day
Avg. Net = average net charge per paient day

NOTES: Civic Health and Rehab Center's license expired on July 1, 2013
Bright Glade Health and Rehab Center decreased bed count to 77 beds on April 1, 2011
Grace Healthcare of Cordova decreased bed count to 240 beds on July 1, 2013
Spring Gate Nursing and Rehab Center is licensed for 233 beds, according to TN DoH

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Basic Financial Statements and Schedules

June 30, 2013 and 2012

(With Independent Auditors' Report Thereon)

NOV 15 '13 PM1:01

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

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SUPPLEMENTAL - # 1
Supplemental C.EF.10
December 17, 2013
1:30pm

KPMG LLP
Suite 900
50 North Front Street
Memphis, TN 38103-1194

Independent Auditors' Report

The Board of Directors
Shelby County Health Care Corporation:

Report on the Financial Statements

We have audited the accompanying statements of net position and statements of revenues, expenses, and changes in net position and cash flows of Shelby County Health Care Corporation, a component unit of Shelby County, Tennessee (d/b/a The Regional Medical Center at Memphis – The Med) as of and for the years ended June 30, 2013 and 2012, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

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

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective net position of Shelby County Health Care Corporation as of June 30, 2013 and 2012, and the respective changes in net position and cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise The Med's basic financial statements. The supplementary information included in Schedule 1, 2, and 3 is presented for the purpose of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the basic financial statements. The information, except for the portion marked "unaudited," on which we express no opinion, has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements as a whole.

Management has omitted management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October 18, 2013 on our consideration of The Med's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering The Med's internal control over financial reporting and compliance.

KPMG LLP

Memphis, Tennessee
October 18, 2013

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Net Position

June 30, 2013 and 2012

Assets		**2013**	**2012**
Assets:			
Cash and cash equivalents	$	15,471,067	18,647,650
Investments		121,197,478	122,945,621
Patient accounts receivable, net of allowances for uncollectible accounts of $102,548,000 in 2013 and $119,208,000 in 2012		45,906,287	50,147,138
Other receivables		9,870,264	8,543,744
Other current assets		4,974,546	4,306,744
Restricted investments		3,720,087	3,323,723
Capital assets, net		87,769,941	63,111,622
Total assets	$	288,909,670	271,026,242
Liabilities and Net Position			
Liabilities:			
Accounts payable	$	12,042,438	9,658,526
Accrued expenses and other current liabilities		27,518,945	27,159,845
Accrued professional and general liability costs		5,200,000	6,018,000
Net postemployment benefit obligation		912,000	912,000
Total liabilities		45,673,383	43,748,371
Net position:			
Net investment in capital assets		87,769,941	63,111,622
Restricted for:			
Capital assets		2,897,689	2,572,798
Indigent care		822,398	750,925
Unrestricted		151,746,259	160,842,526
Total net position		243,236,287	227,277,871
Commitments and contingencies			
Total liabilities and net position	$	288,909,670	271,026,242

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Statements of Revenues, Expenses, and Changes in Net Position

Years ended June 30, 2013 and 2012

	2013	2012
Operating revenues:		
Net patient service revenue (including additional incremental reimbursement from various state agencies for participation in TennCare/Medicaid programs of approximately $72,928,000 in 2013 and $80,997,000 in 2012)	$ 303,785,730	325,541,073
Other revenue	17,299,369	10,225,345
Total operating revenues	321,085,099	335,766,418
Operating expenses:		
Salaries and benefits	150,862,502	146,617,414
Supplies and services	70,047,247	67,116,810
Physician and professional fees	27,904,579	25,813,984
Purchased medical services	23,827,404	22,226,761
Plant operations	12,348,849	13,171,232
Insurance	2,011,533	2,820,277
Administrative and general	31,961,705	22,734,934
Community services	632,390	1,380,063
Depreciation and amortization	13,000,644	11,391,621
Total operating expenses	332,596,853	313,273,096
Operating (loss) gain	(11,511,754)	22,493,322
Nonoperating revenues:		
Investment income	347,504	1,423,480
Appropriations from Shelby County	26,816,001	26,816,511
Other	306,665	2,662
Total nonoperating revenues	27,470,170	28,242,653
Increase in net position	15,958,416	50,735,975
Net position, beginning of year	227,277,871	176,541,896
Net position, end of year	$ 243,236,287	227,277,871

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Cash Flows

Years ended June 30, 2013 and 2012

		2013	2012
Cash flows from operating activities:			
Receipts from and on behalf of patients and third-party payors	$	307,747,888	304,745,173
Other cash receipts		16,361,590	10,172,165
Payments to suppliers		(166,237,587)	(156,711,192)
Payments to employees and related benefits		(152,211,460)	(143,356,032)
Net cash provided by operating activities		5,660,431	14,850,114
Cash flows from noncapital financing activity:			
Appropriations received from Shelby County		26,816,001	26,816,511
Net cash provided by noncapital financing activity		26,816,001	26,816,511
Cash flows from capital and related financing activities:			
Capital expenditures		(37,669,963)	(20,703,680)
Proceeds from sale of capital assets		40,600	18,637
Net cash used in capital and related financing activities		(37,629,363)	(20,685,043)
Cash flows from investing activities:			
Purchases of investments		(236,280,471)	(152,418,086)
Proceeds from sale of investments		240,307,747	101,347,058
Distributions received from joint venture		277,065	—
Investment income proceeds		(2,327,993)	1,919,634
Net cash provided by (used in) investing activities		1,976,348	(49,151,394)
Net decrease in cash and cash equivalents		(3,176,583)	(28,169,812)
Cash and cash equivalents, beginning of year		18,647,650	46,817,462
Cash and cash equivalents, end of year	$	15,471,067	18,647,650

(Continued)

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Cash Flows

Years ended June 30, 2013 and 2012

	2013	2012
Reconciliation of operating (loss) gain to net cash provided by operating activities:		
Operating (loss) gain	$ (11,511,754)	22,493,322
Adjustment to reconcile operating (loss) gain to net cash provided by operating activities:		
Depreciation and amortization	13,000,644	11,391,621
Changes in operating assets and liabilities:		
Patients accounts receivable, net	4,240,851	(20,747,895)
Other receivables	(1,326,520)	(156,760)
Other current assets	(667,802)	(520,021)
Accounts payable	2,383,912	2,806,081
Accrued expenses and other current liabilities	359,100	65,766
Accrued professional and general liability costs	(818,000)	(482,000)
Net cash provided by operating activities	$ 5,660,431	14,850,114
Supplemental schedule of noncash investing and financing activities:		
Net decrease in the fair value of investments	$ 2,674,511	486,477
Gain on capital asset disposals	29,600	2,662

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2013 and 2012

(1) Organization and Summary of Significant Accounting Policies

Shelby County Health Care Corporation (d/b/a The Regional Medical Center at Memphis – The Med) was incorporated on June 15, 1981, with the approval of the Board of County Commissioners of Shelby County, Tennessee (the County). The Med is a broad continuum healthcare provider that operates facilities owned by the County under a long-term lease. The lease arrangement effectively provided for the transfer of title associated with operating fixed assets and the long-term lease (for a nominal amount) of related real property. The lease expires in 2031.

The Med is a component unit of the County as defined by Governmental Accounting Standards Board (GASB) Statement No. 61, *The Financial Reporting Entity: Omnibus – an amendment of GASB Statement No. 14 and No. 34*. The Med's component unit relationship to the County is principally due to financial accountability and financial benefit or burden as defined in GASB Statement No. 61. The Med is operated by a 13-member board of directors, all of whom are appointed by the Mayor of the County and approved by the County Commission.

The Regional Medical Center at Memphis Foundation (The Med Foundation) is a component unit of The Med principally due to The Med's financial accountability and financial benefit or burden for The Med Foundation as defined in GASB Statement No. 61. The Med Foundation is operated by a board of directors, all of whom are appointed by The Med's board. The Med Foundation is a blended component unit of The Med because it provides services entirely to The Med. The Med Foundation issues separate audited financial statements, which can be obtained by writing to The Regional Medical Center Foundation, 877 Jefferson Avenue, Memphis, Tennessee 38103 or by calling 901-545-7482.

GASB Statement No. 34, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments*, requires a management's discussion and analysis (MD&A) section providing an analysis of The Med's overall financial position and results of operations; however, The Med has chosen to omit the MD&A from these accompanying financial statements.

The significant accounting policies used by The Med in preparing and presenting its financial statements follow:

(a) Presentation

The financial statements include the accounts of The Med. All material intercompany accounts and transactions have been eliminated.

(b) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires that management make estimates and assumptions affecting the reported amounts of assets, liabilities, revenues, and expenses, as well as disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Significant items subject to estimates and assumptions include the determination of the allowances for contractual adjustments and uncollectible accounts, reserves for professional and general liability

(Continued)

claims, reserves for employee healthcare claims, net postretirement benefit cost and obligation, and estimated third-party payor settlements.

In addition, laws and regulations governing the Medicare, TennCare, and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates related to these programs will change by a material amount in the near term.

(c) Enterprise Fund Accounting

The Med's financial statements are prepared using the economic resources measurement focus and accrual basis of accounting.

(d) Cash Equivalents

The Med considers investments in highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents.

(e) Investments and Investment Income

Investments are carried at fair value, principally based on quoted market prices. Investment income (including realized and unrealized gains and losses) from investments is reported as nonoperating revenue.

(f) Inventories

Inventories, consisting principally of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out method) or replacement market.

(g) Investments in Joint Ventures

Investments in joint ventures consist of The Med's equity interests in joint ventures as measured by its ownership interest if The Med has an ongoing financial interest in or ongoing financial responsibility for the joint venture. The investments are initially recorded at cost and are subsequently adjusted for additional contributions, distributions, undistributed earnings and losses, and impairment losses.

(h) Capital Assets

Capital assets are recorded at cost, if purchased, or at fair value at the date of donation. Depreciation is provided over the useful life of each class of depreciable asset using the straight-line method. Maintenance and repairs are charged to operations. Major renewals and betterments are capitalized. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts and the gain or loss, if any, is included in nonoperating revenues (expenses) in the accompanying statements of revenues, expenses, and changes in net position.

The Med capitalizes interest cost on qualified construction expenditures, net of income earned on related trusteed assets, as a component of the cost of related projects. No such interest costs were capitalized in 2013 or 2012.

All capital assets other than land are depreciated using the following lives:

Land improvements	5 to 25 years
Buildings and improvements	10 to 40 years
Fixed equipment	5 to 25 years
Movable equipment	3 to 20 years
Software	3 years

(i) Impairment of Capital Assets

Capital assets are reviewed for impairment when service utility has declined significantly. If such assets are no longer used, they are reported at the lower of carrying value or fair value. If such assets will continue to be used, the impairment loss is measured using the method that best reflects the diminished service utility of the capital asset. No charge related to impairment matters was required during 2013 or 2012.

(j) Compensated Absences

The Med's employees accumulate vacation, holiday, and sick leave at varying rates depending upon years of continuous service and payroll classification, subject to maximum limitations. Upon termination of employment, employees are paid all unused accrued vacation and holiday time at regular rate of pay up to a designated maximum number of days. Since the employees' vacation and holiday time accumulates and vests, an accrual for this liability is included in accrued expenses and other current liabilities in the accompanying statements of net positions. An accrual is recognized for unused sick leave expected to be paid to employees eligible to retire.

(k) Net Position

Net position of The Med is classified into the following components:

- *Net investment in capital assets*, consist of capital assets net of accumulated depreciation.
- *Restricted* include those amounts with limits on their use that are externally imposed (by creditors, grantors, contributors, or the laws and regulations of other governments).
- *Unrestricted* represents remaining amounts that do not meet either of the above definitions.

When The Med has both restricted and unrestricted resources available to finance a particular program, it is The Med's policy to use restricted resources before unrestricted resources.

The Med Foundation historically and to-date does not maintain donor-restricted endowment funds, or any Board-designated endowments. The Med Foundation's Board has interpreted Tennessee's State Prudent Management of Institutional Funds Act (SPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. In all material respects, income from The Med Foundation's donor-restricted endowment funds is itself restricted to specific donor-directed purposes, and is, therefore, accounted for within restricted amounts until expended in accordance

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with the donor's wishes. The Med Foundation oversees individual donor-restricted endowment funds to ensure that the fair value of the original gift is preserved.

(l) Statement of Revenues, Expenses, and Changes in Net Position

For purposes of presentation, transactions deemed by management to be ongoing, major, or central to the provision of healthcare services, other than financing costs, are reported as operating revenues and operating expenses. Other transactions, such as investment income, appropriations from Shelby County, gain (loss) on disposal of capital assets, and equity in earnings and impairment losses of joint ventures, are reported as nonoperating revenues and expenses.

(m) Net Patient Service Revenue

Net patient service revenue is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations. Changes in estimates related to prior cost reporting periods resulted in an increase in net patient service revenue of approximately $1,552,000 and $3,992,000 in 2013 and 2012, respectively.

(n) Charity Care

The Med provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because The Med does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

When defining charity care, The Med employs the Federal Poverty Guideline (FPG) to determine the level of discount uninsured patients receive. The level by which assistance is determined is through the scale set by DHHS (Department of Health and Human Services), which includes factors such as residents per household and income. The Med's methodology includes all patients that fall at or below the 150% FPG baseline. The Med does not have a cap to which patients will not qualify for a discount. Additionally, The Med's charity care guidelines provide for an expansive definition of charity care patients, including an upfront discount from standard charges for uninsured patients.

(o) Income Taxes

The Med is a not-for-profit corporation organized by the approval of the Board of County Commissioners of the County and qualifies as a tax-exempt entity under Internal Revenue Code (IRC) Section 501(a) as organizations described in IRC Section 501(c)(3), and therefore, related income is generally not subject to federal or state income taxes, except for tax on income from activities unrelated to its exempt purpose as described in IRC Section 512(a). Thus, no provision for income taxes has been recorded in the accompanying financial statements.

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(p) Appropriations

The County has historically appropriated funds annually to The Med to partially offset the cost of medical care for indigent residents of the County. Appropriations for indigent residents from the County were approximately $26.8 million for both the years ended June 30, 2013 and 2012. Appropriations from the County are reported as nonoperating revenue in the accompanying statements of revenues, expenses, and changes in net position.

(q) Recent Pronouncements

During the year ended June 30, 2013, The Med adopted GASB Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position*, (Statement No. 63). This new accounting pronouncement requires that amounts representing deferred outflows of resources be reported in a balance sheet in a separate section following assets. Similarly, amounts that are required to be reported as deferred inflows of resources should be reported in a separate section following liabilities. Statement No. 63 further requires that the balance sheet report the residual amount as "net position" rather than "net assets." Net position represents the difference between all other elements in a balance sheet and should be displayed in three components – "net investment in capital assets," "restricted," and "unrestricted." The adoption of Statement No. 63 did not have a material impact on The Med's financial statements.

During the year ended June 30, 2013, The Med adopted GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements* (Statement No. 62). The primary objective of the new accounting pronouncement is to directly incorporate the applicable provisions of FASB and American Institute of Certified Public Accountants (AICPA) pronouncements issued on or before November 30, 1989 into the state and local government accounting and financial reporting standards. Statement No. 62 also eliminates the option provided in GASB Statement No. 20 to apply post-November 30, 1989 FASB pronouncements not in conflict with GASB pronouncements. The adoption of Statement No. 62 did not have a material impact on The Med's financial statements.

During the year ended June 30, 2013, The Med adopted GASB Statement No. 61, *The Financial Reporting Entity: Omnibus – amendments of GASB Statements No. 14 and No. 34* (Statement No. 61). This new accounting pronouncement modifies certain requirements for inclusion of component units in the financial reporting entity. Statement No. 61 requires that financial benefit or burden criteria be met for those entities that were previously included by meeting the fiscal dependency criteria. In addition, for organizations that do not meet the financial accountability criteria for inclusion as component units but should be included because the primary government's management has determined that it would be misleading to exclude them, Statement No. 61 clarifies the manner in which such determination should be made and the types of relationships to be considered. Furthermore, Statement No. 61 clarifies when component units should be blended or presented discretely. The adoption of Statement No. 61 did not have a material impact on the Med's financial statements.

GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities* (Statement No. 65), was published in March 2012. This new pronouncement establishes accounting and financial

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reporting standards that reclassify, as deferred outflows of resources or deferred inflows of resources, certain items that were previously reported as assets and liabilities and recognizes, as outflows or inflows of resources, certain items that were previously reported as assets and liabilities. The provisions of Statement No. 65 are effective for financial statements for periods beginning after December 15, 2012 (The Med's fiscal year ending June 30, 2014).

(2) Deposits and Investments

The composition of cash and cash equivalents follows:

		2013	2012
Cash	$	15,449,393	14,534,478
Money market funds		21,674	4,113,172
	$	15,471,067	18,647,650

The Med's and The Med Foundation's bank balances that are considered to be exposed to custodial credit risk at June 30, 2013 are $15,088,140. Federal deposit insurance is $250,000 on all noninterest bearing accounts as of June 30, 2013. Federal deposit insurance is unlimited on all noninterest bearing accounts as of June 30, 2012, therefore, there is no custodial credit risk as of June 30, 2012.

Investments and restricted investments include amounts held by both The Med and The Med Foundation.

The composition of investments and restricted investments follows:

		2013	2012
U.S. agencies	$	64,876,372	77,644,977
Certificates of deposit		1,132,337	710,315
Corporate bonds		33,593,663	26,054,432
Discount notes		—	29,917
Demand deposit accounts and money market funds		6,192,098	19,052,649
U.S. government funds		696,264	173,931
Common stock		3,510,579	1,806,007
Bond funds and Bond exchange-traded fund		14,327,594	—
Accrued interest		588,658	797,116
	$	124,917,565	126,269,344

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SHELBY COUNTY HEALTH CARE CORPORATION
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June 30, 2013 and 2012

At June 30, 2013, The Med and The Med Foundation had investments in debt securities with the following maturities:

		Investment and restricted investment maturities (in years)			
	Fair value	Less than 6 months	6 months to 1 year	1 – 5 years	5+ years
U.S. agencies	$ 64,876,372	—	—	6,957,190	57,919,182
Corporate bonds	33,593,663	1,440,126	616,649	26,579,958	4,956,930
	$ 98,470,035	1,440,126	616,649	33,537,148	62,876,112

At June 30, 2012, The Med and The Med Foundation had investments in debt securities with the following maturities:

		Investment and restricted investment maturities (in years)			
	Fair value	Less than 6 months	6 months to 1 year	1 – 5 years	5+ years
U.S. agencies	$ 77,644,977	1,241,430	51,623	41,544,954	34,806,970
Corporate bonds	26,054,432	454,424	7,522,726	14,719,645	3,357,637
Discount notes	29,917	29,917	—	—	—
	$ 103,729,326	1,725,771	7,574,349	56,264,599	38,164,607

At June 30, 2013, The Med Foundation had one investment totaling $696,263 in the SEI Daily Income Trust Government Fund that represented 5% or more of total investments for The Med Foundation. The Med as of June 30, 2013 had one investment totaling $13,351,894 in iShares Barclays Intermediate Term Corporate Credit Fund that represented more than 5% of total investments. There were no investments that represented 5% or more of total investments as of June 30, 2012.

(Continued)

The Med and The Med Foundation have separate investment policies that are included below. The summary of investments throughout the financial statements include the combined investment totals of The Med and The Med Foundation.

At June 30, 2013, The Med's and The Med Foundation's corporate bonds, collectively, had the following credit ratings per Standard and Poor's:

	Fair value	Credit rating
$	302,061	BBB-
	2,408,467	BBB
	2,820,895	BBB+
	14,018,451	A-
	9,493,989	A
	2,940,469	A+
	541,102	AA-
	1,068,229	AA+
$	33,593,663	

At June 30, 2012, The Med's and The Med Foundation's corporate bonds, collectively, had the following credit ratings per Standard and Poor's:

	Fair value	Credit rating
$	211,957	BBB-
	367,976	BBB
	838,849	BBB+
	16,800,217	A-
	3,696,146	A
	3,357,038	A+
	782,249	AA+
$	26,054,432	

The Med's and The Med Foundation's investments in discount notes at June 30, 2013 and 2012 were not rated.

As of June 30, 2013, The Med's investment strategy, per its investment policy, is to provide liquidity to fund ongoing operating needs and to act as a repository for both the accumulation of cash reserves needed to cushion economic down cycles and to provide cash earmarked for strategic needs.

The portfolio objectives of The Med, listed in order of importance, are as follows:

1. Preserve principal.

2. Maintain sufficient liquidity to meet forecasted cash needs.

(Continued)

3. Maintain a diversified portfolio in order to minimize credit risk.

4. Maximize yield subject to the above criteria.

The duration of the bond investment portfolio should not exceed 6 years.

The authorized investments are as follows:

1. *Commercial Paper* – Any commercial paper issued by a domestic corporation with a maturity of 270 or less days that carries at least the second highest rating by a recognized investor service, preferably Standard and Poor's and Moody's Investors Service. Commercial paper shall not represent more than 50% of the portfolio.

2. *U.S. Treasury Securities* – U.S. Treasury notes, bills, and bonds. There is no upper limit restriction as to the maximum dollar amount or percentage of the portfolio that may be invested in U.S. Treasury securities.

3. *Bank Obligations* – Any certificate of deposit, time deposit, Eurodollar CD issued by a foreign branch of a U.S. bank, bankers' acceptance, bank note, or letter of credit issued by a (U.S.) bank possessing at least the second highest rating by a recognized investor services, preferably Standard and Poor's and Moody's Investors Service. Bank obligations (excluding repurchase agreements, commercial paper, and investments held by money market and mutual funds) may not represent more than 30% of the portfolio. In addition, brokered CDs may be purchased from institutions, irrespective of the institutions' debt ratings, so long as the obligations are fully backed by the FDIC.

4. *Repurchase Agreements* – Any Repurchase Agreement purchased from one of the top 25 U.S. banks or one of the primary dealers regulated by the Federal Reserve that is at least 102% collateralized by U.S. government obligations. Repurchase Agreements may not represent more than 20% of the portfolio.

5. *Money Market Funds* – Any open-end money market fund regulated by the U.S. government under Investment Company Act Rule 2a-7. Any investment fund regulated by a Registered Investment Advisor under Rule 3c-7. Such fund investment guidelines must state that "the fund will seek to maintain a $1 per share net asset value." The Med's investment in any one fund may not exceed 30% of the assets of the fund into which it is invested.

6. *United States Government Obligations* – Any obligation issued or backed (federal agencies) by the U.S. government. No more than 25% may be invested in obligations of any one federal agency.

7. *Corporate Bonds* – Obligations of United States and foreign corporations (including trusts and municipalities of the United States) that carry at least the third highest rating by a recognized rating service, preferably Standard & Poor's or Moody's Investors Service. Corporate bonds, held directly and initially qualifying in one of the above categories, which have been downgraded below the third highest rating, may be sold at the discretion of management. Corporate bonds may not represent more than 40% of the portfolio, foreign corporate bonds may not represent more than 20% of the

(Continued)

portfolio, and corporate bonds in the fourth highest rating category may not represent more than 20% of the portfolio.

8. *Bond Mutual Funds* – Any publicly available investment registered under the Investment Company Act of 1940 as on open-end mutual fund that is managing a portfolio or debt obligations. Each mutual fund should have a minimum of $2 billion invested and hold at least 100 different debt obligations. Bond mutual funds can only hold the Authorized Investments meeting all the criteria described above. Additionally, bond mutual funds can hold corporate bonds in the fifth and sixth highest ratings category as long as such holdings to not exceed 10% of the portfolio. Corporate bonds, held via bond mutual funds and initially qualifying in one of the above categories, which have been downgraded below the sixth highest rating, may not exceed 2% of the portfolio.

9. *Equity Mutual Funds* – Any publicly available investment registered under the Investment Company Act of 1940 as an open-end mutual fund that is managing a portfolio of equity securities. Each mutual fund should have a minimum of $2 billion invested and hold at least 100 different equity securities. Such holdings should not represent more than 20% of the portfolio, Equity Mutual Funds can hold equity securities (including common and preferred stocks) of the 1,000 largest corporations in terms of market capitalization and inclusion in the Russell 1000 Index (representing large cap stocks) that are traded on U.S. exchanges reported in the Wall Street Journal.

10. *Debt Buy Back* Any debt obligation backed directly by Regional Medical Center may be purchased so long as it is purchased at a discount.

11. Notwithstanding the above criteria, direct investments other than mutual funds that meet the following criteria are not permitted: corporations with more than 25% of revenues derived from the manufacture and sale of firearms, ammunition, and ammunition magazines to the general citizenry.

The Finance Committee of the Board of Directors meets periodically to review asset allocation, portfolio performance, and overall adherence to the investment policy guidelines.

As of June 30, 2013, The Med Foundation utilized one investment manager. This manager is required to make investments in adherence to The Med Foundation's current investment policy and objectives.

The Med Foundation follows an investment strategy focused on maximizing total return (i.e., aggregate return from capital appreciation and dividend and interest income) while adhering to certain restrictions designed to promote a conservative portfolio.

Specifically, the primary objective of The Med Foundation investment management strategy is to maintain an investment portfolio designed to generate a high level of current income with above-average stability.

Guidelines for investments and cash equivalents for The Med Foundation follow:

1. The Med Foundation's assets may be invested only in investment grade bonds rated Baa or higher as determined by Moody's Investors Service or by another acceptable rating agency.

2. The overall market-weighted quality rating of the bond portfolio shall be no lower than A.

3. The Med Foundation's assets may be invested only in commercial paper rated P-2 or higher by Moody's Investors Service or by another acceptable rating agency.

4. The market-weighted maturity of the base portfolio shall be no longer than 10 years.

5. Quality of the equity securities will be governed by the federal Employee Retirement and Income Security Act, the Tennessee guidelines for investing trust funds, and the "prudent man rule."

6. Conservative option strategies may be used, with a goal of increasing the stability of the portfolio.

The Med Foundation limits investments in common stock to 40% of its investment portfolio. The remainder of the portfolio is to be invested in fixed income investments.

Investment income is comprised of the following:

		2013	2012
Dividend and interest income	$	3,022,015	1,909,927
Net decrease in the fair value of investments		(2,674,511)	(486,447)
	$	347,504	1,423,480

(3) Business and Credit Concentrations

The Med grants credit to patients, substantially all of whom are local area residents. The Med generally does not require collateral or other security in extending credit to patients; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, Blue Cross, and commercial insurance policies).

The mix of receivables from patients and third-party payors follows, before application of related valuation allowances:

	2013	2012
Commercial insurance	31%	40%
Patients	36	32
Medicaid/TennCare	17	12
Medicare	16	16
	100%	100%

(Continued)

(4) Other Receivables

The composition of other receivables follows:

		2013	2012
Accounts receivable from University of Tennessee Center for Health Services	$	1,618,058	1,508,011
Accounts receivable from the County		49,536	84,936
Accounts receivable from the State of Tennessee		5,277,305	4,998,611
Grants receivable		291,099	294,783
Other		2,634,266	1,657,403
	$	9,870,264	8,543,744

(5) Other Current Assets

The composition of other current assets follows:

		2013	2012
Inventories	$	3,857,425	3,320,733
Prepaid expenses		1,117,121	986,011
	$	4,974,546	4,306,744

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SHELBY COUNTY HEALTH CARE CORPORATION
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Notes to Basic Financial Statements

June 30, 2013 and 2012

(6) Capital Assets

Capital assets and related activity consist of the following:

	Balances at June 30, 2012	Additions	Retirements	Transfers	Balances at June 30, 2013
Capital assets not being depreciated:					
Construction in progress	$ 7,641,128	31,289,335	—	(29,010,649)	9,919,814
Land	108,955	—	—	5,726,371	5,835,326
Total book value of capital assets not being depreciated	7,750,083	31,289,335	—	(23,284,278)	15,755,140
Capital assets being depreciated:					
Land improvements	6,812,481	51,970	—	—	6,864,451
Buildings	65,236,701	—	—	—	65,236,701
Fixed equipment	110,348,027	1,441,911	—	4,185,784	115,975,722
Movable equipment	125,991,913	4,468,458	(21,797)	7,938,927	138,377,501
Software	17,730,009	418,289	(2,826)	11,159,567	29,305,039
Total book value of capital assets being depreciated	326,119,131	6,380,628	(24,623)	23,284,278	355,759,414
Less accumulated depreciation for:					
Land improvements	(5,473,625)	(150,374)	—	—	(5,623,999)
Buildings	(55,773,625)	(804,888)	—	—	(56,578,513)
Fixed equipment	(90,073,720)	(3,152,146)	—	—	(93,225,866)
Movable equipment	(105,150,605)	(6,823,192)	13,623	—	(111,960,174)
Software	(14,286,017)	(2,070,044)	—	—	(16,356,061)
Total accumulated depreciation	(270,757,592)	(13,000,644)	13,623	—	(283,744,613)
Capital assets being depreciated, net	55,361,539	(6,620,016)	(11,000)	23,284,278	72,014,801
Capital assets, net	$ 63,111,622	24,669,319	(11,000)	—	87,769,941

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SHELBY COUNTY HEALTH CARE CORPORATION
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June 30, 2013 and 2012

	Balances at July 1, 2011	Additions	Retirements	Transfers	Balances at June 30, 2012
Capital assets not being depreciated:					
Construction in progress	$ 1,297,077	12,478,213	—	(6,134,162)	7,641,128
Land	—	—	—	108,955	108,955
Total book value of capital assets not being depreciated	1,297,077	12,478,213	—	(6,025,207)	7,750,083
Capital assets being depreciated:					
Land improvements	6,167,621	66,566	—	578,294	6,812,481
Buildings	65,236,701	—	—	—	65,236,701
Fixed equipment	107,454,124	1,909,677	(1,982)	986,208	110,348,027
Movable equipment	118,773,840	5,617,206	(141,092)	1,741,959	125,991,913
Software	14,379,245	632,018	—	2,718,746	17,730,009
Total book value of capital assets being depreciated	312,011,531	8,225,467	(143,074)	6,025,207	326,119,131
Less accumulated depreciation for:					
Land improvements	(5,342,806)	(130,819)	—	—	(5,473,625)
Buildings	(54,871,455)	(902,170)	—	—	(55,773,625)
Fixed equipment	(86,752,175)	(3,321,810)	265	—	(90,073,720)
Movable equipment	(98,997,734)	(6,279,705)	126,834	—	(105,150,605)
Software	(13,528,900)	(757,117)	—	—	(14,286,017)
Total accumulated depreciation	(259,493,070)	(11,391,621)	127,099	—	(270,757,592)
Capital assets being depreciated, net	52,518,461	(3,166,154)	(15,975)	6,025,207	55,361,539
Capital assets, net	$ 53,815,538	9,312,059	(15,975)	—	63,111,622

(7) Investments in Joint Ventures

The Med was a 50% owner in Memphis Managed Care Corporation (MMCC), a TennCare managed care organization, with which The Med contracted to provide services to MMCC enrollees. MMCC is subject to certain regulatory minimum capital requirements and, in that respect, The Med had guaranteed capital deficiencies funding for MMCC up to The Med's proportionate ownership interest in MMCC. No accrual for this obligation was required at either June 30, 2013 or 2012. During fiscal 2008, The Med and University of Tennessee Medical Group entered into a contract to sell the assets of MMCC to a publicly held managed care company. The Med received cash distributions of $277,065 in fiscal 2013 from the final liquidation of the assets of MMCC. A gain of approximately $277,000 was recognized in 2013 related to the final liquidation of these assets. No cash distributions were made or gains recognized in 2012.

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SHELBY COUNTY HEALTH CARE CORPORATION
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Notes to Basic Financial Statements

June 30, 2013 and 2012

(8) Accrued Expenses and Other Current Liabilities

The composition of accrued expenses and other current liabilities follows:

	2013	2012
Due to third-party payors	$ 5,198,000	7,817,000
Compensated absences	7,202,696	6,932,972
Deferred grant revenue	—	46,942
Accrued payroll and withholdings	6,573,249	8,191,931
Accrued employee healthcare claims	1,745,000	1,821,000
Current professional and general liability costs	2,300,000	2,350,000
Other	4,500,000	—
	$ 27,518,945	27,159,845

(9) Net Patient Service Revenue

The Med has agreements with governmental and other third-party payors that provide for reimbursement to The Med at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between billings at established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with major third-party payors follows:

- *Medicare* – Substantially all acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. Certain types of exempt services and other defined payments related to Medicare beneficiaries are paid based on cost reimbursement or other retroactive-determination methodologies. The Med is paid for retroactively determined items at tentative rates with final settlement determined after submission of annual cost reports by The Med and audits thereof by the Medicare fiscal intermediary.

  The Med's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization. The Med's Medicare cost reports have been audited and settled by the Medicare fiscal intermediary through June 30, 2008. Revenue from the Medicare program accounted for approximately 17% and 18% of The Med's net patient service revenue for the years ended June 30, 2013 and 2012, respectively.

- *TennCare* – Under the TennCare program, patients traditionally covered by the State of Tennessee Medicaid program and certain members of the uninsured population enroll in managed care organizations that have contracted with the State of Tennessee to ensure healthcare coverage to their enrollees. The Med contracts with the managed care organizations to receive reimbursement for providing services to these patients. Payment arrangements with these managed care organizations consist primarily of prospectively determined rates per discharge, discounts from established charges, or prospectively determined per diem rates. Revenue from the TennCare program accounted

(Continued)

for approximately 27% and 24% of The Med's net patient service revenue for the years ended June 30, 2013 and 2012, respectively.

The Med has historically received incremental reimbursement in the form of Essential Access payments through its participation in the TennCare Program. Amounts received by The Med under this program were approximately $66.4 million and $74.7 million in 2013 and 2012, respectively. These amounts have been recognized as reductions in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position. There can be no assurance that The Med will continue to qualify for future participation in this program or that the program will not ultimately be discontinued or materially modified. Any material reduction in such funds has a correspondingly material adverse effect on The Med's operations.

- *Arkansas Medicaid* – Substantially all inpatient and outpatient services rendered to Arkansas Medicaid program beneficiaries are paid under prospective reimbursement methodologies established by the State of Arkansas. Certain other reimbursement items (principally inpatient nursery services and medical education costs) are based upon cost reimbursement methodologies. The Med is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual cost reports by The Med and audits thereof by the Arkansas Department of Health and Human Services (DHHS). The Med's Arkansas Medicaid cost reports have been audited and settled by the Arkansas DHHS through June 30, 2007. Revenue from the State of Arkansas Medicaid program accounted for approximately 2% and 1% of The Med's net patient service revenue for the years ended June 30, 2013 and 2012, respectively.

  The Med has historically received incremental reimbursement in the form of Upper Payment Limit (UPL) and additional appropriation payments through its participation in the State of Arkansas Medicaid program. The net benefit for The Med associated with this program, totaling approximately $2.3 million and $2.8 million for the years ended June 30, 2013 and 2012, respectively, has been recognized as a reduction in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position. There can be no assurance that The Med will continue to qualify for future participation in this program or that the program will not ultimately be discontinued or materially modified.

- *Mississippi Medicaid* – Inpatient and outpatient services rendered to Mississippi Medicaid program beneficiaries are generally paid based upon prospective reimbursement methodologies established by the State of Mississippi. Revenue from the State of Mississippi Medicaid program accounted for approximately 3% of The Med's net patient service revenue for both the years ended June 30, 2013 and 2012.

  The Med has historically received incremental reimbursement in the form of Upper Payment Limit (UPL) and additional appropriation payments through its participation in the State of Mississippi Medicaid program. The net benefit for The Med associated with this program, totaling approximately $4.2 million and $3.5 million for the years ended June 30, 2013 and 2012, respectively, has been recognized as a reduction in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position.

- *Other* – The Med has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The reimbursement methodologies under these agreements include prospectively determined rates per discharge, per diem amounts, and discounts from established charges.

The composition of net patient service revenue follows:

		2013	2012
Gross patient service revenue	$	918,361,574	921,201,697
Less provision for contractual and other adjustments		565,394,523	516,648,494
Less provision for bad debts		49,181,321	79,012,130
Net patient service revenue	$	303,785,730	325,541,073

The composition of incremental reimbursement from various state agencies for participation in TennCare/Medicaid programs follows:

		2013	2012
TennCare Essential Access	$	66,428,367	74,695,475
Arkansas UPL/Disproportionate Share		2,268,466	2,770,773
Mississippi Disproportionate Share		4,231,388	3,531,107
Total payments	$	72,928,221	80,997,355

The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 and signed into law in February 2009. In the context of the HITECH Act, The Med must implement a certified Electronic Health Record (EHR) in an effort to promote the adoption and "meaningful use" of health information technology (HIT). The HITECH Act includes significant monetary incentives and payment penalties meant to encourage the adoption of EHR technology. The Med received approximately $2.9 million and $3.7 million of incentive payments related to EHR implementation for the years ended June 30, 2013 and 2012, respectively. These amounts are included within net patient service revenue within the statements of revenues, expenses, and change in net position.

(10) Charity Care

The Med maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. Charges foregone, based on established rates, were approximately $340.7 million and $297.2 million in 2013 and 2012, respectively. Included in the charges foregone is the upfront discount applied to all uninsured patients of approximately $198.0 million and $187.0 million in 2013 and 2012, respectively, as The Med does not pursue collection on these amounts.

(Continued)

(11) Retirement Plans

(a) Defined Benefit Plan

The Med contributes to the Shelby County Retirement System (the Retirement System), a cost-sharing single-employer defined benefit public employee retirement system (PERS) established by Shelby County, Tennessee. The Retirement System is administered by a board, the majority of whose members are nominated by the Shelby County Mayor, subject to approval by the Shelby County Board of Commissioners. The Retirement System issues a publicly available financial report that includes financial statements and required supplementary information. That report may be obtained by writing to the Shelby County Retirement System, Suite 950, 160 North Main, Memphis, Tennessee 38103 or by calling 901-545-3570.

Shelby County provides office space and certain administrative services at no cost to the Retirement System. All other costs to administer the plan are paid from plan earnings.

Substantially all full-time and permanent part-time employees of Shelby County (including The Med and Shelby County's other component units), other than the Shelby County Board of Education employees, employees who have elected to be covered by Social Security with the exception of The Med employees, employees designated as Comprehensive Employment Training Act employees after July 1, 1979, and certain employees of The Med are required, as a condition of employment, to participate in the Retirement System.

The Retirement System consists of three plans (Plans A, B, and C). In 1990, Plans A and B were merged into one reporting entity, whereby total combined assets of the merged plans are available for payment of benefits to participants of either of the two previously existing plans. In 2005, Plan C was added and merged with Plans A and B for funding purposes. While the plans were merged, the Retirement System has retained the membership criteria of the previous plans, which are as follows:

- Plan C, a contributory cost-sharing multiple-employer defined benefit pension plan for employees who are also eligible for Plan A,
- Plan B, a contributory cost-sharing multiple-employer defined benefit pension plan for employees hired prior to December 1, 1978, and
- Plan A, a contributory cost-sharing multiple-employer defined benefit pension plan for employees hired on or after December 1, 1978, and those employees that elected to transfer to Plan A from Plan B before January 1, 1981. Plan A was noncontributory for all years prior to 2013.

The Shelby County Board of Commissioners establishes the Retirement System's benefit provisions. Once a person becomes a participant, that person will continue to participate as long as he or she is an employee of Shelby County or The Med. The Retirement System provides retirement, as well as survivor and disability defined benefits.

The Retirement System's funding policy for employee contribution requirements is established by the Board of Administration of the Retirement System. The Shelby County Board of Commissioners

(Continued)

establishes the Retirement System's funding policy for employer contribution requirements. For fiscal years 2013, 2012, and 2011, the employer contribution requirements were based on the actuarially determined contribution rates, which were 12.75%, 12.01%, and 9.21%, respectively.

The actuarially determined contribution rate was calculated using a projected unit credit service pro rata cost method for Plan A, Plan B, and Plan C participants.

For fiscal years 2013, 2012, and 2011, the following contributions were made to the defined benefit plans:

		2013	2012	2011
The Med's contributions:				
Plan A	$	360,271	365,157	317,039
Plan B		1,999	1,301	164
Plan C		86,391	108,501	134,580
Employee contributions:				
Plan A	$	15,728	8,608	—
Plan B		703	491	89
Plan C		26,524	33,251	48,938

The contributions as a percentage of earned compensation were the same as those for the Retirement System. The Med contributed 100% of its required contributions in 2013, 2012, and 2011.

(b) Defined Contribution Plan

Effective July 1, 1985, The Med established, under the authority of its Board of Directors, The Regional Medical Center at Memphis Retirement Investment Plan, a defined contribution pension plan covering employees 21 years of age and older who have completed one year of service, as defined, and are not participating in any other pension program to which The Med makes contributions. The plan provides for employee contributions of between 2% and 6% of compensation and for equal matching contributions made by The Med. Participants are immediately vested in their contributions plus actual earnings thereon. Participants vest 20% in the employers matching contributions after two years of service, 50% after three years, 75% after four years, and 100% after five years. Forfeitures are returned to The Med to reduce future matching contributions. The defined contribution plan ceased accepting contributions on September 30, 2009; therefore, there were no contributions by The Med or participants for the years ended June 30, 2013 and 2012.

Effective October 1, 2009, The Med established, under the authority of its Board of Directors, The Regional Medical Center at Memphis 403(b) Retirement Plan, a defined contribution pension plan covering employees 21 years of age and older who have completed one year of service. The plan provides for a 50% employer match on employee contributions up to 6% of employee compensation. Participants are immediately vested in their contributions plus actual earnings thereon. Participants vest 20% in the employers matching contributions after two years of service, 50% after three years, 75% after four years, and 100% after five years. Forfeitures remain in the plan for the benefit of

(Continued)

other participants. The Med contributed $1.6 million and $1.5 million to the 403(b) plan for the years ended June 30, 2013 and 2012, respectively. 403(b) plan participants contributed approximately $3.4 million and $3.2 million to the 403(b) plan for the years ended June 30, 2013 and 2012, respectively.

Effective December 1, 2010, The Med established, under the authority of its Board of Directors, The Regional Medical Center at Memphis Nonqualified Supplemental Retirement Plan (Supplemental Retirement Plan). The Supplemental Retirement Plan was formed under Section 457(f) of the IRC of 1986, and management believes that it complies with all provisions applicable to a nonqualified deferred compensation plan under IRC Section 409A. Plan participants contributed approximately $84,000 to the plan for both the years ended June 30, 2013 and 2012.

(12) Postretirement Benefit Plan

Regional Medical Center Healthcare Benefit Plan (the Plan) is a single-employer defined benefit healthcare plan sponsored and administered by The Med. The Plan provides medical and life insurance benefits to eligible retirees and their spouses. The Med's Board of Directors is authorized to establish and amend all provisions. The Med does not issue a publicly available financial report that includes financial statements and required supplementary information for the Plan.

During fiscal year 2010, The Med's Board of Directors approved a plan amendment that eliminated medical coverage for those employees who did not have 15 years of service as of December 31, 2009 and eliminated life insurance coverage for those employees retiring January 1, 2010 or later.

Per GASB Statement No. 45, *Accounting and Financial Reporting Employers for Postemployment Benefits Other Than Pensions*, for financial reporting purposes an actuarial valuation is required at least biennially for postretirement benefit plans with a total membership of 200 or more. The Med's postretirement benefit plan has approximately 531 and 715 members as of the last actuarial valuations of June 30, 2013 and June 30, 2011, respectively.

(a) Funding Policy

The contribution requirements of employees and the Plan are established and may be amended by The Med's Board of Directors. Monthly contributions are required by retirees who are eligible for coverage. The Med pays for costs in excess of required retiree contributions. These contributions are assumed to increase based on future medical plan cost increases. For fiscal 2013 and 2012, The Med contributed approximately $1,214,000 and $1,526,000, respectively, net of retiree contributions, to the Plan. Plan members receiving benefits contributed approximately $335,000 in fiscal 2013 and $345,000 in fiscal 2012 through their required contributions. The following table summarizes the monthly contribution rates for the year beginning July 1, 2009:

	Retiree	Spouse
Pre-Medicare	$ 1,512	1,608
Pre-Medicare Eligible	612	1,440

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(b) Annual OPEB Cost and Net OPEB Obligation

The Med's annual other postemployment benefit (OPEB) cost is calculated based on the annual required contribution of the employer (ARC), an amount actuarially determined in accordance with the parameters of GASB Statement No. 45. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities (or funding excess) over a period of 30 years. The following table shows the components of The Med's annual OPEB cost for fiscal 2013 and 2011, the amounts actually contributed to the Plan, and changes in The Med's net OPEB obligation:

		2013	2011
Annual required contributions and annual OPEB cost	$	1,296,634	1,148,234
Contributions made		1,296,634	1,171,234
Decrease in net OPEB obligation		—	(23,000)
Net OPEB obligation, beginning of year		912,000	935,000
Net OPEB obligation, end of year	$	912,000	912,000

(c) Three-Year Trend Information

Fiscal year ended		Annual OPEB cost	Percentage of annual OPEB cost contributed		Net OPEB obligation
June 30, 2013	$	1,296,634	100.0%	$	912,000
June 30, 2012		1,535,160	103.9		851,000
June 30, 2011		1,148,234	102		912,000

(d) Funded Status and Funding Progress – Required Supplementary Information

As of June 30, 2012, the most recent actuarial valuation date, the Plan was not funded. The actuarial accrued liability for benefits was $20,319,023 resulting in an unfunded actuarial accrued liability (UAAL) of $20,319,023.

Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality, and the healthcare cost trend. Amounts determined regarding the funded status of the Plan and the annual required contributions of the employer are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The schedule of funding progress, as presented below as required supplementary information, presents multiyear trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liabilities for benefits.

(Continued)

(e) Schedule of Funding Progress – Required Supplementary Information

Analysis of the Plan's funding status follows:

Actuarial valuation date*	Actuarial value of plan assets	Actuarial accrued liability (AAL)	Plan assets less than AAL	Funded ratio	Covered payroll	AAL as of a percentage of covered payroll
July 1, 2012	$ —	20,319,023	20,319,023	—	$ 18,693,833	109.0
July 1, 2011	—	24,469,273	24,469,273	—	20,476,034	120.0
July 1, 2010	—	24,469,273	24,469,273	—%	21,995,253	111.0%

* All inputs for valuation is provided as of beginning of the fiscal year being actuarially valuated.

(f) Actuarial Methods and Assumptions

Projections of benefits for financial reporting purposes are based on the substantive plan (the Plan as understood by the employer and the plan members) and include the types of benefits provided at the time of each valuation and the historical pattern sharing of benefit costs between the employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations.

In the July 1, 2012 actuarial valuation, the projected unit credit actuarial method was used. The actuarial assumptions included a 3% investment rate of return, which is a long-term rate of return on general account assets, and an annual inflation rate and annual healthcare cost trend rate of 6.3%, reducing each year until it reaches an annual rate of 3.3% in 2102. The UAAL is being amortized, using a level percentage of pay method, over a 30-year period under the Projected Unit Credit Method.

(13) Transactions with University of Tennessee Center for Health Services

The Med contracts with University of Tennessee Center for Health Services (UTCHS) and University of Tennessee Medical Group (UTMG) to provide, among other things, The Med's house staff, professional supervision of certain ancillary departments, and professional care for indigent patients. The Med also provides its facilities as a teaching hospital for UTCHS.

Operating expenses include approximately $42.1 million in 2013 and $41.9 million in 2012 for all professional and other services provided by UTCHS/UTMG.

(14) Risk Management

The Med has a self-insurance program for professional and general liability risks, both with respect to claims incurred after the effective date of the program and claims incurred but not reported prior to that date. The Med has not acquired any excess coverage for its self-insurance because The Med is afforded sovereign immunity in accordance with applicable statutes. Presently, sovereign immunity limits losses to $300,000 per claim. The Med has recorded an accrual for self-insurance losses totaling approximately $7.5 million and $8.4 million at June 30, 2013 and 2012, respectively.

(Continued)

Incurred losses identified through The Med's incident reporting system and incurred but not reported losses are accrued based on estimates that incorporate The Med's current inventory of reported claims and historical experience, as well as considerations such as the nature of each claim or incident, relevant trend factors, and advice from consulting actuaries.

The following is a summary of changes in The Med's self-insurance liability for professional and general liability costs for fiscal 2013 and 2012:

		2013	2012
Balance at July 1	$	8,368,000	8,900,000
Provision for claims reported and claims incurred but not reported		(333,974)	956,000
Claims paid		(534,026)	(1,488,000)
		7,500,000	8,368,000
Amounts classified as current liabilities		(2,300,000)	(2,350,000)
Balance at June 30	$	5,200,000	6,018,000

Like many other businesses, The Med is exposed to various risks of loss related to theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; and natural disasters. Commercial insurance coverage is purchased for claims arising from such matters. Claims settled through June 30, 2013 have not exceeded this commercial coverage in any of the three preceding years.

The following is a summary of changes in The Med's self-insurance liability for employee health coverage (included in accrued expenses and other current liabilities in the accompanying balance sheets) for fiscal 2013 and 2012:

		2013	2012
Balance at July 1	$	1,821,000	1,510,000
Claims reported and claims incurred but not reported		11,818,341	11,910,368
Claims paid		(11,894,341)	(11,599,368)
Balance at June 30	$	1,745,000	1,821,000

(15) Commitments

The Med has outstanding service contracts for management services, equipment maintenance, and blood supply services. Estimated future payments under the contracts follow:

2014	$	3,785,914
2015		192,960
	$	3,978,874

(Continued)

Expense under these contracts and other contracts was approximately $9.2 million and $9.1 million for the years ended June 30, 2013 and 2012, respectively.

(16) Leases

The Med has entered into noncancelable operating leases for certain buildings and equipment. Rental expense for all operating leases was approximately $4.9 million and $4.6 million for the years ended June 30, 2013 and 2012, respectively. The future minimum payments under noncancelable operating leases as of June 30, 2013 follow:

2014	$ 2,111,155
2015	791,109
2016	200,593
	$ 3,102,857

(17) Current Economic Environment

In light of the current sluggish recovery of the U.S. economy, management at The Med monitors economic conditions closely, both with respect to potential impacts on the healthcare provider industry and from a more general business perspective. While The Med was able to achieve certain objectives of importance in the current economic environment, management recognizes that economic conditions may continue to impact The Med in a number of ways, including (but not limited to) uncertainties associated with U.S. financial system reform and rising self-pay patient volumes and corresponding increases in uncompensated care.

Additionally, the general healthcare industry environment is increasingly uncertain, especially with respect to the impacts of the federal healthcare reform legislation, which was passed in the spring of 2010. Potential impacts of ongoing healthcare industry transformation include, but are not limited to:

- Significant (and potentially unprecedented) capital investment in healthcare information technology (HCIT);
- Continuing volatility in the state and federal government reimbursement programs;
- Lack of clarity related to the health benefit exchange framework mandated by reform legislation, including important open questions regarding the constitutionality of the legislation, exchange reimbursement levels, changes in combined state/federal disproportionate share payments, and impact on the healthcare "demand curve" as the previously uninsured enter the insurance system;
- Effective management of multiple major regulatory mandates, including achievement of meaningful use of HCIT and the transition to ICD-10; and
- Significant potential business model changes throughout the healthcare industry, including within the healthcare commercial payor industry.

(Continued)

The business of healthcare in the current economic, legislative, and regulatory environment is volatile. Any of the above factors, along with changes in appropriations from the County and City of Memphis and others both currently in existence and which may or may not arise in the future, could have a material adverse impact on The Med's financial position and operating results.

Schedule 1

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)
Combining Schedule – Statements of Net Position
June 30, 2013

Assets	Shelby County Health Care Corporation	The Regional Medical Center at Memphis Foundation	Combined
Assets:			
Cash and cash equivalents	$ 15,266,095	204,972	15,471,067
Investments	118,878,545	2,318,933	121,197,478
Patient accounts receivable, net	45,906,287	—	45,906,287
Other receivables	9,812,264	58,000	9,870,264
Other current assets	4,974,296	250	4,974,546
Restricted investments	—	3,720,087	3,720,087
Capital assets, net	87,769,941	—	87,769,941
Total assets	$ 282,607,428	6,302,242	288,909,670
Liabilities and Net Position			
Liabilities:			
Accounts payable	$ 12,026,582	15,856	12,042,438
Accrued expenses and other current liabilities	27,518,945	—	27,518,945
Accrued professional and general liability costs	5,200,000	—	5,200,000
Net postemployment benefit obligation	912,000	—	912,000
Total liabilities	45,657,527	15,856	45,673,383
Net position:			
Net investment in capital assets	87,769,941	—	87,769,941
Restricted for:			
Capital assets	—	2,897,689	2,897,689
Indigent care	—	822,398	822,398
Unrestricted	149,179,960	2,566,299	151,746,259
Total net position	236,949,901	6,286,386	243,236,287
Commitments and contingencies			
Total liabilities and net position	$ 282,607,428	6,302,242	288,909,670

See accompanying independent auditors' report.

Schedule 2

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Revenues, Expenses, and Changes in Net Position

Year ended June 30, 2013

	Shelby County Health Care Corporation	The Regional Medical Center at Memphis Foundation	Combined
Operating revenues:			
Net patient service revenue	$ 303,785,730	—	303,785,730
Other revenue	16,235,583	1,063,786	17,299,369
Total operating revenues	320,021,313	1,063,786	321,085,099
Operating expenses:			
Salaries and benefits	150,862,502	—	150,862,502
Supplies and services	70,047,247	—	70,047,247
Physician and professional fees	27,904,579	—	27,904,579
Purchased medical services	23,827,404	—	23,827,404
Plant operations	12,348,849	—	12,348,849
Insurance	2,011,533	—	2,011,533
Administrative and general	31,961,705	—	31,961,705
Community services	—	632,390	632,390
Depreciation and amortization	13,000,644	—	13,000,644
Total operating expenses	331,964,463	632,390	332,596,853
Operating (loss) gain	(11,943,150)	431,396	(11,511,754)
Nonoperating revenues (expenses):			
Investment (loss) income	(73,824)	421,328	347,504
Appropriations from Shelby County	26,816,001	—	26,816,001
Other	306,665	—	306,665
Total nonoperating revenues, net	27,048,842	421,328	27,470,170
Increase in net position	15,105,692	852,724	15,958,416
Net position, beginning of year	221,844,209	5,433,662	227,277,871
Net position, end of year	$ 236,949,901	6,286,386	243,236,287

See accompanying independent auditors' report.

Schedule 3

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Roster of Management Officials and Board Members

June 30, 2013

(Unaudited)

Management Officials

Reginald Coopwood, M.D., President and CEO

Pam Castleman, MSN, Senior Vice President/Chief Nursing Officer

Susan Cooper, RN, MSN, FAAN, Senior Vice President/Chief Integration Officer

Carl Getto, M.D., Executive Vice President/Chief Medical Officer

Tammie Ritchey, CFRE, Vice President of Development/Foundation Executive Director

Robert Sumter, Ph.D., Executive Vice President/COO/CIO

Tish Towns, FACHE, Senior Vice President, External Relations

Rick Wagers, Senior Executive Vice President/CFO

Monica Wharton, Senior Vice President/Chief Legal Counsel

Board Members

Phil Shannon

Keith Norman

Pamela Brown

Brian Ellis

James Freeman, M.D.

Brenda Hardy, M.D.

Scot Lenoir

Scott McCormick

David Popwell

Heidi Shafer

Anthony Tate

John Vergos

Max Ostner

See accompanying independent auditors' report.

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Attachment C.OD.3

TENNESSEE OCCUPATIONAL WAGES

Total all industries
Memphis, TN-MS-AR MSA, Tennessee

Healthcare Practitioners and Technical Occupations

Occupation	Occ. code	Est. empl.	Mean wage	Entry wage	Exp. wage	25th pct	Median wage	75th pct
HEALTHCARE PRACTITIONERS AND TECHNICAL OCCUPATIONS	29-0000	N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A
Chiropractors	29-1011	70	73,430 35.30	53,610 25.80	83,330 40.05	51,870 24.95	55,930 26.90	60,000 28.85
Dentists, General	29-1021	N/A	180,240 86.65	141,390 68.00	199,660 96.00	157,710 75.80	172,550 82.95	>$145,600 >$70
Dietitians and Nutritionists	29-1031	220	52,460 25.20	39,820 19.15	58,780 28.25	43,870 21.10	51,380 24.70	59,310 28.50
Optometrists	29-1041	190	133,740 64.30	72,480 34.85	164,360 79.00	90,200 43.35	123,770 59.50	148,470 71.40
Pharmacists	29-1051	1,500	115,430 55.50	93,900 45.15	126,190 60.65	106,480 51.20	119,930 57.65	135,910 65.35
Anesthesiologists	29-1061	N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A
Family and General Practitioners	29-1062	170	206,940 99.50	136,090 65.45	242,370 116.50	161,420 77.60	>$145,600 >$70	>$145,600 >$70
Internists, General	29-1063	N/A	251,360 120.85	225,990 108.65	>$145,600 >$70	>$145,600 >$70	>$145,600 >$70	>$145,600 >$70
Obstetricians and Gynecologists	29-1064	N/A	219,270 105.40	139,290 66.95	>$145,600 >$70	170,290 81.85	>$145,600 >$70	>$145,600 >$70
Pediatricians, General	29-1065	140	190,570 91.60	149,490 71.85	211,110 101.50	160,520 77.15	178,200 85.65	>$145,600 >$70
Psychiatrists	29-1066	N/A	150,340 72.30	100,040 48.10	175,490 84.35	107,670 51.75	134,510 64.65	178,850 86.00
Surgeons	29-1067	120	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A
Physicians and Surgeons, All Other	29-1069	1,150	207,510 99.75	121,250 58.30	>$145,600 >$70	150,310 72.25	>$145,600 >$70	>$145,600 >$70
Physician Assistants	29-1071	120	92,330 44.40	50,940 24.50	113,030 54.35	55,870 26.85	73,530 35.35	92,590 44.50
Registered Nurses	29-1111	12,890	65,950 31.70	49,030 23.55	74,420 35.80	52,220 25.10	61,050 29.35	72,300 34.75
Occupational Therapists	29-1122	370	74,430 35.80	56,750 27.30	83,270 40.05	63,010 30.30	74,960 36.05	86,840 41.75
Physical Therapists	29-1123	870	85,190 40.95	65,010 31.25	95,280 45.80	71,490 34.35	82,640 39.75	92,470 44.45
Radiation Therapists	29-1124	60	67,840 32.60	52,480 25.25	75,520 36.30	56,970 27.40	66,010 31.75	74,550 35.85

Recreational Therapists	29-1125	90	44,760 21.50	32,410 15.60	50,940 24.50	34,160 16.40	40,190 19.30	56,420 27.10
Respiratory Therapists	29-1126	700	48,960 23.55	41,240 19.85	52,820 25.40	42,970 20.65	48,890 23.50	55,490 26.70
Speech-Language Pathologists	29-1127	460	65,160 31.35	47,400 22.80	74,050 35.60	51,460 24.75	62,610 30.10	80,070 38.50
Exercise Physiologists	29-1128	50	63,660 30.60	36,110 17.35	77,430 37.25	37,550 18.05	67,930 32.65	82,990 39.90
Veterinarians	29-1131	190	68,820 33.10	46,580 22.40	79,950 38.45	50,840 24.45	63,020 30.30	84,030 40.40
Audiologists	29-1181	50	54,240 26.10	48,450 23.30	57,130 27.45	49,880 24.00	54,510 26.20	59,150 28.45
Health Diagnosing and Treating Practitioners, All Other	29-1199	60	55,790 26.80	45,220 21.75	61,080 29.35	47,250 22.70	54,400 26.15	60,110 28.90
Medical and Clinical Laboratory Technologists	29-2011	1,540	58,280 28.00	45,220 21.75	64,810 31.15	50,040 24.05	57,920 27.85	68,020 32.70
Medical and Clinical Laboratory Technicians	29-2012	1,750	37,790 18.15	26,410 12.70	43,470 20.90	29,710 14.30	38,740 18.65	45,290 21.75
Dental Hygienists	29-2021	620	63,260 30.40	44,460 21.40	72,660 34.95	51,620 24.80	62,960 30.25	73,810 35.50
Cardiovascular Technologists and Technicians	29-2031	200	43,620 20.95	27,620 13.30	51,620 24.80	30,130 14.50	40,170 19.30	56,910 27.35

Entry and Experienced wages represent the mean of the lower third and the mean of the upper two-thirds of the wage distribution respectively. The OES survey does not collect information for entry or experienced workers. Tennessee Department of Labor & Workforce Development, Employment Security Division, Labor Market Information. Publish date May 2012.

TENNESSEE OCCUPATIONAL WAGES

Total all industries
Memphis, TN-MS-AR MSA, Tennessee

Healthcare Support Occupations

Occupation	Occ. code	Est. empl.	Mean wage	Entry wage	Exp. wage	25th pct	Median wage	75th pct
HEALTHCARE SUPPORT OCCUPATIONS	31-0000	N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A
Home Health Aides	31-1011	1,540	22,430 10.80	16,590 7.95	25,350 12.20	17,620 8.45	20,900 10.05	27,100 13.05
Nursing Aides, Orderlies, and Attendants	31-1012	5,370	23,110 11.10	18,660 8.95	25,330 12.20	19,960 9.60	22,630 10.90	26,330 12.65
Psychiatric Aides	31-1013	480	19,170 9.20	16,710 8.05	20,390 9.80	16,820 8.10	18,380 8.85	21,060 10.15
Occupational Therapist Assistants	31-2011	60	58,660 28.20	44,820 21.55	65,580 31.55	50,030 24.05	62,680 30.15	69,910 33.60
Physical Therapist Assistants	31-2021	280	58,680 28.20	43,890 21.10	66,080 31.75	47,420 22.80	62,260 29.95	69,670 33.50
Physical Therapist Aides	31-2022	180	22,440 10.80	16,800 8.10	25,260 12.15	17,870 8.60	20,840 10.00	24,990 12.00
Massage Therapists	31-9011	190	33,110 15.90	17,500 8.40	40,920 19.65	19,000 9.15	28,340 13.65	37,200 17.90
Dental Assistants	31-9091	1,100	34,550 16.60	25,970 12.50	38,830 18.65	27,670 13.30	34,660 16.65	42,110 20.25
Medical Assistants	31-9092	2,490	28,270 13.60	22,540 10.85	31,130 14.95	24,130 11.60	27,390 13.15	30,730 14.75
Medical Equipment Preparers	31-9093	N/A	30,170 14.50	23,080 11.10	33,710 16.20	24,730 11.90	29,370 14.10	34,940 16.80
Medical Transcriptionists	31-9094	240	33,930 16.30	26,570 12.75	37,610 18.10	28,320 13.60	33,250 16.00	38,030 18.30
Pharmacy Aides	31-9095	170	23,480 11.30	18,460 8.90	25,980 12.50	20,010 9.60	23,200 11.15	27,460 13.20
Veterinary Assistants and Laboratory Animal Caretakers	31-9096	260	25,570 12.30	18,450 8.85	29,130 14.00	19,810 9.50	24,690 11.85	30,090 14.45
Healthcare Support Workers, All Other*	31-9799	1,040	30,380 14.60	22,190 10.65	34,480 16.60	23,630 11.35	28,170 13.55	36,640 17.60

Entry and Experienced wages represent the mean of the lower third and the mean of the upper two-thirds of the wage distribution respectively. The OES survey does not collect information for entry or experienced workers. Tennessee Department of Labor & Workforce Development, Employment Security Division, Labor Market Information. Publish date May 2012.

Board for Licensing Health Care Facilities

State of Tennessee

0000C00110

No. of Beds 0631

DEPARTMENT OF HEALTH

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

SHELBY COUNTY HEALTH CARE CORPORATION *to conduct and maintain a*

Hospital THE REGIONAL MEDICAL CENTER AT MEMPHIS

Located at 877 JEFFERSON AVENUE, MEMPHIS

County of SHELBY *, Tennessee.*

This license shall expire MAY 04 *,* 2014 *, 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 4TH *day of* MAY *,* 2013 *.*

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL
TRAUMA CENTER LEVEL 1

NOV 15 '13 PM1:06

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

By John J. Dreyzehner, MD
COMMISSIONER

146

Attachment C.OD.7.c

The Regional Medical Center at Memphis

Memphis, 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

March 19, 2011

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

Organization ID #: 7870
Print/Reprint Date: 06/15/11

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.

carf INTERNATIONAL

A Three-Year Accreditation is awarded to

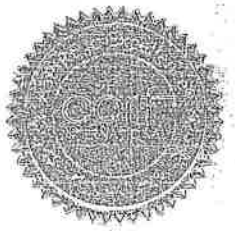
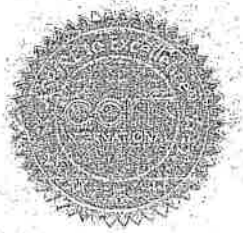
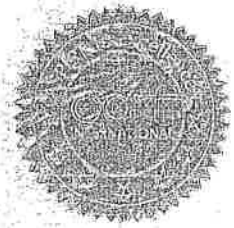
The Rehabilitation Hospital of Memphis

for the following identified program:

Inpatient Rehabilitation Programs - Hospital (Adults)

This accreditation is valid through November 2012

The accreditation seals in place below signify that the organization has met annual conformance requirements for quality standards that enhance the lives of persons served.

This accreditation certificate is granted by authority of:

Cathy Ellis, PT
Chair
CARF International Board of Directors

Brian J. Boon, Ph.D.
President/CEO
CARF International

carf carfcoac carf CANADA

Attachment C.OD.7.d

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 c HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305

Rec'd 10/16/09 FA

October 14, 2009

Mr. Claude Watts, Administrator
Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis, TN 38103

RE: Licensure Surveys

Dear Mr. Watts:

On **September 24, 2009**, licensure surveys were completed at your facility. Your plans of correction for these surveys have been received and were found to be acceptable.

Thank you for the consideration shown during this survey.

Sincerely,

Celia Skelley

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CES/TJW TJW

NOV 15 '13 PM 1:06

The Commercial Appeal
Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Patrick Maddox, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached notice was published in the following editions of The Commercial Appeal to-wit:

November 10, 2013

Helen Curl

Subscribed and sworn to before me this 11th day of November, 2013.

Notary Public

My commission expires 2/15/16

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 Shelby County Health Care Corporation, d/b/a The Regional Medical Center at Memphis, 877 Jefferson Avenue, Memphis (Shelby County), Tennessee 38103 ("Applicant" or "The MED"), owned and managed by itself, is applying for a Certificate of Need for the establishment of a twenty (20) skilled bed nursing unit to be licensed as nursing home beds and operated as a department of The MED. The requested beds are subject to the FY 2013-2014 pool of nursing home beds authorized by T.C.A. § 68-11-1622. Due to the Linton Rule, all beds will be certified for both Medicare and Medicaid. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that the Applicant will serve Medicare, Medicaid, commercially insured, and private-pay patients, and the Applicant will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $300,000.00, plus filing fee.

The anticipated date of filing the application is: November 15, 2013.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at 2021 Richard Jones Road, Suite 350, Nashville, Tennessee, 37215, 615/370-3390.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
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.

COPY-SUPPLEMENTAL-1

The Med

CN1311-044

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

DEC 17 '13 PM 1:19

AFFIDAVIT

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY: The MED (CN1311-044)

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E. Graham Baker, Jr. Attorney at Law
Signature/Title

Sworn to and subscribed before me, a Notary Public, this 17th day of December, 2013; witness my hand at office in the County of Davidson, State of Tennessee.

Nadean E. Poteet
NOTARY PUBLIC
My Commission expires July 3, 2017

NADEAN E. POTEET
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

1. Section A, Applicant Profile, Item 11

Can a nursing home restrict its certification to Level II only?

Response: Not to the knowledge of the Applicant. However, any nursing home can target services for Level II patients and enhance efforts to transfer Level I patients to another facility that has available beds.

2. Section B, Project Description, Item I.

Please further explain the statement "Due to the Linton Rule, all beds will be certified for both Medicare and Medicaid.

Response: Linton v. Commissioner was a federal court case in which two Tennessee nursing home residents filed a complaint involving a procedure being followed by many nursing homes in certifying "distinct parts" of their facilities for Medicaid. In general terms, many facilities set aside, or certified, a part of their respective facilities as the specific section of the nursing home in which Medicaid patients would be served. When the beds in that specific area were filled, the facility would not accept further Medicaid patients, even though there might be empty beds in another part of the facility. Again, in general terms, the lawsuit alleged that even if a distinct part of a facility is certified for Medicaid, the entire facility should be certified, and any empty bed in the nursing home should be available to any Medicaid patient. The court agreed, ruling that certifying "distinct parts" of a nursing home violated the law.

In 1990, the State of Tennessee and the plaintiffs settled the lawsuit and an agreed order was set into place. This agreed order has become known as the "Linton Rule" and is well-known in health planning and regulatory circles. Generally, the Linton Rule provides that if a facility participates in Medicaid, then all beds in that facility must be available for Medicaid patients on a "first-come, first-served" basis.

As the rule applies to this project, The MED is certified for Medicare and Medicaid. We serve many Medicare and Medicaid (TennCare) patients, and more than our share of patients with no payment source. When patients with no financial resources are in a hospital bed, but need to be in a skilled nursing bed, it is difficult to transfer such patients to area nursing facilities. Therefore, these patients stay in an expensive hospital bed, greatly increasing the losses of the hospital. The purpose of this CON application is to set up a few SNF beds for such Level II patients that are already in our hospital, and allow The MED to transfer such patients into less expensive nursing home beds within our own facility. While the nursing facility will be separately licensed, it will still be a department of the hospital. If our hospital patients need a skilled nursing home bed and we can't find a nursing home that will accept that patient, we will provide the service to that patient. As stated in the CON application, even though the nursing home department is anticipated to operate at a loss, the hospital's savings will more than off-set such financial losses of that department.

Irrespective of the anticipated financial loss of the SNF unit, The MED has an obligation to serve all patients who present for care, irrespective of their ability or inability to pay for such care. Therefore, if a patient who is qualified for Medicaid needs a SNF bed and we can't transfer that patient, we will provide care for that patient, thereby complying with the letter and intent of the Linton Rule.

Please identify the floor of the Adams Building that the skilled nursing facility (SNF) unit will be located. Please describe the other services provided in the Adams building by floor.

Response: The proposed SNF unit will be located on the 3rd floor of the Adams Building.

The other services provided in the Adams building by floor at the time of this application are as follows:

Basement Level – Legal, Engineering, Biomed, Storage, IT Support, Consultants and Print Shop.

Ground Floor – Hospital Administration, Auditorium, IT Administration and Business Office

First Floor – Accounts Payable, Revenue Cycle Management, Comptroller and Accounting

Second Floor – Training and Development, Human Resources

Third Floor – Vacant (Proposed SNF)

Fourth Floor – Sleep Rooms, Detention Unit Patient Beds, Shelby County Health Department, University of Memphis Speech and hearing Center, TennCare.

Fifth Floor – Cardiology Services, Health Loop Clinic Administration, TenderCare, Nursing Administration.

Sixth Floor – Sleep Rooms, IT Applications, UT Psych Services, UT Emergency Medicine Offices, Med Administration, Neurosurgery Administration.

Will the applicant admit Medicaid patients to the SNF from other States? If yes, does the Linton ruling apply to these patients? Please explain the ramifications of the Linton ruling as it pertains to the operation of the proposed project.

Response: We do not plan to admit Medicaid patients from other states, but realize that may happen. Since the Linton Rule is a federal law, our SNF unit must comply.

If, for example, a Mississippi resident (who is Medicaid-eligible or -certified) becomes a patient at our hospital and needs to be transferred to a SNF bed, the care for that patient will be paid for by the State of Tennessee if that patient states he/she intends to become a resident of Tennessee. There is no waiting period. The patient can be transferred to an existing nursing home in the area, and that patient's care will be reimbursed by Medicaid (Tennessee). On the other hand, if that patient states he/she does not intend to become a resident of Tennessee, neither Tennessee nor Mississippi will pay for the care. Since there is no reimbursement mechanism for the patient, he/she will be transferred to our SNF unit if we cannot transfer the patient to an area nursing home.

The MED will continue to provide medical care to people who present for care. If that care is in a hospital bed, we will provide it. If that care is in a SNF bed, we will provide it. If any patient has a payor mechanism in place, we will try to transfer that patient to an existing facility, and if no facility will take that patient, we will seek reimbursement. If any patient does not have a payor mechanism in place, we will provide the medical care at a financial loss, as always. However, in such instances our costs will be lower in a SNF unit than in a hospital bed, so our losses will decrease. That is the reason for filing this application: to provide appropriate care to all patients at the least expensive cost to our facility.

Will the source of admission for all SNF unit patients be from the MED's acute care beds?

Response: All admissions to our SNF unit will be from our hospital.

Where is the MED transferring SNF patients now?

Response: Patients who have an identifiable source of reimbursement are normally placed at existing nursing homes in and around Shelby County, based on patient choice and ability of the

area facilities to provide the needed care. We do not have a list showing the number of placements by facility.

Are all uninsured patients requiring SNF care remaining in the acute care beds in the MED?

Response: It is impossible to ascertain whether or not "ALL" of our uninsured patients remain in our hospital beds. However, enough of them do stay in our hospital beds to warrant this application.

As stated, we have many uninsured patients in our hospital beds that need to be in a SNF. In the past, we could not place most of these patients because they have no reimbursement source. As such, we keep them in our hospital beds. This application will allow us to transfer such patients to our own SNF unit, thereby providing the SNF care that these patients need, while decreasing the financial losses (overall) to our hospital. We anticipate that about half of the patients we anticipate "transferring" out of our hospital to our SNF unit will eventually be certified for Medicare, and the other half will have no payment source at all.

Please quantify for the most recent year available the number of potential SNF patients that have remained in an acute care bed beyond the normal discharge time and the patient days that represents.

Response: As stated in the application:

> "A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis."

The study quoted above is proprietary in nature, so it is not being submitted in its entirety. However, the following chart is submitted as further proof of the need for 20 to 35 beds. This chart indicates, by actual discharge data for The MED from July 1, 2012 to June 30, 2013, the number of patients discharged from hospital beds that should have been transferred earlier to SNF beds, as follows:

Medical Diagnosis	Top Zip Codes in TN	All Other TN	MS	AR	Other	Total
Medically Complex	8.88	2.880	2.293	1.660	0.759	16.47
Respiratory	5.04	0.961	1.046	0.604	0.386	8.04
Cardiac Care	2.71	0.169	0.236	0.113	0.131	3.36

Rehabilitation	3.40	1.238	1.266	0.980	0.345	7.22
TOTAL	20.03	5.255	4.841	3.357	1.621	35.1

Notes on the above chart:

(1) "Top Zip Codes in TN" includes those zip codes with the highest number of discharges, in particular those with greater than 100 discharges from The MED. All 20 of these zip codes are inside Shelby County.

(2) "All Other TN" includes all other Tennessee zip codes not included in the first column.

(3) "MS" includes all zip codes from the State of Mississippi. Obviously, most of these discharges were from the northern portion of the state.

(4) "AR" includes all zip codes from the State of Arkansas. Most of these discharges were from the eastern portion of the state.

(5) "Other" includes the remaining zip codes outside TN, MS, and AR. Such discharges involved patients who originated from California to Florida. However, only about 2 beds are needed for such patients.

Please quantify the number of patients being discharged from the MED for SNF services and the expected days that represents.

Response: According to the Director of Case Management and Patient Access, there were 164 patients discharged from The MED from July 1, 2013 through December 15, 2013 to area skilled nursing homes. These patients represented 2,241 patient days at The MED.

The applicant has mentioned that the payor mix will be 50% Medicare and 50% uninsured. Where are TennCare and commercial patients being discharged for SNF care? Will these patients continue to be discharged to the same locations after completion of the proposed project?

Response: Patients with payor sources are discharged to area nursing facilities. They will continue to be transferred to area nursing facilities.

Please explain in detail how it was determined that from the 7100 discharges a need for 20 – 35 beds was determined.

Response: The math shows that 7,100 discharges would equate to 19.45 (or 20) beds, if all beds were operating at 100% (7,100 / 365 = 19.45). You would not want to operate at 100% occupancy, so more than 20 beds would be required to properly care for these patients.

Additionally, and as stated in the application:

> "A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the

previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis."

The study quoted above is proprietary in nature, so it is not being submitted in its entirety. However, the following chart is submitted as further proof of the need for 20 to 35 beds. This chart indicates, by actual discharge data for The MED from July 1, 2012 to June 30, 2013, the number of patients discharged from hospital beds that should have been transferred earlier to SNF beds, as follows:

Medical Diagnosis	Top Zip Codes in TN	All Other TN	MS	AR	Other	Total
Medically Complex	8.88	2.880	2.293	1.660	0.759	16.47
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Cardiac Care	2.71	0.169	0.236	0.113	0.131	3.36
Rehabilitation	3.40	1.238	1.266	0.980	0.345	7.22
TOTAL	20.03	5.255	4.841	3.357	1.621	35.1

Notes on the above chart:

(6) "Top Zip Codes in TN" includes those zip codes with the highest number of discharges, in particular those with greater than 100 discharges from The MED. All 20 of these zip codes are inside Shelby County.

(7) "All Other TN" includes all other Tennessee zip codes not included in the first column.

(8) "MS" includes all zip codes from the State of Mississippi. Obviously, most of these discharges were from the northern portion of the state.

(9) "AR" includes all zip codes from the State of Arkansas. Most of these discharges were from the eastern portion of the state.

(10) "Other" includes the remaining zip codes outside TN, MS, and AR. Such discharges involved patients who originated from California to Florida. However, only about 2 beds are needed for such patients.

It appears that the bed availability from the Nursing Home Bed Pool has changed since the filing of this application. At this point in time only 30 beds have been approved for this fiscal year in Knoxville. There is a pending application in Shelby County for 20 beds (CN1310-039, The Village at Germantown). In the addition to

The MED's application for 20 beds, a second application has been filed this month for 30 beds, also in Shelby County (CN1311-045, The Farms at Bailey Station). If all these bed were approved, the result would be 70 beds of 125 available beds approved for Shelby County with 25 beds remaining in the bed pool for the balance of the fiscal year ending 6/30/14. Does the applicant believe 70 additional SNF beds are needed in Shelby County?

Response: The Applicant believes that the question of need for nursing home beds in Shelby County rests with the Health Services and Development Agency, and has no position on the need for 70 additional SNF beds there. We believe we have a need for 20 SNF beds to handle the need of our own hospital population that requires SNF services but who remain in our hospital beds.

It needs to be stressed that this project, if approved, will merely move 20 patients from one part of our hospital to another part of our hospital – from hospital beds to SNF beds. We will not be impacting existing nursing homes in Shelby County.

Please explain the statement "the patients we will serve are our own hospital patients who cannot be placed in existing facilities".

Response: As stated, we have many uninsured patients in our hospital beds that need to be in a SNF. In the past, we could not place most of these patients because they have no reimbursement source. As such, we keep them in our hospital beds. This application will allow us to transfer such patients to our own SNF unit, thereby providing the SNF care that these patients need, while decreasing the financial losses (overall) to our hospital. We anticipate that about half of the patients we anticipate "transferring" out of our hospital to our SNF unit will eventually be certified for Medicare, and the other half will have no payment source at all.

It needs to be stressed that this project, if approved, will merely move 20 patients from one part of our hospital to another part of our hospital – from hospital beds to SNF beds. We will not be impacting existing nursing homes in Shelby County.

According to the 2012 Joint Annual Report, The MED's occupancy rate was 39.2%. Please explain why the alternative was not selected to convert 20 medical/surgical beds to SNF rather than adding 20 licensed beds to the facility's licensed bed complement.

Response: All of the beds we seek will be skilled beds. The Legislature has set in place a process for the approval of skilled beds in the state. We decided to comply with the law.

Further, the de-licensing of hospital beds does not create a need for nursing home beds. We felt keeping our hospital license at its current level was most advantageous to our hospital.

The applicant has stated that "Existing nursing facilities are reluctant to accept referrals of patients who have little or no ability to pay for such care". (sic) The applicant is projecting a payor mix that includes 50% Medicare. Wouldn't Medicare pay for SNF services in existing nursing facilities? Please explain.

Response: As stated, we have many uninsured patients in our hospital beds that need to be in a SNF. In the past, we could not place most of these patients because they have no reimbursement source. As such, we keep them in our hospital beds. This application will allow us to transfer such patients to our own SNF unit, thereby providing the SNF care that these patients need, while decreasing the financial losses (overall) to our hospital. We anticipate that about half of

the patients we anticipate "transferring" out of our hospital to our SNF unit will eventually be certified for Medicare, and the other half will have no payment source at all.

What is the age range of uninsured patients? Wouldn't a large majority of the patients in the SNF unit be Age 65+ suggesting these patients would be covered by Medicare? Is the estimation of a payor mix of 50% for uninsured patients reasonable?

Response: We did not calculate the exact age range of the patients in our study. Yes, most patients aged 65 and over would probably qualify for Medicare reimbursement. However, many of our "under 65" patients are from our trauma unit. It cannot be stressed enough that we have the busiest Level I trauma center in West Tennessee. The payor mix that we utilized for our CON application is the ACTUAL payor mix for those patients in our hospital that could not be placed in existing nursing homes. It was not an estimate.

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

3. Section B, Project Description, Item III.(A)

Please discuss the feasibility of initiating a skilled nursing unit in an almost 70 year old building.

Response: The building meets all nursing home codes and regulations, and the space is available. Therefore, it is feasible to initiate a skilled nursing unit in the building.

4. Section B, Project Description, Item IV (Floor Plan)

Please identify the patient rooms, dining area, and patient gym by room number.

Response: Private Rooms: 339, 341, 345, 347, 351, 353, 369, 371.
Semi-Private Rooms: 343, 349, 365, 367, 373, 375.
Dining Room: 322.
Gym: 314.

5. Section C, Need, Item 1.a. (Service Specific Criteria (Nursing Home Services) A. Need 1.

It appears that you may need to make some adjustments to your bed need calculations. Acceding (sic) to the Department of Health website there are now 3,976 licensed nursing home beds in Shelby County. There are also two outstanding but unimplemented CONs in Shelby County: CN1202-011 Collins Chapel-28 beds, and CN1303-008, Farms at Bailey Station—30 beds. Additionally The Village of Germantown has a pending application for 20 beds that will be heard at the January HSDA meeting and Farms at Bailey Station has a pending CON application for 30 beds also under review this month.

Please discuss how the Long-term Care Community Choices Act of 2008 has impacted nursing home utilization rates in Knox County for years 2009, 2010, and 2011. The Long-term Care Community Choices Act of 2008 allows TennCare to pay for more community and home-based services for seniors such as household assistance, home delivered meals, personal hygiene assistance, adult day care centers and respite (sic).

Response: As stated in the application:

> "As reported on Joint Annual Reports for existing county facilities, nursing homes in Shelby County have operated 82.6%, 83.8%, and 84.5% for 2009 through 2011, respectively. At least two facilities have decreased facility bed counts since the filing of the 2011 JARs, and one facility has surrendered its license. Civic Health and Rehab Center was licensed for 147 beds, and its license expired on July 1, 2013. Bright Glade Health and Rehab Center decreased its bed count from 81 to 77 beds on July 1, 2013, and Grace Healthcare of Cordova decreased its bed count from 284 to 240 beds on July 1, 2013. Taking these bed losses into consideration, the occupancy rate for Shelby County Nursing Homes would increase from 84.5% to 88.7% for 2011. With these decreases, there currently exist 3,974 nursing home beds in Shelby County, with a need for 5,094 beds by 2016."

The above numbers were based on what was reported in JARs, and further information we had about the decreases (noted above) in various facilities. Apparently, we are "off" by two beds. If Licensure now states there are 3,976 beds, Licensure has changed its total since they advised the Applicant (prior to filing this application) that 3,974 beds were in Shelby County. We have no way of knowing for sure how many beds are actually in Shelby County, other than to rely on Licensure.

According to the State's website,

> "CHOICES" is TennCare's program for long-term care services for elderly (65 years of age and older) or disabled (21 years of age and older). Long-term care includes help doing everyday activities that you may no longer be able to do for yourself as you grow older, or if you have a physical disability-like bathing, dressing, getting around your home, preparing meals, or doing household chores. Long-term care services include care in a nursing home. Long-term care also includes certain services to help a person remain at home or in the community. These are called **H**ome and **C**ommunity **B**ased **S**ervices or **HCBS**."

The Applicant believes the Choices program is an excellent use of limited resources to help the elderly and disabled live at home. The Applicant is not aware of any state-sponsored study that shows the impact of the Choices program in Knox County or any other county in Tennessee. As more people utilize the service, common sense dictates that fewer institutional resources will be required, whether in Knox County or other counties in the state. That stated, if such individuals never qualified for nursing home care, they would not have been admitted to nursing homes under strict preadmission evaluation guidelines. The patients who are the object of this application are not patients who merely have problems conducting everyday activities: These are skilled nursing patients who currently are institutionalized in a hospital bed who need to be transferred to a SNF bed. Therefore, the Choices program should not impact the SNF patients currently residing in our hospital beds.

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6. Section C, Need, Item 1.a. (Service Specific Criteria (Nursing Home Services) B. Occupancy and Size Standards 2.

Please identify individually the 50 bed or more nursing homes in the service area that did not attain 95% occupancy in 2011 and 2012.

Response: Please see attached chart (*Supplemental C.Need.1.a.*)

7. **Section C., Need, Item 5**

Your response is noted. Please complete the following tables:

Response: All of the three following charts are attached as *Supplemental C.Need.5.*

Shelby County Nursing Home Utilization-2012

Facility	Licensed Beds	Beds-Medicare-certified	Beds-Dually Certified	Beds-Medicaid-certified	Licensed Only Beds Non-Certified	SNF Medicare ADC	SNF Medicaid ADC	SNF All other Payors ADC	Non-Skilled ADC	Total ADC
TOTAL										

Source: Nursing Home JAR, 2012 (Provisional)

Shelby County Nursing Home Utilization-2011

Facility	Licensed Beds	Beds-Medicare-certified	Beds-Dually Certified	Beds-Medicaid-certified	Licensed Only Beds Non-Certified	SNF Medicare ADC	SNF Medicaid ADC	SNF All other Payors ADC	Non-Skilled ADC	Total ADC
TOTAL										

Source: Nursing Home JAR, 2011

Shelby County Nursing Home UtilizationTrends-2010-2012

Facility	License d Beds (2012)	2010 Patient Days	2011 Patient Days	2012 Patient Days	'10-'12 % change	2010 % Occupancy	2011 % Occupancy	2012 % Occupancy
TOTAL								

Source: Nursing Home JAR, 2010-2011, 2012 (Provisional)

8. Section C, Need, Item 6

Your response to this item is noted.

Please complete the following tables

THE MED SNF UNIT Projected Utilization

Year	Licensed Beds	*Medicare-certified beds	SNF Medicare ADC	SNF Medicaid ADC	SNF All other Payors ADC	Non-Skilled ADC	Total ADC	Licensed Occupancy %
1	20	10	8	0	8	0	16	80%
2	20	10	8.5	0	8.5	0	17	85%

*** Includes dually-certified beds**

THE MED SNF UNIT Projected Utilization

Year	Licensed Beds	Age 0-64 Patient Days	Age 65-74 Patient Days	Age 75-84 Patient Days	Age 85+ Patient Days	Total Patient Days
1	20	2908	1200	800	907	5815
2	20	3089	1300	865	924	6178

*** Includes dually-certified beds**

THE MED SNF UNIT Projected Utilization

Year	Licensed Beds	Medicare-Patient Days	Medicaid Patient Days	Commercial Patient Days	Uninsured Patient Days	Total Patient Days
1	20	2908	N/A	N/A	2908	5815
2	20	3089	N/A	N/A	3089	6178

*** Includes dually-certified beds**

Response: The charts are completed above. Please note that we anticipate approximately 50% of our patients to be Medicare, and 50% non-reimbursed. The projections are based on that assumption. The CON application stated several times that we do anticipate transferring Medicaid patients to existing nursing homes, as has been our practice in the past. We understand that there may be an occasion when a Medicaid patient has to go to our SNF for a day or so, awaiting transfer. However, we have no way to estimate or project how many patient days that would entail, so we did not show any Medicaid patient days as being projected. Further, in the second chart above, we made the assumption that about half of our Medicare patients would be under 65 years of age, and proportioned the remaining half over the requested age brackets. These are projections, only, as requested in the question.

Please provide the details regarding the methodology used to project patient days during the first year of operation and the second year of operation. The methodology must include detailed calculations or documentation from referral sources. Providing only statements such as "based on the applicant's experience" will not be considered an adequate response.

Response: As stated in the application:

> "A study of hospital discharges indicated the Applicant would have no problem in operating a 20 bed SNF unit at a high utilization rate. In September, 2013, an internal study was conducted which analyzed hospital discharges within the previous fiscal year. The twelve month data included a total of 15,435 total discharges from July 1, 2012 to June 30, 2013. Discharges associated with MDC 14 & 15, pregnancy and childbirth, were discarded and the study focused on the remaining 7,100 discharges. Within this number, a total of 572 different zip codes were represented, and zip codes with in excess of 100 discharges were analyzed. The resultant 18 zip codes showed that the vast majority of our patients originate from Shelby County, with the majority of those cases being in the downtown area. The study showed a need for 20.03 SNF beds for the top zip codes, and a total of 35.1 SNF beds (at full occupancy) for all discharges. Again, the analysis revealed that the majority of bed need is based on neighborhoods surrounding The MED, in particular, Downtown, Midtown, Whitehaven, Bellevue/McKenire, Frayser and North Memphis."

The study quoted above is proprietary in nature, so it is not being submitted in its entirety. However, the following chart is submitted as further proof of the need for 20 to 35 beds. This chart indicates, by actual discharge data for The MED from July 1, 2012 to June 30, 2013, the number of patients discharged from hospital beds that should have been transferred to SNF beds, as follows:

Medical Diagnosis	Top Zip Codes in TN	All Other TN	MS	AR	Other	Total
Medically Complex	8.88	2.880	2.293	1.660	0.759	16.47
Respiratory	5.04	0.961	1.046	0.604	0.386	8.04
Cardiac Care	2.71	0.169	0.236	0.113	0.131	3.36
Rehabilitation	3.40	1.238	1.266	0.980	0.345	7.22
TOTAL	20.03	5.255	4.841	3.357	1.621	35.1

With between 20 and 35 beds needed, we felt we could start transferring patients almost immediately, with the first year averaging 16 patients and increasing from there. It cannot be stressed enough that the approval of this project will merely move existing patients from one part of our hospital to another part of our hospital – from hospital beds to SNF beds.

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

As is noted on the plot plan, the Adams Building will soon be a 70 year old building. As a new skilled nursing facility, the unit in the Adams Building will have to meet all current nursing home standards which include being sprinkled. Will this facility be able to meet all these standards? If yes, please provide the following documentation.

A) Please provide documentation from a licensed architect or construction professional:

1) a general description of the project,

2) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and

3) attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the most recent AIA Guidelines for Design and Construction of Hospital and Health Care Facilities

If necessary, please make the appropriate changes to the Project Cost Chart based on the information in the architect's letter.

Response: The building meets all nursing home codes and regulations, and the space is available. See *Supplemental C.EF.1*, which is a letter from our Project Manager.

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10. Section C, Economic Feasibility, Item 3

Your response to this item is noted. Please use the updated 2010-2012 Cost per Square Foot Table available on the HSDA website under "Applicant's Toolbox" in comparison to the cost per square foot for the proposed project.

Response: Updated pages 31 and 34 are attached.

11. Section C, Economic Feasibility, Item 4 (Historical Data Chart)

Please provide a Historical Data Chart for The MED's total facility.

Response: Discussion with the Assistant Executive Director indicated this chart would not be required.

12. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

Please provide a Projected Data Chart for The MED's total facility to document the increased income for the hospital.

Response: Discussion with the Assistant Executive Director indicated this chart would not be required.

Please submit a revised Projected Data Chart beginning with Gross Operating Revenue so the impact of a 50% payor mix of uninsured can be clearly and accurately presented.

Response: The Projected Data Chart correctly reflects the payor sources for the patients we plan to transfer from our hospital beds to our new SNF unit, if this project is approved.

There appears to be a calculation error in the Year 2 column.

Response: Please see revised page 37.

What is included in Rent?

Response: Space, utilities and housekeeping.

What do Physician Salaries and Wages represent?

Response: Salary expenses include our Medical Director and other physician salaries anticipated with the implementation of this project.

Please complete the following chart for "9. Other Expenses":

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 3	Year 2	Year 1
1. Salaries & Wages	$1,432,308	$1,345,212	$1,213,572
2. Physician Salaries & Wages	26,520	25,752	24,996
3. Med Supplies, Pharmacy, Lab & Radiology	520,232	477,251	436,125
4. Depreciation	30,000	30,000	30,000
5. Rent	238,656	231,756	225,000
6. Contract Services, Marketing, Laundry & Dietary	543,113	508,713	475,742
7.			
Total Other Expenses	$2,790,829	$2,618,684	$2,405,435

Response: The chart is completed above.

13. Section C, Economic Feasibility, Item 6.B.

Please provide the Medicare allowable fee schedule for nursing homes.

Response: Please see *Supplemental C.EF.6.B.*

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14. Section C, Economic Feasibility, Item 10

Please provide Pages 1-3 of the audited financial statements.

Response: Please see *Supplemental C.EF.10.*

15. Section C, Orderly Development, Item 3

Does the applicant plan to hire or contract therapy personnel, i.e., physical therapy, occupational therapy, and speech therapy? What are the expected FTE requirements for therapy personnel? Does the applicant expect to hire or contract for other positions such as social worker, activities director, and any other patient related positions?

Response: Yes, we will contract therapy personnel, as follows: Physical Therapist 1.5; Occupational Therapist 1.0; and Speech Therapist 0.5. We will hire 3 Respiratory Therapists, 1 MDS coordinator, and a 0.5 Activity Coordinator.

Should "CAN" be "CNA"?

Response: Yes.

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16. Section C, Orderly Development, Item 7

Please provide a copy of The MED's most recent Plan of Correction submitted to the Department of Health and/or similar documents submitted to the Joint Commission.

Response: Please see *Supplemental C.OD.7.d.*

Shelby Co. Nursing Home UtilizationTrends-2011-2012

Facility	Licensed Beds (2012)	Pt. Days 2011	Pt. Days 2012	Occ. 2011	Occ. 2012
Allen Morgan Health and Rehab. Ctnr	104	27,178	32,094	71.6%	84.5%
Applingwood Health Care Ctnr	78	24,486	26,651	86.0%	93.6%
Ashton Place Health and Rehab Cntr	211	65,464	68,410	85.0%	88.8%
Ave Maria Home	75	25,652	24,507	93.7%	89.5%
Bright Glade Health and Rehab	77	25,451	25,867	90.6%	92.0%
Harbor View Nursing and Rehab Ctnr, Inc.	120	34,815	36,457	79.5%	83.2%
Dove Health & Rehab of Collierville, LLC	114	34,996	35,754	84.1%	85.9%
Grace Healthcare of Cordova	284	74,167	74,167	71.5%	71.5%
Graceland Nursing Center	240	76,445	75,843	87.3%	86.6%
Memphis Jewish Home	160	44,394	42,920	76.0%	73.5%
MidSouth Health and Rehab Ctnr	155	29,172	49,201	51.6%	87.0%
Millington Healthcare Ctnr	85	28,410	28,917	91.6%	93.2%
Poplar Point Health and Rehab	169	47,604	51,074	77.2%	82.8%
Kindred Transitional Care & Rehab Cntr-Primacy	120	31,637	32,196	72.2%	73.5%
Rainbow Health & Rehab of Memphis, LLC	115	39,763	39,641	94.7%	94.4%
Signature Health of Memphis	140	48,440	49,467	94.8%	96.8%
Spring Gate Nursing and Rehab Ctnr	233	78,591	78,439	92.4%	92.2%
Signature HealthCare at St. Francis	197	62,807	61,821	87.3%	86.0%
Signature Healthcare at St. Peter Villa	180	54,445	60,560	82.9%	92.2%
Highlands of Memphis Health & Rehab	180	55,265	60,143	84.1%	91.5%
Whitehaven Community Living Ctnr	92	30,268	28,888	90.1%	86.0%
TOTAL	3,129	939,450	983,017	82.3%	86.1%

Source: Nursing Home JAR, 2010-2011, 2012 (Provisional)

** No JAR*

Some Figures are rounded

Supplemental SUPPLEMENTAL- # 1
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Nursing Home Bed Utilization 2011

Facility	Beds					ADC				
	Total	SNF M'care	SNF/NF DC	NF M'caid	Non-C	SNF M'care	SNF M'caid	SNF All Other Payors	NF	Total
Allen Morgan Health and Rehab. Ctnr	104	80	0	0	24	12.4	0.0	0.0	62.0	74.5
Allenbrooke Nursing and Rehab. Ctnr, LLC	180	0	180	0	0	16.0	12.7	3.6	139.9	172.2
Civic Health and Rehab Ctnr	147	0	17	130	0	4.0	24.8	7.0	107.3	143.0
Applingwood Health Care Ctnr	78	0	78	0	0	15.8	0.0	0.0	51.3	67.1
Ashton Place Health and Rehab Cntr	211	0	211	0	0	19.5	28.6	0.0	131.3	179.4
Ave Maria Home	75	0	75	0	0	4.0	0.0	0.0	66.2	70.3
Baptist Memorial Hospital - Memphis SNF	35	0	0	0	35	25.2	1.1	2.7	0.0	29.0
Baptist Skilled Rehab Unit - Germantown	18	0	18	0	0	12.8	0.0	1.2	0.0	14.0
Bright Glade Health and Rehab	81	0	81	0	0	16.3	1.1	0.0	52.3	69.7
Harbor View Nursing and Rehab Ctnr, Inc.	120	0	120	0	0	23.8	0.0	0.0	71.6	95.4
Dove Health & Rehab of Collierville, LLC	114	0	114	0	0	18.8	5.0	0.0	72.1	95.9
Grace Healthcare of Cordova	284	0	284	0	0	17.7	29.8	4.2	151.4	203.2
Graceland Nursing Center	240	0	0	120	120	15.7	45.9	1.9	146.0	209.4
Kirby Pines Manor	120	90	0	0	30	19.4	0.0	7.6	88.5	115.5
Memphis Jewish Home	160	0	160	0	0	33.9	2.2	8.3	77.2	121.6
Methodist Healthcare Skilled Nursing Facility	44	0	0	0	44	11.5	0.0	3.2	0.0	14.7
MidSouth Health and Rehab Ctnr	155	0	155	0	0	14.9	5.3	0.0	59.7	79.9
Millington Healthcare Ctnr	85	0	66	0	19	16.8	1.9	1.2	57.9	77.8
Poplar Point Health and Rehab	169	0	54	115	0	13.0	15.9	0.0	101.5	130.4
Parkway Health and Rehab Ctnr	120	0	120	0	0	15.4	20.0	5.1	76.1	116.6
Kindred Transitional Care & Rehab Cntr-Primacy	120	0	0	0	120	56.4	0.0	2.7	27.6	86.7
Quality Care Center of Memphis	48	0	48	0	0	0.5	0.0	0.0	33.0	33.5
Quince Nursing and Rehab Ctnr	188	0	188	0	0	27.8	13.5	2.2	138.3	181.8
Rainbow Health & Rehab of Memphis, LLC	115	0	115	0	0	22.8	8.0	0.0	78.1	108.9
Signature Health of Memphis	140	0	140	0	0	24.3	8.4	0.0	100.0	132.7
Spring Gate Nursing and Rehab Ctnr	231	88	143	0	0	27.1	11.6	21.0	155.6	215.3
Signature HealthCare at St. Francis	197	0	197	0	0	53.8	10.0	15.8	92.5	172.1
Signature Healthcare at St. Peter Villa	180	0	120	60	0	19.9	20.3	7.2	101.8	149.2
The King's Daughters and Sons Home	108	0	108	0	0	15.7	8.8	2.5	76.8	103.9
The Village at Germantown	30	0	0	0	30	23.5	0.0	2.2	0.0	25.7
Highlands of Memphis Health & Rehab	180	0	180	0	0	26.3	7.4	0.0	117.7	151.4
Whitehaven Community Living Ctnr	92	0	92	0	0	10.7	4.3	0.0	67.9	82.9
TOTAL	4,169	258	3,064	425	422	635.6	286.7	99.6	2501.7	3523.7

Source: Nursing Home JAR, 2011

Some Figures are rounded

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Supplemental Docs
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Nursing Home Bed Utilization 2012 (Provisional)

Facility	Beds					ADC				
	Total	SNF M'care	SNF/NF DC	NF M'caid	Non-C	SNF M'care	SNF M'caid	SNF All Other Payors	NF	Total
Allen Morgan Health and Rehab. Ctnr	104	80	0	0	24	18.5	0.0	0.0	69.4	87.9
Allenbrooke Nursing and Rehab. Ctnr, LLC	180	0	180	0	0	14.6	13.9	3.7	139.8	172.0
Civic Health and Rehab Ctnr	*	*	*	*	*	*	*	*	*	*
Applingwood Health Care Ctnr	78	0	78	0	0	17.8	0.0	0.0	55.3	73.0
Ashton Place Health and Rehab Cntr	211	0	211	0	0	21.8	25.8	0.0	139.9	187.4
Ave Maria Home	75	0	75	0	0	8.6	0.0	0.0	58.5	67.1
Baptist Memorial Hospital - Memphis SNF	35	0	0	0	35	23.4	0.7	4.9	0.0	28.9
Baptist Skilled Rehab Unit - Germantown	18	0	0	0	18	13.5	0.0	1.3	0.0	14.9
Bright Glade Health and Rehab	77	0	77	0	0	14.2	1.0	0.0	55.7	70.9
Harbor View Nursing and Rehab Ctnr, Inc.	120	0	120	0	0	19.2	0.0	0.0	80.7	99.9
Dove Health & Rehab of Collierville, LLC	114	0	114	0	0	15.6	6.9	0.0	75.5	98.0
Grace Healthcare of Cordova	284	0	284	0	0	17.7	29.8	4.2	151.4	203.2
Graceland Nursing Center	240	0	0	120	120	14.1	39.6	0.0	154.0	207.8
Kirby Pines Manor	120	90	0	0	30	23.4	0.0	4.0	89.7	117.0
Memphis Jewish Home	160	0	160	0	0	28.7	0.6	27.7	60.5	117.6
Methodist Healthcare Skilled Nursing Facility	44	0	0	0	44	15.2	0.0	3.0	0.0	18.1
MidSouth Health and Rehab Ctnr	155	0	155	0	0	15.3	5.9	0.0	113.6	134.8
Millington Healthcare Ctnr	85	0	66	0	19	20.1	1.0	1.0	57.1	79.2
Poplar Point Health and Rehab	169	0	54	115	0	23.6	142.4	1.4	0.0	139.9
Parkway Health and Rehab Ctnr	120	0	120	0	0	24.0	16.6	0.2	74.5	115.3
Kindred Transitional Care & Rehab Cntr-Primacy	120	0	0	0	120	53.2	0.0	5.6	29.4	88.2
Quality Care Center of Memphis	48	0	48	0	0	0.0	0.0	0.0	34.3	34.3
Quince Nursing and Rehab Ctnr	188	0	188	0	0	28.2	12.7	4.7	134.6	180.2
Rainbow Health & Rehab of Memphis, LLC	115	0	115	0	0	26.0	4.0	0.0	78.6	108.6
Signature Health of Memphis	140	0	140	0	0	24.2	2.2	0.0	109.1	135.5
Spring Gate Nursing and Rehab Ctnr	233	0	143	90	0	21.6	19.8	15.4	158.1	214.9
Signature HealthCare at St. Francis	197	0	113	0	84	51.4	9.2	14.4	94.4	169.4
Signature Healthcare at St. Peter Villa	180	0	120	60	0	26.1	17.3	9.7	112.8	165.9
The King's Daughters and Sons Home	108	0	108	0	0	15.6	8.5	2.3	79.5	105.9
The Village at Germantown	30	0	0	0	30	20.9	0.0	0.0	5.0	25.9
Highlands of Memphis Health & Rehab	180	0	180	0	0	21.2	11.8	0.0	131.8	164.8
Whitehaven Community Living Ctnr	92	0	92	0	0	10.8	4.0	0.0	64.4	79.1
TOTAL	4,020	170	2,941	385	524	648.6	373.7	103.7	2407.3	3505.9

Source: Nursing Home JAR, 2012 (Provisional)

** No JAR*

Some Figures are rounded

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Shelby Co. Nursing Home UtilizationTrends-2010-2012

Facility	Licensed Beds (2012)	Pt. Days 2010	Pt. Days 2011	Pt. Days 2012	'10- '12 Change	Occ. 2010	Occ. 2011	Occ. 2012
Allen Morgan Health and Rehab. Ctnr	104	29,053	27,178	32,094	10.5%	76.5%	71.6%	84.5%
Allenbrooke Nursing and Rehab. Ctnr, LLC	180	61,632	62,846	62,784	1.9%	93.8%	95.7%	95.6%
Civic Health and Rehab Ctnr	*	52,472	52,210	*	*	*	*	*
Applingwood Health Care Ctnr	78	27,076	24,486	26,651	-1.6%	95.1%	86.0%	93.6%
Ashton Place Health and Rehab Cntr	211	72,619	65,464	68,410	-5.8%	94.3%	85.0%	88.8%
Ave Maria Home	75	26,796	25,652	24,507	-8.5%	97.9%	93.7%	89.5%
Baptist Memorial Hospital - Memphis SNF	35	10,378	10,590	10,561	1.8%	81.2%	82.9%	82.7%
Baptist Skilled Rehab Unit - Germantown	18	324	5,123	5,423	1573.8%	4.9%	78.0%	82.5%
Bright Glade Health and Rehab	77	25,709	25,451	25,867	0.6%	91.5%	90.6%	92.0%
Harbor View Nursing and Rehab Ctnr, Inc.	120	23,637	34,815	36,457	54.2%	54.0%	79.5%	83.2%
Dove Health & Rehab of Collierville, LLC	114	27,733	34,996	35,754	28.9%	66.6%	84.1%	85.9%
Grace Healthcare of Cordova	284	86,103	74,167	74,167	-13.9%	83.1%	71.5%	71.5%
Graceland Nursing Center	240	82,117	76,445	75,843	-7.6%	93.7%	87.3%	86.6%
Kirby Pines Manor	120	40,578	42,160	42,722	5.3%	92.6%	96.3%	97.5%
Memphis Jewish Home	160	48,726	44,394	42,920	-11.9%	83.4%	76.0%	73.5%
Methodist Healthcare Skilled Nursing Facility	44	5,472	5,370	6,623	21.0%	34.1%	33.4%	41.2%
MidSouth Health and Rehab Ctnr	155	17,147	29,172	49,201	186.9%	30.3%	51.6%	87.0%
Millington Healthcare Ctnr	85	29,170	28,410	28,917	-0.9%	94.0%	91.6%	93.2%
Poplar Point Health and Rehab	169	53,543	47,604	51,074	-4.6%	86.8%	77.2%	82.8%
Parkway Health and Rehab Ctnr	120	36,359	42,549	42,102	15.8%	83.0%	97.1%	96.1%
Kindred Transitional Care & Rehab Cntr-Primacy	120	41,826	31,637	32,196	-23.0%	95.5%	72.2%	73.5%
Quality Care Center of Memphis	48	13,026	12,244	12,535	-3.8%	74.3%	69.9%	71.5%
Quince Nursing and Rehab Ctnr	188	65,719	66,343	65,776	0.1%	95.8%	96.7%	95.9%
Rainbow Health & Rehab of Memphis, LLC	115	38,767	39,763	39,641	2.3%	92.4%	94.7%	94.4%
Signature Health of Memphis	140	49,005	48,440	49,467	0.9%	95.9%	94.8%	96.8%
Spring Gate Nursing and Rehab Ctnr	233	73,826	78,591	78,439	6.2%	86.8%	92.4%	92.2%
Signature HealthCare at St. Francis	197	72,715	62,807	61,821	-15.0%	101.1%	87.3%	86.0%
Signature Healthcare at St. Peter Villa	180	56,578	54,445	60,560	7.0%	86.1%	82.9%	92.2%
The King's Daughters and Sons Home	108	38,768	37,908	38,653	-0.3%	98.3%	96.2%	98.1%
The Village at Germantown	30	10,002	9,371	9,462	-5.4%	91.3%	85.6%	86.4%
Highlands of Memphis Health & Rehab	180	53,561	55,265	60,143	12.3%	81.5%	84.1%	91.5%
Whitehaven Community Living Ctnr	92	30,136	30,268	28,888	-4.1%	89.7%	90.1%	86.0%
TOTAL	4,020	1,300,573	1,286,164	1,279,658	-1.6%	88.6%	87.7%	87.2%

Source: Nursing Home JAR, 2010-2011, 2012 (Provisional)

** No JAR*

Some Figures are rounded

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

December 16, 2013

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

Re: The MED, CN1311-044
20 Bed SNF Unit

Ms. Hill:

Please find below the information requested for the above mentioned project.

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

As is noted on the plot plan, the Adams Building will soon be a 70 year old building. As a new skilled nursing facility, the unit in the Adams Building will have to meet all of the current nursing home standards which include being sprinklered. Will the facility be able to meet all these standards? If yes, please provide the following documentation.

A) Please provide documentation from a licensed architect or construction professional:

1) a general description of the project,

Response: The project is the conversion of a recently decanted 21 bed inpatient rehabilitation unit to a 20 bed skilled nursing unit. The area is approximately 20,000 ft2.The license for the inpatient rehabilitation unit was recently renewed.

2) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and

Response:

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase.

1. Architectural and Engineering Fees	$	-0-
2. Legal, Administrative (Excluding CON Filing Fee), Consultant	$	50,000
3. Acquisition of Site	$	-0-
4. Preparation of Site	$	-0-
5. Construction Costs	$	37,128

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6.	Contingency Fund	$ -0-
7.	Fixed Equipment (Not included in Construction Contract)	$ -0-
8.	Moveable Equipment (List all equipment over $50,000)	$ 209,872
9.	Other (Specify) _____	
	Subsection A Total	$ 297,000

B. Acquisition by gift, donation, or lease.

1.	Facility (Inclusive of Building and Land)	$ -0-
2.	Building Only	$ -0-
3.	Land Only	$ -0-
4.	Equipment (Specify) _____	$ -0-
5.	Other (Specify) _____	$ -0-
	Subsection B Total	$ -0-

C. Financing costs and fees

1.	Interim Financing	$ -0-
2.	Underwriting Costs	$ -0-
3.	Reserve for One Year's Debt Service	$ -0-
4.	Other (Specify)_____	$ -0-
	Subsection C Total	$ -0-

D.	Estimated Project Cost (A + B + C)		$ 297,000
E.	CON Filing Fee		$ 3,000
F.	Total Estimated Project Cost (D + E)	TOTAL	$ 300,000

3) attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the most recent AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

Response: To the best of our knowledge based on visual observation and review of existing construction documents of the proposed location, it appears that the evacuated inpatient rehabilitation, meets the standards and guidelines for a nursing home.

I hope this provides the information needed. If you have questions or need additional information please contact me.

Sincerely,

Warren N. Goodwin, FAIA
President & CEO

SUPPLEMENTAL - # 1
December 17, 2013
1:30pm

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Skilled Nursing Facility PPS

CASE MIX PROSPECTIVE PAYMENT FOR SNFs BALANCED BUDGET ACT OF 1997:

Section 4432(a) of the Balanced Budget Act (BBA) of 1997 modified how payment is made for Medicare skilled nursing facility (SNF) services. Effective with cost reporting periods beginning on or after July 1, 1998, SNFs are no longer paid on a reasonable cost basis or through low volume prospectively determined rates, but rather on the basis of a prospective payment system (PPS). The PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).

Implementing instructions relating to coverage and physician certification/recertification are forthcoming and are not included in these sections.

The Balanced Budget Act of 1997 mandates the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities (SNFs) covering all costs (routine, ancillary and capital) related to the services furnished to beneficiaries under Part A of the Medicare program. Major elements of the system include:

- Rates: Federal rates are set using allowable costs from FY 1995 cost reports. The rates also include an estimate of the cost of services which, prior to July 1, 1998, had been paid under Part B but furnished to SNF residents during a Part A covered stay. FY 1995 costs are updated to FY 1998 by a SNF market basket minus 1 percentage point for each of fiscal years 1996, 1997 and 1998. Providers which received new provider exemptions in FY 1995 are excluded from the data base. Routine cost limit exceptions payments are also excluded. The data is aggregated nationally by urban and rural area to determine standardized federal per diem rates to which case mix and wage adjustments apply.
- **Case Mix Adjustment**: Per diem payments for each admission are case-mix adjusted using a resident classification system (Resource Utilization Groups IV) based on data from resident assessments (MDS 3.0) and relative weights developed from staff time data.
- **Geographic Adjustment**: The labor portion of the federal rates is adjusted for geographic variation in wages using the hospital wage index.
- **Annual Updates**: Payment rates are increased each Federal fiscal year using a SNF market basket index.
- **Transition**: A three-year transition that blends a facility-specific payment rate with the federal case mix adjusted rate is used. The facility-specific rate includes allowable costs (from FY 1995 cost reports) including exceptions payments. Payments associated with 'new provider' exemptions are included but limited to 150 percent of the routine cost limit. It also includes an add-on for related Part B costs similar to the federal rate.
- **Effective Date**: The PPS system is effective for cost reporting periods beginning on or after July 1, 1998.
- For further information on the prospective payment system and its full legislative history, please refer to the document entitled "Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Legislative History," available via the Downloads list below.

SKILLED NURSING FACILITY (SNF) CENTER
For a one-stop resource web page focused on the informational needs and interests of Medicare Fee-for-Service (FFS) skilled nursing facilities go to the SNF Center.

Downloads

Nursing & Therapy Minutes (Used in Calculating Preliminary Rates: April 10, 2000 Federal Register PPS Update [ZIP, 104KB]

Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Legislative History [PDF, 99KB]

Related Links

Manuals

MDS 3.0 for Nursing Homes and Swing Bed Providers

Nursing Home Quality Initiative

Skilled Nursing Facility Center

FFS SNFABN and SNF Denial Letters

Skilled Nursing Facilities (SNF PPS) PC Pricer

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Page last Modified: 07/31/2013 3:29 PM

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A federal government website managed by the Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

Legislative History

Updated: July 31, 2013

Historically, each rule or update notice issued under the annual Skilled Nursing Facility (SNF) prospective payment system (PPS) rulemaking cycle included a detailed reiteration of the various individual legislative provisions that have affected the SNF PPS over the years, a number of which represented temporary measures that have long since expired. This document now serves to provide that discussion.

I. Legislative History of the SNF Prospective Payment System (PPS)

A. Current System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (BBA, Pub. L. 105-33, enacted on August 5, 1997) amended section 1888 of the Act to provide for the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital-related) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. Major elements of the SNF PPS include:

- Rates. As explained in the May 12, 1998 interim final rule (63 FR 26252, available online at www.gpo.gov/fdsys/pkg/FR-1998-05-12/pdf/98-12208.pdf), we established per diem Federal rates for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included a "Part B add-on" (an estimate of the cost of those services that, before July 1, 1998, were paid under Part B, but furnished to Medicare beneficiaries in a SNF during a Part A covered stay). We adjust the rates annually using a SNF market basket index to reflect changes in the costs of goods and services used to provide SNF care, and we also adjust the rates by the hospital inpatient wage index to account for geographic variation in wages. As described in Section I.F, effective FY 2012, we include an annual multifactor productivity adjustment to ensure that the annual market basket update also accounts for increases in provider productivity. We also apply a case-mix adjustment to account for the relative resource utilization of different patient types. Originally, this adjustment involved the 44-group Resource Utilization Groups, version 3 (RUG-III) case-mix classification system, using information obtained from the required resident assessments under version 2.0 of the Minimum Data Set (MDS 2.0). As of FY 2011, this adjustment now utilizes the 66-group version 4 of the RUG model (RUG-IV), as well as version 3.0 of the MDS (MDS 3.0). Additionally, the payment rates at various times have also reflected specific legislative provisions for certain temporary adjustments, as discussed in the following sections of this document.

- Transition. Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the Federal case-mix adjusted rate. The

transition extended through the facility's first three cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full Federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments entirely on the adjusted Federal per diem rates, the SNF PPS no longer utilizes adjustment factors related to facility-specific rates.

- Coverage. The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system. This approach includes an administrative presumption under which a beneficiary's initial classification to one of the designated upper RUGs serves to assist in making certain SNF level of care determinations. In the July 30, 1999 final rule (64 FR 41670, available online at www.gpo.gov/fdsys/pkg/FR-1999-07-30/pdf/99-19478.pdf), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure.

- Consolidated Billing. The SNF PPS includes a consolidated billing provision that requires a SNF to submit consolidated Medicare bills to its fiscal intermediary or Medicare Administrative Contractor for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, this provision places with the SNF the Medicare billing responsibility for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a non-covered stay. The statute excludes a small list of services from the consolidated billing provision (primarily those of physicians and certain other types of practitioners), which remain separately billable under Part B when furnished to a SNF's Part A resident. A more detailed discussion of this provision appears in Section II of this document and on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html.

- Payment for SNF-Level Swing-Bed Services. Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, these services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002.

- Availability of Wage Index Values. For a number of years, the Wage Index for Urban Areas Based on CBSA Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas were published in the **Federal Register** as Tables A and B, respectively, in an Addendum to the annual SNF PPS rulemaking (that is, the SNF PPS proposed and final rules or, when applicable, the current update notice). However, as of FY 2012, a number of other Medicare payment systems adopted an approach in which such tables were no longer published in the **Federal Register** in this manner, and instead have been made available exclusively through the Internet; see, for example, the FY 2012 Hospital Inpatient PPS (IPPS) final rule (76 FR 51476, August 18, 2011, available online at www.gpo.gov/fdsys/pkg/FR-2011-

08-18/pdf/2011-19719.pdf). To be consistent with these other Medicare payment systems and streamline the published content to focus on policy discussion, we have adopted a similar approach for the SNF PPS as well. Under this approach, effective October 1, 2013, the individual wage index values formerly displayed as Tables A and B in the annual SNF PPS rulemaking are instead made available exclusively through the Internet on CMS's SNF PPS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. Consistent with the provisions of section 1888(e)(4)(H)(iii) of the Act, we continue to publish in the **Federal Register** the specific "factors to be applied in making the area wage adjustment" (for example, the SNF prospective payment system's methodological use of the hospital wage index exclusive of its occupational mix adjustment) as part of our annual SNF PPS rulemaking process, but that document will no longer include a listing of the individual wage index values themselves, which instead are made available exclusively through the Internet on the CMS website.

B. Requirements of the Balanced Budget Act of 1997 (BBA) for Updating the Prospective Payment System for Skilled Nursing Facilities

As added by section 4432(a) of the BBA, section 1888(e)(4)(H) of the Act requires that we provide for publication annually in the **Federal Register**:

1. The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the upcoming FY.
2. The case-mix classification system to be applied with respect to these services during the upcoming FY.
3. The factors to be applied in making the area wage adjustment with respect to these services.

C. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)

There were several provisions in the BBRA (Pub. L. 106-113, Appendix F, enacted on November 29, 1999) that resulted in adjustments to the SNF PPS. We described these provisions in detail in the FY 2001 SNF PPS final rule (65 FR 46770, July 31, 2000, available online at www.gpo.gov/fdsys/pkg/FR-2000-07-31/pdf/00-19004.pdf). In particular, section 101(a) of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified groups in the original, 44-group RUG-III case-mix classification system. In accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired on January 1, 2006, upon the implementation of a refined, 53-group version of the RUG-III system, RUG-53. We included further information on BBRA provisions that affected the SNF PPS in Program Memoranda A-99-53 and A-99-61 (December 1999).

Also, section 103 of the BBRA designated certain additional services for exclusion from the consolidated billing requirement, as discussed in Section II of this document. Further, for swing-bed hospitals with more than 49 (but less than 100) beds, section 408 of the BBRA provided for the repeal of certain statutory restrictions on length of stay and aggregate payment for patient days, effective with the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the FY 2002 final rule (66 FR 39562, July 31, 2001, available

online at www.gpo.gov/fdsys/pkg/FR-2001-07-31/pdf/01-18869.pdf), we made conforming changes to the regulations at §413.114(d), effective for services furnished in cost reporting periods beginning on or after July 1, 2002, to reflect section 408 of the BBRA.

D. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

The BIPA (Pub. L. 106-554, Appendix F, enacted December 21, 2000) also included several provisions that resulted in adjustments to the SNF PPS. We described these provisions in detail in the FY 2002 final rule (66 FR 39562, July 31, 2001, available online at www.gpo.gov/fdsys/pkg/FR-2001-07-31/pdf/01-18869.pdf)). In particular:

- Section 203 of the BIPA exempted CAH swing beds from the SNF PPS. We included further information on this provision in Program Memorandum A-01-09 (Change Request #1509), issued January 16, 2001, which is available online at www.cms.gov/transmittals/downloads/a0109.pdf.

- Section 311 of the BIPA revised the statutory update formula for the SNF market basket, and also directed us to conduct a study of alternative case-mix classification systems for the SNF PPS. In 2006, we submitted a report to the Congress on this study, which is available online at www.cms.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf.

- Section 312 of the BIPA provided for a temporary increase of 16.66 percent in the nursing component of the case-mix adjusted Federal rate for services furnished on or after April 1, 2001, and before October 1, 2002; accordingly, this add-on is no longer in effect. This section also directed the Government Accountability Office (GAO) to conduct an audit of SNF nursing staff ratios and submit a report to the Congress on whether the temporary increase in the nursing component should be continued. The report (GAO-03-176), which GAO issued in November 2002, is available online at www.gao.gov/new.items/d03176.pdf.

- Section 313 of the BIPA repealed the consolidated billing requirement for services (other than physical therapy, occupational therapy, and speech-language pathology services) furnished to SNF residents during non-covered stays, effective January 1, 2001. (A more detailed discussion of this provision appears in Section II of this document.)

- Section 314 of the BIPA corrected an anomaly involving three of the RUGs that section 101(a) of the BBRA had designated to receive the temporary payment adjustment discussed above in section I.C. of this document. (As noted previously, in accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired upon the implementation of case-mix refinements on January 1, 2006.)

- Section 315 of the BIPA authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. To date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

We included further information on several of the BIPA provisions in Program Memorandum A-01-08 (Change Request #1510), issued January 16, 2001, which is available online at www.cms.gov/transmittals/downloads/a0108.pdf.

E. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)

The MMA (Pub. L. 108-173, enacted on December 8, 2003) included a provision that resulted in a further adjustment to the SNF PPS. Specifically, section 511 of the MMA amended section 1888(e)(12) of the Act, to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special AIDS add-on was to remain in effect until ". . . the Secretary certifies that there is an appropriate adjustment in the case mix . . . to compensate for the increased costs associated with [such] residents . . . ." The AIDS add-on is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at www.cms.gov/transmittals/downloads/r160cp.pdf. In the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-08-11/pdf/E9-18662.pdf), we did not address the certification of the AIDS add-on in that final rule's implementation of the case-mix refinements for RUG-IV, thus allowing the temporary add-on payment created by section 511 of the MMA to remain in effect.

Implementation of this provision results in a significant increase in payment, but only for the limited number of SNF residents that actually qualify for the AIDS add-on. For example, using FY 2011 data, we identified less than 4,100 SNF residents with a diagnosis of Human Immunodeficiency Virus (HIV) Infection.

In addition, section 410 of the MMA contained a provision that excluded from consolidated billing certain services furnished to SNF residents by rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs). (Further information on this provision appears in section II of this document.)

F. The Affordable Care Act

On March 23, 2010, the Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted. Then, the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010) amended certain provisions of Pub. L. 111-148 and certain sections of the statute and, in certain instances, included "freestanding" provisions (Pub. L. 111-148 and Pub. L. 111-152 are collectively referred to here as the "Affordable Care Act").

Effective FY 2012, section 3401(b) of the Affordable Care Act requires that the market basket percentage under the SNF payment system as described in section 1888(e)(5)(B)(i) of the Social Security Act (the Act) is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. As explained in the Senate Finance Committee report that accompanied S.1796 ("America's Healthy Future Act of 2009," the Senate's initial version

of the health care reform legislation that ultimately was enacted in Pub. L. 111-148), the purpose of this type of productivity adjustment is to help ensure that the market basket update, in accounting for changes in the costs of goods and services used to provide patient care, also reflects ". . . increases in provider productivity that could reduce the actual cost of providing services (such as through new technology, fewer inputs, etc.)" (S. Rep. No. 111-89 at 261). Specifically, section 3401(a) of the Affordable Care Act amends section 1886(b)(3)(B) of the Act to add clause (xi)(II), which sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period) (the "MFP adjustment"). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. Please see www.bls.gov/mfp to obtain the BLS historical published MFP data.

Section 10325 of the Affordable Care Act included an additional provision involving the SNF PPS. That provision postponed the implementation of the RUG-IV case-mix classification system published in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-08-11/pdf/E9-18662.pdf), requiring that the Secretary not implement the RUG-IV case-mix classification system before October 1, 2011. Notwithstanding this postponement of overall RUG-IV implementation, section 10325 of the Affordable Care Act further specified that the Secretary implement, effective October 1 2010, the changes related to concurrent therapy and the look-back period that were finalized as components of RUG-IV (see 74 FR 40315-19, 40322-24, August 11, 2009). As we noted in the FY 2011 SNF PPS notice with comment period (75 FR 42889, July 22, 2010, available online at www.gpo.gov/fdsys/pkg/FR-2010-07-22/pdf/2010-17628.pdf), implementing the particular combination of RUG-III and RUG-IV features specified in section 10325 of the Affordable Care Act would require developing a revised grouper, something that could not be accomplished by that provision's effective date (October 1, 2010) without risking serious disruption to providers, suppliers, and State agencies. Accordingly, in the FY 2011 notice with comment period, we announced our intention to proceed on an interim basis with implementation of the full RUG-IV case-mix classification system as of October 1, 2010, followed by a retroactive claims adjustment, using a hybrid RUG-III (HR-III) system reflecting the Affordable Care Act configuration, once we had developed a revised grouper that could accommodate it.

However, section 202 of the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309, enacted on December 15, 2010) subsequently repealed section 10325 of the Affordable Care Act. We have, therefore, left in place permanently the implementation of the full RUG-IV system as of FY 2011, as finalized in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-08-11/pdf/E9-18662.pdf). In addition, we note that implementation of version 3.0 of the Minimum Data Set (MDS 3.0) proceeded as originally scheduled, with an effective date of October 1, 2010. The MDS 3.0 RAI Manual and MDS 3.0 Item Set are published on the MDS 3.0 Training Materials Web site, at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. Accordingly, as discussed above, effective October 1, 2010, we implemented and began paying claims under the RUG-IV system that was finalized in the FY 2010 SNF PPS final rule.

We note that a parity adjustment was applied to the RUG-53 nursing case-mix weights when the RUG-III system was initially refined in 2006, in order to ensure that the implementation of the refinements would not cause any change in overall payment levels (70 FR 45031, August 4, 2005, available online at www.gpo.gov/fdsys/pkg/FR-2005-08-04/pdf/05-15221.pdf). Similarly, a parity adjustment was applied to the RUG-IV nursing case-mix weights for FY 2011 when the new classification system was implemented. A detailed discussion of the parity adjustment in the specific context of the RUG-IV payment rates appears in the FY 2010 SNF PPS proposed rule (74 FR 22236-38, May 12, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-05-12/pdf/E9-10461.pdf) and final rule (74 FR 40338-40339, August 11, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-08-11/pdf/E9-18662.pdf), and in the FY 2011 notice with comment period (75 FR 42892-42893, July 22, 2010, available online at www.gpo.gov/fdsys/pkg/FR-2010-07-22/pdf/2010-17628.pdf).

For FY 2012, the RUG-IV parity adjustment was recalibrated in order to restore the intended parity in overall payments between the RUG-IV and RUG-53 case mix classification systems, as discussed in the FY 2012 SNF PPS proposed rule (76 FR 26370-26373, May 6, 2011, available online at www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10555.pdf) and final rule (76 FR 48492-48500, 48537-48538 August 8, 2011, available online at www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf).

II. Legislative History of SNF Consolidated Billing

Section 4432(b) of the BBA established a consolidated billing requirement that places with the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. As noted previously in Section I of this document, subsequent legislation enacted a number of modifications in the consolidated billing provision.

Specifically, section 103 of the BBRA amended this provision by further excluding a number of individual "high-cost, low probability" services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the FY 2001 proposed and final rules (65 FR 19231 through 19232, April 10, 2000, available online at www.gpo.gov/fdsys/pkg/FR-2000-04-10/pdf/00-8481.pdf, and 65 FR 46790 through 46795, July 31, 2000, available online at www.gpo.gov/fdsys/pkg/FR-2000-07-31/pdf/00-19004.pdf), as well as in Program Memorandum AB-00-18 (Change Request #1070), issued March 2000, which is available online at www.cms.gov/transmittals/downloads/ab001860.pdf.

Section 313 of the BIPA further amended this provision by repealing its Part B aspect; that is, its applicability to services furnished to a resident during a SNF stay that Medicare Part A does not cover. (However, physical therapy, occupational therapy, and speech-language pathology services remain subject to consolidated billing, regardless of whether the resident who receives these services is in a covered Part A stay.) We discuss this BIPA amendment in greater

detail in the FY 2002 proposed and final rules (66 FR 24020 through 24021, May 10, 2001, available online at www.gpo.gov/fdsys/pkg/FR-2001-05-10/pdf/01-11560.pdf, and 66 FR 39587 through 39588, July 31, 2001, available online at www.gpo.gov/fdsys/pkg/FR-2001-07-31/pdf/01-18869.pdf).

In addition, section 410 of the MMA amended this provision by excluding certain practitioner and other services furnished to SNF residents by RHCs and FQHCs. We discuss this MMA amendment in greater detail in the FY 2005 update notice (69 FR 45818 through 45819, July 30, 2004, available online at www.gpo.gov/fdsys/pkg/FR-2004-07-30/pdf/04-17443.pdf), as well as in Medicare Learning Network (MLN) Matters article #MM3575, which is available online at www.cms.gov/MLNMattersArticles/downloads/MM3575.pdf.

Further, while not substantively revising the consolidated billing requirement itself, a related provision was enacted in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110-275). Specifically, section 149 of MIPPA amended section 1834(m)(4)(C)(ii) of the Act to add subclause (VII), which adds SNFs (as defined in section 1819(a) of the Act) to the list of entities that can serve as a telehealth "originating site" (that is, the location at which an eligible individual can receive, through a telecommunications system, services of a physician or other practitioner who is located elsewhere at a "distant site").

As explained in the Medicare Physician Fee Schedule (PFS) final rule for calendar year (CY) 2009 (73 FR 69726, 69879, November 19, 2008, available online at www.gpo.gov/fdsys/pkg/FR-2008-11-19/pdf/E8-26213.pdf), a telehealth originating site receives a facility fee which is always separately payable under Part B outside of any other payment methodology. Section 149(b) of MIPPA amended section 1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under section 1834(m)(4)(C)(ii)(VII) of the Act from the definition of "covered skilled nursing facility services" that are paid under the SNF PPS. Thus, a SNF ". . . can receive separate payment for a telehealth originating site facility fee even in those instances where it also receives a bundled per diem payment under the SNF PPS for a resident's covered Part A stay" (73 FR 69881). By contrast, under section 1834(m)(2)(A) of the Act, a telehealth distant site service is payable under Part B to an eligible physician or practitioner only to the same extent that it would have been so payable if furnished without the use of a telecommunications system. Thus, as explained in the CY 2009 Physician Fee Schedule final rule (73 FR 69726, 69880), eligible distant site physicians or practitioners can receive payment for a telehealth service that they furnish

> . . . only if the service is separately payable under the PFS when furnished in a face-to-face encounter at that location. For example, we pay distant site physicians or practitioners for furnishing services via telehealth only if such services are not included in a bundled payment to the facility that serves as the originating site.

This means that in those situations where a SNF serves as the telehealth originating site, the distant site professional services would be separately payable under Part B only to the extent that they are not already included in the SNF PPS bundled per diem payment and subject to consolidated billing. Thus, for a type of practitioner whose services are not otherwise excluded from consolidated billing when furnished during a face-to-face encounter, the use of a telehealth

distant site would not serve to unbundle those services. In fact, consolidated billing does exclude the professional services of physicians, along with those of most of the other types of telehealth practitioners that the law specifies at section 1842(b)(18)(C) of the Act; that is, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, and clinical psychologists (see section 1888(e)(2)(A)(ii) of the Act and 42 CFR 411.15(p)(2)). However, the services of clinical social workers, registered dietitians and nutrition professionals remain subject to consolidated billing when furnished to a SNF's Part A resident and, thus, cannot qualify for separate Part B payment as telehealth distant site services in this situation. Additional information on this provision appears in MLN Matters article #MM6215, which is available online at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6215.pdf.

To date, the Congress has enacted no further legislation affecting the SNF PPS or the consolidated billing provision.

SUPPLEMENTAL- # 1
December 17, 2013
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Nursing and Therapy Minutes Used in Calculating Preliminary Rates:

April 10, 2000 Federal Register PPS Update

(65 FR 19188)

We have received comments that the chart shown below was not easily readable in the Federal register. A clear copy of the chart is provided here for your use.

Table 3 -- Mean Resident and Non-Resident Specific Minutes for Nursing and Therapy Disciplines by RUG-III+ Group

				LPN Resident Specific	LPN Non-Resident		RN Resident Specific	RN Non-Resident	Total Nurse Aide	Nurse Aide Resident Specific	Nurse Aide Non-Resident
RUG-III Group**	RUG-III Group Name	Number of Residents	Total LPN Minutes/ Day	Minutes/ Day	Specific Min/Day***	Total RN Minutes/ Day	Minutes/ Day	Specific Min/Day***	Minutes/ Day	Minutes/Day	Specific Minutes/Day***
1	RUC+SE	9	84.89	61.44	23.44	160.67	106.67	54.00	200.67	111.67	89.00
2	RUB+SE	20	56.55	37.85	18.70	132.85	82.55	50.30	134.30	79.45	54.85
3	RUA+SE	1	112.00	90.00	22.00	29.00	21.00	8.00	140.00	84.00	56.00
4	RVC+SE	7	56.29	35.00	21.29	83.43	47.14	36.29	176.43	107.14	69.29
5	RVB+SE	17	40.41	20.88	19.53	156.47	95.18	61.30	129.35	74.24	55.12
6	RVA+SE	7	73.14	55.71	17.43	131.43	83.71	47.72	151.29	85.43	65.86
7	RHC+SE	26	48.69	26.31	22.38	130.42	82.04	48.39	155.39	93.81	61.58
8	RHB+SE	16	69.00	49.56	19.44	117.25	65.38	51.88	127.00	75.63	51.38
9*	RHA+SE										
10	RMC+SE	45	91.36	62.76	28.60	162.00	103.24	58.76	195.76	126.51	69.25
11	RMB+SE	31	62.68	39.06	23.61	166.61	97.16	69.45	147.07	85.03	62.03
12*	RMA+SE										
13	RLB+SE	5	59.00	31.60	27.40	119.60	51.20	68.40	169.80	110.40	59.40
14	RLA+SE	3	48.67	0.00	48.67	112.33	41.00	71.33	70.67	22.67	48.00
15	RUC	36	46.03	29.44	16.58	100.75	56.89	43.86	174.86	108.39	66.47
16	RUB	192	34.94	21.33	13.61	84.12	46.07	38.05	123.13	73.78	49.35
17	RUA	81	39.49	22.60	16.89	64.98	36.77	28.21	97.91	54.10	43.82
18	RVC	29	50.21	29.34	20.86	93.31	53.52	39.79	163.59	102.55	61.03

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19	RVB	105	42.54	26.96	15.58		85.90	46.53	39.36	138.37	84.77	53.60
20	RVA	80	26.53	15.26	11.26		72.04	37.78	34.26	103.49	52.78	50.71
21	RHC	54	45.04	28.24	16.80		94.85	52.89	41.96	166.48	103.70	62.78
22	RHB	94	34.80	21.33	13.47		100.85	57.97	42.88	130.40	73.39	57.01
23	RHA	41	27.51	16.78	10.73		89.76	49.68	40.07	102.59	51.17	51.41
24	RMC	74	49.35	30.93	18.42		78.01	46.20	31.81	172.16	107.78	64.38
25	RMB	179	38.05	22.82	15.22		88.69	47.98	40.71	140.23	78.54	61.69
26	RMC	74	34.41	19.92	14.49		94.15	54.23	39.92	116.54	59.65	56.89
27	RLB	21	46.52	24.14	22.38		69.38	37.76	31.62	196.33	122.67	73.67
28	RLA	56	33.02	18.66	14.36		60.88	29.36	31.52	124.29	71.11	53.18
29	SE3	70	101.33	70.47	30.86		143.56	91.31	52.24	193.50	124.09	69.41
30	SE2	233	86.06	56.97	29.09		108.52	67.31	41.21	163.54	105.15	58.40
31	SE1	19	57.68	33.79	23.89		80.79	48.05	32.74	191.79	128.68	63.11
N = 3,791												
Data Source: Staff-Time Measurement Studies, 1995 and 1997												
NOTES:												
*None of the residents in our Staff Time sample qualified for RUG-III+ groups 9 or 12												
**Mean minutes for nursing and therapy disciplines were only calculated for the first thirty-one (31) RUG-III+ groups												
***Abt staff time data did not include data for non-resident specific time only. Mean non-resident specific was calculated by subtracting resident specific mean minutes from total mean minutes for each applicable discipline.												

SUPPLEMENTAL- # 1
December 17, 2013
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Table 3 -- Mean Resident and Non-Resident Specific Minutes for Nursing and Therapy Disciplines by RUG-III+ Group (cont'd)

			PT Resident Specific	PT Asst Resident Specific	OT Resident Specific	OT Asst Resident Specific	ST Resident Specific	ST Asst Resident Specific
RUG-III Group**	RUG-III Group Name	Number of Residents	Minutes/Day	Minutes/Day	Minutes/Day	Minutes/Day	Minutes/Day	Minutes/Day
1	RUC+SE	9	11.78	19.78	7.89	13.22	22.67	8.89
2	RUB+SE	20	27.60	18.85	28.55	14.70	28.90	11.55
3	RUA+SE	1	35.00	9.00	0.00	0.00	2.00	0.00
4	RVC+SE	7	20.57	3.57	9.00	1.43	6.86	12.71
5	RVB+SE	17	14.59	13.94	13.18	1.41	3.00	12.76
6	RVA+SE	7	12.14	10.29	14.86	0.14	6.57	10.43
7	RHC+SE	26	13.77	5.85	7.92	1.38	4.81	9.96
8	RHB+SE	16	17.69	10.81	9.19	5.88	3.75	10.13
9*	RHA+SE							
10	RMC+SE	45	8.16	4.22	5.84	1.80	6.47	11.62
11	RMB+SE	31	15.71	6.32	9.55	5.35	4.03	15.35
12*	RMA+SE							
13	RLB+SE	5	5.80	1.00	0.00	0.00	4.00	13.60
14	RLA+SE	3	26.67	20.67	20.33	2.33	2.33	41.00
15	RUC	36	19.81	19.33	21.22	9.78	17.89	21.50
16	RUB	192	27.89	16.36	22.98	12.31	12.89	13.49
17	RUA	81	22.80	16.85	20.12	11.80	12.85	10.75
18	RVC	29	11.10	8.10	10.07	5.83	14.76	15.79
19	RVB	105	18.78	10.82	13.88	5.49	5.08	11.69
20	RVA	80	16.46	14.19	13.03	4.95	3.05	5.85
21	RHC	54	14.52	8.72	8.46	5.87	4.31	8.22
22	RHB	94	15.30	12.43	12.72	6.36	2.27	5.74
23	RHA	41	16.17	13.44	10.12	4.22	2.41	5.98
24	RMC	74	13.45	6.65	9.31	4.82	10.28	6.38
25	RMB	179	13.45	9.36	10.25	4.94	2.74	7.14

26	RMC	74	14.72	8.45		12.58	2.78		3.53	7.28
27	RLB	21	5.38	3.81		1.81	0.62		0.62	5.19
28	RLA	56	11.91	5.95		11.18	4.79		4.07	9.48
29	SE3	70	2.19	0.43		1.51	0.17		0.49	3.14
30	SE2	233	1.39	0.27		1.23	0.41		0.67	2.65
31	SE1	19	0.00	0.00		0.00	0.00		0.05	0.00
N = 3,791										
Data Source: Staff-Time Measurement Studies, 1995 and 1997										
NOTES:										
*None of the residents in our Staff Time sample qualified for RUG-III+ groups 9 or 12										
**Mean minutes for nursing and therapy disciplines were only calculated for the first thirty-one (31) RUG-III+ groups										
***Abt staff time data did not include data for non-resident specific time only. Mean non-resident specific was calculated by subtracting resident specific mean minutes from total mean minutes for each applicable discipline.										

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December 17, 2013
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Table 3- Resident & Specific and Non Resident-Specific Minutes for Nursing and Therapy Disciples by RUG III Group (cont'd)

RUG-III Group Name	Number of Residents	Weighted Non-Resident Specific LPN Time	Weighted Non-Resident Specific PT Time	Weighted Non-Resident Specific PT Asst. Time	Weighted Non-Resident Specific OT Time	Weighted Non-Resident Specific OT Asst. Time	Weighted Non-Resident Specific ST Time	Weighted Non-Resident Specific Ther. Aide Time
RUC+SE	9	4.57	2.14121	2.8075	1.52039	1.65717	3.76344	0.68296
RUB+SE	20	3.65	5.06932	2.6673	5.41565	1.85928	4.77175	0.90906
RUA+SE	1	4.29	6.25951	1.22666	0	0	0.32508	0
RVC+SE	7	4.15	3.72065	0.54772	1.69803	0.17811	1.15237	0.98008
RVB+SE	17	3.81	2.69068	1.97541	2.46746	0.19805	0.49241	0.99912
RVA+SE	7	3.40	2.28684	1.4019	2.76747	0.01781	1.07976	0.83577
RHC+SE	26	4.37	2.51507	0.85654	1.52393	0.17263	0.83077	0.76164
RHB+SE	16	3.79	3.26966	1.50143	1.76081	0.74809	0.65787	0.76019
RHA+SE								
RMC+SE	45	5.58	1.55113	0.6225	1.11852	0.23378	1.07553	0.91065
RMB+SE	31	4.60	2.8493	0.89037	1.8027	0.71144	0.65804	1.20587
RMA+SE								
RLB+SE	5	5.34	1.04177	0.1363	0	0	0.65017	1.03649
RLA+SE	3	9.49	4.79901	2.87366	3.74693	0.29091	0.37926	3.09024
RUC	36	3.23	3.79154	2.78628	4.1998	1.30926	3.03377	1.73408
RUB	192	2.65	5.08089	2.29255	4.33363	1.57793	2.19014	1.03415
RUA	81	3.29	4.18506	2.38996	3.88032	1.52584	2.22315	0.82982
RVC	29	4.07	2.09234	1.17567	1.98356	0.75402	2.61787	1.25037
RVB	105	3.04	3.54184	1.54107	2.66845	0.70609	0.86851	0.91008
RVA	80	2.20	3.02147	1.97615	2.4746	0.63061	0.52756	0.46543
RHC	54	3.28	2.71183	1.2833	1.69583	0.76543	0.74958	0.66998
RHB	94	2.63	2.85576	1.74819	2.42635	0.83833	0.39105	0.45549
RHA	41	2.09	3.04988	1.88163	1.92488	0.53521	0.39844	0.46605
RMC	74	3.59	2.52304	0.96061	1.79994	0.62954	1.78322	0.49977

RMB	179		2.97		2.49872	1.33098	1.95392	0.63334	0.47235	0.55529
RMC	74		2.82		2.73055	1.20119	2.40818	0.35889	0.63215	0.5732
RLB	21		4.36		1.03593	0.51922	0.35872	0.07718	0.11128	0.40484
RLA	56		2.80		2.17134	0.82053	2.08012	0.5975	0.66214	0.71882
SE3	70		6.02		0.39378	0.05841	0.27905	0.02137	0.07895	0.24423
SE2	233		5.67		0.26138	0.03927	0.23609	0.05579	0.11241	0.21138
SE1	19		4.66		0	0	0	0	0.00855	0
N = 3,791										
Data Source: Staff-Time Measurement Studies, 1995 and 1997										
NOTES:										
*None of the residents in our Staff Time sample qualified for RUG-III+ groups 9 or 12										
**Mean minutes for nursing and therapy disciplines were only calculated for the first thirty-one (31) RUG-III+ groups										
***Abt staff time data did not include data for non-resident specific time only. Mean non-resident specific was calculated by subtracting resident specific mean minutes from total mean minutes for each applicable discipline.										

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

Regional Medical Center at Memphis

October 8, 2009

Celia Skelley, MSN, R.N.
State of Tennessee
Department of Health
West Tennessee Health Care Facilities
2975 Hwy 45, Bypass #C
Jackson, Tennessee 38305

Dear Ms. Skelley:

Attached you will find The Regional Medical Center at Memphis' response to the licensure survey conducted September 22 – 24, 2009. All deficiencies have been addressed with completion dates no later than 45 days from the dates of survey.

Please feel free to contact us if you should need any additional clarifications.

We anticipate your approval of our submission of this plan of correction.

Sincerely,

Claude Watts, CEO

Enclosure

CE/jmp

877 Jefferson Avenue Memphis, TN 38103 901.545.7100

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

PRINTED: 10/24/2007
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: TNP531110	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/24/2009
NAME OF PROVIDER OR SUPPLIER REGIONAL MEDICAL CENTER AT MEMPHIS		877 JEFFERSON AVENUE MEMPHIS, TN 38103	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
H 6751	1200-8-1-.06 (4)(b) Basic Hospital Functions (4) Nursing Services. (b) The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The chief nursing officer must be a licensed registered nurse who is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This Rule is not met as evidenced by: Based on policy review, record review, observation and interview, it was determined the hospital failed to ensure nursing services were provided in an organized manner and met the needs of I of I (Patient #9) patients reviewed with pressure sores. The patient suffered significant weight loss of 17 percent of his admission weight and developed a pressure sore which continues to deteriorate. The findings included: 1. The facility documented the following policy and procedures: "Prediction and Prevention of Pressure ulcers" Turn patient at least every 2 hours (unless contraindicated) or more frequently if necessary. Document each position change. 2. Medical record review for Patient #9 documented an admission on 7/19/09 after an assault with a head injury and a rib fracture and the following information:	H 675	<u>Nursing Services</u> Patient Care Services takes responsibility for patient care to meet the needs of patients with pressure sores. This will be accomplished by: I. PROCESS A) Review for identification of policy/procedures/standards/ and other resource materials available to staff responsible for patient care. This review is inclusive of: *Pressure Ulcer Treatment Care plan outlining turning requirements; *Pressure Ulcer Resource Guide. B) Review of functionality of current electronic medical record documentation system. C) Review of educational opportunities associated with staff involvement in current pressure ulcer management processes. II. ACTION A) Developed policy for Monitoring Patient Weight. B) Update hospital's intranet to include policies contained in Pressure Ulcer Resource Guide as individual titles to increase ease of location during search capability of staff for day to day practice reference.	11/7/09

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO DATE 10/8/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2009
NAME OF PROVIDER OR SUPPLIER REGIONAL MEDICAL CENTER AT MEMPHIS		STREET ADDRESS, CITY, STATE, ZIP CODE 877 JEFFERSON AVENUE MEMPHIS, TENNESSEE 38103	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
H 675	Continued From page 1 On 8/9/09, the patient acquired a Stage 2 sacral pressure ulcer. On 8/17/09 the patient continued with a stage 2 pressure ulcer that was 2 centimeters (cm) in length and 1.5 cm in width with 0 depth. On 8/24/09 the pressure sore was 4.5 cm in length and 4 cm in width and 0.1 cm in depth. It was still classified as a stage 2. On 8/31/09 there were 2 pressure ulcers. The sacral to left buttocks was now 5.5 cm in length and 4 cm in width with a depth of .1 cm. The new wound was on the right buttock, a stage 2 that was 3 cm in length, 2 cm in width with a wound depth of 0. On 9/6/09, the sacral to left buttock wound was now a stage 3 with a length of 5 Cm, a width of 3.5 cm and a depth of .3 cm. The wound on the right buttock was a stage 2 with a length of 2 cm, a width of 1 cm and a depth of 0. On 9/15/09 the sacral wound included the right and left buttock and was 7 cm in length, 4 cm in width with a depth of .2 cm. There was a skin tear on the left hip which was 4.5 cm in length, 1.5 cm in width with a depth of 0. 3. Medical/nutritional therapy note dated 8/20109 documented the patient was 65 inches tall with a weight of 64 kilograms or 140.8 pounds. The albumin was low at I .7gm/dl (normal is 3.5 gm/dl) The Registered Dietitian (RD) documented estimated calorie needs using the facility protocol of 30-35 calories per kilogram to be 1920-2240 calories and 128-160 grams of protein. On 9/2/09 the RD recommended the enteral feeding be changed to bolus of 6 cans Glucerna 1.2 each day and increase the protein supplement to 40 grams BID (twice a day) for 2030 calories and 164 grams of protein. 4. On 9/16/09 the patient was transferred to the medicine/Surgery unit 5C. Physician orders dated 9/17/09 included I can Glucerna 1.2 q (every) 4 hourS (total of 6 cans /day).	H 675	Continued from page 1 C) Develop query process for Meditech electronic documentation modules that consolidates view of patient weights, turning and vital signs into a single, reviewable screen-shot available to all staff providing care (RN, LPN, Dietician, CNA, PCA, MD). The addition of Yes/No documentation box related to physician notification alert for any patient weight change + or – five pounds at time of query. D) Revision to flowsheet for Intake and Output documentation in Meditech to populate with gastric residual amount as reference where nutritional supplements are recorded. Patient Care Notes for exception documentation will assist in identification of reasons nutritional supplements may differ from MD orders (i.e. increased residual, pt off unit, pt in surgery, pt refusal, pt being made NPO). E) Completion and deployment of the two (2) physician order sets for pressure ulcer prevention and treatment for pressure ulcers which was pending approval at time of survey and has been subsequently passed by Medical Staff Executive Council. III. EDUCATION A) Conduct education for staff through Training and Development department regarding deployment/expectations of the two order-sets related to pressure ulcers up to and including the care of patient and monitoring weight and nutritional status. To be completed by Nov. 7, 2009. B) Electronic reminder via hospital's *"Practice Pause"* publication related to revisions to processes/policies for Pressure Ulcer Management in Patient Care by October 31, 2009.	

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2009
NAME OF PROVIDER OR SUPPLIER REGIONAL MEDICAL CENTER AT MEMPHIS		STREET ADDRESS, CITY, STATE, ZIP CODE 877 JEFFERSON AVENUE MEMPHIS, TENNESSEE 38103	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Continued from page 2 5. Review of the intake and output record for9/17/09 through 9/20/09, revealed the patient only received 5 cans of Glucerna 1.2 rather than the 6 cans as ordered. 6. Review of the activity record for 9/17/09, revealed the patient was on the right side at 2 PM, on the right side at 8:54 PM and Supine at 4 AM. That was the only documentation of a position change that day. On 9/18/09 the patient was up in a chair at 9:18 AM, supine at 8 PM and on the right side at midnight. That was the only documentation of a position change on that day. On 9/19/09 the patient was Supine at 9:12 AM and on the right side at 2:16 AM. There was only I documented change on the 20th. There was no documented position change on the 21st. One documented position change on the 22nd. The Nurse Manager for the unit confirmed these findings on 9/23/09 at 1:00 PM. 7. During an interview on 9/23/09, at 1:30 PM, the Nurse Manager for the unit confirmed the patient had not been weighed and would only be weighed on admission and if requested by the Nurse Manager. 6. Observations on 9/23/09, at 2:00 PM in the patients room revealed Resident #9 being weighed at the Surveyor's request. The patient weighed 117.4 pounds. The admission weight on 7/19/09, which was the only weight in the medical record, was 140.8 pounds revealing the resident had lost 23.4 pounds or a significant weight loss of 17 percent of his original body weight The RD confirmed, at this time, she was unaware of the weight loss. 9. Observations in the patient's room on 9/24/09, at 8:30 AM revealed the sacral wound had been debrided and was 7.5 cm in length with a width of 4.8 cm. a distal depth of .4 cm and a proximal depth of .5 cm. There was another stage 2 wound on the buttocks which was 2.5 cm by .8 cm.		Continued from page 2 C) Conduct Meditech documentation module training/refresher beginning October 13, 2009 on documentation of pressure ulcers to include: *Intake/Output changes *Query availability and use *Exception charting/documentation *Expectations/follow-up processes D) Deployment of flyer for education and protocol from Nutrition Services containing references/instructions related to pressure ulcer knowledge with evidence of review by staff recorded in Computer Based Learning Module (CBL). IV. MONITORS A) Nursing a. Conduct random chart audits for next 3 months in all patient care units to validate compliance with policy for patientt weight. b. Conduct random chart audits for next 3 months of patients with pressure ulcers to validate complaince with pressure ulcer management and care. c. Monitor completion of education efforts and Computer Based Learning module CBL post test for assigned staff. d. Results of audits will be reported to the Quality Council, Nursing Performance Improvement and Patient Quality Care Committee. B) DIETARY a. Conduct weekly audits of response timeliness for dietician consults and documentation of patient weights and status changes. b. Incidents of non-compliance will be investigated with appropriate resolution to improve patient care processes. c. Results of audits will be reported	

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

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NAME OF PROVIDER OR SUPPLIER REGIONAL MEDICAL CENTER AT MEMPHIS		STREET ADDRESS, CITY, STATE, ZIP CODE 877 JEFFERSON AVENUE MEMPHIS, TENNESSEE 38103	

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H 732	Continued from page 3 1200~-8-1-.D8 (9)(b) Basic Hospital Functions (9) Food and Dietetic Services. (b) The hospital must designate a person to serve as the food and dietetic services director with responsibility for the daily management of the dietary services. The food and dietetic services director shall be: 1. A dietitian; or 2. A graduate of a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association; or 3. A graduate of a state-approved course that provided ninety (90) or more hours of classroom instruction in food service supervision and has experience as a food service supervisor in a health care institution with consultation from a qualified dietitian. This Rule is not met as evidenced by: Based on review of employee files, and interview, it was determined the hospital failed to ensure the Dietetic Services Director with responsibility for the daily management of the dietary service met licensure requirements for this position. The findings included: Review of the personnel file for the Dietetic Services Director failed to show he met the state licensure requirements for a Dietetic Services Director. During an interview on 9/22/09, at 11:15 AM, the Director confirmed that he did not meet any of the licensure requirements for a Dietetic Services Director.	H 732	Continued from page 3 to the organization's Nursing Performance Improvement Committee, Quality Council and Patient Quality Care Committee. C) WOUND/OSTOMY CARE NURSE (WOCN) a. Compare requests for consultation to patient assessments for appropriate care management based of Pressure Ulcer Resource Guide. b. Results of comparisons and compliance to be reported to the organization's Quality Council, Nursing Performance Improvement Committee and Patient Quality Care Committee. <u>Food and Dietetic Services</u> The Regional Medical Center will designate a food and dietetic services director meeting state licensure requirements for a Dietetic Services Director. This will be accomplished by: 1. Replacement of current Dietetic Services Director responsible for daily management of the dietary service on 10/2/2009. 2. Revision to job description to include state licensure requirements for qualification/certifications necessary to work at hospital facility. 3. Establishment of on-site personnel record containing documentation of requirements for state licensure. 4. Review of personnel record annually or with any personnel change of director position to ensure requirements for state licensure.	H732 11/5/09

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

PRINTED: 09/29/2009
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING_ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2009
NAME OF PROVIDER OR SUPPLIER REGIONAL MEDICAL CENTER AT MEMPHIS		STREET ADDRESS, CITY,STATE, ZIP CODE 877 JEFFERSON AVENUE MEMPHIS, TENNESSEE 38103	

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H 871	1200-8-1-08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the facility in a manner that would ensure the safety of the residents. The findings included: Observations during the facility tour on 9-23/9-24-09 beginning at 9:00 AM, the following deficiencies were found: ADAMS BLDG 3RD FLOOR REHAB 1. The ceiling tile at the entry to the gym had a hole in it. JEFFERSON BLDG 5TH FLOOR 1. The sprinkler escussion cover was missing outside room B528. 2. The exit doors were blocked open in unit 5C2. 3. The ceiling tile had a hole in it at room C516. 4. The corridor fire door closure at room 516 was inoperative.	H 871	The Regional Medical Center will maintain building standards to ensure the safety of the patient as evidenced by the following: ADAMS BUILDING: 3rd FLOOR REHAB The ceiling tile at the entry to the gym was replaced prior to 10/8/09 following submission of work order number 1941652. Staff were reminded to be alert for such problems and the process for requesting work orders related to building maintenance issues. Ceiling tile examinations will occur with Environment of Care (EOC) rounds and tracer activities to monitor for problems. JEFFERSON BUILDING: 5th FLOOR New sprinkler excutcheon was installed prior to 10/8/09 following submission of work order number 1947652. Specific purpose inspections of sprinkler escutcheons will occur by Facilities staff with an increased level of inspections during EOC rounds and tracer activities to monitor for problems. Door wedge allowing door on 5C2 to be blocked open was immediately removed.	10/30/2009

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — DATE: 10/8/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44D0314859	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	

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H871	Continued from page 1 5. The elevator lobby door was blocked open. ROUT BLDG Ground floor 1. In Labor and Delivery the soiled utility room door did not close and latch. 2nd floor 1. The hold open device was loose in the wall on the main corridor. 4th floor 1. The physician sleep room 426 did not have a smoke detector in it. 2. The corridor fire door at the nurse station did not close and latch, Chandler Bldg Ground Floor 1. The main corridor door entering Dialysis, the closure was inoperative. 2. The rear exit door in Dialysis was inoperative.	H 871	Continued from page 1 Manager and staff were reminded of policies related to exit doors. Inspections will occur with Environment of Care (EOC) rounds and tracer activities to monitor for problems. The ceiling tile with a hole in C516 was replaced prior to 10/8/09 following submission of work order number 1947952. Staff on the unit were reminded to be alert for such problems and the process for requesting work orders related to building maintenance issues. Ceiling tile examinations will occur with Environment of Care (EOC) rounds and tracer activities to monitor for problems. The fire door closure at room 516 was adjusted to close properly by 10/8/09 following submission of work order number 1848152. Staff on the unit were reminded to be alert for such problems and the process for requesting work orders related to building maintenance issues. Focused inspections will occur with EOC rounds and tracer activities to monitor for problems. Door wedge allowing elevator lobby doors to be blocked open was immediately removed upon discovery. Facilities services and directors/managers were reminded of policies related to exit doors. Inspections will occur with Environment of Care (EOC) rounds and tracer activities to monitor for problems. ROUT BUILDING In Labor and Delivery, the soild utility room door was adjusted by 10/8/09 to square for proper closure following submission of work order number 2036059. Staff on the unit were reminded to be alert for such problems and the process for requesting work orders related to building maintenance issues. Focused inspections will occur with EOC rounds and tracer activities to monitor for problems.	

SUPPLEMENTAL- # 1
December 17, 2013
1:30pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44D0314859	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED
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			Continued from page 2 On the second floor, additional anchors for the hold open devices will be installed before 10/8/09, following submission of work order number 2036652. Staff were reminded on proper use of hold open devices and to be alert for such problems and the process for requesting work orders related to building maintenance issues. Focused inspections will occur with EOC rounds and tracer activities to monitor for problems. The use of room 426 as a physician sleep room will be discontinued before 10/30/09. All physician sleep room assignments must be approved through an established space utilization committee. Management was educated on process for obtaining space to designate as sleep rooms. Focused inspections related to physician sleep rooms will occur to monitor for problems. The corridor fire door at the nurses station will be adjusted to allow proper closure following submission of work order number 2036552 before 10/8/09. Staff on the unit were reminded to be alert for such problems and the process for requesting work orders related to building maintenance issues. Focused inspections will occur with EOC rounds and tracer activities to monitor for problems. CHANDLER BUIDLING: GROUND FLOOR The main corridor for entry into the Dialysis unit fire door closure was adjusted to prevent the astragal from binding the closing following submission of work order number 1958157 before 10/8/09. Staff in the unit were reminded to be alert for such problems and the process for requesting work orders related to building maintenance issues. Focused inspections will occur with EOC rounds and tracer activities to monitor for problems. The rear exit door of the Dialysis unit hinges were adjusted to allow door closure by 10/8/09 following submission of work order number 1957957. Staff on the unit were reminded to	

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December 17, 2013
1:30pm

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			Continued from page 3 be alert for such problems and the process for requesting work orders related to building maintenance issues. Focused inspections will occur with EOC rounds and tracer activities to monitor for problems.	

SUPPLEMENTAL - #2
-COPY-

The MED

CN1311-044

SUPPLEMENTAL #2
December 30, 2013
3:03 pm

AFFIDAVIT

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY: The MED (CN1311-044)

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E. Graham Baker, Jr. Attorney at Law
Signature/Title

Sworn to and subscribed before me, a Notary Public, this 30th day of December, 2013; witness my hand at office in the County of Davidson, State of Tennessee.

Nadeau C. Poteet
NOTARY PUBLIC
My Commission expires July 3, 2017

NADEAU E. POTEET
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY

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

When you used your example to demonstrate need of 7100 discharges, did you mean to say patient days?

Response: These were actual discharges.

By continuing to state that the payor mix of the SNF will be 50% Medicare and 50% uninsured, is the applicant saying that no TennCare patients in a MED hospital bed will be directly transferred to the SNF unit and that no commercially insured patients in a MED hospital bed will be transferred to the SNF unit.? The Letter of Intent states that "....the Applicant will serve Medicare, Medicaid, commercially insured, and private-pay patients....." Please explain.

Response: The MED is certified by Medicare and Medicaid. The SNF unit, as a department of the hospital, will be available for any hospital patient who cannot be transferred to, or accepted by, an existing nursing home in the area. The MED feels obligated to maintain certification necessary to treat any patient who presents for treatment. While we plan to continue transferring hospital patients (who need skilled care) to area facilities, we do understand the possibility of having a patient who cannot transfer, whether such patient is Medicare, Medicaid, insured, or with no reimbursement whatsoever.

As stated in the application, we maintain enough patients in our hospital beds to fill a 20 bed SNF unit at our hospital. Usually, these patients have no payor mechanism and we cannot transfer them to an area skilled nursing facility. These patients are "stuck" in an expensive hospital bed with no place to go. The two-fold reasons for this application are: (1) to provide services (SNF services) that are more appropriate for such patients; and (2) to lessen the negative economic impact that such patients have on our hospital, by transferring such patients to a less expensive SNF bed.

Based on our internal study (previously reported in both the application and the first supplemental response), we believe about half of these patients will probably be able to be certified for skilled Medicare reimbursement, and the other half will not be reimbursed at all. We certainly concede that there is a possibility that a TennCare patient may wind up in our SNF unit, and if need be, we want to maintain certification in order to provide such care. However, we believe such possibility is (1) remote, and (2) will be for such a short period of time that we have no financial or other projections for that to happen. We will continue to try to transfer hospital patients who need nursing facility care and who are TennCare-eligible to area facilities.

It appears that the applicant does not fully understand the impact of the Linton ruling. The applicant could choose to certify the beds only for Medicare. In that case it would make sense to project that there would be no TennCare utilization; however the applicant is expecting to be dually certified. It is not reasonable to assume that no TennCare patients will be transferred to the SNF unit.

Response: The MED is certified by Medicare and Medicaid. The SNF unit, as a department of the hospital, will be available for any hospital patient who cannot be transferred to, or accepted by, an existing nursing home in the area. The MED feels obligated to maintain certification necessary to treat any patient who presents for treatment. While we plan to continue transferring hospital patients (who need skilled care) to area facilities, we do understand the possibility of

having a patient who cannot transfer, whether such patient is Medicare, Medicaid, insured, or with no reimbursement whatsoever.

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How many TennCare patients in the past year were admitted to the MED that were either eligible for SNF care and remained in the hospital or were transferred to an area nursing home?

Response: The number of TennCare patients eligible for SNF care who were admitted at The MED was negligible. Most of our TennCare patients are either OB patients or children. They are not eligible for SNF care. The remaining patients who would normally be eligible for TennCare who require SNF care are also eligible for Medicare. The only reason we stated (in our notice and in the application) that we would take accept TennCare patients is in case a TennCare patient does, in fact, qualify for SNF care but is not eligible for another payor source. Again, The MED accepts all patients who present for care. It is noteworthy that we did not include any reimbursement in our Projected Data Chart for TennCare SNF patients.

Please provide documentation from the hospital's discharge planner attesting to the number of hospital patients that were denied admission to area nursing homes for the most recent one year period.

Response: The Applicant believes that the information requested is of limited value, and exacting documentation will take an exorbitant amount of time to research. Please understand that many of these patients have socio-economic and demographic issues that, in the past, have rendered them unacceptable by area nursing homes. In effect, we stopped asking local facilities to accept many of these patients, who continue to be taken care of in hospital beds.

In order to account for the impact of the Linton ruling and the requirements of a TennCare contract for nursing home care, it does not appear that this application can be deemed complete until the projected utilization accounts for the likelihood of some TennCare utilization and that the Projected Data Chart accounts for some TennCare utilization.

Response: The MED is certified by Medicare and Medicaid. The SNF unit, as a department of the hospital, will be available for any hospital patient who cannot be transferred to, or accepted by, an existing nursing home in the area. The MED feels obligated to maintain certification necessary to treat any patient who presents for treatment. While we plan to continue transferring hospital patients (who need skilled care) to area facilities, we do understand the possibility of having a patient who cannot transfer, whether such patient is Medicare, Medicaid, insured, or with no reimbursement whatsoever.

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Based on our internal study (previously reported in both the application and the first supplemental response), we believe about half of these patients will probably be able to be certified for skilled Medicare reimbursement, and the other half will not be reimbursed at all. We certainly concede that there is a possibility that a TennCare patient may wind up in our SNF unit, and if need be, we want to maintain certification in order to provide such care. However, we believe such possibility is (1) remote, and (2) will be for such a short period of time that we have no financial or other projections for that to happen. We will continue to try to transfer hospital patients who need nursing facility care and who are TennCare-eligible to area facilities.

2. Section C, Need, Item 1.a. (Service Specific Criteria (Nursing Home Services) A. Need 1.

Regarding the CHOICES Act question, Knox County was mistakenly referenced. Please provide a response regarding Shelby County.

Response: As stated in the application:

> "As reported on Joint Annual Reports for existing county facilities, nursing homes in Shelby County have operated 82.6%, 83.8%, and 84.5% for 2009 through 2011, respectively. At least two facilities have decreased facility bed counts since the filing of the 2011 JARs, and one facility has surrendered its license. Civic Health and Rehab Center was licensed for 147 beds, and its license expired on July 1, 2013. Bright Glade Health and Rehab Center decreased its bed count from 81 to 77 beds on July 1, 2013, and Grace Healthcare of Cordova decreased its bed count from 284 to 240 beds on July 1, 2013. Taking these bed losses into consideration, the occupancy rate for Shelby County Nursing Homes would increase from 84.5% to 88.7% for 2011. With these decreases, there currently exist 3,974 nursing home beds in Shelby County, with a need for 5,094 beds by 2016."

The above numbers were based on what was reported in JARs, and further information we had about the decreases (noted above) in various facilities. Apparently, we are "off" by two beds. If Licensure now states there are 3,976 beds, Licensure has changed its total since they advised the Applicant (prior to filing this application) that 3,974 beds were in Shelby County. We have no way of knowing for sure how many beds are actually in Shelby County, other than to rely on Licensure.

According to the State's website,

> "CHOICES" is TennCare's program for long-term care services for elderly (65 years of age and older) or disabled (21 years of age and older). Long-term care includes help doing everyday activities that you may no longer be able to do for yourself as you grow older, or if you have a physical disability-like bathing, dressing, getting around your home, preparing meals, or doing household chores. Long-term care services include care in a nursing home. Long-term care also includes certain services to help a person remain at home or in the community. These are called **H**ome and **C**ommunity **B**ased **S**ervices or **HCBS**."

The Applicant believes the Choices program is an excellent use of limited resources to help the elderly and disabled live at home. The Applicant is not aware of any state-sponsored study that shows the impact of the Choices program in Shelby County or any other county in Tennessee. As more people utilize the service, common sense dictates that fewer institutional resources will be required, whether in Shelby County or other counties in the state. That stated, if such individuals never qualified for nursing home care, they would not have been admitted to nursing homes under strict preadmission evaluation guidelines. The patients who are the object of this application are not patients who merely have problems conducting everyday activities while living at home: these are skilled nursing patients who currently are institutionalized in a hospital bed who need to be transferred to a SNF bed. Therefore, the Choices program should not impact the SNF patients currently residing in our hospital beds.

3. Section C, Need, Item 6

Your response to this item is noted. As stated earlier it does not appear to be reasonable that a dually-certified SNF unit would have no TennCare utilization. In fact any TennCare patient whose level of payment went from Level 2 to Level 1 would be considered non-skilled days once Level 1 was reached.

Response: The MED is certified by Medicare and Medicaid. The SNF unit, as a department of the hospital, will be available for any hospital patient who cannot be transferred to, or accepted by, an existing nursing home in the area. The MED feels obligated to maintain certification necessary to treat any patient who presents for treatment. While we plan to continue transferring hospital patients (who need skilled care) to area facilities, we do understand the possibility of having a patient who cannot transfer, whether such patient is Medicare, Medicaid, insured, or with no reimbursement whatsoever.

As stated in the application, we maintain enough patients in our hospital beds to fill a 20 bed SNF unit at our hospital. Usually, these patients have no payor mechanism and we cannot transfer them to an area skilled nursing facility. These patients are "stuck" in an expensive hospital bed with no place to go. The two-fold reasons for this application are: (1) to provide services (SNF services) that are more appropriate for such patients; and (2) to lessen the negative economic impact that such patients have on our hospital, by transferring such patients to a less expensive SNF bed.

Based on our internal study (previously reported in both the application and the first supplemental response), we believe about half of these patients will probably be able to be certified for skilled Medicare reimbursement, and the other half will not be reimbursed at all. We certainly concede that there is a possibility that a TennCare patient may wind up in our SNF unit, and if need be, we want to maintain certification in order to provide such care. However, we believe such possibility is (1) remote, and (2) will be for such a short period of time that we have no financial or other projections for that to happen. We will continue to try to transfer hospital patients who need nursing facility care and who are TennCare-eligible to area facilities.

Please explain why the applicant has only listed 10 beds as being Medicare certified.

Response: All 20 beds will be certified for Medicare. The chart in question requested projected utilization. As stated, we believe that half of our proposed 20 bed SNF unit (or 10 beds) will be utilized by Medicare patients.

Please explain how half of Medicare patients will be under Age 65.

Response: As stated, many of our "under 65" patients are from our trauma unit. It cannot be stressed enough that we have the busiest Level I trauma center in West Tennessee. The payor mix that we utilized for our CON application is the ACTUAL payor mix for those patients in our hospital that could not be placed in existing nursing homes. It was not an estimate. About half of those actual patients would not qualify for Medicare.

Will the SNF unit accept patients from other hospitals and other admission sources?

Response: We do not plan to accept patients from other hospitals or other admission sources. With that said, we will not refuse to accept a patient for which we can provide care. Such refusal

SUPPLEMENTAL #2
December 30, 2013
3:03 pm

would violate not only federal and state law, but more importantly to us, it would violate our mission as a health care provider.

Evidently, we need to continue to stress some important issues about this project, as follows:

1. The MED does not refuse treatment for any person who presents for health care, if we provide that care;
2. The MED is licensed by the TN Department of Health, is fully accredited by JCAHO, and is certified by Medicare and Medicaid;
3. We will knowingly do nothing to jeopardize our license/accreditation/certifications;
4. We will not knowingly violate any federal, state, or local law;
5. The MED has transferred skilled patients to area nursing facilities for decades, and will continue to transfer patients who are accepted for transfer by those nursing facilities;
6. When our hospital patients require skilled nursing care, we will continue to attempt to locate a bed in an area skilled nursing facility;
7. In the past, when such skilled nursing patients could not be transferred out of our hospital, we continued to provide health care for those skilled patients whether we were reimbursed or not, and that process will continue;
8. We realize that keeping a skilled nursing patient in a hospital bed is not cost-effective;
9. We conducted an internal study which indicated we could fill a 20 bed SNF unit with just those hospital patients in our facility who could not be transferred, or more on point, were not accepted by area nursing facilities;
10. We decided that receiving little or no reimbursement for a skilled patient in an SNF bed at our facility would be more cost-effective than receiving little or no reimbursement for a skilled patient in a hospital bed at our facility;
11. We do not plan to accept transfers from other hospitals or other referral sources, but, again, we will absolutely not refuse to treat patients who present for health care;
12. Based on our internal study, we believe that about half of the patients who are transferred to our SNF unit will eventually be certified for Medicare, and the other half will have no reimbursement, whatsoever (which is why we can't transfer them to area facilities, now);
13. This 20 bed SNF unit will lose money, but The MED will not lose as much money by having these patients in a lower-cost SNF bed than in a hospital bed, resulting in a cost-savings to The MED;
14. We understand that by maintaining our Medicaid/TennCare certification, we may well have a Medicaid/TennCare patient in our SNF unit on occasion, but we believe that due to the acceptability of such patients by area nursing facilities and the probability of such patients also being eligible for Medicare, placement of such patients in our SNF unit will be so remote that we cannot provide financial or other projections; and
15. We are not filing this application in order to compete with area nursing facilities…we are filing this application to establish and operate a small, 20 bed SNF unit at the MED in order to: (a) to provide services (SNF services) that are more appropriate for such patients; and (b) to lessen the negative economic impact that such patients have on our hospital, by transferring such patients to a less expensive SNF bed.

4. **Section C, Economic Feasibility, Item 4 (Historical Data Chart)**

It is understood that the applicant was told that a Historical Data Chart was not needed; however the review of the Projected Data Chart for the 20 bed SNF unit indicates that a net operating loss is projected during the first three years of operation. A Historical Data Chart for the MED is being requested to establish that the MED is financially viable and is able to absorb the loss projected for the SNF unit.

Response: Please see replacement page 36.

5. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

Please explain why there are no contractual adjustments.

Response: We provided net payments – not gross charges – based on estimated payment rates. These net payments represent 50% Medicare and 50% uncompensated patients.

With approximately 3,000 patient days annually of uninsured care please explain why there are no provisions for bad debt and why the provisions for charity care are only $38,051 in Year 1, $41,642 in Year 2, and $45,379 in Year 3.

Response: The charity care amounts should have been listed as bad debt. Please see replacement page 37. Charity care is not shown because the revenue line is estimated net payments, and about half of our patients will have no payor source whatsoever, thereby qualifying as charity care.

Please provide a detailed analysis demonstrating the annual cost savings of providing SNF care versus the expense of SNF-eligible patients remaining in an acute care bed.

Response: In Year 3, we anticipate 18 ADC, which equates to 6,570 patient days. Based on this amount, the SNF unit will lose $1,323,643 in the SNF unit, but the hospital will save $2,811,960 in decreased hospital costs. The decreased hospital cost is based on a $428 per patient day savings.

Your "Other Expense" chart is noted but does not answer the question.
Please complete the following chart for the individual "other expenses" on Line D.9. According to the revised Projected Data Chart, these are the expenses that total to $385,742 in Year 1, $518,713 in Year 2, and $453,113 in Year 3:

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year__1__	Year__2_	Year__3_
1. Contract Services	141,482	190,252	161,976
2. Marketing	7,657	10,296	8,765
3. Laundry	94,642	127,267	108,344
4. Dietary	141,961	190,898	174,028
Total Other Expenses	**$385,742**	**$518,713**	**$453,113**

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

Your response to this item is noted. Please review Page 24 of the 2012 Nursing Home JAR for several Shelby County nursing homes and report their Medicare/Skilled Care (Average Daily Charge).

Response: The Applicant reviewed all nursing homes in Shelby County, and selected each 4th entry in order to arrive at "several" nursing homes, as follows:

Nursing Home	Avg. Daily Charge
Allen Morgan Health and Rehab. Cntr	$251
Ashton Place Health and Rehab Cntr	$450
Bright Glade Health and Rehab	$496
Graceland Nursing Center	$170
MidSouth Health and Rehab Cntr	$435
Kindred Transitional Care & Rehab Cntr-Primacy	$436
Signature Health of Memphis	$190
The King's Daughters and Sons Home	$230

7. Section C, Orderly Development, Item 3

Your response to this item is noted. Are the expenses form (sic) the therapists and coordinators noted in your response reflected in the Projected Data Chart?

Response: Yes.

8. Section C, Orderly Development, Item 7

Your response to this item is noted. Please provide documentation from the Department of Health signifying acceptance of the Plan of Correction.

Response: The documentation from the Department of Health signifying acceptance of the Plan of Correction was submitted with the original application as *Attachment C.OD.7.d.* Another copy of this attachment is attached. This letter is dated October 14, 2009.

Is there not more recent than 2009 documentation of a survey by either the Department of Health or the Joint Commission.? (sic) If yes please provide this documentation.

Response: The last survey by the Department of Health was September 22 – 24, 2009, as we reported. We do not schedule these surveys.

The last survey by the Joint Commission was completed on March 19, 2011, as stated on our certification. That certificate also states that the certification is good for 36 months. Our facility will probably be surveyed by the Joint Commission in February or March, 2014.

SUPPLEMENTAL #2
December 30, 2013
3:03 pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 c HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305

Rec'd 10/16/09 FA

October 14, 2009

Mr. Claude Watts, Administrator
Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis, TN 38103

RE: Licensure Surveys

Dear Mr. Watts:

On September 24, 2009, licensure surveys were completed at your facility. Your plans of correction for these surveys have been received and were found to be acceptable.

Thank you for the consideration shown during this survey.

Sincerely,

Celia Skelley

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CES/TJW TJW

NOV 7 '13 PM 12:55

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the *Commercial Appeal* (Name of Newspaper) which is a newspaper

of general circulation in Shelby County (County), Tennessee, on or before November 10, 2013 (Month / day) (Year) for one day.

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that Shelby County Health Care Corporation, d/b/a The Regional Medical Center at Memphis, 877 Jefferson Avenue, Memphis (Shelby County), Tennessee 38103 ("Applicant" or "The MED"), owned and managed by itself, is applying for a Certificate of Need for the establishment of a twenty (20) skilled bed nursing unit to be licensed as nursing home beds and operated as a department of The MED. The requested beds are subject to the FY 2013-2014 pool of nursing home beds authorized by T.C.A. § 68-11-1622. Due to the Linton Rule, all beds will be certified for both Medicare and Medicaid. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that the Applicant will serve Medicare, Medicaid, commercially insured, and private-pay patients, and the Applicant will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $300,000.00, plus filing fee.

The anticipated date of filing the application is: November 15, 2013.

The contact person for this project is E. Graham Baker, Jr. (Contact Name) Attorney (Title)

who may be reached at: his office at (Company Name) 2021 Richard Jones Road, Suite 350 (Address)

Nashville	TN	37215	615/ 370-3380
(City)	(State)	(Zip Code)	(Area Code / Phone Number)

E. Graham Baker, Jr. (Signature) 11/07/13 (Date) graham@grahambaker.net (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
502 Deaderick Street, 9th Floor
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.

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CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
OFFICE OF HEALTH STATISTICS
615-741-1954

DATE: January 31, 2014

APPLICANT: Shelby County Health Care Corporation
d/b/a The Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis, Tennessee 38103

CON#: CN1311-044

CONTACT PERSON: E. Graham Baker, Jr.
2021 Richard Jones Road, Suite 350
Nashville, Tennessee 37215

COST: $300,000

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

SUMMARY:
The applicant, Shelby County Health Care Corporation d/b/a The Regional Medical Center at Memphis (Shelby County), a hospital, owned and managed by itself, is seeking Certificate of Need (CON) approval for the establishment of a twenty (20) bed skilled nursing facility (SNF) to be operated as a department of the hospital. The hospital, if this application is approved by the Health Services and Development Agency (HSDA), will delete twenty (20) acute care beds from its 631 licensed acute care beds and the SNF unit will be separately licensed as a nursing home facility with twenty (20) dually certified beds.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the *Tennessee State Health Plan*.

NEED:
The applicant's designated service area is Shelby County. The 2014 population of Shelby County is estimated to be 943,812, according to the Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics, *2013 Tennessee Population Series for 2010-2020*. Shelby County is estimated to have a population of 949,178 in 2016, according to the same source. The total population is estimated to increase by 0.6% during this period, however, the over 65 population is estimated to increase by 7.5% during this period.

The estimated gross nursing home bed need, as calculated by the Office of Health Statistics will be 5,094 beds in 2016. The Tennessee Department of Health, Division of Health, Licensure and Regulation-Office of Health Care Facilities, documents on its website, as of 1/27/2014, that Shelby County has 31 currently licensed nursing home facilities with 3,976 nursing home beds. The net

bed need, less the 168 nursing home beds approved but not licensed will total 950 beds by 2016. The following is a list of Shelby County projects that are approved but not yet in operation:

1. CN0908-045A-Christian Care Center of Memphis, 90 nursing home beds;

2. CN1202-011A-Collins Chapel Health and Rehabilitation Center, 28 new SNF nursing home beds;

3. CN1303-008A-The Farms at Bailey Station, 30 new SNF nursing home beds; and

4. CN1311-045A-The Village at Germantown, 20 new SNF nursing home beds

Shelby County Nursing Home Utilization 2012 Final

Nursing Home	Licensed Beds	2012 Patient Days	Licensed Occupancy
Allan Morgan Health and Rehab Center	104	32,094	84.5%
Allenbrooke Nursing and Rehab Center	180	62,784	95.6%
Applewood Healthcare Center	78	26,651	93.6%
Ashton Place Health and Rehab	211	68,410	88.8%
Ava Marie Home	75	24,507	89.5%
Baptist Memorial Hospital-Memphis SNF	35	10,561	82.7%
Baptist Memorial Rehab Unit	18	5,423	82.5%
Bright Glade Health and Rehab Center	77	25,867	92.0%
Dove Health and Rehab of Collierville	114	35,754	85.9%
Grace Healthcare of Cordova	284	72,642	70.1%
Graceland Nursing Center	240	75,843	86.6%
Harbor View Nursing and Rehab Center, Inc.	120	36,457	83.2%
Kindred Transitional Care	120	32,196	73.5%
Kirby Pines Manor	120	42,722	97.5%
Memphis Jewish Home	160	42,920	73.5%
Methodist Healthcare SNF	44	6,623	41.2%
Midsouth Health and Rehab Center	155	49,201	87.0%
Millington Healthcare Center	85	28,917	93.2%
Poplar Point Health and Rehab	120	42,102	96.1%

Parkway Health and Rehab Center	169	51,074	82.8%
Quality Care Center of Memphis	48	12,535	71.5%
Quince Nursing and Rehab Center	188	65,776	95.9%
Rainbow Health and Rehab Center	115	39,641	94.4%
Signature Healthcare at Saint Francis	197	61,821	86.0%
Signature Healthcare at Saint Peter Villa	180	60,560	92.2%
Signature Healthcare of Memphis	140	49,467	96.8%
Spring Gate Rehab and Healthcare Center	233	78,439	92.2%
The Highlands of Memphis Health and Rehab	180	60,143	91.5%
The King's Daughters and Sons Home	108	38,653	98.1%
The Village at Germantown	30	9,462	86.4%
Whitehaven Community Living Center	92	28,888	86.0%
Total	4,020	1,278,133	87.1%

Source: *Joint Annual Report of Nursing Homes 2012,* Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics

The average facility occupancy for all Shelby County nursing facilities is 87.1% according to the *Joint Annual Report of Nursing Homes 2012 (Final)* as reported by Shelby County nursing homes.

Note to Agency Members: Of interest, one possible explanation for the occupancy of intermediate care patients in beds certified for skilled care is the legal precedent established in the Linton Ruling, a Tennessee lawsuit settled in 1990. HSDA deputy legal counsel provides a summary of the Linton Ruling as follows: "Mildred Lea Linton, a nursing home resident, represented a class of plaintiffs who alleged that Tennessee's nursing home bed certification policy, in which fewer than all beds within a particular wing or floor could be available for Medicaid recipients, violated the Medicaid Act. Ms. Linton's nursing home apportioned only 40 of its 87 intermediate care facility beds as Medicaid beds. When Medicaid officials reduced Ms. Linton's care eligibility from skilled to intermediate, Ms. Linton's nursing home informed her that it was decertifying her Medicaid bed and would not likely have available any Medicaid beds. The District Court found that Tennessee's "limited bed policy" violated the Medicaid Act, and the state was instructed to submit a remedial plan, which, among other provisions, required Medicaid providers to certify all available, licensed nursing home beds within their facilities and to admit residents on a first-come, first-serve basis."

The applicant based their decision to create a dually certified 20 bed skilled nursing facility to address the need to reduce the hospital's deficit caused by keeping patients who are not eligible for Medicare/Medicaid or other reimbursement as acute care patients in hospital beds. The solution the applicant devised would be to establish a 20 bed SNF unit that would serve these residents at lower skilled nursing home rates. The specific economic factors and financial feasibility of this project can be found in a later section of this report.

The applicant maintains the "actual need for nursing home beds is of little consequence for this project, since The MED has to provide care for skilled nursing patients within existing hospital beds, which are more costly" as set forth on page 11 of the application. As the applicant notes, moving these residents to the proposed 20 dually certified SNF beds will result in a positive cash flow for The Med even though, as they observe, the SNF facility will experience a negative cash flow.

TENNCARE/MEDICARE ACCESS:
The applicant will be certified by and participate in Medicare and TennCare (Medicaid). The applicant will also serve commercially insured and private pay residents. The Regional Medical Center at Memphis projects that 50% of the residents will be paid for by Medicare and the rest of the residents will receive indigent/charity care. They project that few, if any, residents will be eligible for TennCare/Medicaid and, in fact, no TennCare/Medicaid revenue is shown in the application. It is also noted by the applicant on page 16 of Supplemental 1 that SNF Medicare average daily census (ADC) would be 8 while the SNF Medicaid ADC would be 0 during the first year of the project. The projected number of Medicare billable resident days during this same period would total 2,908 days and the number of projected Medicaid billable resident days would be N/A or zero during this period with 2,908 uninsured resident days. The total number of projected resident days would total 5,815 in the first year of the project or 80% licensed occupancy and only 85% during the second year of the project. The applicant states it will meet the 90% occupancy requirement by the third year of the project. It should be noted, the applicant does not project any TennCare/Medicaid patient days during the first three (3) years of this project.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

> **Project Costs Chart:** The Project Costs Chart is located in the application on page 32 of the initial CON application. The total project cost is $300,000.
>
> **Historical Data Chart:** There is no Historical Data Chart required due to this being a new proposed facility. The applicant submitted a historical data chart that did not reflect comparable revenue and patient days to those of the proposed dually certified skilled nursing facility. This chart can be found on page R-36 of Supplemental 2.
>
> **Projected Data Chart:** The Projected Data Chart is located in Supplemental 2 on page R-37. The applicant projects licensed bed occupancy of 16 and 17 beds in years 1 and 2 respectively or 80% and 85% licensed bed occupancy. The applicant did not provide any information regarding its gross charges and any contractual adjustments. The total net operating revenue in year one is projected to be ($1,175,088) and ($1,372,283) in year two of the project.

The applicant's average net charge in year one is projected to be $217.20. The applicant states the project will result in a savings of approximately $2,500,000 to the hospital.

The initial application and the two Supplemental applications involve some assumptions regarding TennCare/Medicaid. They (the applicant) believe that the Linton ruling requires the applicant to be dually certified for both Medicare and TennCare/Medicaid. The Linton ruling only governs Medicaid

admissions and continued stay criteria for Level 1 and Level 2 residents and/or potential residents. It does not apply to residents in Medicare only SNF facilities. The Linton Ruling requires the nursing home to maintain a Linton waiting list. The proposed dually certified skilled nursing facility does not plan to admit any potential residents from other nursing homes, hospitals, health care facilities or their places of residence. The applicant proposes to transfer patients from The Med's inpatient units to the proposed dually certified SNF if they have been inpatients for at least three (3) consecutive days and are approved by the nursing home medical director which would allow them to bypass the mandated Linton wait list.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
This project will serve as a means to reduce the cost to the hospital caused by using acute care hospital beds with their attendant higher room charges by transferring these patients to a 20 bed skilled nursing facility with lower costs per bed.

The projected staffing pattern for this project includes 5 FTE registered nurses, 4 FTE licensed practical nurses, 3 FTE respiratory therapists and 5 FTE certified nursing assistants. The applicant stated it would contract with the following additional personnel, as follows: 1.5 FTE physical therapists; 1.0 FTE occupational therapist; 0.5 FTE speech therapist; 1.0 FTE MDS coordinator and a 0.5 FTE activity coordinator.

The applicant states it will not need to hire additional staff to staff the proposed SNF because it will simply reassign nurses and other personnel as listed from other departments of the hospital as needed based on the resident census. The applicant did not clarify if the trauma care patients would be followed by trauma care nurses given the high level of activity in that unit or for any other acute care setting. The rotation of staff from various departments may not address consistency of staffing and continuity of care within the separately licensed dually certified skilled nursing facility.

It was not certain if the proposed separately licensed nursing home SNF facility would employ a licensed nursing home administrator or seek clarification from the Tennessee Department of Health regarding this matter.

The use of certified nursing assistants by the nursing home facility could be met by staff of the hospital but they must currently be on the Nurse Aide Registry or be trained in an approved Nurse Aide Training/Competency Evaluation Training program and be tested to be deemed competent to provide care to nursing home residents.

The Health Center of Hermitage intends to be licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

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

This project requests the establishment of a 20 bed dually certified skilled nursing facility in renovated space previously used for an inpatient physical rehabilitation facility.

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

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

      This criterion is not applicable.

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

      Population projections for Shelby County show the continued growth of the age groups who use long term care services; however, the applicant only projects a need for 10 Medicare beds with 10 other skilled nursing beds being used by hospital patients with no reimbursement source.

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

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

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

      The above criteria are not applicable for this project. This project converts existing space to a separately licensed dually certified Medicare/TennCare (Medicaid) SNF which, may or may not, serve TennCare/Medicaid residents in the future.

NURSING HOME SERVICES

Public Chapter No. 1112, Senate Bill No. 2463, which passed during the 1998 legislative session, amended and changed the code sections establishing the bed need formula that the Health Facilities Commission must follow when granting certificates of need for nursing home beds in Tennessee. During a fiscal year (July 1-June 30), the Commission shall issue no more than the designated number of Medicare skilled nursing facility beds for applicants filing for a certificate of need. The number of Medicare skilled nursing facility beds issued shall not exceed the allocated number of beds for each applicant. The applicant must also specify in the application the skilled services to be provided and how the applicant intends to provide such services.

A. Need

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

      County bed need = .0005 x pop. 65 and under, plus
      .0120 x pop. 65-74, plus

.0600 x pop. 75-84, plus
.1500 x pop. 85, plus

The Division of Policy, Planning, and Assessment-Office of Health Statistics calculated a need for 5,094 beds in Shelby County, based upon the formula, according to TCA 68-11-108.

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

   The Division of Policy, Planning, and Assessment-Office of Health Statistics calculated a need for 5,094 licensed beds in Shelby County in 2016.

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

   The current supply and utilization is from the Joint Annual Report of Nursing Homes, 2011 Final which is 4,124 licensed beds. The current number of nursing home beds total 3,976 according to the Division of Health Licensure and Regulation as of 12/31/2013.

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

   The majority of the population in the service area lies within 30 minutes travel time of the proposed nursing home facility.

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

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

      The Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics notes that the number of approved but not operational skilled nursing home beds totals 168 as of 2/18/2014. However, Shelby County has a need for 950 nursing home beds according to the Division of Policy, Planning and Assessment-Office of Health Statistics.

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

      The need for 10 additional Medicare certified beds or 20 dually certified beds, as proposed by this applicant, would address the need for Shelby County nursing home beds. The current bed need shows a need for 950 additional nursing home beds of all types. The applicant did not appear to document any difficulties in placing Medicare eligible patients who no longer require acute care hospital services in other Medicare beds in area nursing homes or in dually certified nursing home facilities in Shelby County. The hospital did

indicate that it does transfer TennCare/Medicaid patients to area nursing home facilities, and may do so in the future, when they become TennCare eligible, rather than keeping them in the proposed dually certified 20 bed SNF. It is apparent that Shelby County's 2012 bed occupancy rate of 87.1% does accommodate some of the applicant's skilled care caseload since they have referred these patients to other facilities in Shelby County. The issue of the 10 beds to be utilized for uncompensated care residents currently in hospital's acute care beds may be at the core of the applicant's proposed dually certified skilled nursing home project. The applicant makes a case that care of uncompensated patients in licensed hospital beds imposes a financial burden upon the hospital and one reason for this project is to transfer these patients to lower cost nursing home beds.

B. Occupancy and Size Standards:

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

   This project proposes to have at least 85% annual occupancy after two years of operation and 90% occupancy in the third year.

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

   The chart on pages 2 and 3 of this report documents that not all nursing home facilities within Shelby County meet the 95% occupancy rate criterion.

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

   Not applicable because this project is for a new dually certified skilled nursing facility.

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

   This project is for a 20 bed dually certified facility within a hospital.