COPY-Application

Hendersonville Medical Center

CN1302-002

DSG Development Support Group

2013 FEB 14 PM 2 16

February 14, 2013

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: CON Application Submittal--Hendersonville Medical Center
Bed Relocations and Initiation of Level II-B NICU Services
Hendersonville, Sumner County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Jerry Taylor of Stites & Harbison is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

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Consultant

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2013 FEB 14 PM 2 16

TRISTAR HENDERSONVILLE MEDICAL CENTER

CERTIFICATE OF NEED APPLICATION TO CONSTRUCT A FOURTH FLOOR OF REPLACEMENT BEDS AND TO ESTABLISH A NEONATAL INTENSIVE CARE SERVICE

Filed February 2013

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

This is an existing facility that is already certified for both programs.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

TriStar Hendersonville Medical Center contracts with all three of the available TennCare MCO's in its service area.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contracted
United Community Healthcare Plan (formerly AmeriChoice)	contracted
TennCare Select	contracted

Source: Hospital management.

SECTION B: PROJECT DESCRIPTIONB.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

• Construction of a new medical-surgical fourth floor to replace older beds already licensed to this facility; moving 13 beds from the applicant's satellite campus to its main campus; no change in the consolidated 148-bed license that covers both campuses.

• Initiation of Level II-B Neonatal Intensive Care in a new nursery with 6 NICU beds (Neonatal Intensive Care bassinets, licensed as hospital beds); staffed by neonatal nurse practitioners and RNs, and medically supervised by the neonatology organization that supervises the majority of Middle Tennessee NICU's.

• Reassignment of OB/Gyn beds from 6 LDRP and 10 postpartum beds (16 total) to 10 LDRP and 4 postpartum beds (14 total).

Ownership Structure

• TriStar Hendersonville Medical Center is wholly owned by Hendersonville Hospital Corporation, which through subsidiaries is wholly owned by HCA Holdings, Inc., the parent of HCA.

• Attachment A.4 contains more details, an organization chart, and information on the Tennessee facilities owned by this facility's parent organization.

Service Area

• Sumner County, part of adjoining Robertson County, and far north Davidson County.

Need

• Replacement, relocation, and reassignment of the applicant's own licensed beds within Sumner County are needed to meet current and future demand for medical-surgical and obstetrics admissions at the main campus. Bed shortages during 2012 have made it clear that the hospital must act now, to avoid chronic bed shortages for medical-surgical admissions in the near future. Last year, more than 100 requested admissions were declined due to bed capacity issues. The project will solve this problem without increasing licensed hospital beds. This is a bed relocation and replacement proposal, not a proposal to increase bed licenses.

• The provision of Neonatal Intensive Care services in a new 6-bed NICU is needed to meet perinatal needs of suburban service area mothers and infants who are not within reasonable drive times of Level II-B (NICU) services at downtown Nashville hospitals. Level II-B nurseries exist all around downtown Nashville in suburban and rural locations; but not yet in the populous growth areas north of Nashville.

• In addition, this hospital's Nursery is affiliated with the very large and busy Level III NICU at Centennial Medical Center's Women's and Children's Hospital. Utilization of that nursery's 60 beds already exceeds 90% in peak periods. With the coming addition of more pediatric subspecialties there, the demand for its NICU beds will continue to increase and it will be consistently full. This makes it important to upgrade the HMC nursery program, so that HMC can retain and care for Level II-B infants from the HMC service area, who are now being transported to Women's and Children's Hospital.

• A local, clinically excellent Level II-B infant care program for residents of this service area north of Nashville will provide significant benefits, by reducing the emotional cost of separation of a newborn from the family, reducing significant family travel times and expense of daily drives to Nashville to be with the newborn, reducing delays in neonatal care while awaiting neonatal transport (affecting c. 100 newborns annually in this project), and reducing neonatal ambulance transport costs for II-B infants born in, and cared for entirely at, HMC.

Existing Resources

• There are two hospitals in the service area with medical-surgical services: the applicant, TriStar Hendersonville Medical Center and Sumner Regional Medical Center They are owned and operated by two national hospital companies based in Nashville.

• There is no Level II-B NICU program in the service area as defined by zip codes. The closest NICU's are in downtown Nashville, at Centennial Women's and Children's Hospital, Baptist Hospital, and Vanderbilt Children's Hospital.

Project Cost, Funding, and Financial Feasibility

• The estimated cost of the project is $32,255,000. It includes not only the fourth floor and nursery renovations and expansions but also some general updating in other parts of the campus, such as the powerhouse and various structural upgrades to the 35-year old building.

• The project will be funded by a cash transfer from HCA, the parent company, through the applicant's local Division office, TriStar Health Services.

• The hospital will continue to have a positive financial margin with all project components operational. The NICU itself will have a positive operating margin.

Staffing

• The project requires the addition of 44.5 FTE's, in positions including NNP (neonatal nurse practitioner), RN, LPN, Nurse Tech, Scrub Tech, and telemetry tech personnel.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR OPERATIONAL AREAS, ROOM CONFIGURATION, ETC.

1. The Applicant

The applicant, TriStar Hendersonville Medical Center ("HMC"), is a 148-bed hospital located in Sumner County, one of several suburban counties adjoining Nashville-Davidson County. Sumner County extends from Davidson County north to Kentucky.

HMC is operated by HCA, a national hospital company headquartered in Nashville. Its Hendersonville facility is one of 96 HCA hospitals on the Joint Commission's nationwide list of 620 "Top Performers"—based on composite and individual scores of 95% or above on all reported Joint Commission accountability data. These accountability measures pertain to clinical practices correlated with improved outcomes.

HMC is also Joint Commission certified for its Joint Replacement Program and as a Primary Stroke Center. It is separately certified as an accredited Chest Pain Center.

HMC operates two campuses in Sumner County, under one consolidated 148-bed license. Its main campus of 110 hospital beds is located in Hendersonville, in southwest Sumner County, beside the Vietnam Veterans Boulevard (an interstate-size roadway running east off I-65). HMC also operates a satellite 38-bed campus in Portland, in the northwest part of Sumner County (close to I-65 in adjoining Robertson County).

2. Overview of the Project

This project has three related components—none of which will increase the applicant's or Sumner County's licensed beds. First, it will (a) create a new fourth floor

at HMC's Hendersonville campus, through relocation of older licensed beds existing at both its Sumner County campuses. Second, it will increase the number of LDRP (Labor/Delivery/ Recovery/Discharge) beds in Obstetrics on the second floor. Third, it will (b) establish a 6-bed Level II-B Neonatal Intensive Care Unit on the obstetrical floor of the main hospital, in an area vacated by moving beds to the fourth floor. The project will move a net total of 13 inpatient beds from HMC's satellite campus back to HMC's main campus, all within the same county and within the same facility license.

2. Physical Changes to the Building

Table Two: Summary of Construction and Changes in Size	
	Total Square Feet
Facility Before Project	160,015 SF
Facility After Project	184,447 SF
Net Increase in Size (%)	24,432 SF (+15.3%)
Area of New Construction	24,432 SF
Area of Buildout or Renovation	18,761 SF
Total New & Renovated Construction	43,193 SF

Source: Project architect.
Note: Additional detail on a departmental level is provided in Attachment B.II.A.

The addition of the new fourth floor will be the only new construction in this project. The NICU will be created in renovated second-floor nursing unit space that will become available as second-floor medical-surgical beds are consolidated on the new fourth floor for efficiency of staffing.

3. Changes in Location and Assignment of HMC's Licensed Beds

This project will make several adjustments in bed allocations within, and between, the two campuses. First, at the main campus in Hendersonville, it will construct a new fourth floor for medical-surgical patients. To that floor, it will relocate 19 licensed medical-surgical beds from the 2nd floor, and 13 of the 34 medical-surgical beds at the Portland campus. These relocations will give the new fourth floor a complement of 32 medical-surgical beds.

Second, the Obstetrics area with its 6 LDRP's and 10 postpartum beds (total of 16) will be remodeled into 10 LDRP's and 4 postpartum beds (total of 14).

Third, the project will relocate and re-assign 6 beds from the second floor postpartum area, to a new 6-bed Neonatal Intensive Care Unit ("NICU") adjoining Obstetrics on the second floor. (The NICU will occupy space vacated when medical-surgical beds are moved to the new fourth floor.)

Fourth, as these relocated and remodeled bed areas are opened, HMC will reduce the Portland satellite's bed complement by 13 beds, so that the consolidated license that covers both campuses will remain at 148 beds—123 at the main campus and 25 at the Satellite campus.

Tables Three-A, Three-B, and Three-C below show the proposed licensed bed changes by bed assignments, floor, and campus. In the tables, the abbreviations "HV" and "PL" indicate the Hendersonville and Portland campuses, respectively. All patient rooms at Hendersonville are already used as private accommodations; all will continue to be used as private.

Table Three-A: Proposed Changes in Licensed Bed Capacity and Assignments TriStar Hendersonville Medical Center—Main (HV) and Satellite (PL) Campuses

Bed Assignment and Floor	Current Licensed Bed Capacity	Proposed Licensed Bed Capacity	Change
Medical-Surgical			
HV 2nd floor	23	0	-23
HV 3rd floor	51	51	NC
HV 4th floor	Floor not yet constructed	32	+32
PL 1st floor	34	21	-13
(Subtotal)	*(108)*	*(104)*	*(-4)*
ICU/CCU			
HV 2nd floor	20	20	NC
PL 1st floor	4	4	NC
Obstetrics LDRP's			
HV 2nd floor	6	10	+4
Post-partum / Gyn			
HV 2nd floor	10	4	-6
NICU			
HV 2nd floor	0	6	+6
TOTAL BEDS	**148**	**148**	**NC**

Source: Hospital Management

Table Three-B: Proposed Changes in Licensed Bed Assignments By Floor TriStar Hendersonville Medical Center Main (HV) and Satellite (PL) Campuses						
Floor	Med-Surg Beds	ICU/CCU Beds	LDRP Beds	Postpartum Beds	NICU Beds (IIB)	Total Beds
HV-2nd						
Current	23	20	6	10	0	59
Proposed	*0*	*20*	*10*	*4*	*6*	*40*
HV-3rd						
Current	51	0	0	0	0	51
Proposed	*51*	*0*	*0*	*0*	*0*	*51*
HV-4th						
Current	none	none	none	none	none	none
Proposed	*32*	*0*	*0*	*0*	*0*	*32*
HV-Subtotal						
Current	74	20	6	10	0	110
Proposed	*83*	*20*	*10*	*4*	*6*	*123*
PL-1st						
Current	34	4	0	0	0	38
Proposed	*21*	*4*	*0*	*0*	*0*	*25*
HV + PL						
Current	108	24	6	10	0	148
Proposed	*104*	*24*	*10*	*4*	*6*	*148*

Table Three-C: Proposed Changes in Licensed Bed Assignments By Campus TriStar Hendersonville Medical Center--Main (HV) and Satellite (PL) Campuses						
	Current Assignment			**Proposed Assignment**		
	Main Campus	Portland Campus	Combined	Main Campus	Portland Campus	Combined
Med/Surg	74	34	108	83	21	104
ICU	20	4	24	20	4	24
Obstetric & Gyn	16	0	16	14	0	14
NICU beds	0	0	0	6	0	6
Total Licensed	**110**	**38**	**148**	**123**	**25**	**148**

4. Project Timetable and Operating Schedule

The hospital and its services operate continuously, 24/7, year-round. This will not change. Construction will be phased to avoid interruption of inpatient care.

If granted CON approval by July 1, 2013, the project will require up to 42 months to complete. Its first full calendar year of operation will be CY 2017.

5. Project Cost and Financing

The estimated cost of the project is $32,255,000, all of which will be provided by HCA, the applicant's parent company, in the form of a cash transfer to HMC through TriStar, HCA's divisional office for its Tennessee hospitals.

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART. 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.

See Attachment B.II.A for this chart.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

Hospital construction projects approved by the HSDA in 2009-2011 had the following construction costs per SF:

Table Four: Hospital Construction Cost PSF Years: 2009 – 2011			
	Renovated Construction	**New Construction**	**Total Construction**
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$125.84/sq ft	$324.00/sq ft	$301.74/sq ft

Source: HSDA, from CON approved applications during 2009-2011.

This project, which is priced for a CY 2014-2016 construction period, is consistent with the HSDA's 2009-2011 average cost ranges, when five years of future cost inflation are taken into account. The project construction cost by the time it opens in 2016 is projected to be approximately $362 PSF overall. However, this includes some other campus construction that will be undertaken at the same time, but is only partly related to this project--upgrading of the campus's powerhouse and some major structural upgrades to the 35-year-old facility in several areas. If those components are excluded, the 2016 final construction cost will be $329 PSF, only 9% above the 2009-2011 average for third quartile.

Table Five: This Project's Construction Costs			
	Renovation	**New Construction**	**Total Project**
Square Feet	36,394 SF	21,871 SF	58,265 SF
Construction Cost			$21,068,150
Constr. Cost PSF			$361.66

Source: HCA Design and Construction data.

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

TriStar Hendersonville Medical Center has a consolidated 148-bed license, for 110 beds at its main campus in Hendersonville, and 38 beds at its satellite campus in Portland (also in Sumner County). The 38 licensed beds at Portland are temporarily unstaffed, waiting for partial relocation to the main campus in phases, over the next several years. Tables Three-A and –B below (*repeated from response B.II.A*) show proposed changes. The abbreviations "HV" and "PL" indicate the Hendersonville and Portland campuses.

Tables Three-A, Three-B, and Three-C below, reproduced from question B.II.B above, show the proposed licensed bed changes by bed assignments, floor, and campus. In the tables, the abbreviations "HV" and "PL" indicate the Hendersonville and Portland campuses, respectively. All patient rooms at Hendersonville are already used as private accommodations; all will continue to be used as private.

Table Three-A: Proposed Changes in Licensed Bed Capacity and Assignments TriStar Hendersonville Medical Center—Main (HV) and Satellite (PL) Campuses

Bed Assignment and Floor	Current Licensed Bed Capacity	Proposed Licensed Bed Capacity	Change
Medical-Surgical			
HV 2nd floor	23	0	-23
HV 3rd floor	51	51	NC
HV 4th floor	Floor not yet constructed	32	+32
PL 1st floor	34	21	-13
(Subtotal)	*(108)*	*(104)*	*(-4)*
ICU/CCU			
HV 2nd floor	20	20	NC
PL 1st floor	4	4	NC
Obstetrics LDRP's			
HV 2nd floor	6	10	+4
Post-partum / Gyn			
HV 2nd floor	10	4	-6
NICU			
HV 2nd floor	0	6	+6
TOTAL BEDS	**148**	**148**	**NC**

Source: Hospital management.

Table Three-B: Proposed Changes in Licensed Bed Assignments By Floor TriStar Hendersonville Medical Center Main (HV) and Satellite (PL) Campuses						
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Current	23	20	6	10	0	59
Proposed	*0*	*20*	*10*	*4*	*6*	*40*
HV-3rd						
Current	51	0	0	0	0	51
Proposed	*51*	*0*	*0*	*0*	*0*	*51*
HV-4th						
Current	none	none	none	none	none	none
Proposed	*32*	*0*	*0*	*0*	*0*	*32*
HV-Subtotal						
Current	74	20	6	10	0	110
Proposed	*83*	*20*	*10*	*4*	*6*	*123*
PL-1st						
Current	34	4	0	0	0	38
Proposed	*21*	*4*	*0*	*0*	*0*	*25*
HV + PL						
Current	108	24	6	10	0	148
Proposed	*104*	*24*	*10*	*4*	*6*	*148*

Table Three-C: Proposed Changes in Licensed Bed Assignments By Campus TriStar Hendersonville Medical Center--Main (HV) and Satellite (PL) Campuses						
	Current Assignment			**Proposed Assignment**		
	Main Campus	Portland Campus	Combined	Main Campus	Portland Campus	Combined
Med/Surg	74	34	108	83	21	104
ICU	20	4	24	20	4	24
Obstetric & Gyn	16	0	16	14	0	14
NICU beds	0	0	0	6	0	6
Total Licensed	**110**	**38**	**148**	**123**	**25**	**148**

This project will make several adjustments in TriStar Hendersonville Medical Center's bed allocations between, and within, its two campuses. The impacts of these reassignments and relocations will be positive. They will permit the creation of a needed NICU to serve newborns in the service area north of Davidson County; they will relocate unstaffed beds from the satellite campus to the main campus where patients need more beds, and they will do those things without increasing the service area's licensed beds.

First, at the main campus in Hendersonville, the project will relocate 19 licensed medical-surgical beds from other floors to a new medical-surgical fourth floor; and it will relocate 13 of the 34 medical-surgical beds at the Portland campus to that new floor, giving the Hendersonville fourth floor a complement of 32 medical-surgical beds. A unit of beds on that floor will be oversized rooms to better accommodate orthopedic patients and to approve the hospital's Joint Commission-certified Joint Replacement program.

Second, the Obstetrics area with its 6 LDRP's and 10 postpartum beds (total of 16) will be remodeled into 10 LDRP's and 4 postpartum beds (total of 14).

Third, the project will relocate and re-assign 6 beds from the second floor postpartum area, to a new 6-bed Neonatal Intensive Care Unit ("NICU") adjoining Obstetrics on the second floor. (The NICU will occupy space vacated when medical-surgical beds are moved from the second floor to the proposed new fourth floor.)

Fourth, as these relocated and remodeled bed areas are opened, HMC will reduce the Portland satellite's bed complement from its current 38 beds to 25 beds, so that the consolidated license that covers both campuses will remain at 148 beds. The main campus will operate 123 licensed beds; the satellite campus will contain 25 licensed beds.

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION):

1. **ADULT PSYCHIATRIC SERVICES**
2. **ALCOHOL AND DRUG TREATMENT ADOLESCENTS >28 DAYS**
3. **BIRTHING CENTER**
4. **BURN UNITS**
5. **CARDIAC CATHETERIZATION SERVICES**
6. **CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**
7. **EXTRACORPOREAL LITHOTRIPSY**
8. **HOME HEALTH SERVICES**
9. **HOSPICE SERVICES**
10. **RESIDENTIAL HOSPICE**
11. **ICF/MR SERVICES**
12. **LONG TERM CARE SERVICES**
13. **MAGNETIC RESONANCE IMAGING (MRI)**
14. **MENTAL HEALTH RESIDENTIAL TREATMENT**
15. **NEONATAL INTENSIVE CARE UNIT**
16. **NON-RESIDENTIAL METHADONE TREATMENT CENTERS**
17. **OPEN HEART SURGERY**
18. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

1. The Need to Replace, Relocate, and Reassign Licensed Beds

a. Medical-Surgical Beds

HMC's main campus has only 74 medical-surgical beds. But not all are currently available for patient use. Until late December of 2012, only 55 were available, because 19 beds were being pre-empted for other purposes (offices, waiting, consults, etc.), or to convert a double room to a single room to meet AIA Guidelines to house patients in private rooms. In late December, to meet challenges in finding beds in peak periods, 5 more medical-surgical bed spaces were recaptured for inpatient use by relocating offices and storage to other areas. But still, only 60 of the hospital's 74 beds are now available for inpatient use—81% of its assigned medical-surgical complement.

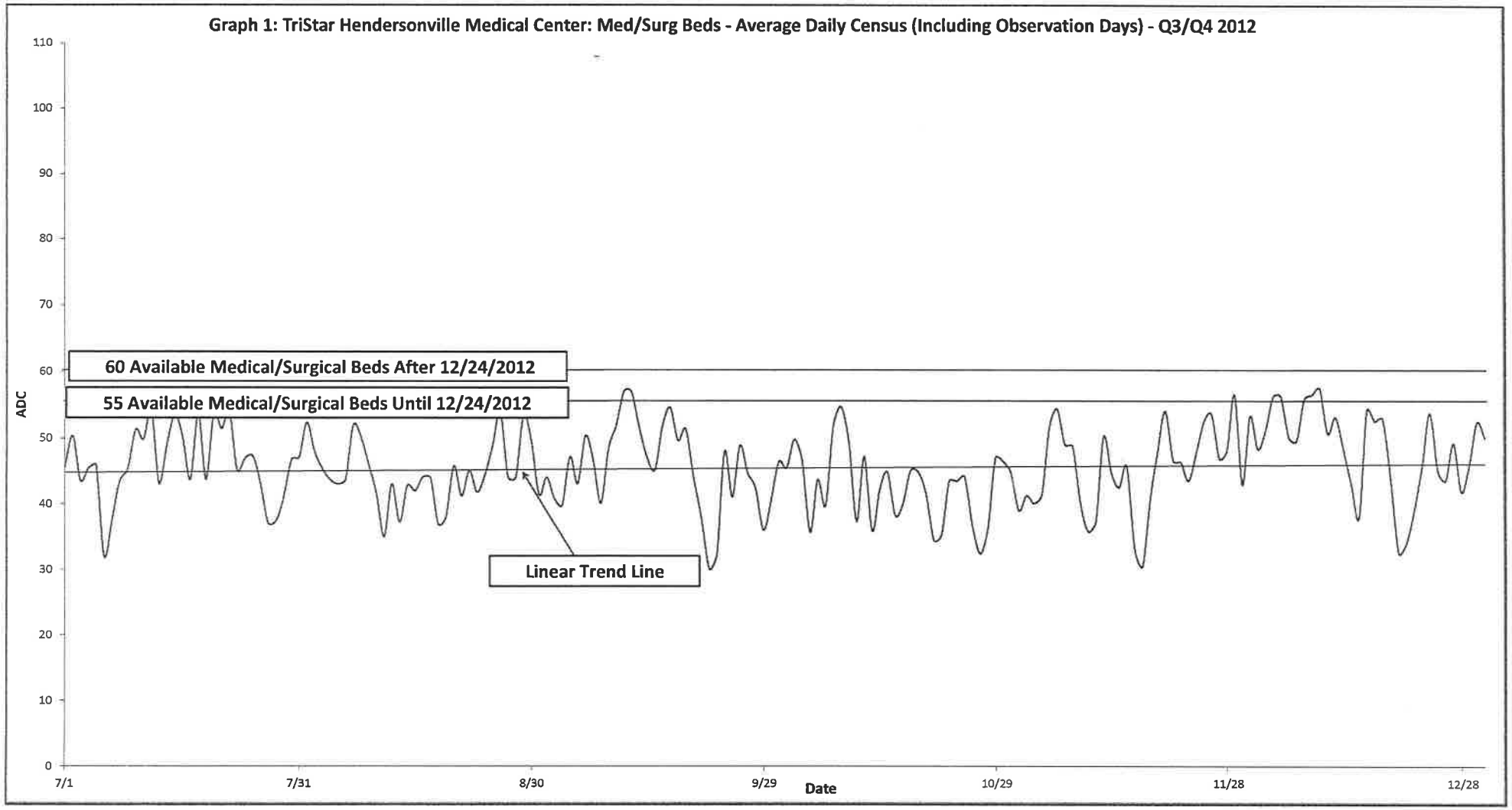
The service area population of childbearing age women is increasing and the medical staff is expanding. In 2012, the hospital had to decline more than 100 admissions due to bed capacity limitations.

Denied admissions will become even more chronic until HMC constructs new medical-surgical rooms to recapture its normal complement of licensed beds. Fortunately, this can be done without increasing the hospital's license. HMC's current 148-bed license includes not only its 110-bed Hendersonville main campus, but also 38 unstaffed acute care beds at a nearby Portland satellite campus. This project will construct a new 32-bed medical-surgical fourth floor at the main campus; and all 32 will be relocations of existing licensed patient beds--13 from the satellite campus, plus 19 beds from the second floor of the main campus. (Section B.II.B above provides details of these relocations and reassignments.)

Graph 1 on the following page illustrates the need for these shifts. It shows peak medical-surgical census, at midnight, at the main campus during the last half of CY2012. It includes accumulated hours of bed use for "observation" patients in the medical-surgical units because those patients occupy beds. Observation patients are those whose physicians request that they be given bed space and nursing supervision for less than 23 hours, to monitor their conditions. They occupy medical-surgical beds just as admitted medical-surgical patients do. Their insurers reimburse for this care. Some observation patients convert to admissions.

Horizontal lines with label boxes show the 55 medical-surgical beds available until 12/24/12, and the 60 available now. The peaks rising close to and above the 55-bed and 60-bed lines (total med-surg capacity then and now) illustrate the difficulties faced by the hospital in CY2012. And the linear trend line is rising. Because it may take three and a half years to open the new fourth floor and the NICU, the hospital must seek immediate project approval in order to have enough beds to meet community needs.

(Note: Not even this graph fully captures the bed demand relative to supply, because it shows only each day's midnight patient census—a point-in-time snapshot. In reality, patients are sometimes unable to find a bed, and are sent elsewhere, prior to the midnight census. For example, the medical-surgical beds might be full in the morning, requiring denial of morning admission requests; but later that day, patient discharges may open up a few beds not re-filled by afternoon or evening admissions. The graph would show bed availability at midnight that day, but not show that admissions requests had been declined earlier that day.)



Source: Casemix Db

Average Daily Census (Obs)
Hville - Med.Surg Utilization Graph - FY 2012.xlsx

The main campus bed shortage is not a temporary issue. As shown later in Section C(I)6 of this application, medical-surgical patient days have increased steadily; and they will continue to increase as the population increases and ages, and as additional specialists locate practices in the Hendersonville service area. In January 2013, an orthopedic surgeon, a general surgeon, and an interventional cardiologist joined the staff and began practice at HMC. Recruitment is underway for a pulmonologist, two internists/family practitioners, and an obstetrician; all of whom are expected to be in place in CY2014.

Section C(I)6 conservatively projects that the hospital's 60 available medical-surgical beds will reach 95% in CY2016, the year before this project opens. That is average occupancy; on peak days (typically midweek) there will obviously be chronic shortages of this type of bed unless more beds are made available as proposed here. The following Table, summarizing data in Section C(I)6, illustrates the unacceptably high occupancies that will be experienced, if this project is not allowed to go forward.

Table Six: TriStar Hendersonville Medical Center
Projected Medical-Surgical Patient Utilization Without Project, 2013-2018

Year	M/S Bed Days (Admissions & Observation)	Current M/S Capacity @ 60 M/S Beds	M/S Occupancy (Rounded)
2013	17,992	21,900 Pat. Days	82%
2014	18,921	21,900 Pat. Days	86%
2015	19,850	21,900 Pat. Days	91%
2016	20,779	21,900 Pat. Days	95%

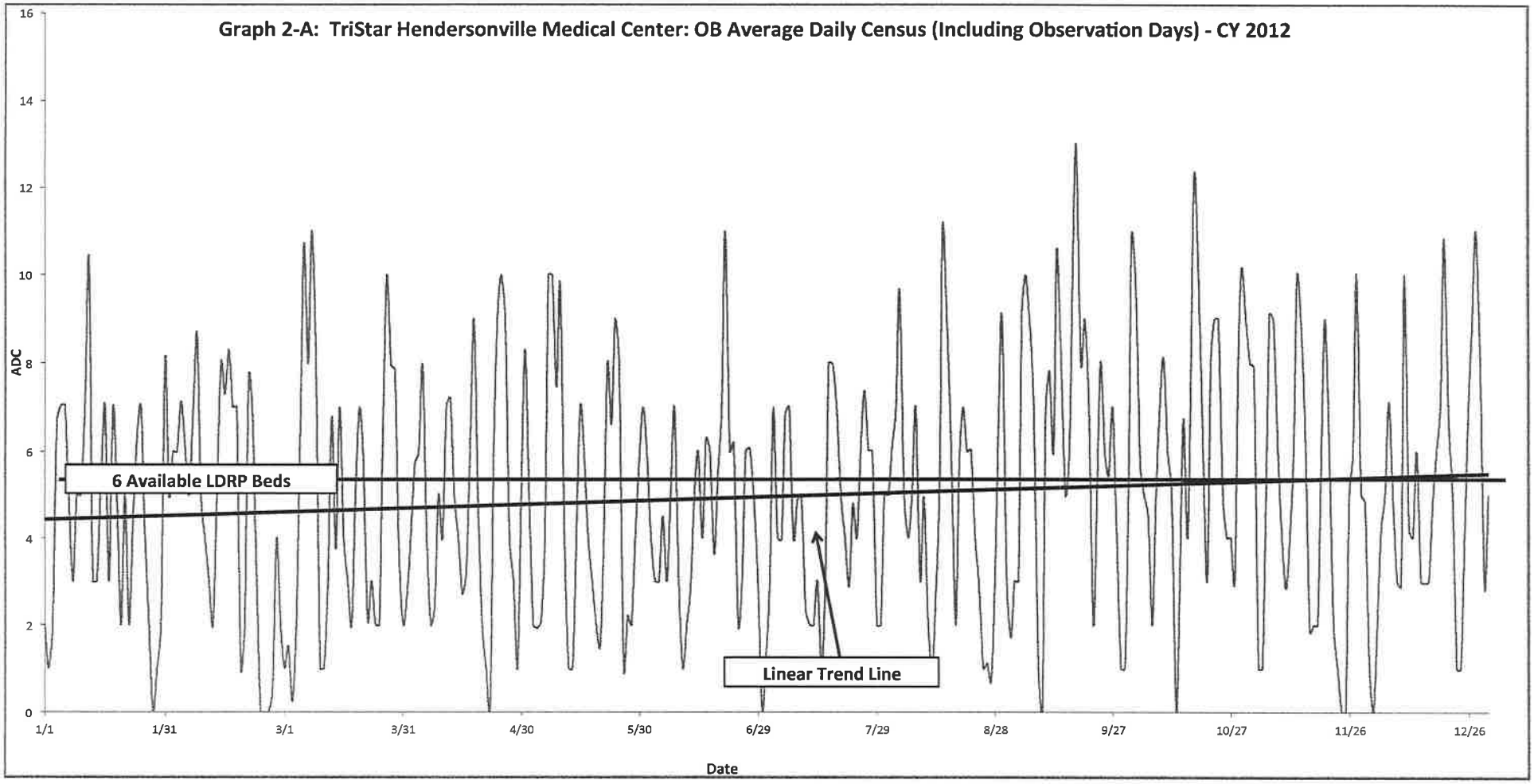
Source: Hospital Management. See detailed projections, Section C(I)6 below.

b. Obstetrics Beds

The project will increase HMC's LDRP beds from 6 to 10. LDRP means "labor/delivery/recovery/postpartum". It is sometimes called "single-room obstetrics" or "family-centered care." LDRP means that the mother is not moved from one room to another, immediately after giving birth. She is initially admitted into a comfortable, home-like room, where she labors, delivers, and then remains with her baby and family members as she chooses, until discharge to home. This has become the most requested type of obstetrical care in most cities.

Currently HMC is unable to meet its service area demand for an LDRP birth experience, and must therefore transfer many mothers after birth to a "postpartum" room to make room for the next mother to deliver in the LDRP. Graph 2-A on the following page shows the CY2012 swings in census on the OB unit, and demonstrates how often the hospital has no LDRP room available (where the graphed census line exceeds the 6-bed LDRP line). Graph 2-B shows the high midweek peak of demand in this service.

To meet the public's needs for an optimal family birthing experience, HMC proposes to increase its LDRP capacity by two-thirds (from 6 to 10 LDRP rooms). That will provide LDRP rooms for at least 1,000 births per year at a planning standard of 100 births per room per year. There will still be some peak birthing days when even 10 LDRP beds are not sufficient. For those days, the hospital will also retain 4 postpartum beds.



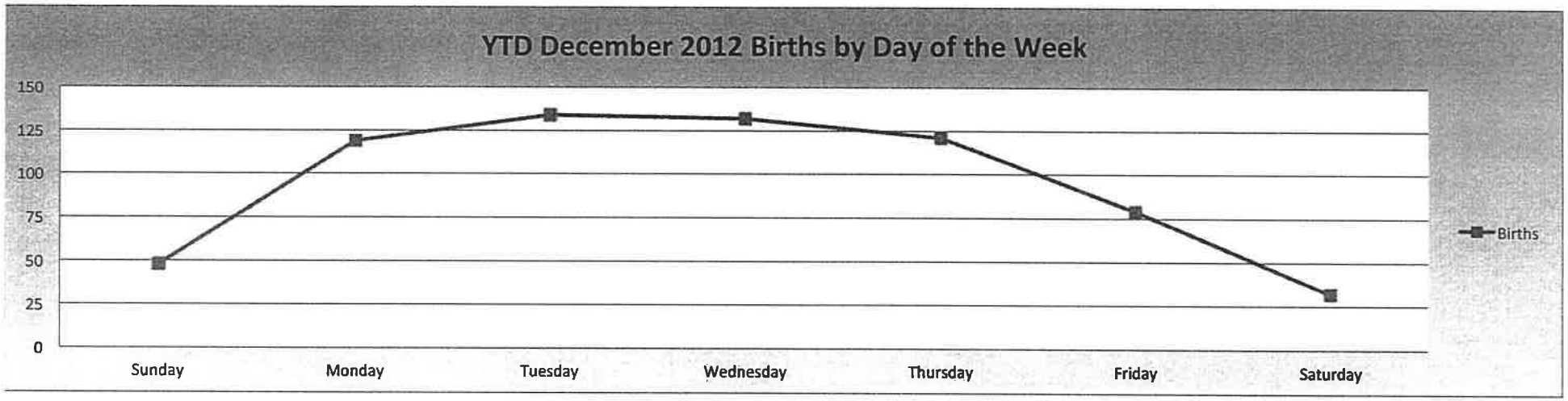
Source: Casemix Db

Average Daily Census (Obs + OB)
GR2A-HMC- OB/obs2012.xlsx

Graph 2-B: Hendersonville Medical Center

Total Births by Day of the Week

YTD December 2012



Source: Casemix Db

Births - Day of the Week
Hville - Births by DOW - YTD December 2012.xlsx

2. NICU (Neonatal Intensive Care Unit) Beds

(1) Level II-B Care

The project includes expanding and upgrading the nursery area and staff to provide Level II-B neonatal care, under the medical direction of a Board-certified neonatologist and staffed by Neonatal Nurse Practitioners onsite 24/7. The HMC NICU will be developed and operated as an affiliate of the Level III NICU at Women's and Children's Hospital at Centennial Medical Center (a 60-bed comprehensive NICU, the second largest in Middle Tennessee).

Upgrading to II-B will enable it to care for approximately a hundred infants a year that currently must be transported by ambulance to Nashville. Level II-B programs, unlike Level lII-A programs, have equipment and staff capable of caring for moderately ill infants with conditions or needs such as the following (and there are others):

- born after only 32-34 weeks of gestation; (fewer weeks requires Level III; longer gestations receive Level I care unless unstable
- born weighing 1500 or more grams who have physiological immaturity or who are moderately ill with problems expected to resolve rapidly, and who are not expected to need subspecialty services on an urgent basis;
- convalescing after intensive care;
- requiring mechanical ventilation for less than 24 hours, or continuous nasal positive airway pressure (CPAP), or oxygen therapy under an oxygen hood;
- needing stabilization for transfer to Level III facility;
- needing continuous and prolonged IV therapy/antibiotic or antiviral administration;
- needing umbilical arterial catheter (UAC) or umbilical venous catheter (UVC);
- needing total parenteral nutrition (TPN);
- needing continuous blood pressure monitoring or frequent blood gas assessment;
- needing intensive phototherapy for jaundice with risk of exchange transfusion.

Lengths of stay for Level II-B infants vary between NICU's. CMC Women's and Children's and HMC clinical staff have projected an ALOS of 13 days for this unit. This was based on (a) reviewing medical records of infants transported from this service

area in CY2012, (b) the experience of the Summit Medical Center NICU in eastern Davidson County, and (c) the anticipated increase of long-stay observation (28 days) of infants of drug-using mothers, more of whom will be identified by mandatory newborn drug screening tests expected to begin later this year.

(2) Potential for Level II-B Care at TriStar Hendersonville Medical Center

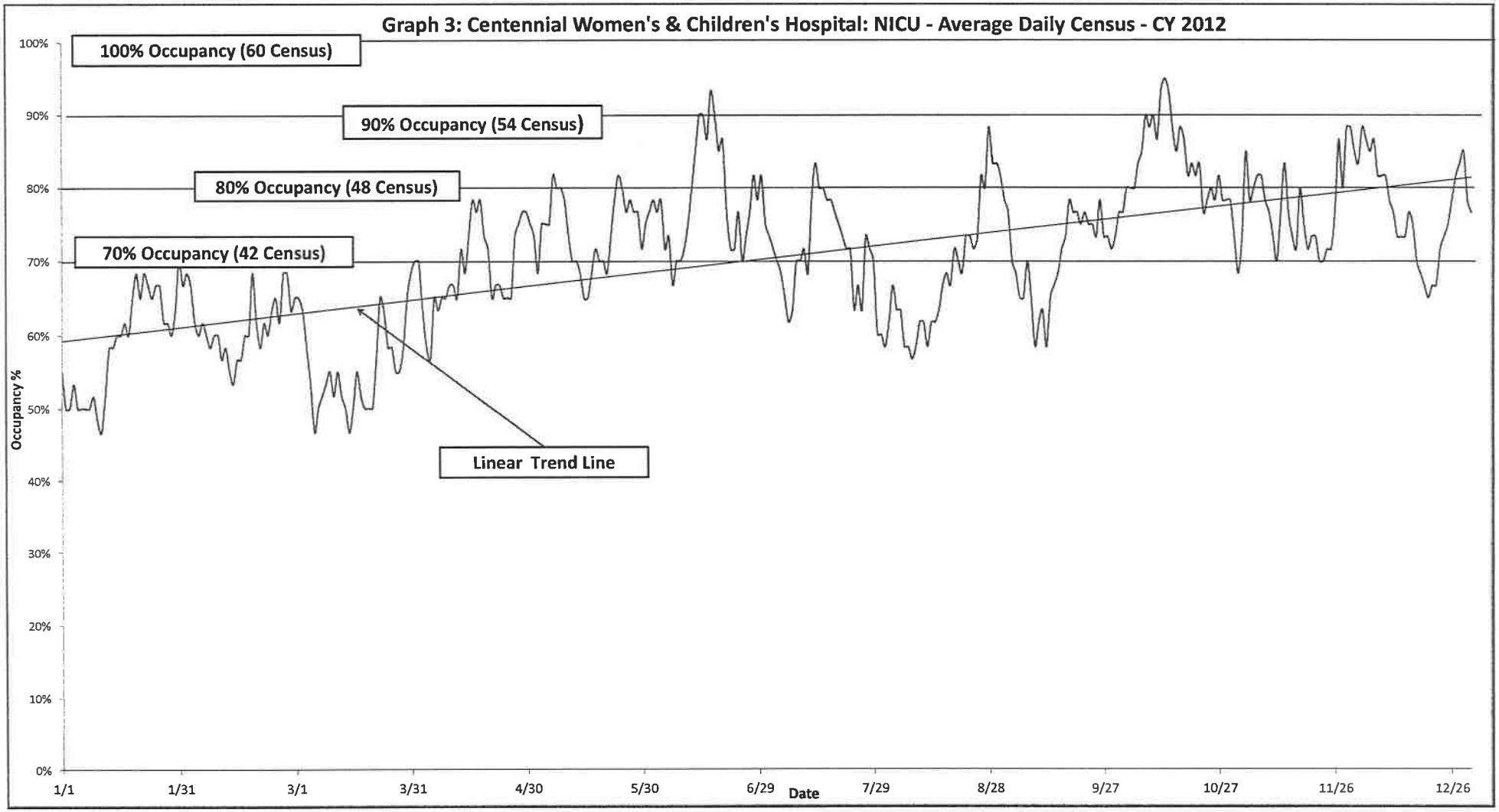
As an HCA facility, HMC is affiliated with the Women's and Children's Hospital at Centennial Medical Center in Nashville. That dedicated 155-bed facility at Centennial has a highly utilized 60-bed NICU that is Middle Tennessee's second largest, in terms of both bed capacity and days of care provided). Its NICU utilization increased 18.2% last year, the highest growth rate of any NICU in the region. With multiple pediatric subspecialties available, and more coming online in CY2013, Women's and Children's has one of the State's most comprehensive NICU programs, and it is the neonatal destination of choice for most mothers who deliver at HMC and find that their infant needs Level II-B or Level III care.

That NICU's beds will also soon be full, consistently. See Graph 3 at the end of this subsection. So Women's and Children's Hospital clinicians are working with HMC to enable Sumner County area Level II-B newborns to safely remain in, or be more quickly returned to, Hendersonville for II-B care, freeing up beds at the downtown NICU. Women's and Children's is assisting TriStar Hendersonville Medical Center with NICU program definition, utilization projections, staff specifications and qualifications, recruitment screening and interviews, establishing training rotations through the downtown NICU, and continuing education for the NICU staff. Their coordination reflects HCA's "hub and spoke" approach to distributing high quality specialty services to suburban locations to improve patient care closer to home.

In planning this project, a medical records review of infants transported from HMC and its service area to Women's and Children's Hospital was conducted by a team of nurses from both facilities. The team concluded that approximately 9% of HMC's current births will require Level II-B care that can be cared for in a NICU in Hendersonville. The HMC NICU staff will be jointly recruited and trained by HMC and Women's and Children's Hospital, and will be medically supervised by the same

neonatologist organization that supervises care at six Nashville area NICU's (five in Davidson County, and two in Rutherford County). That is Pediatrix Medical Group of Tennessee. The group consists of neonatologists and neonatal nurse practitioners (NNP) who are Board-certified specialists in maternal-fetal-newborn care. Their physicians and NNP's are listed in the Attachments to this application.

As shown by detailed projections in Section C(I)6 of this application, the HMC Level II-B program is projected to care for 95 infants in its first year of operation (CY2017) and 111 in its second year. In the second year, admissions will include 14 infants transferred to HMC from other hospitals, as well as 97 born at HMC.



MM

Average Daily Census (Print)
CMC - Neonatology Volume and Census Analysis - FY 2012.xls

(3) Justification for Offering a Level II-B NICU Program at HMC in Sumner County

It is orderly and timely now for TriStar Hendersonville Medical Center to develop Level II-B NICU services for residents of Sumner and nearby counties. The care is needed for sufficient numbers of local newborns to make such a unit feasible from a quality standpoint as well as from a financial standpoint. Its safety and staff competencies will be assured by strong development support and operational supervision from Nashville-based neonatologists, on-site neonatal nurse practitioner leadership, and staff rotations through the large Level III NICU at Women's and Children's Hospital in Nashville.

Having that service available is also an appropriate community expectation for one of the region's most populous counties. A large number of families are affected by not having local access to II-B care. Although Sumner County is in the Nashville Metropolitan Service Area (MSA), it is a long drive to downtown Nashville NICU's for most Sumner County residents. With II-B infants staying in a Nashville NICU for 11 to 28 days, long round-trip commuting times for parents and siblings can be a real hardship.

Table Six below, taken from a Tennessee Department of Health report in the Attachments, lists Middle Tennessee's eight counties whose residents had 1,000 or more births in CY2011, and projects the Guidelines' NICU bed need in CY2017 for that population. The applicant has added whether NICU care is locally available.

- Of the seven Middle Tennessee counties whose residents had 1,000 or more births, only two lack local NICU care--Sumner and Wilson.

- Sumner County residents have the Middle Tennessee's fifth largest number of births, and the fifth largest NICU bed need for them (16 beds). But of the top five counties, Sumner is the only one without its own NICU. One county, Maury (Columbia), has far fewer births, and less NICU bed need (Maury), has an NICU.

- Sumner County is the only one of these eight counties whose mothers have approximately 2,000 or more annual births but have no local NICU option and are a long drive time from any NICU. Because of that, the outmigration for delivery of all babies is

high. For example, in CY2011, as a precaution, it appears that approximately half of Sumner County mothers chose to deliver in Nashville, where NICU care is available within minutes.

Table Six: CY2017 NICU Bed Need Eight Middle Tennessee Counties Whose Residents Had 1,000 or more Births			
County (City)	**NICU Bed Need CY2017**	**NICU II-B or III in County?**	**CY 2011 Births to County Residents**
Davidson	76	yes (five)	9,601
Rutherford	30	yes (two)	3,648
Montgomery	26	yes (one)	3,042
Williamson	18	yes (one)	2,012
Sumner	***16***	***no***	***1,922***
Wilson	12	no	1,338
Maury	10	yes (one)	1,136

Source: Tenn. Dept. of Health Report of NICU Bed Need, CY2017 (see Attachments).
Note: In 2011, THA data indicates that Sumner County hospitals delivered only 48% of infants born to Sumner County residents.

Drive times are burdensome for Sumner County residents who need to visit their infants in a Nashville NICU every day for one to four weeks. For residents of this northern sector of the MSA, access to downtown Nashville hospitals is via the I-65 north-south corridor, I-40/I-240, and Highways 386 (Vietnam Veterans Expressway) and 31E across southern Sumner County. Those who drive it frequently know that the I-65 corridor is a very busy, often very congested or "backed-up" highway between Sumner County and Nashville, as are the downtown interstates and streets connecting I-65 to the hospitals. Table Seven-A below shows average drive times to Nashville NICU's from numerous communities in Sumner and nearby edges of Robertson and north Davidson Counties. Table Seven-B on the following page, compares those drive times to other suburban locations that have NICU beds, as an illustration of similarly situated communities that have already added small NICU's. Table Seven-C, following that, shows the range of round-trip drive time savings for service area residents if this project is approved. These three tables illustrate that:

(a) this project's service area communities are significantly farther from downtown Nashville NICU's than are the communities of Hermitage and Smyrna--which have already been approved for NICU's; and that

(b) the round-trip drive times savings for most service area residents will be significant if an NICU is approved for TriStar Hendersonville Medical Center.

Table Seven-A: Distance & One-Way Drive Times From the Service Area To the Closest NICU Destinations (Central Nashville)								
Service Area Communities	**To TriStar Hendersonville Medical Center**		**To Centennial Women's & Children's Hospital**		**To Baptist Hospital**		**To Vanderbilt Children's Hospital**	
	Miles	Time	Miles	Time	Miles	Time	Miles	Time
SUMNER								
Gallatin	12.3	18 min	31.1	36 min	30.6	34 min	31.4	36 min
Hendersonville	1.5	4 min	19.6	23 min	19.1	21 min	20.0	24 min
Millersville	10.1	18 min	18.6	23 min	18.2	22 min	19.0	24 min
Portland	25.3	32 min	41.3	45 min	40.8	43 min	41.7	46 min
Oak Grove	27.6	38 min	46.3	56 min	45.8	54 min	46.7	57 min
Westmoreland	30.3	41 min	49.1	60 min	48.6	58 min	49.4	60 min
Cottontown	16.3	20 min	35.2	39 min	34.6	37 min	35.4	39 min
Bethpage	22.4	31 min	41.2	50 min	40.7	48 min	41.5	50 min
Castalian Sprgs	20.5	31 min	39.2	49 min	38.7	48 min	39.6	50 min
DAVIDSON								
Goodlettsville	7.1	12 min	15.7	18 min	15.2	17 min	16.0	19 min
Madison	10.9	13 min	11.9	16 min	11.4	14 min	12.2	17 min
ROBERTSON								
Cross Plains	20.4	32 min	34.3	36 min	33.8	34 min	34.6	36 min
Greenbrier	16.3	25 min	25.1	30 min	24.6	28 min	25.5	31 min
Orlinda	25.8	42 min	42.6	46 min	42.1	44 min	42.9	46 min
Ridgetop	14.1	22 min	22.9	27 min	22.4	26 min	23.2	28 min
Springfield	23.8	35 min	30.7	39 min	30.2	37 min	31.0	39 min
White House	11.7	20 min	28.1	32 min	27.6	30 min	28.5	32 min

Source: Google Maps, mid morning or mid-afternoon. Point of origin query was for town names, not their zip codes. Data show Google's recommended route mileage and average one-way drive time.

Table Seven-B: One-Way Drive Times From Suburban NICU Programs To downtown Nashville NICU Programs						
Other Suburban NICU Locations in the MSA	**To Centennial Medical Center**		**To Baptist Hospital**		**To Vanderbilt Univ. Medical Center**	
	Miles	Min.	Miles	Min.	Miles	Min.
StoneCrest NICU (Smyrna, in north Rutherford County)	24.4	31 min.	23.9	29 min.	24.3	29 min.
Summit NICU (Hermitage, eastern Davidson Co.)	13.5	20 min.	13.1	19 min.	13.5	20 min.
Williamson Medical Center NICU (Franklin, in north Williamson County	20.0	23 min.	19.4	22 min.	18.9	22 min.

Table Seven-C: Average Drive Time Savings in Having an NICU At TriStar Hendersonville Medical Center (HMC)			
From Service Area Communities	Average RT Drive Time to HMC NICU (Minutes)	Average RT Drive Time to 3 Nearest Nashville NICU's (Minutes)	Round-Trip Drive Time Savings (Minutes)
SUMNER			
Gallatin	36	71	35
Hendersonville	8	45	37
Millersville	36	46	10
Portland	64	89	25
Oak Grove	76	111	35
Westmoreland	82	119	37
Cottontown	40	77	37
DAVIDSON			
Goodlettsville	24	36	12
Madison	26	31	5
ROBERTSON	26	31	5
Cross Plains	64	71	7
Orlinda	84	91	7
Ridgetop	44	54	10
Springfield	70	77	7
White House	40	63	23

There are also some important benefits of this project that are not quantifiable.

It will reduce the emotional burden of separation of a newborn from its parents, over long distances, for periods of many days.

Having that care available close to home will reduce parents' considerable effort, time, and expense in scheduling and making trips to downtown Nashville to be with their newborn, over periods of weeks after its birth.

All infants with Level II-B needs at the time they are born at TriStar Hendersonville Medical Center, or transferred to Hendersonville when born at other service area hospitals, will have less delay in obtaining neonatologist and neonatal nurse practitioner care. For the former (II-B infants born at HMC), the project will eliminate the substantial charges (and some risk) of neonatal ambulance transport to and from downtown Nashville--estimated currently at a minimum of $2,500 per round trip.

And with neonatologists and neonatal nurse practitioners available in the Hendersonville program (NNP's on-site 24/7), vulnerable infants born at HMC will no longer be delayed in obtaining specialized care pending arrival of a transport team dispatched from Nashville.

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

Not applicable. No facility will be changing its location or undergoing replacement.

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. **For fixed site major medical equipment (not replacing existing equipment):**
    a. **Describe the new equipment, including:**
        1. **Total Cost (As defined by Agency Rule);**
        2. **Expected Useful Life;**
        3. **List of clinical applications to be provided; and**
        4. **Documentation of FDA approval.**
    b. **Provide current and proposed schedule of operations.**
2. **For mobile major medical equipment:**
    a. **List all sites that will be served;**
    b. **Provide current and/or proposed schedule of operations;**
    c. **Provide the lease or contract cost;**
    d. **Provide the fair market value of the equipment; and**
    e. **List the owner for the equipment.**
3. **Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.**

Not applicable. The project contains no major medical equipment as defined by HSDA rules.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:

1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

The hospital's main campus, where this project will be constructed, is within sight of Vietnam Veteran's Boulevard ("VVB"), Highway 386. The VVB is an interstate-size expressway running east from Exit 96 on I-65, past Hendersonville and joining Highway 31E west of Gallatin. Farther north in Sumner County, just east of the I-65 corridor from Nashville to Kentucky, TriStar Hendersonville Medical Center operates a satellite campus in Portland, with 38 licensed beds (not currently staffed), outpatient diagnostic services, and an Emergency Department that is being modernized to re-open in late 2013.

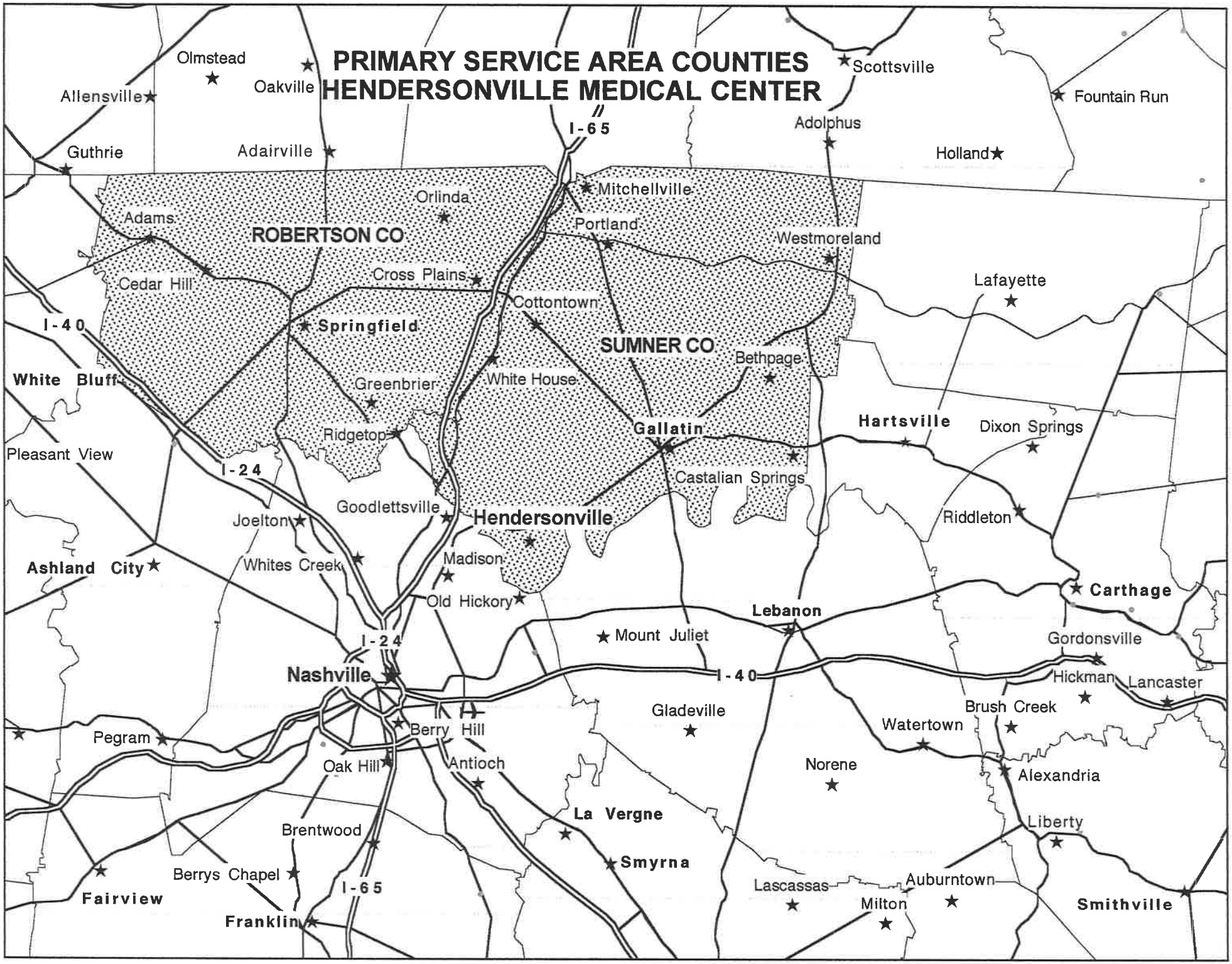
Hendersonville is accessible from other parts of Sumner County via several good roadways, including: the I-65/VVB corridors, Highway 258 to White House, and VVB/Highway 31E to Gallatin. Portland is accessible via Highways 31W, I-65, 52, and 109. Please see the following tables and the county map on the following page. Hendersonville and other communities in Sumner County do not have city bus services.

Drive times between service area communities and downtown NICU's are provided in a prior part of the application, at the end of Section B(II)C (Project Need).

Table Eight-A: Mileage and Drive Times By Personal Automobile Between HMC Hendersonville Campus & Communities in the Service Area			
	County	**Distance**	**Drive Time**
1. Hendersonville	Sumner	1.5 mi.	4 min.
2. Gallatin (Sumner Reg. M.Cntr)	Sumner	12.2 mi.	18 min.
3. Gallatin (Sumner Station, So. Side)	Sumner	6.8 mi.	9 min.
4. Portland (City of)	Sumner	25.3 mi.	32 min.
5. HMC Portland (satellite hospital)	Sumner	23.8 mi.	31 min.
5. White House	Sumner	11.7 mi.	20 min.
6. Goodlettsville (eastern sector)	Sumner/Davidson	7.9 mi.	15 min.

Table Eight-B: Mileage and Drive Times by Personal Automobile Between HMC Portland Campus & Communities in the Service Area			
	County	**Distance**	**Drive Time**
1. Mitchellville	Sumner	6.3 mi.	14 min.
2. Oak Grove	Sumner	9.9 mi.	18 min.
3. Westmoreland	Sumner	16.8 mi.	27 min.
4. Gallatin	Sumner	14.4 mi.	21 min.
5. White House	Sumner	11.0 mi.	17 min.
5. Millersville	Sumner	19.3 mi.	29 min.
6. HMC Hendersonville (main campus)	Sumner	23.8 mi.	31 min.

Source: Google Maps.


PRIMARY SERVICE AREA COUNTIES
HENDERSONVILLE MEDICAL CENTER
Olmstead
Oakville
Allensville
Guthrie
Adairville
Scottsville
Fountain Run
Adolphus
Holland
I-65
Mitchellville
Orlinda
Adams
ROBERTSON CO
Portland
Westmoreland
Cedar Hill
Cross Plains
Lafayette
Cottontown
I-40
Springfield
SUMNER CO
Bethpage
White Bluff
Greenbrier
White House
Hartsville
Dixon Springs
Ridgetop
Gallatin
Pleasant View
I-24
Castalian Springs
Goodlettsville
Hendersonville
Riddleton
Joelton
Madison
Ashland City
Whites Creek
Carthage
Old Hickory
Lebanon
Mount Juliet
Gordonsville
I-24
Nashville
I-40
Hickman
Lancaster
Gladeville
Brush Creek
Watertown
Pegram
Berry Hill
Oak Hill
Antioch
Norene
Alexandria
La Vergne
Liberty
Brentwood
Smyrna
Berrys Chapel
I-65
Lascassas
Auburntown
Fairview
Milton
Smithville
Franklin

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

The only new service included in the project is an upgrade of nursery staffing and medical supervision from Level II-A to Level II-B (Neonatal Intensive Care under HSDA rules). It is discussed in Sections B.II.C above, and in specific review criteria following this subsection.

2. For relocation or replacement of an existing licensed healthcare institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Criteria 2a and 2b are not applicable. The project is not a relocation or replacement of a licensed facility.

3. For renovation or expansion of an existing licensed healthcare institution:

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

Data provided in response B.II.C demonstrate that the main campus needs to improve and expand its medical-surgical bed complements through the addition of a fourth floor. There is no more space on existing floors, or on the campus, for expanding

the medical-surgical bed complements in any other way. It makes no sense to build a partial floor; so HMC logically is moving unstaffed, available beds from other floors and from its Portland campus, to fill its fourth floor to meet peak demands in both the short and long term planning horizon.

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

The HMC main campus in Hendersonville is in good condition; this project is not to remedy physical plant deficiencies. It is only to expand treatment capacity for the service area population.

Project -Specific Review Criteria: Neonatal Intensive Care Unit

1. **The total number of neonatal intensive and intermediate care beds should not exceed eight beds per 1,000 live births per year in a defined neonatal service area.**
2. **The need shall be based upon the current year's population projected four years forward.**

Using the above methodology, the Tennessee Department of Health has projected a need for 16 NICU beds for mothers residing in Sumner County. The TDH projection is provided in Table 9 at the end of this section of the Guidelines. This HMC application is for only 6 NICU beds, to meet 38% of the need locally instead of in Nashville. That is a reasonable objective because the most recent calendar year of THA data (CY 2011) indicates that 48% of mothers from Sumner County delivered in Sumner County hospitals.

The TDH projection also shows that there are a mere 5.6% more NICU beds in all of Middle Tennessee than are needed in CY2017 (267 needed; 282 reported in 2011 and 2012 Joint Annual Reports). There are two reasons why this is not significant.

The first is that community access to this type of care is a more important consideration than a negligible region-wide bed surplus. The second reason is that areawide NICU bed complements were not intended to be capped or limited by the CON

program. By statute, established NICU providers are free to convert their general beds to NICU beds at will regardless of the Guidelines' need projection. For example, in their 2012 JARs, Vanderbilt and Williamson Medical Center (supervised by Vanderbilt) report having added a total of five more NICU beds last year--almost as many as the 6 beds requested in this project.

So the legislative intent appears not to be to limit the supply of NICU beds in the region; instead, it is to decide which communities have sufficient local demand and clinical expertise to establish a high quality NICU at a bed size appropriate to that specific hospital and service area.

Like the three suburban hospitals south, southeast, and east of Nashville that have already been granted small NICU's (StoneCrest, Summit, Williamson County Medical Center), HMC in the suburban areas north of Davidson County also will have the birth volumes, the clinical staff, the Level III NICU relationships and support, and the financial resources to serve moderately ill or vulnerable Level II-B infants. And infants born at hospitals in this northern service area are at the same, or greater, distances from existing downtown Nashville NICU's as were those three hospital's infants when they were granted NICU's.

3. A single neonatal special care unit shall contain a minimum of 15 beds. This is considered to be the minimum necessary to support economical operation of this service. An adjustment in the number of beds may be justified due to geographic remoteness.

The project is 6 beds. Nonetheless it operates with a positive margin, as shown in its projected income and expense analysis (Project Data Form) later in this application.

The distance of this service area from Nashville NICU's, farther than for several communities with NICU's granted CON's, justifies an exception to criterion #3. It is a hardship for families needing to stay close to their infants on a daily basis. The drive time to downtown Nashville NICU's for residents of its largest cities is even longer than the drive time from Smyrna (north Rutherford County), Franklin (north Williamson County) and Hermitage (eastern Davidson County), all towns that have NICU care for Level II-B babies. And six of Middle Tennessee's authorized NICU programs with only

II-B care are between 8 and 12 beds (one at Williamson Medical Center operated only 5 NICU beds until CY2012). All of these units are medically supervised either by the Pediatrix neonatology organization that will supervise this project, or by Vanderbilt neonatologists; and their care appears to be of high quality and economically feasible.

4. The applicant shall designate a specific service area that is compatible with Department of Health guidelines pertaining to this service.

The application has defined the primary and secondary NICU project service area as Sumner County and parts of adjoining north Davidson County and eastern Robertson County.

5. The applicant should demonstrate the ability to comply with the standards developed in the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing, and Facilities.

The applicant's response to the Perinatal Care Guidelines is a fourteen-page document located in Attachment C, Need--I.A at the back of this application. It demonstrates that the project will meet or exceed every standard in those Guidelines.

This NICU's Medical Director, Dr. Ismael, is a highly trained Board-certified neonatologist whose Fellowship training was at the Medical College of Virginia in Richmond. He is Medical Director of the Level III NICU and Neonatal Transport Service at Centennial Women's and Children's Hospital. The group with which he practices, Pediatrix, directs medical care at five local hospitals in the region, through two large groups of neonatologists.

The HMC NICU will be staffed 24/7 not only with NICU-trained RN's, but also with Pediatrix neonatal nurse practitioners. The staffing of the NICU will vary with the needs and numbers of the infants on the unit; it will comply with the ratios of RN-to-infant prescribed in Perinatal System Guidelines Section III.B.3 (p. 11), which vary with the type of medical care needed by the infant. All staff education and training, and maintenance of staff competencies, will meet or exceed the State Perinatal Guidelines. The unit will work closely with the Centennial Women's and Children's Hospital in development, staff recruitment and training, and operations. The two NICU's will share

an existing electronic medical records and imaging system, and are planning a telemedicine connection to connect their staff and their subspecialists.

6. The target population shall have access to the proposed service in terms of payment for services, transportation, parking, geographical barriers, and access for the handicapped.

None of these considerations will be a barrier to neonatal care at TriStar Hendersonville Medical Center.

a. Payment for Services--These infants will have total financial accessibility to the proposed NICU at HMC. First, HMC's policy, like that of Centennial Women's and Children's Hospital, will be to provide all needed NICU care regardless of coverage. Second, almost all Tennessee newborns requiring NICU care already have, or can be quickly qualified for, insurance coverage from a commercial payor or from TennCare.

b. Transportation--Centennial Women's and Children's has long operated a ground emergency transport program for its NICU and this will provide network-wide service to NICU's at Summit, Smyrna, and Hendersonville as well. This vehicle is on call 24/7 and can leave for its destination within 30 minutes of notification. On board are typically a neonatal nurse practitioner, a registered nurse, and a respiratory therapist (where ventilator support is needed for the infant). The only exception to this is when the unit is "back-transporting" a stable infant to its home area after care at the NICU.

c. Parking, Handicapped Access, Geographic Barriers--None of these will be an issue at TriStar Hendersonville Medical Center. The entire campus is handicapped-accessible with ample parking for families. There is no geographic barrier to service area infants and their families reaching Hendersonville via either ambulance or personal vehicles.

Table Nine: NICU Bed Need by County in CY2017--Guidelines for Growth
Middle Tennessee Perinatal Services Area

COUNTY	TOTAL NUMBER	TOTAL RATE	Est. 2017 * 15-44 Pop.	Est. 2017 Births	Proj. Bed Needs	Approved Beds	Beds Reported or Scheduled to Open
REGION	**32,072**	**66.5**	**501,633**	**33,363**	**267**	**277**	**284**
BEDFORD	598	61.9	10,595	656	5		
CANNON	138	48.2	2,967	143	1		
CHEATHAM	429	51.0	8,806	449	4		
CLAY	81	53.2	1,513	80	1		
COFFEE	612	58.9	10,842	638	5		
DAVIDSON	9,601	78.6	120,914	9,504	76	230	232
DEKALB	222	62.2	3,638	226	2		
DICKSON	582	59.1	10,149	600	5		
FRANKLIN	390	45.4	9,033	410	3		
GILES	287	50.9	5,637	287	2		
HICKMAN	270	57.3	5,121	294	2		
HOUSTON	78	54.9	1,447	79	1		
HUMPHREYS	203	56.8	3,601	205	2		
JACKSON	107	51.4	2,113	109	1		
LAWRENCE	568	68.9	8,387	578	5		
LEWIS	120	52.8	2,329	123	1		
LINCOLN	354	56.7	6,356	360	3		
MACON	305	65.3	4,915	321	3		
MARSHALL	372	60.6	6,428	390	3		
MAURY	1,136	67.8	17,853	1,210	10	8	8
MONTGOMERY	3,042	88.8	36,404	3,231	26	12	12
MOORE	47	39.3	1,231	48	0		
OVERTON	268	67.4	4,006	270	2		
PERRY	102	75.5	1,367	103	1		
PUTNAM	898	62.3	14,750	919	7		
ROBERTSON	931	67.7	14,806	1,003	8		
RUTHERFORD	3,648	64.6	58,409	3,771	30	22	24
SMITH	231	59.0	4,070	240	2		
STEWART	133	48.7	2,946	143	1		
SUMNER	1,922	59.7	34,125	2,038	16		
TROUSDALE	94	57.7	1,701	98	1		
VAN BUREN	48	46.6	996	46	0		
WARREN	467	59.0	8,161	482	4		
WAYNE	132	46.3	2,874	133	1		
WHITE	306	64.1	4,847	311	2		
WILLIAMSON	2,012	53.0	43,383	2,300	18	5	8
WILSON	1,338	58.1	24,913	1,449	12		

Sources: Tennessee Department of Health, Office of Health Statistics; HSDA records; Jan 2013.

Notes:

1. Feb. 2008 Tennessee Population Series.
2. Birth data is number of resident births with general fertility rates (total births, all ages per 1000 females aged 15-44) for counties of Middle Tennesse, resident data, 2011.
3. Approved NICU bed data from applicant's review of HSDA records.
4. Reported & U.C.:

Vanderbilt	100.0	Wmson MC	8
CMC	60	MTMC	16
Baptist	52	StoneCrest	8
Metro NV	10	Gateway	12
So Hills	0	Maury	8
Summit	10		
Totals	232		52

The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.
Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

This project will relocate licensed medical-surgical beds within Sumner County to a location where they are more needed. The relocation is in accordance with bed need guidelines of the State Health Plan, which do not support increased licensed hospital bed complements in the service area.

The project will create a Neonatal Intensive Care Unit whose development, training and operational requirements will be supported by staff of the second largest NICU provider in Middle Tennessee (60-bed NICU at Centennial Medical Center), in a collaboration to help ensure optimal neonatal care outcomes.

2. Access to Care

Every citizen should have reasonable access to health care.
Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

The project will provide suburban and rural areas north of Davidson County with a high quality neonatal care resource that is more accessible than similar units in downtown Nashville. Drive times from the service area to those Nashville units are long, because of daily I-65 traffic "bottlenecks" between Hendersonville and downtown Nashville. An

NICU in Hendersonville will make it much easier for service area mothers to remain close to their infants when their newborns need brief Level II-B care before going home.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

This project will extend NICU services into suburban and rural sectors of the metropolitan service area, whose residents live far from NICU's at downtown Nashville hospitals. It will enable mothers delivering in local obstetrics programs to have a more comprehensive range of care for their infants, closer to their families.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

TriStar Hendersonville Medical Center is a good community hospital for introduction of such programs as NICU care. HMC is one of 96 HCA hospitals on the Joint Commission's List of 620 "Top Performers" nationwide—based on composite and individual scores of 95% or above on all reported accountability data. These accountability measures pertain to clinical practices correlated with better care outcomes.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

The project will require employment of highly trained and experienced nursing professionals, supporting these goals of creating a qualified healthcare workforce. It will require ongoing employee training to continuously maintain and improve caregiver skills.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

This project has three components--relocating HMC's own medical-surgical bed complements to where they can be better used to meet current and near-term demand; increasing LDRP capacity to improve the birthing experience for families now using HMC; and upgrading nursery care to NICU Level II-B through adding neonatologist supervision and staffing with neonatal nurse practitioners who will be in the nursery or onsite 24/7.

All three are consistent with the hospital's plan and mission to provide needed acute care services to its service area, where feasible and clinically appropriate. The need to relocate the beds from another campus and from the second floor is due to normal census growth and the operational benefit of concentrating orthopedic and other medical-surgical patients on a (new) 32-bed floor. The need to increase LDRP capacity is required to meet community preferences for that type of birthing experience. The NICU project fulfills the hospital's plan to offer all appropriate care for a service area whose mothers deliver almost 2,000 infants a year, more than half of them at the two hospitals in Sumner County.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

Current Service Areas

HMC - NICU App Subm - p 48-92

The hospital's current primary and secondary medi defined by counties, consist of Sumner, Davidson, Roberts (which generate 94.7% of HMC's non-perinatal admissions.) I consist of twelve zip codes based in those same counties. Th medical-surgical admissions (79.2% of admissions) is com populous Sumner County zip codes, plus the Goodlettsville a Davidson County. The secondary service area for medical-surg admissions) is comprised of two Robertson County zip codes, County zip codes, and the zip code for Lafayette in Macon Co admissions originate from other areas, no one of which con hospital medical-surgical admissions.

The hospital's current primary and secondary perinatal (newborn) service areas, defined by counties, consist of Sumner, Davidson, and Robertson Counties (which contribute 96.3% of HMC's births). Defined by zip codes, they consist of twelve zip codes based in those same three counties. The primary service area for perinatal care (80.0% of the hospital's births) is comprised of the four most populous Sumner County zip codes, plus the Goodlettsville and Madison zip codes in Davidson County. The secondary service area for perinatal care (12.3% of the hospital's births) is comprised of two Robertson County zip codes plus four additional Sumner County zip codes. Another 7.8% of the births originate from other areas, no one of which contributes 1% of the total hospital births.

Tables Nine-A and Nine-B on the following page provide the relevant current service area data for both perinatal care and medical-surgical care.

Table Nine-A: TriStar Hendersonville Medical Center CY2012 Service Areas by County—Births & Medical-Surgical Admissions					
		Newborn Services		**Medical-Surgical IP Services**	
County		*Births*	*Percent*	*Admissions*	*Percent*
Sumner		472	69.7%	3,938	70.9%
Davidson		107	15.8%	678	12.2%
Robertson		73	10.8%	477	8.6%
Macon		--	--	169	3.0%
Subtotal		*652*	*96.3%*	*5,093*	*94.7%*
Other Co's		25	3.7%	459	8.3%
Total		*677*	*100.0%*	*5,552*	*100.0%*

Table Nine-B: TriStar Hendersonville Medical Center CY2012 Service Areas by Zip Code—Births & Medical-Surgical Admissions					
		Newborn Services		**Med-Surg IP Services**	
Zip Code	*Name of Zip/County*	*Births*	*Percent*	*Admissions*	*Percent*
37075	Hendersonville (S)	217	32.1%	2,482	44.7%
37066	Gallatin (S)	133	19.7%	740	13.3%
37148	Portland (S)	70	10.3%	376	6.8%
37072	Goodlettsville (D)	52	7.7%	358	6.5%
37188	White House (S)	36	5.3%	298	5.4%
37115	Madison (D)	33	4.9%	140	2.5%
	PSA Subtotal	*541*	*80.0%*	*4,394*	*79.2%*
37172	Springfield (R)	19	2.8%	72	1.3%
37186	Westmoreland (S)	17	2.5%	98	1.8%
37048	Cottontown (S)	17	2.5%	123	2.2%
37073	Greenbrier (R)	12	1.8%	54	1.0%
37022	Bethpage (S)	10	1.5%	66	1.2%
37071	Castalian Springs(S)	8	1.2%	--	--
37083	Lafayette (M)	--	--	137	2.5%
	SSA Total	*83*	*12.3%*	*550*	*10.0%*
	Other	53	7.8%	608	11.0%
	Total	*677*	*100.1%*	*5,552*	*100.2%*

Source: Hospital records

Notes:

1.County name abbreviated: S=Sumner; D=Davidson; R=Robertson; M=Macon

2. Totals do not exactly equal 100% due to rounding of individual percentages.

Maps showing the service area and the location of the service within the State of Tennessee are provided as Attachments C, Need--3 at the back of the application.

Proposed Service Areas

The applicant does not project significant changes in its medical-surgical service area, resulting from this project. Its admissions at the main campus since 2009 have included the great majority of the population living in Sumner County in the far north Davidson County communities of Goodlettsville and Madison, and in the eastern edge of Robertson County. The relocation of medical-surgical beds from a dormant inpatient program in Portland (the western part of Sumner County) to Hendersonville (southern Sumner County) should not alter patient origin for medical-surgical care.

The NICU project is unlikely to alter the hospital's obstetrics service area either, whether regarded on a county level or a zip code level. Hendersonville's obstetrics program is growing rapidly and already draws from the zip codes in its area that have the largest population of women of child-bearing age (15-44 years).

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

Please see Table Ten on the following page. It shows that between 2013 and 2017, the three-county service area (in terms of entire counties) will increase 3.4% in population, with less than a 1% increase in the population of childbearing women. But this is misleading, because the only parts of Davidson County that are part of the service area are the far northern edges in Goodlettsville and Madison. Those areas more closely resemble Sumner and Robertson Counties in their demographics with respect to female populations.

Focusing on Sumner and Robertson Counties, from which most of this project's patients reside, a very different picture emerges. There, the total population will be increasing 5%-6% over the projection period, and within that the female population ages 15-44 (childbearing age) will increase 4%-5%. In those two counties, residents living below the poverty level are 10% to 13% of the total population; and 14% to 17% of the counties' populations are in TennCare.

Table Ten: Demographic Characteristics of Primary Service Area Counties
Hendersonville Medical Center
2013-2017

Demographic	Sumner County	Davidson County	Robertson County	PRIMARY SERVICE AREA	STATE OF TENNESSEE
Median Age-2010 US Census	38.6	33.9	37.6	36.7	38.0
Total Population-2013	164,575	605,923	69,680	840,178	6,361,070
Total Population-2017	172,718	622,476	73,853	869,047	6,575,165
Total Population-% Change 2013 to 2017	4.9%	2.7%	6.0%	3.4%	3.4%
Age 65+ Population-2013	21,732	72,486	8,329	102,547	878,496
% of Total Population	13.2%	12.0%	12.0%	12.2%	13.8%
Age 65+ Population-2017	24,948	81,389	9,711	116,048	987,074
% of Population	14.4%	13.1%	13.1%	13.4%	15.0%
Age 65+ Population-% Change 2013-2017	14.8%	12.3%	16.6%	13.2%	12.4%
Women Age 15-44 Population--2013	32,808	121,587	14,089	168,484	1,267,193
% of Population	19.9%	20.1%	20.2%	20.1%	19.9%
Women Age 15-44 Population--2017	34,125	120,914	14,806	169,845	1,287,243
% of Population	19.8%	19.4%	20.0%	19.5%	19.6%
Women Age 15-44 % Change 2013-2017	4.0%	-0.6%	5.1%	0.8%	1.6%
Median Household Income	$55,211	$46,737	$50,579	$50,842	$43,314
TennCare Enrollees (08/12)	23,292	120,668	11,510	155,470	1,211,113
Percent of 2012 Population Enrolled in TennCare	14.2%	19.9%	16.5%	18.5%	19.0%
Persons Below Poverty Level (2013)	16,293	107,248	9,198	132,739	1,049,577
Persons Below Poverty Level As % of Population (US Census)	9.9%	17.7%	13.2%	15.8%	16.5%

Sources: TDH Population Projections, Feb. 2008; U.S. Census QuickFacts and FactFinder2; TennCare Bureau. PSA data is unweighted average or total of county data.
NR means not reported in U.S. Census source document.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

With respect to the NICU component of the application, the young couples in this area one-half hour north of downtown Nashville need NICU care locally for their Level II-B moderately vulnerable or ill infants. Those newborns spend their first several weeks of life in an NICU bassinet; and both the infants and their parents need the best possible access to one another where feasible and safe—as proposed in this project. The healthcare system also needs to minimize emergency neonatal transport where feasible, and to shorten the time it now takes for II-B infants in the area to be transported to NICU care in downtown Nashville.

This is a need of all income groups in the community, who are of childbearing age. Addressing it through this project will benefit all young couples and families in the area regardless of their insurance coverage, because these infants will have total access to care in the HMC II-B NICU.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

This project does not increase the number of licensed hospital beds in the service area, or even the number of medical-surgical beds licensed to this two-campus hospital.

Table Eleven on the next page shows overall utilization of the three hospitals within the project service area counties. The project constructs just medical-surgical and LDRP beds. But total inpatient utilization is shown in the table because there is not enough publicly available data to break out utilization by type of bed. Davidson County hospitals are not included because that large bloc of data is irrelevant: The project will draw only from the two northern zip codes in Davidson County, neither of which contains a hospital.

Table Eleven: Primary Service Area Hospital Bed Utilization 2009-2011

2009	Lic. Beds	Admiss.	Days	ADC	Occ'y
Hendersonville Med Cntr	110	4,652	18,476	50.6	46.0%
Sumner Regl Med Cntr	155	6,178	27,574	75.5	48.7%
Northcrest Hospital	109	4,749	19,904	54.5	50.0%

2010	Lic. Beds	Admiss.	Days	ADC	Occ'y
Hendersonville Med Cntr	110	4,608	17,618	48.3	43.9%
Sumner Regl Med Cntr	155	6,837	27,359	75.0	48.3%
Northcrest Hospital	109	5,247	18,622	51.0	46.8%

2011	Lic. Beds	Admiss.	Days	ADC	Occ'y
Hendersonville Med Cntr	110	4,748	18,732	51.3	46.6%
Sumner Regl Med Cntr	155	6,566	26,274	72.0	46.4%
Northcrest Hospital	109	3,836	15,747	43.1	39.6%

Source: Joint Annual Reports

Notes:

1. *(S) indicates Sumner County; (R) indicates Robertson County*
2. *JAR days reported by Sumner Regional and Northcrest are discharge days. so HMC days in Table Eleven above are also discharge days--which are slightly larger than the patient day data showing department level bed utilization in Tables 14A-B and presented in other parts of this application.*
3. *HMC beds and utilization are at main campus. The Portland satellite campus had no inpatient admissions after 2008.*

Table Twelve below provides 2009-2012 size and utilization data for all existing and approved NICU units in the 37-county Middle Tennessee Perinatal Planning Area.

There was a rapid increase from 2011 to 2012 (6.5%) in NICU utilization, and a 12.2% increase that year in the combined Level III NICU programs (which also treat large numbers of Level II-B infants).

The patient days in area NICU's were "flat" for several years, but in 2011-2012 resumed overall annual growth. In this period of time, restrictions were placed on physicians' induction of labor for premature babies, which reduced infant complications at birth. However, NICU demand is again on the rise. One factor is the normal population growth of childbearing-age women (strongest in suburban areas like this project's service area.). Another is that II-B infant days are expected to increase when hospitals begin testing all newborns for residual drugs in their system, to identify more at-risk newborns. Such newborns will utilize the II-B nursery for 28-day observation stays or transfer to Level III care in some cases.

Table Twelve: Utilization of Neonatal Intensive Care Beds (Levels II-B & III)
Middle Tennessee Perinatal Region
2009-2012

NICU PROVIDER, HIGHEST LEVEL OF NICU CARE, LOCATION	AS OF 2013: CON APPROVED BEDS	2009				2010				2011				2012 Provisional			
		REPORTED BEDS	DAYS	ADC	OCC'Y	REPORTED BEDS	DAYS	ADC	OCC'Y	REPORTED BEDS	DAYS	ADC	OCC'Y	REPORTED BEDS	DAYS	ADC	OCC'Y
Vanderbilt Medical Center III & II-B	**98**	78	24,755	67.8	87.0%	**77**	24,106	66.0	85.8%	**83**	25,666	70.3	84.7%	**100**	29,611	81.1	81.1%
Nashville / Davidson County																	
Centennial Medical Center III & II-B	**60**	60	15,956	43.7	72.9%	**60**	15,539	42.6	71.0%	**60**	12,959	35.5	59.2%	**60**	15,312	42.0	69.9%
Nashville / Davidson County																	
Baptist Hospital III & II-B	**52**	52	10,184	27.9	53.7%	**52**	9,602	26.3	50.6%	**52**	9,747	26.7	51.4%	**52**	9,353	25.6	49.3%
Nashville / Davidson County																	
Metro General Hospital II-B	**10**	10	926	2.5	25.4%	**10**	668	1.8	18.3%	**10**	759	2.1	20.8%	**10**	757	2.1	20.7%
Nashville / Davidson County																	
Southern Hills Medical Center II-B*	**0**	6	0	0.0	0.0%	**0**	0	0.0	0.0%	**6**	0	0.0	0.0%	**6**	0	0.0	0.0%
Nashville / Davidson County																	
Summit Medical Center II-B	**10**	10	786	2.2	21.5%	**10**	825	2.3	22.6%	**10**	976	2.7	26.7%	**10**	750	2.1	20.5%
Hermitage / Davidson County																	
Middle TN Medical Center II-B	**16**	13	3,085	8.5	65.0%	**16**	2,875	7.9	49.2%	**16**	3,230	8.8	55.3%	**16**	3,048	8.4	52.2%
Murfreesboro / Rutherford County																	
StoneCrest Medical Center II-B*	**6**																
Smyrna / Rutherford County																	
Maury Regional Medical Center II-B	**8**	8	1,752	4.8	60.0%	**8**	1,060	2.9	36.3%	**8**	1,048	2.9	35.9%	**8**	902	2.5	30.9%
Columbia / Maury County																	
Gateway Medical Center II-B	**12**	12	2,088	5.7	47.7%	**12**	2,016	5.5	46.0%	**12**	1,587	4.3	36.2%	**12**	NR	NR	NR
Clarksville / Montgomery County																	
Williamson Medical Center II-B	**5**	5	737	2.0	40.4%	**5**	644	1.8	35.3%	**5**	1,047	2.9	0.0%	**8**	1,004	2.8	34.4%
Franklin / Williamson County																	
PERINATAL REGION TOTAL	**277**	254	60,269	165.1	65.0%	250	57,335	157.1	62.8%	**262**	57,019	156.2	59.6%	**282**	60,737	166.4	59.0%

Sources: 2009-2012 TDH Joint Annual Reports and 2012 HCA hospital records.
**During CY2013, Stonecrest in Rutherford County will open its 6 approved beds and Southern Hills will delicense its 6 beds.*
So the proisional 2012 Provisional area totals are accurate assuming that the Clarksville NICU has maintained its 2011 complement at 12 beds.

2012 = 6.5% increase in NICU days without Gateway Clksv. days for 2012

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

Tables Fourteen-A and Fourteen-B on the third and fourth following pages provide historical and projected bed utilization data for the applicant, by bed category. Historical data are from the HMC Joint Annual Reports and the hospital's own records. Projections were made using the following conservative methodologies. The resulting data totals to the overall hospital bed utilization section at the top of the tables.

1. Medical-Surgical Beds: The average annual increase in admissions over the past three years (average gain of 174/year from 2009-2012) was added each projection year, and a 4.5 day average length of stay (ALOS) was assumed based also on the historical average. Observation days were projected on the same basis (average historical gain of 146/year).

2. Critical Care Beds: The average annual increase in admissions over the past three years (average gain of 130/year from 2009-2012) was added each projection year, and a 3.06 day average length of stay (ALOS) was assumed based also on the historical average. (The ALOS shows on the table as 3.1 due to rounding). Observation days were projected on the basis of their average historical level of 87 such days per year (no increase projected).

3. LDRP and Postpartum Beds: The methodology here is best illustrated in the table on the following page.

a. Columns 1-3: Total births were first projected by adding 32 per year to the base year of CY2012, through CY 2018 (Year Two of project). The hospital has had approximately 32 additional births per year recently as current OB staff practices have grown.

b. Columns 4-5: An additional 110 births per year were added in CY2014 and again in CY2015 to reflect the addition of two obstetricians joining the staff the prior year. One is committed; one is being recruited. The last two OB's who were recruited added an average of approximately 110 births annually to the hospital.

c. Columns 6-7: The resulting total births were divided between the LDRP's and the postpartum beds, to reflect projected normal vs. C-section deliveries. LDRP's are not used for expected C-section admissions.

d. Columns 8-9: A small number of other admissions to the postpartum beds were added each projection year, reflecting 119 such admissions in CY2012, increasing at their historical average increase of 4 per year (Gyn; plastic surgery; etc.).

Table Thirteen: Methodology for Projecting OB Department Bed Utilization

1	2	3	4	5	6	7	8	9
Year	Actual or Projected Births	Av'ge Annual Increase	Increase from new OB staff	Total Increase from Prior Yr	Births to LDRP	Births to Post Partum	Other Admits to Post Partum	Total Post Partum Admits
2012	670	--	--	--	--	--	119	--
2013	702	+32	0	+32	470	232	123	355
2014	844	+32	+110	+142	574	270	127	397
2015	986	+32	+110	+142	675	311	131	442
2016	1,018	+32	0	+32	702	316	135	451
2017	1,050	+32	0	+32	724	326	139	465
2018	1,082	+32	0	+32	747	335	143	478

Source: Hospital management.
Note: Assumes births equal maternal admissions in columns 6 & 7; declining C-section rate through 2016.

The methodology included no observation days for postpartum beds, but included observation days in the LDRP area based on adding 2 days annually to the 2012 experience. The LDRP ALOS was held constant with prior years; the postpartum ALOS was the average of the last three years.

4. NICU Beds: This is a new service. Its Year One admissions were projected on the basis of 9% of births. Its Year Two admissions were projected as 9% of HMC births plus

14 more admissions of estimated births occurring at a similar hospital in Sumner County, which also does not offer II-B NICU care.

The 9% factor was identified by the clinician teams of Women and Children's Hospital and HMC, as a reasonable planning factor for babies born at HMC. It was based on reviews of medical records of II-B infants transported to Women's and Children's after having been born at HMC.

NICU length of stay is estimated from the experience with II-B care at two Nashville HCA NICU's (Women's and Children's and Summit Medical Center).

The Year Two addition of 14 admissions of II-B infants born at the other hospital in Sumner County assumes receipt of 25% of the other Sumner County hospital's II-B transports, due to family preference for having II-B care closer to home, rather than in Nashville. That other hospital's II-B infants were projected as equal to those of HMC, since the two hospitals are estimated to have had almost identical numbers of births in CY2012 (full year data is not yet available).

Table Fourteen-A: Hendersonville Medical Center
Actual Utilization of Licensed Beds at Main Campus, CY 2009-CY 2012
With Comparison Table for Available Medical-Surgical Beds

	Actual 2009	Actual 2010	Actual 2011	Actual 2012
Total Beds	110	110	110	110
Admissions	4,564	4,550	4,718	5,522
Patient Days	18,221	17,468	18,748	20,323
ALOS on Admissions	3.99	3.84	3.97	3.68
ADC on Admissions	49.92	47.86	51.36	55.53
Occupancy on Admissions	45.4%	43.5%	46.7%	50.5%
23-Hour Observation Days	976	1,356	2,097	1,376
Total Bed Days	19,197	18,824	20,845	21,699
Total ADC	52.59	51.57	57.11	59.45
Total Occupancy	47.8%	46.9%	51.9%	54.0%
Medical-Surgical Beds	84	84	84	74
Admissions	3,004	2,994	3,218	3,527
Patient Days	14,017	13,365	14,437	15,177
ALOS on Admissions	4.7	4.5	4.5	4.3
ADC on Admissions	38.4	36.6	39.6	41.6
Occupancy on Admissions	45.7%	43.6%	47.1%	56.2%
23-Hour Observation Days	753	1,137	1,845	1,191
Total Bed Days	14,770	14,502	16,282	16,368
Total ADC	40.5	39.7	44.6	44.8
Total Occupancy	48.2%	47.3%	53.1%	60.6%
Critical Care Beds	10	10	10	20
Admissions	816	838	803	1,206
Patient Days	2,538	2,481	2,764	3,440
ALOS on Admissions	3.1	3.0	3.4	2.9
ADC on Admissions	7.0	6.8	7.6	9.4
Occupancy on Admissions	69.5%	68.0%	75.7%	47.1%
23-Hour Observation Days	81	78	114	77
Total Bed Days	2,619	2,559	2,878	3,517
Total ADC	7.2	7.0	7.9	9.6
Total Occupancy	71.8%	70.1%	78.8%	48.2%
Labr/Del/Recov/Dschg (LDRP) Beds	6	6	6	6
Admissions	437	392	413	444
Patient Days	909	815	859	924
ALOS on Admissions	2.1	2.1	2.1	2.1
ADC on Admissions	2.5	2.2	2.4	2.5
Occupancy on Admissions	41.5%	37.2%	39.2%	42.2%
23-Hour Observation Days	142	141	138	108
Total Bed Days	1,051	956	997	1,032
Total ADC	2.9	2.6	2.7	2.8
Total Occupancy	48.0%	43.7%	45.5%	47.1%
Postpartum Beds	10	10	10	10
Admissions	307	326	284	345
Patient Days	757	807	688	782
ALOS on Admissions	2.5	2.5	2.4	2.3
ADC on Admissions	2.1	2.2	1.9	2.1
Occupancy on Admissions	20.7%	22.1%	18.8%	21.4%
23-Hour Observation Days				
Total Bed Days	757	807	688	782
Total ADC	2.1	2.2	1.9	2.1
Total Occupancy	20.7%	22.1%	18.8%	21.4%
NICU Beds	0	0	0	0
Admissions				0
Patient Days				0
ALOS on Admissions				
ADC on Admissions				
Occupancy on Admissions				
23-Hour Observation Days				
Total Bed Days				
Total ADC				
Total Occupancy				

Note: See Table below for utilization of the AVAILABLE med-surg beds at this hospital.

Medical-Surgical Beds AVAILABLE	56	56	55	55
Admissions	3,004	2,994	3,218	3,527
Patient Days	14,017	13,365	14,437	15,177
ALOS on Admissions	4.7	4.5	4.5	4.3
ADC on Admissions	38.4	36.6	39.6	41.6
Occupancy on Admissions	68.6%	65.4%	71.9%	75.6%
23-Hour Observation Days	753	1,137	1,845	1,191
Total Bed Days	14,770	14,502	16,282	16,368
Total ADC	40.5	39.7	44.6	44.8
Total Occupancy	72.3%	70.9%	81.1%	81.5%

Source: Hospital management. Days are patient days, not the larger discharge days reported on p. 25 of the JAR.

Table Fourteen-B: Hendersonville Medical Center
Projected Utilization of Licensed Beds, CY 2013-2018
With Comparison Table for Available Medical-Surgical Beds

					Year One	Year Two
	Proj. 2013	Proj. 2014	Proj. 2015	Proj. 2016	Proj. 2017	Proj. 2018
Total Beds	110	110	110	110	123	123
Admissions	5,862	6,312	6,762	7,102	7,537	7,893
Patient Days	22,582	24,082	25,583	26,842	28,102	29,363
ALOS on Admissions	3.9	3.8	3.8	3.8	4	4
ADC on Admissions	61.9	66.0	70.1	73.3	77.0	80.4
Occupancy on Admissions	56.2%	60.0%	63.7%	66.7%	62.6%	65.4%
23-Hour Observation Days	1,534	1,682	1,830	1,978	2,126	2,274
Total Bed Days	24,116	25,764	27,413	28,820	31,465	33,082
Total ADC	66.1	70.6	75.1	78.7	86.2	90.6
Total Occupancy	60.1%	64.2%	68.3%	71.6%	70.1%	73.7%
Medical-Surgical Beds	74	74	74	74	83	83
Admissions	3,701	3,875	4,049	4,223	4,397	4,571
Patient Days	16,655	17,438	18,221	19,004	19,787	20,570
ALOS on Admissions	4.5	4.5	4.5	4.5	4.5	4.5
ADC on Admissions	45.6	47.8	49.9	51.9	54.2	56.4
Occupancy on Admissions	61.7%	64.6%	67.5%	70.2%	65.3%	67.9%
23-Hour Observation Days	1,337	1,483	1,629	1,775	1,921	2,067
Total Bed Days	17,992	18,921	19,850	20,779	21,708	22,637
Total ADC	49.3	51.8	54.4	56.8	59.5	62.0
Total Occupancy	66.6%	70.0%	73.5%	76.7%	71.7%	74.7%
Critical Care Beds	20	20	20	20	20	20
Admissions	1,336	1,466	1,596	1,726	1,856	1,986
Patient Days	4,088	4,486	4,884	5,282	5,679	6,077
ALOS on Admissions	3.1	3.1	3.1	3.1	3.1	3.1
ADC on Admissions	11.2	12.3	13.4	14.4	15.6	16.6
Occupancy on Admissions	56.0%	61.5%	66.9%	72.2%	77.8%	83.2%
23-Hour Observation Days	87	87	87	87	87	87
Total Bed Days	4,175	4,573	4,971	5,369	5,766	6,164
Total ADC	11.4	12.5	13.6	14.7	15.8	16.9
Total Occupancy	57.2%	62.6%	68.1%	73.3%	79.0%	84.4%
Labr/Del/Recov/Disch (LDRP) Beds	6	6	6	6	10	10
Admissions	470	574	675	702	724	747
Patient Days	987	1,205	1,418	1,474	1,520	1,569
ALOS on Admissions	2.1	2.1	2.1	2.1	2.1	2.1
ADC on Admissions	2.7	3.3	3.9	4.0	4.2	4.3
Occupancy on Admissions	45.1%	55.0%	64.7%	67.1%	41.7%	43.0%
23-Hour Observation Days	110	112	114	116	118	120
Total Bed Days	1,097	1,317	1,532	1,590	1,638	1,689
Total ADC	3.0	3.6	4.2	4.3	4.5	4.6
Total Occupancy	50.1%	60.2%	69.9%	72.4%	44.9%	46.3%
Postpartum Beds	10	10	10	10	4	4
Admissions	355	397	442	451	465	478
Patient Days	852	953	1,061	1,082	1,116	1,147
ALOS on Admissions	2.4	2.4	2.4	2.4	2.4	2.4
ADC on Admissions	2.3	2.6	2.9	3.0	3.1	3.1
Occupancy on Admissions	23.3%	26.1%	29.1%	29.6%	76.4%	78.6%
23-Hour Observation Days						
Total Bed Days	852	953	1,061	1,082	1,116	1,147
Total ADC	2.3	2.6	2.9	3.0	3.1	3.1
Total Occupancy	23.3%	26.1%	29.1%	29.6%	76.4%	78.6%
NICU Beds	0	0	0	0	6	6
Admissions					95	111
Patient Days					1,237	1,445
ALOS on Admissions					13.0	13.0
ADC on Admissions					3.4	4.0
Occupancy on Admissions					56.5%	66.0%
23-Hour Observation Days					0	0
Total Bed Days					1,237	1,445
Total ADC					3.4	4.0
Total Occupancy					56.5%	66.0%

Note: See Table below for utilization of the AVAILABLE med-surg beds at this hospital.

Medical-Surgical Beds AVAILABLE	60	60	60	60	83	83
Admissions	3,701	3,875	4,049	4,223	4,397	4,571
Patient Days	16,655	17,438	18,221	19,004	19,787	20,570
ALOS on Admissions	4.5	4.5	4.5	4.5	4.5	4.5
ADC on Admissions	45.6	47.8	49.9	51.9	54.2	56.4
Occupancy on Admissions	76.0%	79.6%	83.2%	86.5%	65.3%	67.9%
23-Hour Observation Days	1,337	1,483	1,629	1,775	1,921	2,067
Total Bed Days	17,992	18,921	19,850	20,779	21,708	22,637
Total ADC	49.3	51.8	54.4	56.8	59.5	62.0
Total Occupancy	82.2%	86.4%	90.6%	94.6%	71.7%	74.7%

Source: Hospital management. Days are patient days, not the larger discharge days reported on p. 25 of the JAR.

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1.

On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, were estimated by the applicant.

Line A.5, construction cost, and line A.6, contingency were estimated by the architect working with the HCA corporate office design and construction staff.

Line A.7 includes both fixed and moveable equipment costs, estimated by HCA's corporate office of equipment planning. The project contains no major medical equipment or equipment items over $50,000 in price.

Line A.9 includes such costs as miscellaneous fees and overhead, information and telecommunications systems, and corporate preplanning expenses.

Line E9, filing fee, is the maximum review fee under CON rules.

PROJECT COSTS CHART – HENDERSONVILLE MEDICAL CENTER BEDS & NICU PROJECT

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A. Construction and equipment acquired by purchase:

1. Architectural and Engineering Fees		$ 1,333,416
2. Legal, Administrative, Consultant Fees (Excl CON Filing)		50,000
3. Acquisition of Site		0
4. Preparation of Site		600,000
5. Construction Cost		21,068,150
6. Contingency Fund		2,166,511
7. Fixed Equipment (Not in Construction Contract)	in A8	
8. Moveable Equipment (List all equipment over $50,000)		3,236,570
9. Other (Specify) IS, telecom; envir/testg/bldg fees and preplanning expense		2,310,480

B. Acquisition by gift, donation, or lease:

1. Facility (inclusive of building and land)	0
2. Building only	0
3. Land only	0
4. Equipment (Specify)	0
5. Other (Specify)	0

C. Financing Costs and Fees:

1. Interim Financing	1,444,873
2. Underwriting Costs	0
3. Reserve for One Year's Debt Service	0
4. Other (Specify)	0

D. Estimated Project Cost (A+B+C) 32,210,000

E. CON Filing Fee 45,000

F. Total Estimated Project Cost (D+E) TOTAL $ 32,255,000

Actual Capital Cost	32,255,000
Section B FMV	0

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

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a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

_____A. Commercial Loan—Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
_____B. Tax-Exempt Bonds—copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
_____C. General Obligation Bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting;
_____D. Grants—Notification of Intent form for grant application or notice of grant award;
__x__E. Cash Reserves—Appropriate documentation from Chief Financial Officer; or
_____F. Other—Identify and document funding from all sources.

The project will be funded/financed by HCA (the hospital's parent company) by a cash transfer through TriStar Health Services, the applicant's Division Office. Documentation of financing is provided in Attachment C, Economic Feasibility--2.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The justification of costs was provided in an earlier section, which is repeated here:

Hospital construction projects approved by the HSDA in 2009-2011 had the following construction costs per SF:

Table Four: Hospital Construction Cost PSF
Years: 2009 – 2011

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

Source: HSDA, from CON approved applications during 2009-2011.

This project, which is priced for a CY 2014-2016 construction period, is consistent with the HSDA's 2009-2011 average cost ranges, when five years of future cost inflation are taken into account. The project construction cost by the time it opens in 2016 is projected to be approximately $362 PSF overall.

However, this includes some other campus construction that will be undertaken at the same time, but is only partly related to this project--upgrading of the campus's powerhouse and some major structural upgrades to the 35-year-old facility in several areas. If those components are excluded, the 2016 final construction cost will be $329 PSF, only 9% above the 2009-2011 third quartile average.

Table Five: This Project's Construction Costs

	Renovation	New Construction	Total Project
Square Feet	36,394 SF	21,871 SF	58,265 SF
Construction Cost			$21,068,150
Constr. Cost PSF			$361.66

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES—DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable.

HISTORICAL DATA CHART--HENDERSONVILLE MEDICAL CENTER (COMBINED CAMPUSES)

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

		Year 2010	Year 2011	Year 2012
A.	Utilization Data (JAR discharge days)	17,618	18,732	20,434
B.	Revenue from Services to Patients			
1.	Inpatient Services	$ 145,757,447	174,768,200	205,649,595
2.	Outpatient Services	196,876,721	215,348,899	236,720,160
3.	Emergency Services	32,505,687	36,069,363	42,575,090
4.	Other Operating Revenue (Specify) See notes	264,439	230,349	249,951
	Gross Operating Revenue	$ 375,404,294	$ 426,416,811	$ 485,194,796
C.	Deductions for Operating Revenue			
1.	Contractual Adjustments	$ 284,067,950	323,626,378	371,036,792
2.	Provision for Charity Care	419,897	5,642,674	6,655,715
3.	Provisions for Bad Debt	7,927,539	8,622,535	13,554,895
	Total Deductions	$ 292,415,386	$ 337,891,587	$ 391,247,402
	NET OPERATING REVENUE	$ 82,988,908	$ 88,525,224	$ 93,947,394
D.	Operating Expenses			
1.	Salaries and Wages	$ 24,009,524	24,792,121	26,189,401
2.	Physicians Salaries and Wages			
3.	Supplies	11,945,622	13,871,100	14,001,256
4.	Taxes	325,112	274,521	360,268
5.	Depreciation	4,622,957	4,216,643	4,339,332
6.	Rent	684,083	437,046	420,767
7.	Interest, other than Capital	(500,939)	(784,150)	(1,070,704)
8.	Management Fees			
	a. Fees to Affiliates	6,138,604	6,013,768	5,568,770
	b. Fees to Non-Affiliates			
9.	Other Expenses (Specify) See notes	22,105,586	24,123,988	26,313,756
	Total Operating Expenses	$ 69,330,549	72,945,037	76,122,846
E.	Other Revenue (Expenses) -- Net (Specify)	$	$	$
	NET OPERATING INCOME (LOSS)	$ 13,658,359	$ 15,580,187	$ 17,824,548
F.	Capital Expenditures			
1.	Retirement of Principal	$	$	$
2.	Interest			
	Total Capital Expenditures	$ 0	$ 0	$ 0
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$ 13,658,359	$ 15,580,187	$ 17,824,548

Hendersonville Medical Center
Historical Expense (Other)

	Combined		
	2010	2011	2012
Contract Labor	389,768	931,345	1,021,158
Employee Benefits	6,155,641	6,453,044	7,400,234
Professional Fees	223,880	559,577	746,081
Contract Services	9,441,194	10,035,089	10,836,244
Repairs & Maintenance	2,518,773	2,465,419	2,630,574
Utilities	1,273,793	1,391,753	1,355,628
Insurance	606,886	609,073	635,480
Interest Income	(10,770)	(14,391)	(10,816)
Gain/Loss Sale of Assets	7,002	6,351	(4,804)
Other Income/Expense	-	-	(2,742)
Legal & Accounting	87,478	100,103	200,760
Marketing	335,213	340,003	298,842
Postage/Transportation	136,049	132,663	128,825
Travel, Meals & Entertainment	167,693	158,943	172,680
Dues/Subscriptions	93,012	88,181	97,434
Education/Development	(33,962)	19,970	20,977
Employee Recruitment	8,949	5,043	528
Physician Recruitment	407,813	545,022	380,284
Contributions	11,010	14,732	42,122
Software	169,473	130,049	196,594
Licenses & Permits	61,082	47,697	50,166
Other	55,609	104,322	117,507
		-	
	22,105,586	24,123,988	26,313,756

PROJECTED DATA CHART

HENDERSONVILLE MEDICAL CENTER (Combined Campuses Including NICU)

Give information for the two (2) years following the completion of this proposal.

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The fiscal year begins in January.

			Year 2017	Year 2018
		Admissions	7,537	7,893
A.	Utilization Data	Patient Days	28,102	29,363
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 415,937,275	$ 463,084,796
	2. Outpatient Services		394,975,649	431,681,633
	3. Emergency Services		86,701,972	94,759,383
	4. Other Operating Revenue	(See Historical Notes)	285,000	290,000
		Gross Operating Revenue	$ 897,899,896	$ 989,815,812
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 737,347,573	$ 820,670,474
	2. Provision for Charity Care		12,341,140	13,610,757
	3. Provisions for Bad Debt		25,087,633	27,656,832
		Total Deductions	$ 774,776,346	$ 861,938,063
NET OPERATING REVENUE			$ 123,123,550	$ 127,877,750
D.	Operating Expenses			
	1. Salaries and Wages		$ 36,263,114	$ 37,823,758
	2. Physicians Salaries and Wages		438,000	447,000
	3. Supplies		19,326,331	20,233,182
	4. Taxes		458,959	480,163
	5. Depreciation		5,523,935	5,603,935
	6. Rent		520,398	530,806
	7. Interest, other than Capital		(1,070,704)	(1,220,704)
	8. Management Fees		-	-
	a. Fees to Affiliates		5,568,770	5,568,770
	b. Fees to Non-Affiliates		-	-
	9. Other Expenses (Specify)	See notes	34,165,194	35,397,730
		Total Operating Expenses	$ 101,193,997	$ 104,864,640
E.	Other Revenue (Expenses) -- Net (Specify)		$ -	$ -
NET OPERATING INCOME (LOSS)			$ 21,929,553	$ 23,013,110
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 21,929,553	$ 23,013,110

Hendersonville Medical Center
Projected Expense (Other)

	Combined	
	2017	2018
Contract Labor	835,890	852,634
Employee Benefits	10,244,852	10,686,344
Professional Fees	968,948	1,003,878
Contract Services	13,976,969	14,482,392
Repairs & Maintenance	3,353,982	3,549,969
Utilities	1,728,426	1,816,542
Insurance	828,237	873,543
Interest Income	-	-
Gain/Loss Sale of Assets	-	-
Other Income/Expense	-	-
Legal & Accounting	248,494	261,162
Marketing	469,922	399,929
Postage/Transportation	142,260	145,095
Travel, Meals & Entertainment	190,639	194,438
Dues/Subscriptions	107,567	109,711
Education/Development	23,159	23,620
Employee Recruitment	5,520	5,630
Physician Recruitment	591,677	535,250
Contributions	46,503	47,429
Software	217,040	221,365
Licenses & Permits	55,383	56,487
Other	129,728	132,313
	34,165,194	35,397,730

PROJECTED DATA CHART-HMC NICU

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

2013 FEB 14 PM 2 18

		Year 2017	Year 2018
	Admissions	95	111
A. Utilization Data	Patient Days	1,237	1,445
B. Revenue from Services to Patients			
1. Inpatient Services		$ 4,247,000	$ 5,310,000
2. Outpatient Services			
3. Emergency Services			
4. Other Operating Revenue (Specify)			
	Gross Operating Revenue	$ 4,247,000	$ 5,310,000
C. Deductions for Operating Revenue			
1. Contractual Adjustments		$ 2,022,000	$ 2,642,000
2. Provision for Charity Care		102,000	127,000
3. Provisions for Bad Debt		118,000	148,000
	Total Deductions	$ 2,242,000	$ 2,917,000
NET OPERATING REVENUE		$ 2,005,000	$ 2,393,000
D. Operating Expenses			
1. Salaries and Wages		$ 607,000	$ 619,000
2. Physicians Salaries and Wages		438,000	447,000
3. Supplies		245,000	292,000
4. Taxes		10,000	11,000
5. Depreciation		142,835	142,835
6. Rent			
7. Interest, other than Capital			
8. Management Fees			
a. Fees to Affiliates			
b. Fees to Non-Affiliates			
9. Other Expenses (Specify)	See notes	252,000	262,000
	Total Operating Expenses	$ 1,694,835	$ 1,773,835
E. Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)		$ 310,165	$ 619,165
F. Capital Expenditures			
1. Retirement of Principal		$	$
2. Interest			
	Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ 310,165	$ 619,165

Hendersonville Medical Center NICU only
Projected Expense (Other)

	2017	2018
Contract Labor	-	-
Employee Benefits	172,000	176,000
Professional Fees	-	-
Contract Services	12,000	14,000
Repairs & Maintenance	-	25,000
Utilities	-	-
Insurance	18,000	22,000
Interest Income	-	-
Gain/Loss Sale of Assets	-	-
Other Income/Expense	-	-
Legal & Accounting	-	-
Marketing	50,000	25,000
Postage/Transportation	-	-
Travel, Meals & Entertainment	-	-
Dues/Subscriptions	-	-
Education/Development	-	-
Employee Recruitment	-	-
Physician Recruitment	-	-
Contributions	-	-
Software	-	-
Licenses & Permits	-	-
Other	-	-
	252,000	262,000

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Fifteen-A: Average Charges, Deductions, and Net Operating Income TriStar Hendersonville Medical Center--Hospital Including NICU		
	CY2017	**CY2018**
Patient Days	28,102	29,363
Admissions or Discharges	7,537	7,893
Average Gross Charge Per Day	$31,951	$33,710
Average Gross Charge Per Admission (13 day ALOS)	$119,132	$125,404
Average Deduction from Operating Revenue per Day	$27,570	$29,355
Average Deduction from Operating Revenue per Admission	$102,796	$109,203
Average Net Charge (Net Operating Revenue) Per Day	$4,381	$4,355
Average Net Charge (Net Operating Revenue) Per Admission	$16,336	$16,201
Average Net Operating Income after Expenses, Per Day	$780	$784
Average Net Operating Income after Expenses, Per Admission	$2,910	$2,916

Source: Hospital Management, from Projected Data Chart. Dollars rounded.

Table Fifteen-B: Average Charges, Deductions, and Net Operating Income TriStar Hendersonville Medical Center – II-B NICU Only		
	CY2017	**CY2018**
Patient Days	1,237	1,445
Admissions or Discharges	95	111
Average Gross Charge Per Day	$3,433	$3,675
Average Gross Charge Per Admission (13 day ALOS)	$44,705	$2,019
Average Deduction from Operating Revenue per Day	$1,812	$2,019
Average Deduction from Operating Revenue per Admission	$23,600	$26,279
Average Net Charge (Net Operating Revenue) Per Day	$1,621	$1,656
Average Net Charge (Net Operating Revenue) Per Admission	$21,105	$21,559
Average Net Operating Income after Expenses, Per Day	$251	$428
Average Net Operating Income after Expenses, Per Admission	$3,265	$5,578

Source: Hospital Management, from Projected Data Chart. Dollars rounded.

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

Response C(II).6.B below provides in Table Sixteen the most frequent current charges for inpatient admissions at all three area hospitals, as reported for 2011 in their Joint Annual Reports.

That response also compares the proposed most frequent NICU and medical-surgical charges at TriStar Hendersonville Medical Center in CY2017-18 to CY2012 Medicare reimbursement and to CY2012 charges at three other area HCA hospitals with NICU's.

There is no publicly available data on NICU charges at non-HCA hospitals in the service area.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

The applicant has no access to current gross charge statistics for other hospitals in its service area. The following two tables compare the applicant's gross charges for medical-surgical care to several Davidson County HCA hospitals to whose data the applicant has access.

TABLE SIXTEEN-A: HENDERSONVILLE MEDICAL CENTER AND COMPARISON FACILITIES CHARGE DATA FOR MOST FREQUENT PROCEDURES IN MEDICAL- SURGICAL ADMISSIONS

CPT or DRG	Descriptor	Current Medicare Allowable	Current Hendersonville Medical Center	Current Centennial Medical Center	Current Summit Medical Center	Current Stonecrest Medical Center	Yr 1-2017* Hendersonville Medical Center	Yr 2-2018* Hendersonville Medical Center
	Medical Private Room		$ 1,217	$ 1,116	$ 1,190	$ 1,350	$ 1,788	$ 1,931
	Surgical Private Room		$ 2,336	$ 1,116	$ 1,190	$ 1,350	$ 3,432	$ 3,707
	Critical Care Room		$ 3,457	$ 3,544	$ 3,567	$ 3,190	$ 5,079	$ 5,486
36415	Collj Ven Bld Vnpnxr	$ 3	$ 16	$ 27	$ 48	$ 24	$ 34	$ 25
71010	Radex Ch 1 View Frnt	$ 45	$ 419	$ 496	$ 419	$ 290	$ 616	$ 665
71020	Radex Ch 2 Views Frnt&Lat	$ 45	$ 510	$ 576	$ 537	$ 405	$ 749	$ 809
80048	Basic Metabolic Panel Calcium Total	$ 9	$ 256	$ 323	$ 378	$ 332	$ 376	$ 406
80053	Compre Metab Panel	$ 12	$ 325	$ 562	$ 421	$ 424	$ 478	$ 516
80101	Drug Scr Qual 1 Drug Class Meth Ea Drug Class	$ -	$ 53	$ 38	$ 51	$ 67	$ 78	$ 84
81001	Urnls Dip Stick/Tablet Rgnt Auto Mic	$ 4	$ 162	$ 185	$ 155	$ 114	$ 238	$ 257
83735	Magnesium	$ 9	$ 179	$ 273	$ 225	$ 108	$ 263	$ 284
83874	Myoglobin	$ 18	$ 220	$ 309	$ 390	$ 422	$ 323	$ 349
84484	Troponin Quan	$ 14	$ 235	$ 228	$ 496	$ 335	$ 345	$ 373
85025	Bld# Compl Auto Hhrwp&Auto Diffial	$ 11	$ 254	$ 373	$ 263	$ -	$ 373	$ 403
85027	Bld# Compl Auto Hhrwp	$ 9	$ 242	$ 179	$ 195	$ 210	$ 356	$ 384
85610	Prothrombin Tm	$ 5	$ 163	$ 185	$ 147	$ 193	$ 240	$ 259
85730	Thromboplastin Tm Prtl Plsm/Whl Bld	$ 8	$ 177	$ 228	$ 197	$ 202	$ 260	$ 281
87086	Cul Bact Quan Colony Cnt Urine	$ 11	$ 310	$ 363	$ 185	$ 322	$ 455	$ 492
93005	Ecg Routine Ecg W/Least 12 Lds Trcg Only W/O I&R	$ 26	$ 605	$ 386	$ 370	$ 322	$ 889	$ 960
94640	Press/N-Press Inhlj Tx F/Aao/Sptm Indctj	$ 34	$ 172	$ 184	$ 234	$ 155	$ 253	$ 273
96361	Iv Infusion Hydration Each Additional Hour	$ 26	$ 142	$ 121	$ 127	$ 117	$ 209	$ 225
96372	Therapeutic Prophylactic/Dx Injection Subq/Im	$ 38	$ 161	$ 143	$ 135	$ 131	$ 237	$ 255
96374	Ther Proph/Dx Njx Iv Push Single/1St Sbst/Drug	$ 38	$ 360	$ 399	$ 394	$ 268	$ 529	$ 571
96375	Ther Proph/Dx Njx Ea Seql Iv Push Sbst/Drug	$ 38	$ 299	$ 235	$ 253	$ 285	$ 439	$ 474

Source: Hospital Management *Estimated 2017-18 pricing based on average annual gross charge increase of 8%

TABLE SIXTEEN-B: HENDERSONVILLE MEDICAL CENTER & COMPARISON FACILITIES CHARGE DATA FOR MOST FREQUENT PROCEDURES IN NICU

CPT or DRG	Descriptor	Current Medicare Allowable	Current Hendersonville Medical Center	Current Centennial Medical Center	Current Summit Medical Center	Current Stonecrest Medical Center
	NICU Room Rate			$ 3,438	$ 1,815	
71010	XR Chest 1 view	$ 45	$ 419	$ 496	$ 419	$ 290
80048	BMP Total Calcium	$ 9	$ 256	$ 323	$ 378	$ 332
82247	Bilirubin Tot	$ 7	$ 226	$ 95	$ 223	$ 226
82248	Bilirubin Direct	$ 7	$ 192	$ 117	$ 148	$ 200
82261	Biotindase EA Spec	$ 8	$ 24	$ 46	$ -	$ 26
82760	Galactose	$ 15	$ 40	$ 490	$ -	$ 444
82803	ABG with Calc O2 Sat	$ 27	$ 478	$ 465	$ 447	$ 553
83021	Hemoglobin Fract HPLC	$ 25	$ 44	$ 139	$ 156	$ -
83498	Hydroxyprog 17D	$ 37	$ 109	$ 834	$ 172	$ 567
83520	Cystic Fibrosis IA QN	$ 18	$ 33	$ 46	$ -	$ 26
84443	TSH	$ 23	$ 262	$ 535	$ 301	$ 184
85014	Hematocrit	$ 3	$ 120	$ 137	$ 129	$ 72
85025	CBC	$ 11	$ 254	$ 373	$ 263	$ -
85045	Retic Count Auto	$ 6	$ 226	$ 162	$ -	$ -
86140	C-Reactive Protein	$ 7	$ 186	$ 213	$ 147	$ 169
87040	Culture Blood	$ 14	$ 163	$ 342	$ 398	$ 223
92526	TX Swal/Oral Function SP	$ 73	$ 410	$ 436	$ 289	$ 188
97530	Ther Activ Dir 15 min OT	$ 33	$ 148	$ 263	$ 198	$ 182

Source: Hospital Management *Estimated 2017-18 pricing based on average gross charge increase of 8%

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

The projected inpatient days in medical-surgical and all other services are sufficient to show a strong positive net operating income. The utilization assumptions are historically based in terms of admissions and lengths of stay. Cost-effectiveness is assured.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

The proposed NICU projects a small positive net operating income in each of its first two years. Although the service is new, reimbursement relationships are already in place with NICU care insurers; so there will be no initial start-up period in which cash flow will be delayed. The consolidated hospital-wide Projected Data Chart shows that the hospital has sufficient cash flow to absorb any losses that the NICU could incur, if utilization projections prove in future years to have been overstated.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

Table Seventeen-A: Medicare and TennCare/Medicaid Revenues, Year One—Whole Hospital		
	Medicare	**TennCare/Medicaid**
Gross Revenue	$166,790,847	$57,815,281
Percent of Gross Revenue	40.1%	13.9%

Source: Hospital Management.

Table Seventeen-B: Medicare and TennCare/Medicaid Revenues, Year One—NICU		
	Medicare	**TennCare/Medicaid**
Gross Revenue	0	$2,165,970
Percent of Gross Revenue	0	59.1%

Source: Hospital management.

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:
A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.
B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

The construction of an additional floor was unavoidable, to obtain needed licensed beds from HMC's satellite campus and from the second floor where the nursery needs to expand. Acceptable ground-level expansion options have not been identified. The campus has limitations of size and utility infrastructure that would make such expansions difficult. Expanding bed capacity vertically is a better use of capital investment.

It is also considered a better alternative than re-staffing the 38-bed Portland facility, which was operated by HMC for some time after its acquisition. That facility would require too much costly alteration and its re-opening would inefficiently duplicate staffing at the main facility, which the public strongly prefers to the satellite facility.

Not offering a Level II-B NICU resource was rejected because Sumner County and edges of adjoining counties now generate more than 2,000 births annually, at all locations; and a child-bearing population of that size needs faster and less burdensome access to NICU care than is available through continuously transporting these infants to Nashville by ambulance.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

Please see the following page.

Local Health Care Providers that are frequently used:

HOME HEALTH:

Amedisys#615-230-0945

CareAll#615-835-4445 or #615-644-4972

Gentiva (Deaconess) #615-360-9000

High Point #615-328-5515

Home Health of Middle Tn. #615-361-4859

NHC#615-822-9444

Suncrest#615- 230-0009

Willowbrook#615-824-4931

HOME HOSPICE:

Alive#615-327-1085 (they also have inpatient services)

Caris#615-384-3833

High Point#615-328-6690 (they also have inpatient services)

Willowbrook#615-791-8499

LTAC FACILITIES:

Kindred#615-687-2600

Select Speciality#615-284-4599

Medical Supplies:

Ed Medical#615-822-8888

Lincare Medical#615-206-1875

Medical Necessities#615-515-3669

NURSING HOMES:

Bridge at Highland#615-325-9263

Gallatin Healthcare#615-452-2322

Golden Living#615-452-7132

Imperial Gardens#615-865-5001

Life Care Center of Old Hickory#615-847-1502

NHC#615-824-0720

Vancomanor#615-859-6600

OUTPATIENT THERAPY:

Hendersonville#615-338-2550

Physiotherapy Associates#615-338-4391

Results#615-507-1552

REHAB FACILITIES:

Skyline Rehab#615-769-7336

Sumner Rehab#615-328-5083

Vanderbilt#615-320-7600

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

The proposed NICU will have very positive impacts on its suburban and rural service area. It will reduce the emotional strain of separation of a newborn from the family, reduce significant family travel times and expense of daily drives to Nashville to be with newborns, and reduce delays in neonatal care while awaiting neonatal transport. For II-B infants born and cared for entirely at HMC, the project will eliminate the substantial charges (and some risk) of neonatal ambulance transport to and from downtown Nashville--estimated currently at a minimum of $2,500 per round trip.

It will positively impact its affiliated Level III NICU in downtown Nashville, at Centennial Women's and Children's Hospital, by relieving it of Level II-B care for substantial numbers of infants from this northern service area, freeing up resources for the additional census seeking care at that Level III nursery as its pediatric subspecialties expand in this and subsequent years.

The NICU should not have any significant adverse impact on other Level II-B's. First, there is no II-B NICU in the service area that can be affected. Second, the downtown NICU programs that could be affected other than Centennial—Vanderbilt and Baptist—likely do not derive a large percent of their NICU admissions from this service area (clear data is not currently reported or publicly available). Third, the HMC's NICU projects that more than 87% of its Year Two admissions (97 of 111) will be service area infants who otherwise would be in the HCA perinatal care system at Women's and Children's.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

Please see the following page for Table Nineteen, a chart of projected FTE's and salary ranges.

The Department of Labor and Workforce Development website provides the following service area salary information for clinical employees of this project. Positions not listed in the table are not included in the TDOL data.

Table Eighteen: TDOL Surveyed Average Salaries for the Region

Position	Entry Level	Mean	Median	Experienced
Neonatal Nurse Practitioner (NNP)	not listed			
RN	$21.43	$30.34	$28.68	$34.79
LPN	not listed			
Nurse Tech	not listed			
Telemetry Tech	not listed			

Source: TDOL Website

Table NIneteen: Hendersonville Medical Center Fourth Floor and NICU Additions Staffing Requirements				
Position Type (RN, etc.)	**Current FTE's**	**Year One FTE's**	**Year Two FTE's**	**Salary Range (Hourly)**
MEDICAL-SURGICAL UNITS				
Director	1.7	2.0	2.0	Salaried $72K - 116K
Assistant Director	1.6	2.0	2.0	Hourly $27.57 - $41.36
RN	48.6	55.1	57.5	Hourly - $22.00 - $32.49
Adminission & Discharge RN	1.5	2.0	2.0	Hourly - $22.00 - $32.49
LPN	3.8	-	-	Hourly - $15.82 - $20.89
Unit Secretary	2.0	2.9	3.0	Hourly - $10.77 - $14.71
Telemetry Techs	4.8	5.0	5.0	Hourly - $11.63 - $15.35
Nurse Techs	15.6	25.1	26.1	Hourly - $10.77 - $14.71
OBSTETRICS UNIT				
Director	1.0	1.0	1.0	Salaried 81K - 120K
Clinical Coord	1.0	1.0	1.0	Hourly $27.57 - $41.36
RN	16.2	28.2	29.0	Hourly - $22.00 - $32.49
OB Scrub Tech	4.6	4.6	4.6	Hourly -$ 17.41 -$22.97
Communication Coord	0.8	0.8	0.8	Hourly - $15.82 - $20.89
Lactation Coord	0.8	0.8	0.8	Hourly - $24.96 -35.17
NICU				
RN	-	9.5	9.5	Hourly - $22 to $32.49
Neonatal Nurse Practitioner	-	4.2	4.2	Contracted at $50/hour
				FTE Increase
Total FTE's	103.9	144.2	148.5	44.55

Source: Facility Human Resources and Departmental Operations Reports

Note: These positions are those affected by the project and not every position in the hospital. For example, the table does not cover departments such as ED, Critical Care, etc.

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

The applicant hospital has thirty-five years of successful experience with staffing its medical-surgical services and maintaining compliance with State requirements and standards. This project can be staffed without delay.

The applicant's parent company, HCA, and its local Division office and hospitals, also have many years of successful experience in this regard with respect to staffing Neonatal Intensive Care services appropriately. The Division's Level III NICU in Nashville will continue to assist TriStar Hendersonville Medical Center in developing this project, and by recruiting and training the staff required to operate a II-B NICU in compliance with the Tennessee Perinatal Guidelines, State licensing standards., and accreditation requirements.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW POLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

Hendersonville Medial Center is a clinical rotation site for numerous students in the health professions. Please see the following page for a summary of current training activity.

HENDERSONVILLE MEDICAL CENTER--MAIN CAMPUS TRAINING ROTATIONS FOR HEALTH PROFESSIONALS		
School/University	**Modalities**	**Ave # students per year**
Belmont University	Nursing	2
Belmont University	Pharmacists	10
Cumberland University	Nursing	8
Lipscomb College of Pharmacy	Pharmacists	2
Fortis (MedVance)	Cookeville Campus-Medical Laboratory Tech	1
Fortis (MedVance)	Nashville Campus-Medical Laboratory Tech	2
Madisonville Community College	Surgical First Assist	1
Meridian Institute of Surgical Assisting	Surgical Assisting	1
Middle Tennessee School of Anesthesia	Nurse Anesthetists	65
Nashville State Community College	Surgical Tech Students	2
Tennessee State University (TSU)	Physical & Occupational Therapy	4
Union University	Nursing	New, anticipate 4 this year
University of Alabama_Huntsville	Nursing Doctorate	1
Vanderbilt University School of Nursing	Nursing	10
Volunteer State Community College	Clinical Lab Student agreement	0
Volunteer State Community College	Sonography	6
Volunteer State Community College	EMT	12
Volunteer State Community College	HIM	0
Volunteer State Community College	Physical Therapy Assist PTA	2
Volunteer State Community College	Polysomnography	0
Volunteer State Community College	Rad Tech	4

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION.

LICENSURE:	Board for Licensure of Healthcare Facilities Tennessee Department of Health
CERTIFICATION:	Medicare Certification from CMS TennCare Certification from TDH
ACCREDITATION:	Joint Commission

C(III).7©. IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission.

The applicant is also currently recognized by the Commission as one of the Joint Commission's national 620 "Top Performers"—based on composite and individual scores of 95% or above on all reported Joint Commission accountability data. These accountability measures pertain to clinical practices correlated with improved outcomes. (Ninety-six HCA hospitals are on this list nationwide.) HMC also holds Joint Commission certifications for its Joint Replacement Program and as a Primary Stroke Center (the only such hospital in the service area currently).

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

The applicant anticipates needing 42 months to completely implement the project. Almost a year of structural work will need to be done on the hospital and in its powerhouse, before any construction of bed areas can begin. To be cautious, the applicant is asking here for an implementation period of four years.

2013 FEB 14 PM 2 18

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609©:

May 22, 2013

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

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	8	1-13
2. Construction documents approved by TDH	128	10-13
3. Construction contract signed	158	11-13
4. Building permit secured	172	11-13
5. Site preparation completed	202	12-13
6. Building construction commenced	217	1-14
7. Construction 40% complete	582	1-15
8. Construction 80% complete	947	1-16
9. Construction 100% complete	1312	12-16
10. * Issuance of license	1357	12-16
11. *Initiation of service	1372	1-16
12. Final architectural certification of payment	1462	4-16
13. Final Project Report Form (HF0055)	1492	5-16

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

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

INDEX OF ATTACHMENTS

A.4	Ownership—Legal Entity and Organization Chart (if applicable)
A.6	Site Control
B.II.A.	Square Footage and Costs Per Square Footage Chart
B.III.	Plot Plan
B.IV.	Floor Plan
C. Need—1.A	Documentation of Project-Specific Criteria • Compliance with Perinatal Guidelines • Qualifications of Medical Director • Pediatrix Neonatologists & NNPs
C, Need--3	Service Area Maps
C, Economic Feasibility--1	Documentation of Construction Cost Estimate
C, Economic Feasibility--2	Documentation of Availability of Funding
C, Economic Feasibility--10	Financial Statements
C, Orderly Development--7(C)	TDH Inspection & Plan of Correction
Miscellaneous Information	TennCare Enrollments Demographic Data from QuickFacts AIA Standard--Private Patient Rooms
Support Letters	

A.4--Ownership
Legal Entity and Organization Chart

Board for Licensing Health Care Facilities

State of Tennessee

0000000135

No. of Beds 0148

DEPARTMENT OF HEALTH

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

HENDERSONVILLE HOSPITAL CORPORATION *to conduct and maintain a*

Hospital TRISTAR HENDERSONVILLE MEDICAL CENTER

Located at 355 NEW SHACKLE ISLAND ROAD, HENDERSONVILLE

County of SUMNER *, Tennessee.*

This license shall expire SEPTEMBER 17 *,* 2013 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 1ST *day of* JULY *,* 2012 *.*

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

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

By John J. Dreyzehner, MD
COMMISSIONER

State of Tennessee

Department of State

Certificate

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of

HENDERSONVILLE HOSPITAL CORPORATION,

was duly executed in accordance with the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.

Therefore, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on November 19th, 1987.

Gentry Crowell
Secretary of State

by Carolyn Pinson

The Joint Commission

August 2, 2011

Regina Bartlett, RN
CEO
Hendersonville Hospital Corporation
355 New Shackle Island Road
Hendersonville, TN 37075

Joint Commission ID #: 5174
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 08/02/2011

Dear Ms. Bartlett:

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

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning March 18, 2010. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

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

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

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

Sincerely,

Ann Scott Blouin RN, PhD

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

The Joint Commission

February 10, 2012

Regina Bartlett, RN
CEO
Hendersonville Hospital Corporation
355 New Shackle Island Road
Hendersonville, TN 37075

Joint Commission ID #: 5174
Program: Advanced Primary Stroke Center
Certification Activity: 60-day Evidence of Standards Compliance
Certification Activity Completed: 02/09/2012

Dear Ms. Bartlett:

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

The Joint Commission is granting your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

- Disease Specific Care Certification Manual

This certification cycle is effective beginning December 23, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 24 months.

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

We encourage you to share this certification decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's certification decision.

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

Sincerely,

Ann Scott Blouin RN, PhD

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

The Joint Commission

December 16, 2011

Regina Bartlett, RN
CEO
Hendersonville Hospital Corporation
355 New Shackle Island Road
Hendersonville, TN 37075

Joint Commission ID #: 5174
Certification Program: Joint Replacement - Hip
Certification Activity: Initial Full Event
Certification Activity Completed: 12/16/2011

Dear Ms. Bartlett:

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

The Joint Commission is granting your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

- Disease Specific Care Certification Manual

This certification cycle is effective beginning December 17, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 24 months.

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

We encourage you to share this certification decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's certification decision.

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

Sincerely,

Ann Scott Blouin RN, PhD

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

The Joint Commission

January 9, 2012

Regina Bartlett, RN
CEO
Hendersonville Hospital Corporation
355 New Shackle Island Road
Hendersonville, TN 37075

Joint Commission ID #: 5174
Program: Joint Replacement - Knee
Certification Activity: 60-day Evidence of Standards Compliance
Certification Activity Completed: 01/09/2012

Dear Ms. Bartlett:

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

The Joint Commission is granting your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

- Disease Specific Care Certification Manual

This certification cycle is effective beginning December 23, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 24 months.

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

We encourage you to share this certification decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's certification decision.

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

Sincerely,

Ann Scott Blouin RN, PhD

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

1987 NOV 1-

ARTICLES OF AMENDMENT TO THE CHARTER
OF
HENDERSONVILLE HOSPITAL CORPORATION

Pursuant to the provisions of Section 48-1-303 of the Tennessee General Corporation Act, the undersigned corporation adopts the following Articles of Amendment to its Charter:

1. The name of the corporation is Hendersonville Hospital Corporation.

2. The amendment adopted is:

   The address of the corporation's principal office in the State of Tennessee is changed to 4525 Harding Road, Nashville, Tennessee 37205.

3. The amendment was duly adopted by the unanimous written consent of the Board of Directors on November 16, 1987.

4. This amendment will not effect issued shares.

5. This amendment is to be effective when these articles are filed by the Secretary of State.

Dated: November 16, 1987

HENDERSONVILLE HOSPITAL CORPORATION

By: Charles R. Gaston
Charles R. Gaston,
Secretary

State of Tennessee

BOOK 7233 PAGE 101

Department of State

Certificate

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of

HENDERSONVILLE HOSPITAL CORPORATION,

was duly executed in accordance with the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.

Therefore, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on April 30th, 19 87.

Gentry Crowell
Secretary of State

by Carolyn Pinson

IDENTIFI REFERENC

24787

MAY 12 8 42 AM

FELIX Z. VALLEY, JR. REGIS
DAVIDSON COUNTY, TN

FILED
SECRETARY OF STATE
1987 APR 30 AM 9:24

CHARTER

OF

HENDERSONVILLE HOSPITAL CORPORATION

The undersigned natural persons, having capacity of contract and acting as the incorporators of a corporation under the Tennessee General Corporation Act, adopt the following Charter for such corporation:

1. The name of the corporation is Hendersonville Hospital Corporation.

2. The duration of the corporation is perpetual.

3. The address of the principal office of the corporation in the State of Tennessee shall be One Park Plaza, Nashville, County of Davidson. BOOK 7233 PAGE 102

4. The corporation is for profit.

5. The purposes for which the corporation is organized are:

(a) To purchase, lease, or otherwise acquire, to operate, and to sell, lease, or otherwise dispose of hospitals, convalescent homes, nursing homes and other institutions for the medical care and treatment of patients; to purchase, manufacture, or prepare and to sell or otherwise deal in, as principal or as agent, medical equipment or supplies; to construct, or lease, and to operate restaurants, drug stores, gift shops, office buildings, and other facilities in connection with hospitals or other medical facilities owned or operated by it; to engage in any other act or acts which a corporation may perform for a lawful purpose or purposes.

(b) To consult with owners of hospitals and all other types of health care or medically-oriented facilities or managers thereof regarding any matters related to the construction, design, ownership, staffing or operation of such facilities.

FILED
SECRETARY OF STATE
1997 APR 30 AM 9:25

(c) To provide consultation, advisory and management services to any business, whether corporation, trust, association, partnership, joint venture or proprietorship.

(d) To engage in any lawful businesses which are directly or indirectly related to the above purposes.

6. The maximum number of shares which the corporation shall have the authority to issue is One Thousand (1,000) shares of Common Stock, par value of $1.00 per share.

7. The corporation will not commence business until the consideration of One Thousand Dollars ($1,000) has been received for the issuance of shares. BOOK 7233 PAGE 103

8. (a) The shareholders of this corporation shall have none of the preemptive rights set forth in the Tennessee General Corporation Act.

(b) The initial bylaws of this corporation shall be adopted by the incorporations hereof, and thereafter, the bylaws of this corporation may be amended, repealed or adopted by a majority of the outstanding shares of capital stock.

(c) This corporation shall have the right and power to purchase and hold shares of its capital stock; provided, however, that such purchase, whether direct or indirect, shall be made only the extent of unreserved and unrestricted capital surplus.

Dated as of April 28, 1987

Bettye D. Daugherty

Bettye D. Daugherty

Vivian D. West

Vivian D. West

Secretary of State
Business Information Search

Secretary of State Web Site | Instructions

Name	I.D. Number
HCA INC.	0280381

Business Type*:	CORPORATION
Profit/Nonprofit:	FOR PROFIT
Status*:	ACTIVE
Date of Formation/Qualification:	06/14/1994
Domestic/Foreign:	FOREIGN
Place of Incorporation/Organization:	DE
Duration:	PERPETUAL
FYC(Fiscal Year Closing) **Month:**	DECEMBER

Principal Office:

Address Line 1:	ONE PARK PLAZA .
Address Line 2:	
City:	NASHVILLE
State:	TN
Zip:	372030000
Other than USA:	

Registered Agent:

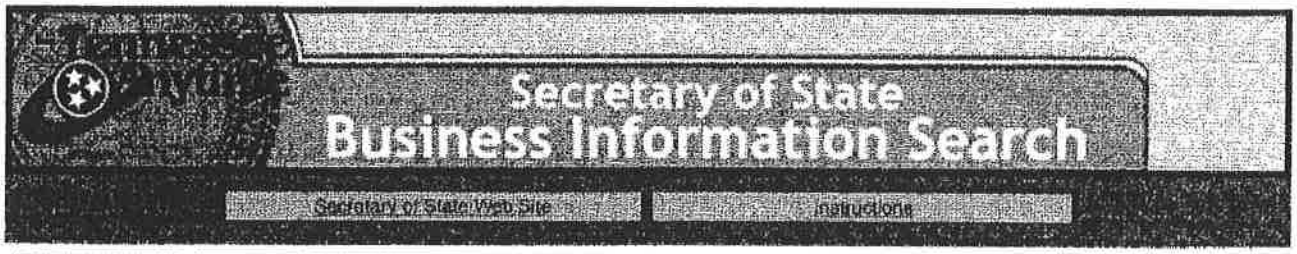
Name:	C T CORPORATION SYSTEM
Address Line 1:	800 S. GAY STREET
Address Line 2:	SUITE 2021
City:	KNOXVILLE
State:	TN
Zip:	379299710

Business Filing History

*** Important Note: Business filing History includes information about (1) the basis for an inactive status and (2) the current true name and filing status of a business with an assumed name or a changed status.**

Note: This information is current as of three working days prior to today's date.

Search Again



Name	I.D. Number
HEALTHTRUST, INC. - THE HOSPITAL COMPANY	0191382

Business Type*:	CORPORATION
Profit/Nonprofit:	FOR PROFIT
Status*:	ACTIVE
Date of Formation/Qualification:	07/13/1987
Domestic/Foreign:	FOREIGN
Place of Incorporation/Organization:	DE
Duration:	PERPETUAL
FYC(Fiscal Year Closing) **Month:**	DECEMBER

Principal Office:

Address Line 1:	ONE PARK PLAZA
Address Line 2:	
City:	NASHVILLE
State:	TN
Zip:	372030000
Other than USA:	

Registered Agent:

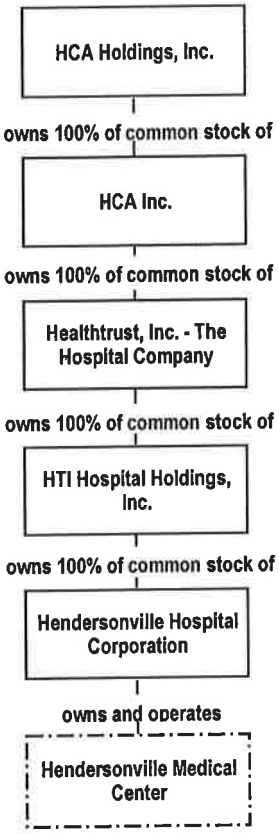
Name:	C T CORPORATION SYSTEM
Address Line 1:	800 S. GAY STREET
Address Line 2:	SUITE 2021
City:	KNOXVILLE
State:	TN
Zip:	379299710

Business Filing History

* Important Note: Business filing History includes information about (1) the basis for an inactive status and (2) the current true name and filing status of a business with an assumed name or a changed status.

Note: This information is current as of three working days prior to today's date.

Search Again


HCA Holdings, Inc.
owns 100% of common stock of
HCA Inc.
owns 100% of common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of common stock of
HTI Hospital Holdings, Inc.
owns 100% of common stock of
Hendersonville Hospital Corporation
owns and operates
Hendersonville Medical Center

HCA FACILITIES IN TENNESSEE
JANUARY 12, 2013

Centennial Surgery Center
345 23rd Avenue North, Suite 201
Nashville, TN 37203
615-327-1123

Parkridge East Hospital
941 Spring Creek Road
Chattanooga, TN 37412
423-855-3500

Parkridge Medical Center
2333 McCallie Avenue
Chattanooga, TN 37404
423-493-1772

Parkridge Valley Hospital
200 Morris Hill Road
Chattanooga, TN 37421
423-499-1204

Premier Orthopedics Surgery Center
394 Harding Place
Suite 100
Nashville, TN 37211
615-332-3600

Summit Surgery Center
3901 Central Pike
Suite 152
Hermitage, TN 37076
615-391-7200

Surgery Center of Chattanooga
400 North Holtzclaw Avenue
Chattanooga, TN 37404
423-698-6871

TriStar Ashland City Medical Center
313 North Main Street
Ashland City, TN 37015
615-792-3030

TriStar Centennial Medical Center
2300 Patterson Street
Nashville, TN 37203
615-342-1040

TriStar Hendersonville Medical Center
355 New Shackle Island Road
Hendersonville, TN 37075
615-338-1102

TriStar Horizon Medical Center
111 Highway 70 East
Dickson, TN 37055
615-441-2357

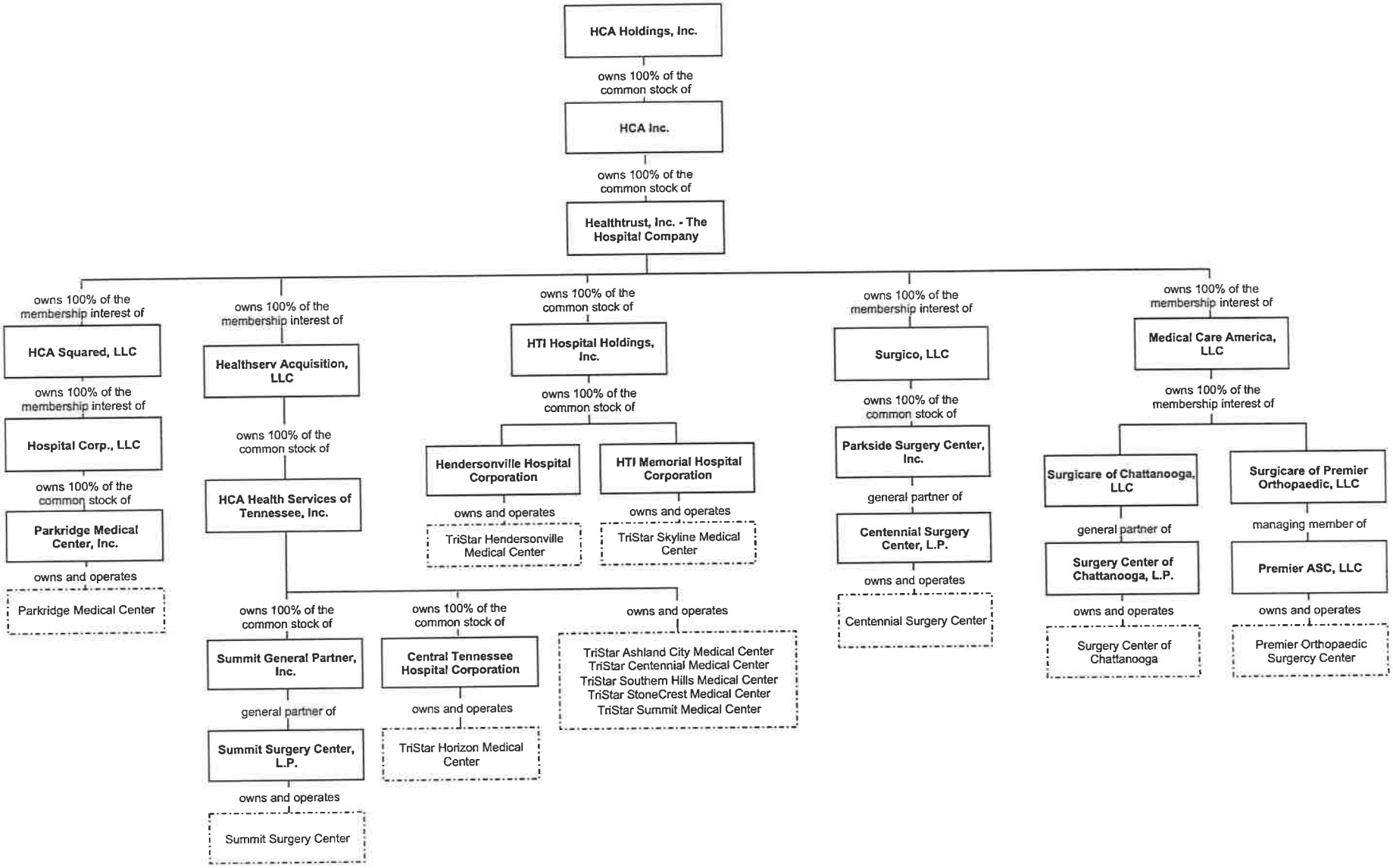
TriStar Skyline Madison Campus
500 Hospital Drive
Madison, TN 37115
615-860-6301

TriStar Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207
615-769-7114

TriStar Southern Hills Medical Center
391 Wallace Road
Nashville, TN 37211
615-781-4000

TriStar StoneCrest Medical Center
200 StoneCrest Blvd.
Smyrna, TN 37167
615-768-2508

TriStar Summit Medical Center
5655 Frist Blvd.
Hermitage, TN 37076
615-316-4902


HCA Holdings, Inc.
owns 100% of the common stock of
HCA Inc.
owns 100% of the common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of the membership interest of
HCA Squared, LLC
owns 100% of the membership interest of
Hospital Corp., LLC
owns 100% of the common stock of
Parkridge Medical Center, Inc.
owns and operates
Parkridge Medical Center
owns 100% of the membership interest of
Healthserv Acquisition, LLC
owns 100% of the common stock of
HCA Health Services of Tennessee, Inc.
owns 100% of the common stock of
Summit General Partner, Inc.
general partner of
Summit Surgery Center, L.P.
owns and operates
Summit Surgery Center
owns 100% of the common stock of
Central Tennessee Hospital Corporation
owns and operates
TriStar Horizon Medical Center
owns and operates
TriStar Ashland City Medical Center
TriStar Centennial Medical Center
TriStar Southern Hills Medical Center
TriStar StoneCrest Medical Center
TriStar Summit Medical Center
owns 100% of the common stock of
HTI Hospital Holdings, Inc.
owns 100% of the common stock of
Hendersonville Hospital Corporation
owns and operates
TriStar Hendersonville Medical Center
HTI Memorial Hospital Corporation
owns and operates
TriStar Skyline Medical Center
owns 100% of the membership interest of
Surgico, LLC
owns 100% of the common stock of
Parkside Surgery Center, Inc.
general partner of
Centennial Surgery Center, L.P.
owns and operates
Centennial Surgery Center
owns 100% of the membership interest of
Medical Care America, LLC
owns 100% of the membership interest of
Surgicare of Chattanooga, LLC
general partner of
Surgery Center of Chattanooga, L.P.
owns and operates
Surgery Center of Chattanooga
Surgicare of Premier Orthopaedic, LLC
managing member of
Premier ASC, LLC
owns and operates
Premier Orthopaedic Surgercy Center

A.6--Site Control

7703

KATHRYN BROWN, REG.
SUMNER COUNTY, TENN.
RECORDING 12.00
STATE TAX $ 1
REG. FEE $
TOTAL $ 12.00
REC. NO. 7532

THIS INSTRUMENT PREPARED BY:

Joseph A. Sowell, III
Waller Lansden Dortch & Davis
2100 One Commerce Place
Nashville, TN 37239

QUITCLAIM DEED

ADDRESS NEW OWNER AS FOLLOWS
Hendersonville Community Hospital, L.P.
c/o Hendersonville Hospital Corporation
4525 Harding Road
Nashville, Tennessee 37205

SEND BILLS TO:

Hendersonville Community Hospital, L.P.
c/o Hendersonville Hospital Corporation
4525 Harding Road
Nashville, TN 37205

MAP PARCEL NUMBERS

MAP	GROUP	CONT. MAP	PARCEL
144			110

FOR AND IN CONSIDERATION of One dollar ($1.00), cash in hand paid, the receipt of which is hereby acknowledged, Hospital Development Properties, Inc., a Delaware corporation, by these presents does hereby quitclaim and convey unto Hendersonville Community Hospital, L.P., a Delaware limited partnership, it successors and assigns, all right, title and interest in and to the land described on Exhibit "A" attached hereto and made a party hereof.

Said property is conveyed subject to such limitations, restrictions, and encumbrances as may affect the premises.

Witness the hand as of this 30th day of June, 1988, the corporate party, having caused its name to be signed hereto by its duly authorized officer as of said day and date.

ENTERED

JUN 30 1988

THOMAS C. MARLIN
TAX ASSESSOR

HENDERSONVILLE HOSPITAL CORPORATION

By: Stuart Voepel

Title: Vice-President

STATE OF TENNESSEE
COUNTY OF DAVIDSON

REC'D JUN 30 1988 AT 3:16 REC. IN Record BOOK 30 PAGE 153
KATHRYN BROWN, REGISTER SUMNER COUNTY, TENN.

Before me, Beth A. Campbell, a Notary Public of the State and County aforesaid, personally appeared Stuart Voepel with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence, and who, upon oath, acknowledged himself to be the Vice-president of Hospital Development Properties, Inc., the within named bargainor, a corporation, and the he as such Vice-president, executed the foregoing instrument for the purpose therein contained by signing the name of the corporation by the said Vice-president.

Witness my hand and seal, at office in Nashville, Tennessee this 30th day of June, 1988.

Beth A. Campbell
Notary Public
My Commission Expires: 1/10/89

PREPARED BY:
James L. Smith, Atty. 313 E. Main St., Hendersonville, TN 37075

MAP 144 GROUP CONT. MAP 144 PARCEL 110

WARRANTY DEED

ADDRESS NEW OWNER (S) AS FOLLOWS	SEND TAX BILLS TO	MAP PARCEL NUMBERS
Hospital Corporation of America	Same Address	
(NAME)	(NAME)	
One Park Plaza - P.O. Box 550		
(STREET ADDRESS OR ROUTE NUMBER)	(STREET ADDRESS)	
Nashville, TN 37202		
(CITY) (STATE) (ZIP)	(CITY) (STATE) (ZIP)	

THOMAS C. MAGLIN
TAX ASSESSOR

FOR AND IN CONSIDERATION of the sum of TEN AND NO/100 ($10.00)---------- Dollars,

cash in hand paid by Hospital Corporation of America, and other good and valuable considerations, including the assumption of an indebtedness evidenced by a deed of trust of record in DT Book 378, page 763, Register's Office for Sumner County, Tennessee.

Hendersonville Medical Office Building Associates, a Joint Venture who's Joint Verturers are L. H. Hardaway, Sr., and L. H. Hardaway, Jr.,

have this day bargained and sold, and do hereby transfer and convey unto the said Hospital Corporation of America,

a Tennessee Corporation, its successors

the Grantees herein, their (successors), heirs and assigns,

certain real estate in Sumner County, Tennessee, as follows:

Land in Sumner County, Tennessee, described as follows:

Beginning at a concrete monument in the westerly margin of New Shackle Island Road, said monument being in the northerly property line of Knox Doss School property; thence, with said Northerly line North 86° 57' 22" West, 1,064.82 feet to a point; thence with a line North 02° 14' 26" East, 766.64 feet to a point; thence South 88° 32' 07" East, 957.27 feet to a point; thence, South 75° 48' 05" West, 177.55 feet to a point; thence, South 88° 53' 29" East, 281.94 feet to a point on the westerly margin of New Shackle Island Road; thence with a curve to the right of Radius 2,864.93 feet a distance of 645.32 feet to the point of beginning.

Being the same property conveyed to Hendersonville Medical Office Building Associates, a Joint Venture who's managing Joint Verturers are L. H. Hardaway, Sr., and L. H. Hardaway, Jr., by deed from M. H. Hurt, Jr., Trustee, of record in Deed Book 424, page 7, Register's Office for Sumner County, Tennessee.

REC'D JUN 17 1983 AT 10:52 REC. IN Deed BOOK 470 PAGE 325
BROWN, REGISTER SUMNER COUNTY, TENN

STATE OF TENNESSEE }
COUNTY OF DAVIDSON }

326

Personally appeared before me, Dorothy Blevins *, a Notary Public in and for said County and State,* L. H. Hardaway, Sr. and L. H. Hardaway, Jr.

the within named bargainor S *., with whom I am personally acquainted, and who acknowledged that* they *executed the within instrument for the purposes therein contained.*

Witness my hand and official seal at Nashville *Tennessee*
this 17th *day of* June *, 19*83

Dorothy Blevins *Notary Public*

Commission expires May 12, 1984

STATE OF TENNESSEE }
COUNTY OF DAVIDSON }

Before me, , a Notary Public of the State and County aforesaid, personally appeared with whom I am personally acquainted, and who, upon oath, acknowledged self to be of the the within named bargainor, a corporation, and that he as such being authorized so to do, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by self as .

Witness my hand and seal, at office in this day of , 19

Notary Public

Commission expires

WARRANTY DEED

FROM

Hendersonville Medical
Office Building Associates

TO

Hospital Corporation of America,
a Tennessee Corporation

SUMNER COUNTY, TENNESSEE
Filed for record
10:52 o'clock A. M.

JUN 17 1983

Registered in Deed
Book 470 Page 325
KATHRYN BROWN, Register of Deeds

Compliments of
Chicago Title Insurance Company
First Floor — First American Center

Phone 255-4631
NASHVILLE, TENNESSEE 37238

154

STATE OF TENNESSEE
COUNTY OF DAVIDSON

The actual consideration for the transfer is $-0-.

Affiant

Sworn to and subscribed before me this 30 day of June, 1988.

Beth A. Campbell
Notary Public

My Commission Expires: 1/10/89

EXHIBIT 'A'

Land in Sumner County, Tennessee, described as follows:

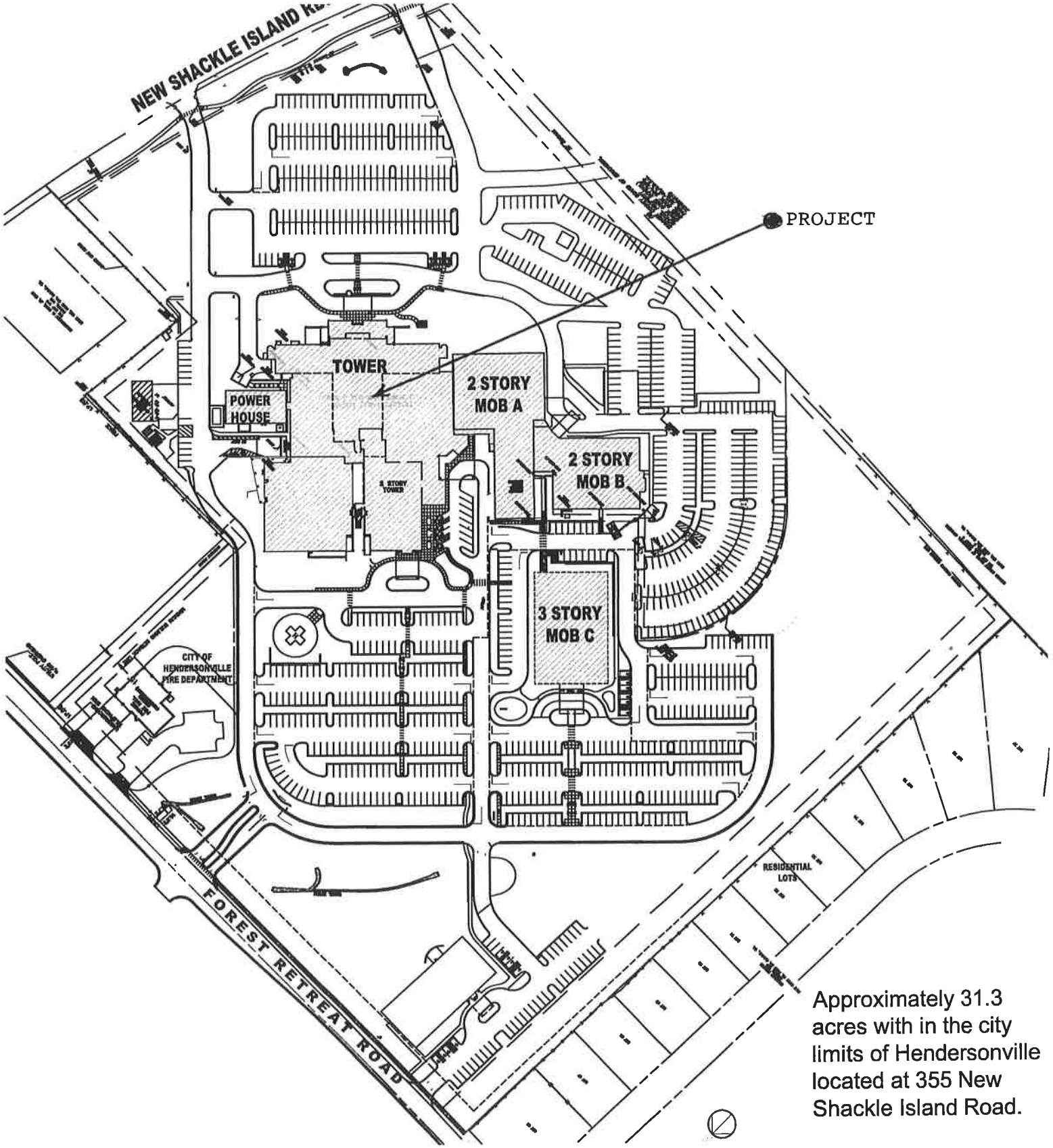
Beginning at a concrete monument in the westerly margin of New Shackle Island Road, said monument being in the northerly property line of Knox Doss School property; thence, with said northerly line North 86degrees 57minutes 22seconds West, 1,064.82 feet to a point; thence with a line North 02degrees 14minutes 26seconds East, 766.64 feet to a point; thence South 88degrees 32minutes 07seconds East, 957.27 feet to a point; thence, South 05degrees 48minutes 05seconds West, 177.55 feet to a point; thence, South 88degrees 53minutes 29seconds East, 281.94 feet to a point on the westerly margin of New Shackle Island Road; thence with a curve to the right of radius 2,864.93 feet a distance of 645.32 feet to the point of beginning.

Being the same property conveyed to Hospital Corporation of America, a Tennessee corporation, its successors by deed from Hendersonville Medical Office Building Associates, a Joint Venture who's Joint Venturers are L.H. Hardaway, Sr., and L. H. Hardaway, Jr., of record in Deed Book 470, page 325, and corrected by Deed of Correction of record in Deed Book 520, page 402, Register's Office for Sumner County, Tennessee.

155

B.II.A.—Square Footage and Costs Per Square Footage Chart

B.III.—Plot Plan



Approximately 31.3 acres with in the city limits of Hendersonville located at 355 New Shackle Island Road.

Hendersonville Medical Center
Existing Facilities

Site Plan
Scale: N.T.S.

February 10, 2013

Lyman
Davidson
Dooley, Inc.

209 10th Ave. South - Suite 327, Cummins Station - Nashville, TN 37203 - tel 615.244.7399 - fax 615.244.6697 - Copyright as dated.

B.IV.—Floor Plan

KEY TO FLOOR PLANS

The floor plans of the main campus hospital show 110 numbered licensed bed spaces, consistent with Licensure.

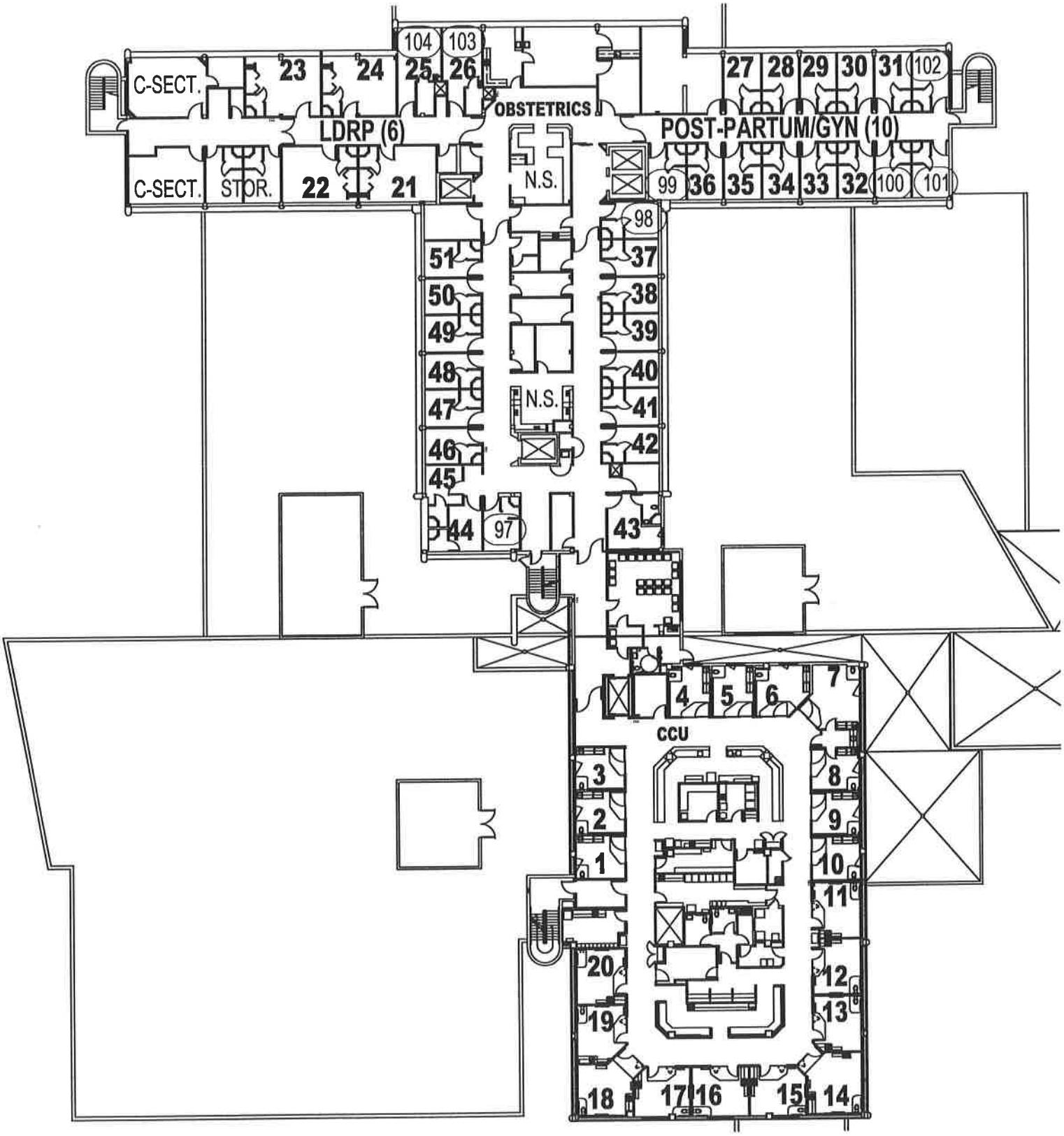
Spaces numbered 1 through 96 indicate 96 licensed beds that are currently available for inpatient admissions. They consist of 20 ICU/CCU beds, 6 labor/delivery/recovery/discharge ("LDRP") beds, 10 postpartum/gyn beds, and 74 medical-surgical beds.

The smaller, circled room numbers 97 - 110 indicate 14 licensed medical-surgical bed spaces that currently cannot be used for inpatient admissions, either because they are needed for other important purposes, or because they are semi-private (double) rooms being used as private (single) rooms in accordance with AIA standards.

Without the use of these 14 beds, the hospital has the use of only 60 (81%) of its 74 licensed medical-surgical beds.

The following key shows the current use of these licensed but unavailable bed spaces.

Hendersonville Medical Center—Main Campus Current Use of Licensed But Unavailable Bed Spaces			
Floor	**Room Number**	**Current Use**	**Licensed Bed Capacity Currently Unavailable in Room**
Second	97	Staff office	1
Second	98	Family waiting area	1
Second	99	Patient & family counseling area	1
Second	100-101	Physician sleep-rooms	2
Second	102	Staff office	1
Second	103-4	Double rooms used as private LDRP rooms	2
Third	105	Double room used as a private room	1
Third	106-107	Double rooms used as private rooms	2
Third	108-110	Double rooms used as private rooms	3
Total			*14*



Hendersonville Medical Center - Main Campus (Sumner County)
Existing Facilities

Existing Second Floor

January 31, 2013

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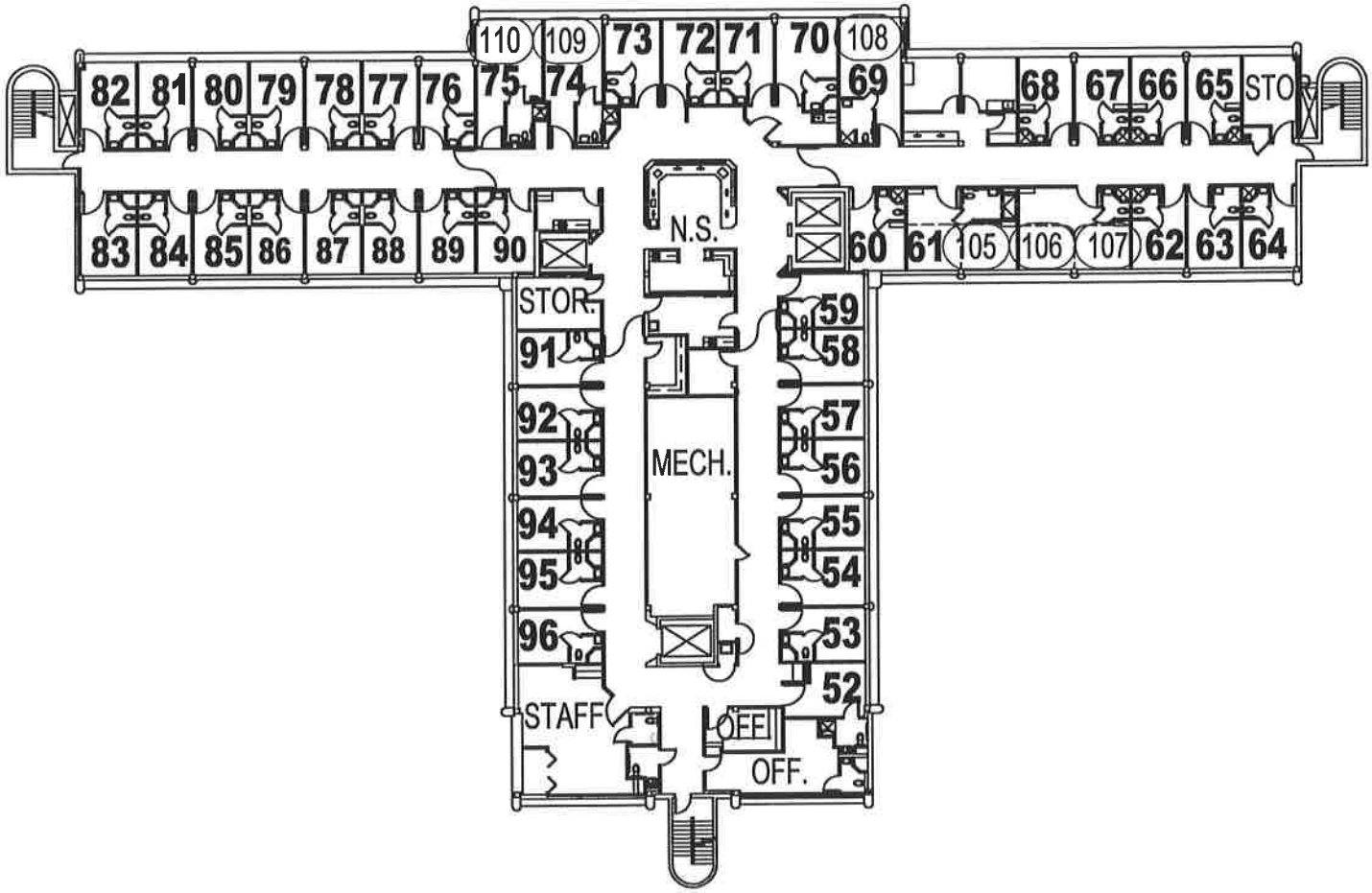

Hendersonville Medical Center - Main Campus (Sumner County)
Existing Facilities

Existing Third Floor

January 31, 2013

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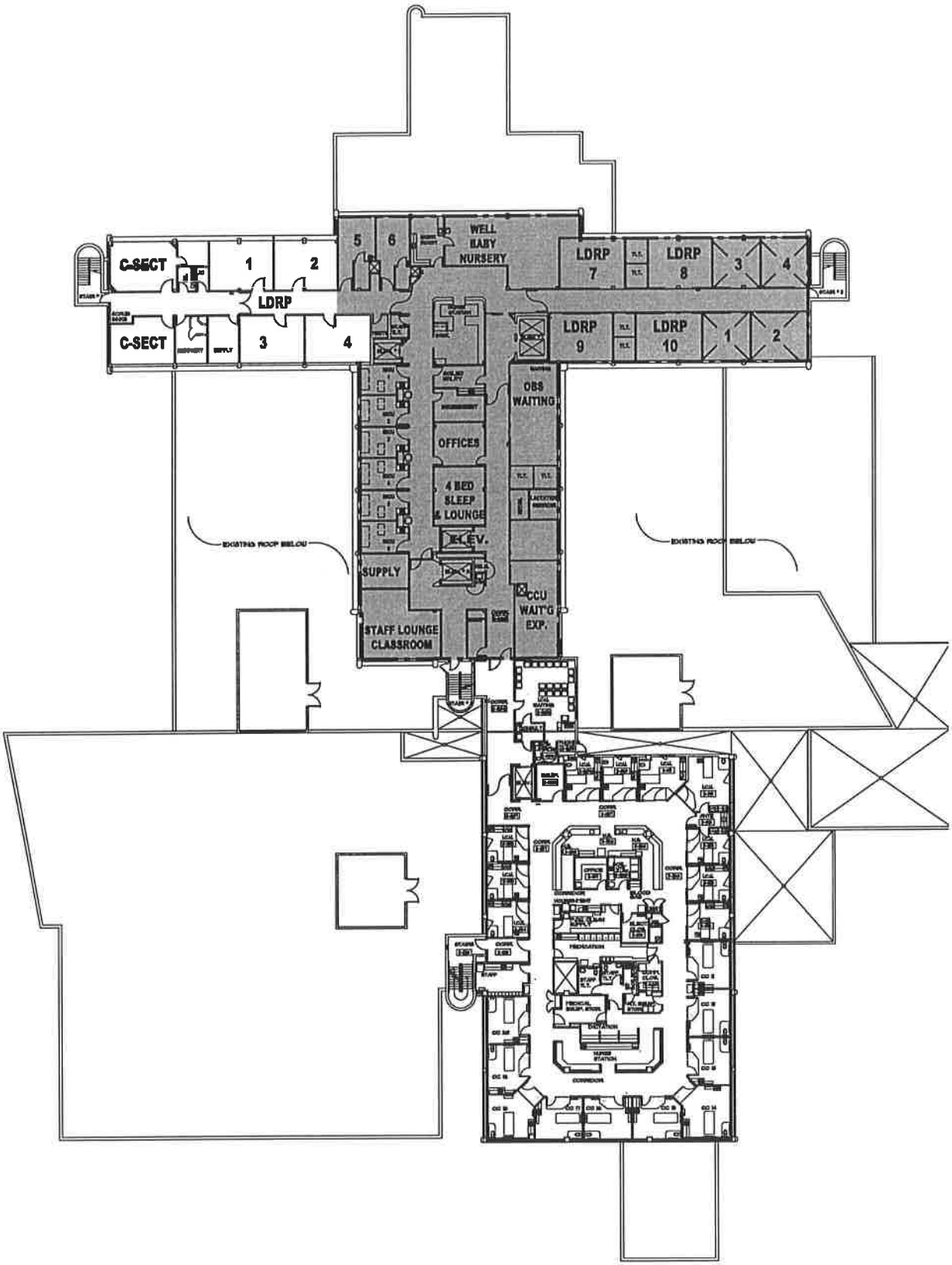

Major Renovation: 14,209 S.F.

Minor Renovation: 4,552 S.F.

Hendersonville Medical Center
Master Plan

Proposed Second Floor

Scale: 1/32"=1'-0"

April 3, 2012

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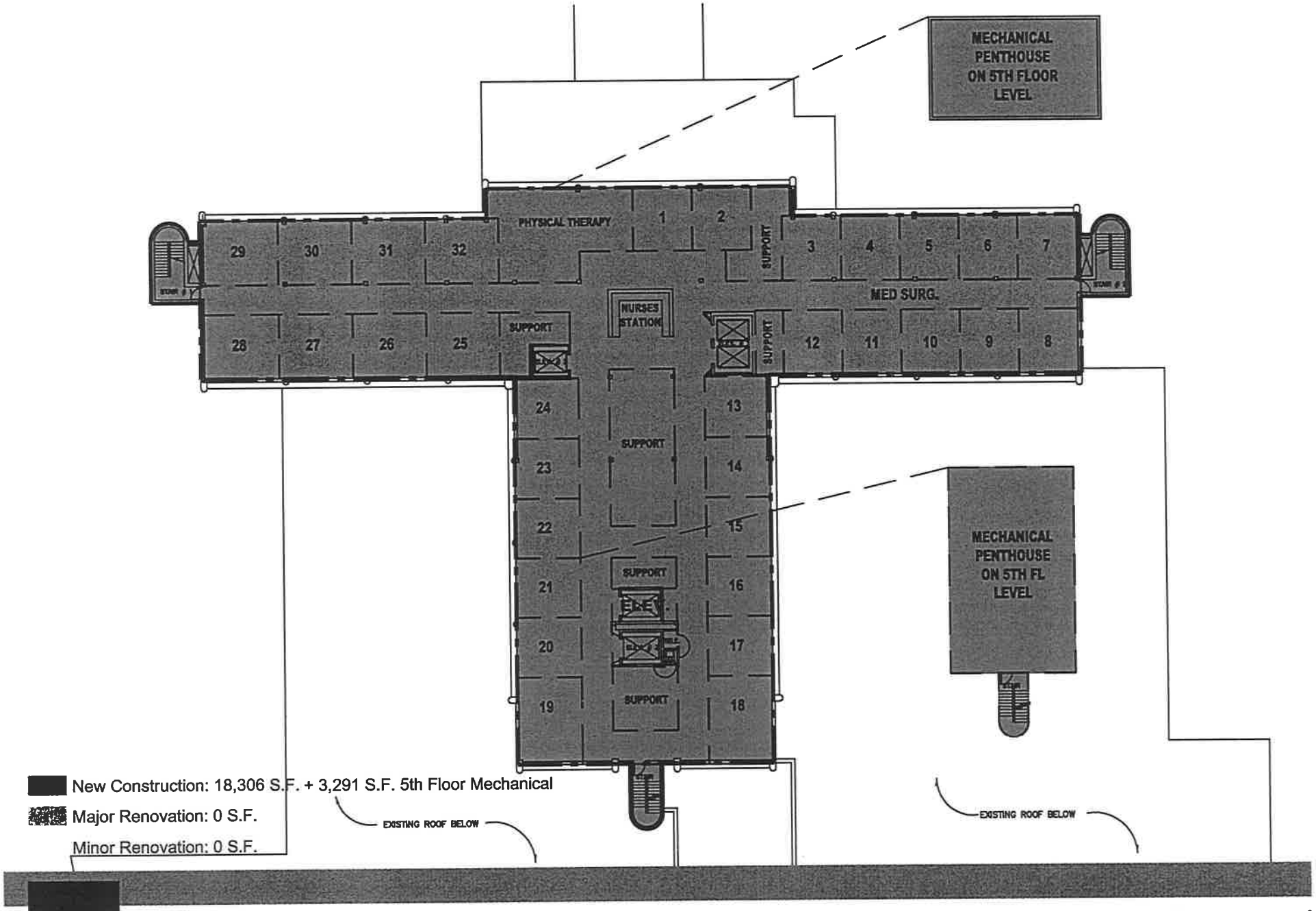

New Construction: 18,306 S.F. + 3,291 S.F. 5th Floor Mechanical

Major Renovation: 0 S.F.

Minor Renovation: 0 S.F.

Hendersonville Medical Center
Existing Facilities

Proposed Fourth Floor

February 11, 2013

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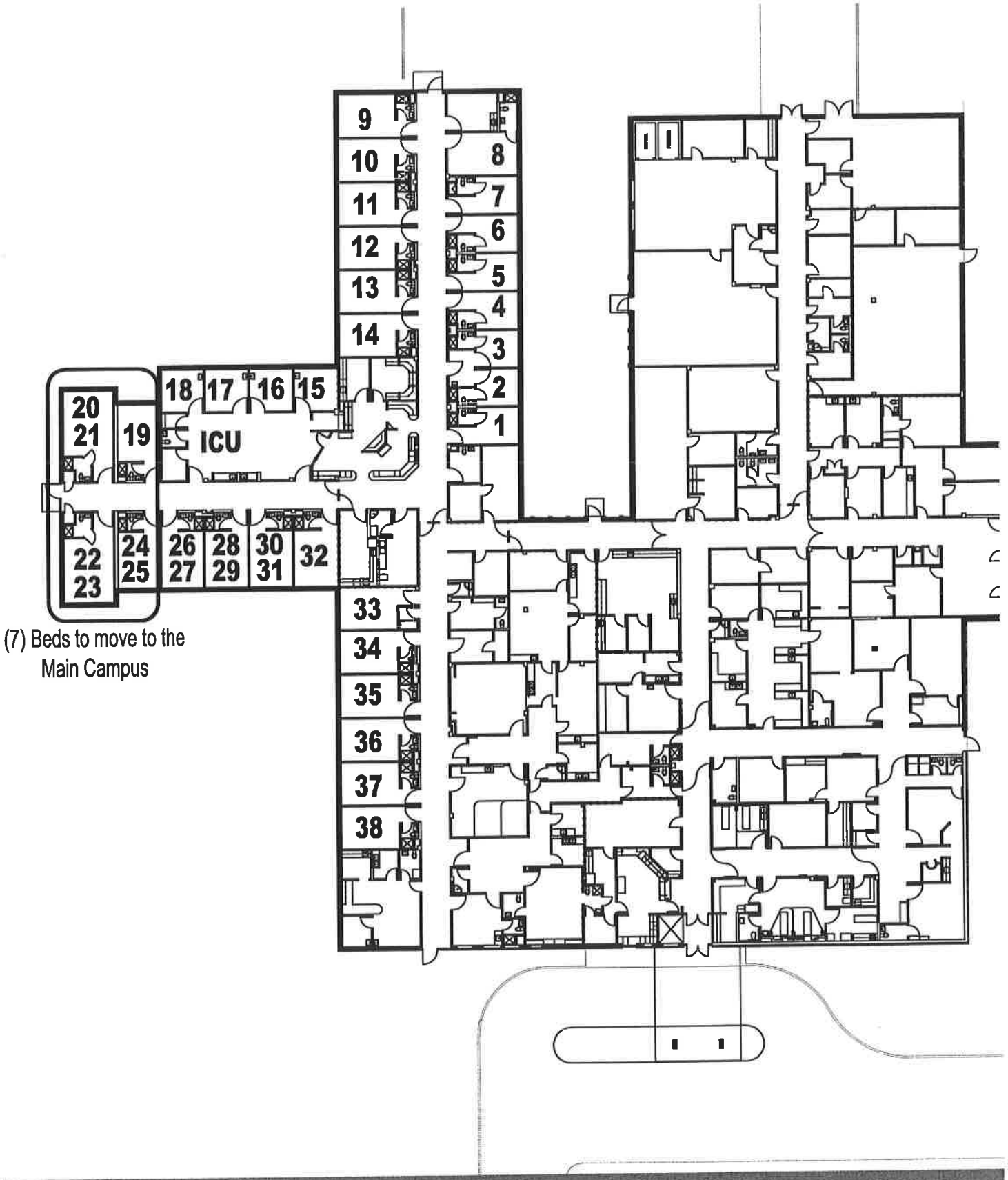

Hendersonville Medical Center in Portland (Sumner County)
Existing Facilities

Lyman
Davidson
Dooley, Inc.

January 31, 2013

209 10th Ave. South - Suite 327, Cummins Station - Nashville, TN 37203 - tel 615.244.7399 - fax 615.244.6697 - Copyright as dated.

C, Need--1.A
Documentation of Project-Specific Criteria

SUMMARY OF
HOSPITAL PERINATAL SERVICE LEVELS

LEVEL I UNITS (Omitted)
LEVEL II-A UNITS (Omitted)
LEVEL II-B UNITS
LEVEL III UNITS (Omitted)

Level II-B nurseries provide specialty neonatal services. They provide care for infants born at > 32 weeks gestation and weighing ≥ 1500 grams who have physiologic immaturity or who are moderately ill with problems that are anticipated to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. Level II-B units also have the capability to provide mechanical ventilation for brief durations (<24 hours) or continuous positive airway pressure.

The addition of 6 Level II-B NICU beds to Hendersonville Medical Center will meet or exceed the standards of the State Perinatal Care System Guidelines ("Guidelines" in this document).

The NICU program will consist of a Level II-B nursery with the full range of equipment and staff expertise required by the Guidelines. Medical direction of neonatal care will be provided by neonatologists (pediatricians board-certified as neonatologists and neonatology/perinatal medicine specialists), and neonatal nurse practitioners.

The NICU will continue Hendersonville Medical Center's philosophy and dedication to Family Centered Care. The 6 NICU beds will be private rooms that have full accommodations for parents. This will provide parents the opportunity to participate in the care and nurturing of their newborn. We support non-separation of mother and baby because of its many benefits, both short and long term.

LEVEL II-B FACILITIES--NEONATAL

I. INTRODUCTION

Level II nurseries provide specialty neonatal services. They are subdivided into two categories (Level II-A and Level II-B) based on their ability to provide assisted ventilation, including continuous positive airway pressure.

Level II-B units have the capabilities to:

- ***Resuscitate and stabilize preterm and/or ill infants before transfer to a facility at which a Level III newborn intensive care is provided;***
- ***Provide care for infants born at > 32 weeks' gestation and weighing ≥ 1500 grams (1) who have physiologic immaturity such as apnea of prematurity, inability to maintain body temperature, or inability to take oral feedings, or (2) who are moderately ill with problems that are anticipated to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis;***
- ***Provide mechanical ventilation for brief durations (<24 hours) or continuous positive airway pressure;***
- ***And provide care for infants who are convalescing after intensive care.***
- ***Level II-B units must be directed by a board-certified neonatologist.***

Complies: Hendersonville Medical Center will have all of the above capabilities in its Level II-B NICU program.

The NICU Medical Director will be Dr. Sami Ismael, who is the Director of Neonatology of the Level III NICU at Centennial Women's and Children's Hospital in Nashville. He is a member of Pediatrix, a neonatology group that directs medical care at the NICU's at Centennial Women's and Children's Hospital, Williamson Medical Center in Franklin, Metro General Hospital in Nashville, Summit Medical Center in Hermitage, and StoneCrest Medical Center in Smyrna (opening July 2013).

II. SERVICES PROVIDED

A. Educational Services

Educational services should include the following:

1. *Parent Education: Ongoing perinatal education programs for parents.*

   Complies. Comprehensive perinatal education programs are provided to the community through certified instructors, e.g., preparation for labor, newborn care, sibling classes and breastfeeding.

A lactation consultant is available to patients 7 days per week.

Special printed materials are also available to educate our patients on various pregnancy complications. In the inpatient phase, personalized mother/baby instruction is provided.

Upon the addition of a six bed Level II-B NICU, all parents taking NICU infants home will be instructed in infant CPR and room in with their infants at least one night prior to discharge, to become comfortable with assuming routine care responsibilities. They will also receive specialized instruction as needed, e.g., administering medications, operating home apnea monitors, etc.

2. *Nurses' Education: Programs for nurses that conform to the latest edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, Level II, for neonatal nurses, published by the Tennessee Department of Health. These neonatal courses should be made available periodically at Level II-A and Level II-B facilities by instructors on the staff of that institution and/or the staff from a Regional Perinatal Center. Courses may also transpire at a Regional Perinatal Center or at another site remote from the Level II-A or Level II-B hospital, thus requiring that the hospital provide nurses with educational leave for attendance. Level II-A and Level II-B hospitals are responsible for the necessary arrangements for nurse education. Nurses caring for infants on mechanical ventilator support in Level II-B units must be educated according to the guidelines specified for Level III, neonatal.*

Complies. All nursery RN's are already required to complete the Perinatal Educational Objectives for Level II-B nurses and to maintain S.T.A.B.L.E. certification (this acronym stands for sugar & safe care; temperature; airway; blood pressure; labwork; and emotional support). RN's and RT's must maintain certification in neonatal resuscitation and must complete comprehensive initial orientation competencies. Continuing education at all levels will be provided by the medical staff (neonatologists) and neonatal nurse practitioners.

Hendersonville Medical Center is part of the HCA network of hospitals and has the unique opportunity for RN's to utilize education, mentoring, shared staffing, policy and protocol resources from the HCA corporate staff, from the Women's & Children's Hospital, and from other HCA NICU's in the Nashville market.

Prior to the addition of the HMC Level II-B NICU, the NICU RN's and respiratory therapists will receive additional training in the NICU at Centennial Women's and Children's Hospital. Under the oversight of NICU nurses at Centennial Women's and Children's, the RN's and

respiratory therapists will complete an initial orientation and will receive ongoing training until they achieve the competencies required to care for Level II-B newborns.

The RN's will also complete the Level III neonatal course.

There will be an NNP (neonatal nurse practitioner) present at Hendersonville Medical Center 24/7, to provide specialized care and oversight to its NICU patients, as well as to provide ongoing support and training to the nursery's RN's and respiratory staff.

3. *Physicians' Education: A program of courses for physicians should be provided by the instructional staff of the Regional Perinatal Center and by qualified individuals on the staff of the Level II institution.*

   Complies. At the physician level, the contracted neonatologists will complete continuing education courses to maintain certification and be abreast of new methods and treatments to ensure optimal patient outcomes.

4. *All neonatal care providers should maintain both current NRP and S.T.A.B.L.E. provider status.*

   Complies. All neonatal care providers currently maintain NRP and S.T.A.B.L.E. certification.

B. *Neonatal Care*

Level II facilities should provide specialty neonatal care as follows (See the most recent edition of the Guidelines for Perinatal Care, jointly published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists):

1. *A specialty care nursery has the capabilities to:*
   - *Provide care for preterm infants with birth weight ≥ 1500 grams.*
   - *Provide resuscitation and stabilization of preterm and /or ill infants before transfer to a facility at which a Level III newborn intensive care is provided.*

   Complies. Hendersonville Medical Center will comply with these requirements in this Level II-B NICU.

2. *Level II-B nurseries can provide mechanical ventilation for brief durations (less than 24 hours) or continuous positive airway pressure.*

Complies. Hendersonville Medical Center will comply with this requirement in its Level II-B NICU.

3. *Level II-B nurseries must have the personnel (e.g., physicians, specialized nurses, respiratory therapists, radiology technicians, laboratory technicians) and equipment (e.g., portable chest radiograph, blood gas laboratory) continuously available to provide ongoing care as well as to address emergencies. When the unit has an infant on a ventilator, specialized personnel should be available on site to manage respiratory emergencies.*

   Complies. Hendersonville Medical Center will comply with these requirements upon addition of Level II-B NICU. The NICU will be staffed by a Neonatal Nurse Practitioner and NICU-trained RN's 24/7. There will be a respiratory therapist in the hospital 24/7 who has the competencies to care for a level II infant. The hospital is also working with Pediatrix and Women's and Children's to have telemedicine consultation services available/

4. *Laboratory Services: Laboratory capabilities should include the following determinations on microvolume samples, when possible:*

   a. *Routine Availability*

      - *Clotting factors*
      - *Serum total protein*
      - *Serum albumin*
      - *Serum IgM*
      - *Serum triglycerides (for parenteral nutrition)*
      - *Metabolic screen*
      - *Liver function tests*
      - *Serologic test for syphilis*
      - *Serology for hepatitis*
      - *Screening for HIV*
      - *TORCH titers*
      - *Viral cultures*

   b. *Available 24 Hours-7 Days Per Week*

      - *Hematocrit*
      - *Hemoglobin*
      - *Complete blood count*
      - *Reticulocyte count*

- *Blood typing: major groups and Rh*
- *Cross match*
- *Minor blood group antibody screen*
- *Coombs' test*
- *Prothrombin time*
- *Partial thromboplastin time*
- *Platelet count*
- *Fibrinogen concentration*
- *Serum sodium, potassium, chloride*
- *Serum calcium*
- *Serum phosphorus*
- *Serum magnesium*
- *Serum or blood glucose*
- *Therapeutic drug levels*
- *Serum bilirubin, total and direct*
- *Blood gases/pH*
- *Blood urea nitrogen*
- *Serum creatinine*
- *Serum/urine osmolatities*
- *Urinalysis*
- *Cerebrospinal fluid: cells, chemistry*
- *Bacterial cultures and sensitivities*
- *C-reactive protein (CRP)*
- *Gram stain*
- *Toxicology*
- *Group B strep screening*

Complies. Hendersonville Medical Center already has all of the above testing capabilities.

5. *Blood Bank Services: Blood bank services should be maintained at all times. An appropriately trained technician should be in-house 24 hours daily. All blood components must be available on an emergency basis, either on the premises or by pre-arrangement with another facility.*

Complies. Hendersonville Medical Center currently has this service and operates it in compliance with this standard.

C. Consultation and Transfer

The Level II-B facilities should maintain active relationships with a Level III facility in the region for consultation and transfer. Protocols for transport should conform to the most recent edition of the Tennessee

Perinatal Care System Guidelines on Transportation, published by the Tennessee Department of Health.

Neonatal Consultation and Transport: When the severity of an illness requires a level of care that exceeds the capacity of the Level II-B facility, the infant should be transferred to a Level III institution capable of providing required care. Transport of these infants should be provided after consultation with the receiving Level III unit. Refer to the most recent edition of the Tennessee Perinatal Care System Guidelines on Transportation, published by the Tennessee Department of Health, for more information.

Complies. Hendersonville Medical Center currently has relationships with two different Level III facilities in Nashville: Centennial Women's and Children's Hospital and Vanderbilt Children's Hospital. Both facilities accept HMC's neonatal transports if the newborn's condition requires a higher level of care.

Transferred newborns will have a neonatology consult prior to the transport. Appropriate communications before and after the transfer will be facilitated by the presence of neonatal nurse practitioners, telemedicine, and (when Centennial is the destination) an electronic medical record and imaging system shared by HMC and Centennial.

D. Maintenance of Data

The following items represent the minimum information that should be in medical records maintained at Level II-B facilities:

- *Name, hospital number*
- *Date of birth*
- *Birthweight*
- *Gestational age*
- *Apgar scores (per current NRP guidelines)*
- *Maternal complications*
- *Discharge diagnoses*
- *Special care administered (specify)*
- *Documentation of newborn metabolic and hearing screen and immunizations and medications given*
- *Bilirubin screen (according to American Academy of Pediatrics guidelines)*
- *Disposition*
  --discharged home
  --transferred to Level III facility/receiving hospital/transport
  --expired

Complies. Hendersonville Medical Center currently maintains in the patient's medical record all of the documentation listed above.

III. PERSONNEL: QUALIFICATIONS AND FUNCTIONS

Requirements for adequate staffing are based upon the assumption that patients will be transferred to a Level III facility when their illnesses necessitate a level of care that exceeds the capability of Level II-B facilities

A. Physicians

1. *At a hospital with a Level II nursery, a board-certified obstetrician/gynecologist with special interest, experience, and, in some situations, a subspecialty in maternal-fetal medicine, should be chief of the obstetric service.*

   Complies. Hendersonville Medical Center has a Perinatal committee. The chairman of the committee is Dr. Brent Nason, board certified OB/GYN. The co-chairman of the committee is Dr. Saagar Karlekar, board certified pediatrician. The committee meets quarterly to discuss any new policies, procedures, or process changes within the departments or facility. All obstetricians, gynecologists and pediatricians on staff are invited to attend these meetings. Neonatology, perinatology, anesthesiology, quality and administration are also represented as appropriate.

2. *In a hospital with a Level II-B nursery, a board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine should be chief of the neonatal care service.*

   Complies. Dr. Sami Ismail, board certified neonatologist with Pediatrix is currently the Medical Director of our Level II-A special care nursery. He has served as the Medical Director for the special care nursery since 1992. Upon the addition of a six bed Level II-B NICU, he will continue to serve as Medical Director.
   Dr. Ismail joined the medical staff of Centennial Medical Center in 1989 as the Director of Neonatology. He continues to maintain that position. The following is a list of positions that he has held:

   - Director of Newborn Intensive Care Unit at Centennial Women's and Children's.
   - Director of Newborn Intensive Care Unit Transport Services.
   - Director of Neonatal Nurse Practitioner Program
   - President of Mid-TN Neonatology Associates
   - Medical Director of Pediatrix Medical Group of TN

- Board of Trustees for Centennial Medical Center

3. *These physicians should coordinate the hospital's perinatal care services and, in conjunction with other medical, anesthesia, nursing, respiratory therapy, and hospital administration staff, develop policies concerning staffing, procedures, equipment, and supplies. The specialty chairman of obstetrics and neonatology are responsible for setting the hospital's standard of perinatal care by working together to incorporate evidence-based practice patterns and nationally recognized care standards.*

Complies. Hendersonville Medical Center has a very involved medical staff that consistently and routinely is involved in setting our standards of perinatal care. They are very active participants in committees and policy development. Hendersonville Medical Center is part of the HCA network of hospitals and has the unique opportunity for MD's to utilize education, mentoring, consultation, policy and protocol resources from the HCA corporate Women's & Children's department as well as from HCA hospitals in the Nashville market.

4. *Normal deliveries should be attended by a physician or a certified nurse midwife, and a registered nurse.*

   Complies. Currently, 5 OB/GYN MD's manage all deliveries at Hendersonville Medical Center;, 2RN's and a CRNA attend all vaginal deliveries; 2 RN's, a CRNA and a MD of anesthesia attend all C-section deliveries.

5. *Every delivery should be attended by at least one person whose primary responsibility is for the newborn and who is capable of initiating neonatal resuscitation according to the American Heart Association and American Academy of Pediatrics Neonatal Resuscitation Program guidelines. Either that person or someone else who is immediately available should have the skills required to perform a complete resuscitation, including endotracheal intubation and administration of medications.*

   Complies. Hendersonville Medical Center currently meets this requirement. All RN's, respiratory therapists, anesthesia personnel and pediatricians are required to maintain NRP certification. 2 RN's and a CRNA attend every vaginal delivery. 2 RN's, a CRNA and a MD of anesthesia attend all C-section deliveries.

Hendersonville Medical Center employs a RN in Women's Services who is an NRP instructor. She is also responsible for resuscitation competency monitoring and mentoring.

Upon the addition of a six bed Level II-B NICU, there will be an NNP and an NICU RN in house 24/7 to attend deliveries of infants requiring extensive resuscitation or continued specialized care.

6. *Deliveries of high-risk fetuses should be attended by an obstetrician and at least two other persons qualified in neonatal resuscitation whose only responsibility is the neonate. With multiple gestations, each newborn should have his or her own dedicated team of care providers who are capable of performing neonatal resuscitation according to the American Heart Association and American Academy of Pediatrics Neonatal Resuscitation Program guidelines.*

   Complies. Hendersonville Medical Center currently meets this requirement. 2 RN's, a CRNA and a Respiratory Therapist attend all high-risk deliveries. A pediatric care provider, when asked to do so, will attend any high-risk delivery. Multiple gestations have a dedicated team of care providers for each infant. Upon the addition of the proposed Level II-B NICU, there will an NNP and an NICU RN in house 24/7 to attend all high risk deliveries.

B. Nurses

1. *The nurse manager (RN) is responsible for all nursing activities in the nurseries of Level II-B facilities. The nurse manager of a Level II-B unit must complete the Level III neonatal course prescribed for nurses in the most recent edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, published by the Tennessee Department of Health.*

   Complies. Beth Gupton, RN is the Clinical Manager of Women's Services at Hendersonville Medical Center. She has completed the neonatal course as outlined in the *Tennessee Perinatal Care System Educational Objectives for Nurses (Fourth Edition).* She is a member of HCA's Perinatal Workgroup (RN's & MD's) that meets annually to develop standards of care, policy and protocol for perinatal care at HCA hospitals nationwide.

2. *All staff nurses (RN) must be skilled in the observation and treatment of sick infants. For Level II-B facilities they should complete the Level III neonatal course for nurses. Nurses should maintain institutional*

unit-specific competencies. In addition, all nurses should be current NRP and S.T.A.B.L.E providers.

Complies. All nursery staff have completed unit-specific competencies, as well as the neonatal course as outlined in the *Tennessee Perinatal Care System Educational Objectives for Nurses (Fourth Edition).* Also, they maintain current certifications in NRP and S.T.A.B.L.E.

Hendersonville Medical Center employs an RN in Women's Services who is an NRP instructor. She is responsible for NRP instruction as well resuscitation competency monitoring and mentoring.

Prior to the addition of a six bed Level II-B NICU, the NICU RN's and respiratory therapists will receive additional training in the NICU at Centennial Women's and Children's. Under the oversight of NICU nurses at Centennial Women's and Children's, the RN's and respiratory therapists will complete an initial orientation and will receive ongoing training until they achieve the competencies required to care for Level II-B newborns. The RN's will also complete the Level III neonatal course.

There will be an NNP (neonatal nurse practitioner) at Hendersonville Medical Center 24/7 to provide specialized care and oversight to the NICU patients. The NNP will also provide ongoing support and training to the NICU RN's and respiratory staff.

3. *Recommended Registered Nurse (RN) / Patient Ratios for Newborn Care (refer to the 6th edition, Guidelines for Perinatal Care):*

Ratio	***Care Provided***
1:6-8	*Newborns requiring only routine care*
1:3-4	*Newborns requiring continuing care*
1:2-3	*Newborns requiring intermediate care*
1:1-2	*Newborns requiring intensive care*
1:1	*Newborns requiring multisystem support*
1:1 or greater	*Unstable newborns requiring complex critical care*

Complies. Hendersonville Medical Center meets and exceeds the nurse/ patient ratios as outlined for Level I and Level II-A care. With the addition of six Level II-B NICU beds, Hendersonville Medical Center will meet the above ratios at a minimum.

C. Respiratory Therapists:

Respiratory therapists who can supervise the assisted ventilation of neonates with cardiopulmonary disease should be available.

Complies. Hendersonville Medical Center complies with this requirement.

Prior to the addition of a six bed Level II-B NICU, the respiratory therapists will receive additional training in the NICU at Centennial Women's and Children's. Under the oversight of NICU respiratory therapists at Centennial Women's and Children's, the respiratory therapists will complete an initial orientation and will receive ongoing training until they achieve the competencies required to care for Level II-B newborns.

There will be an NNP (neonatal nurse practitioner) at Hendersonville Medical Center 24/7 to provide specialized care and oversight to the NICU patients. The NNP will also provide ongoing support and training to the NICU respiratory staff.

D. Social Workers:

Personnel experienced in dealing with perinatal issues, discharge planning and education, follow-up and referral, home care planning, and bereavement support should be available to intermediate and intensive care unit staff members and families.

Complies. Hendersonville Medical Center complies with this requirement.

E. Nutritionist/Dietitian/Lactation Consultant

The staff must include at least one dietitian or nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high risk neonates. Lactation services and consultation should be available. Staffing ratios for lactation consultants should be based on the number of births and/or the number of admissions to the neonatal intensive care unit at the facility. According to the Journal of Human Lactation (2006), the hospital's Mother/Baby unit should be staffed with one full-time equivalent (FTE) lactation consultant for every 783 breastfeeding couplets. In addition, there should be one full-time

equivalent (FTE) lactation consultant for every 235 infants admitted to the neonatal intensive care unit.

Complies. Hendersonville Medical Center complies with this requirement.

F. Pharmacist

A registered pharmacist with expertise in compounding and dispensing medications, including total parenteral nutrition (TPN) for neonates must be available 24 hours per day.

Complies. Hendersonville Medical Center complies with this requirement.

IV. SPACE AND EQUIPMENT FOR LEVEL II-B FACILITIES

A. *Physical facilities and equipment should meet criteria published in the latest edition of the Guidelines for Perinatal Care, jointly published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.*

Complies. Hendersonville Medical Center complies with this requirement.

B. *Minimal equipment for care of the normal infant includes:*

1. *A platform scale, preferably with metric indicators.*
2. *A controlled source of continuous and/or intermittent suction.*
3. *Incubators and/or radiant warmers for adequate thermal support.*
4. *Equipment for determination of blood glucose at the bedside.*
5. *Ability to provide intensive phototherapy.*
6. *A device for the external measurement of blood pressure from the infant's arm or thigh.*

7. *Oxygen flow meters, tubing, binasal cannulas for short-term administration of oxygen.*
8. *A headbox assembly (oxygen hood), an oxygen blending device, and warming nebulizer for short-term administration of oxygen.*
9. *An oxygen analyzer that displays the ambient concentration of oxygen.*
10. *A newborn pulse oximeter for non-invasive blood oxygen monitoring.*
11. *An infusion pump that can deliver appropriate volumes of continuous fluids and/or medications for newborns.*
12. *A fully equipped neonatal resuscitation cart.*
13. *A positive pressure bag and mask; endotracheal tubes in all the appropriate sizes for neonates.*
14. *A laryngoscope with premature and infant size blades.*
15. *A CO2 detector.*

Complies. Hendersonville Medical Center has all of the equipment listed above available for every newborn.

C. *Intermediate Care Nursery*

Additional equipment needed for intermediate care newborns include:

1. *A servo-controlled incubator or heated open bed for each infant who requires a controlled thermal environment.*
2. *Cardiorespiratory monitors that include pressure and waveform monitoring.*
3. *Oxygen analyzers, blenders, heaters, and humidifiers sufficient for anticipated census.*
4. *A sufficient number of head box assemblies (oxygen hoods).*
5. *Modes of respiratory support: binasal cannulas, conventional mechanical ventilator, mechanism to deliver nasal CPAP.*
6. *A resuscitation bag and mask for each infant.*
7. *An adequate supply of endotracheal tubes and other intubation supplies.*
8. *A device for viewing x-rays in the infant area.*

Complies. Hendersonville Medical Center currently owns all of the above equipment. Additional equipment will be purchased upon approval of the CON and addition of six NICU beds.

PEDIATRIX MEDICAL GROUP

Search

Online Bill Payment LEARN MORE

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Meet the Team

Clinician	Specialty
Campbell, Susan B., MD	Neonatologist
Hamdan, Ashraf , MD	Neonatologist
Hassell, Sarah E., MD	Neonatologist
Ismail, M. Sami , MD	Neonatologist
Karmo, Hadeer N., MD	Neonatologist
McKee, Lara , MD	Neonatologist
Palmer, Scott , MD	Neonatologist
Pearson, Delinda , MD	Neonatologist
Ravenscroft, Jenny , MD	Neonatologist
Walker, Donna-Jean , MD	Neonatologist
Adams, Mary Lou , MSN, APN, PNP - BC	Neonatal Nurse Practitioner
Allen, Kathy , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Brogdon, Elizabeth , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Cashion, Lisa , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Collins, Mary Helen , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Douglass, Lane , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Eklund, Wakako , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Harrison, Kathy , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Kleinfeld, Cori , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Perry, Brooke , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Sawyer, Christie , MSN, APN, NNP - BC	Neonatal Nurse Practitioner
Scott, Patti , MSN, APN, NNP - BC	Neonatal Nurse Practitioner

Back

CURRICULUM VITAE

Muhammad Sami Ismail, M.D.
101 Wyn Oak Circle
Nashville, TN 37205
615-386-3685

Born: March 22, 1954
Antioche, Turkey

Citizenship: U.S.A.

Visa Type: Permanent Resident

Social Security: 221-64-2442

Marital Status: Married, wife Hanan
Three daughters

Office: Pediatrix Medical Group of TN
2201 Murphy Ave. #207
Nashville, TN 37203
Office# (615) 342-4660
Fax# (615) 342-4662

LICENSURE

ECFMG - #284-659-0
Virginia State Board of Medicine, #0101-036388, 2/84
Delaware Board of Medicine, #C1002509, 9/84
Tennessee Board of Medicine, #MD19241, 10/88
Board Certified, American Board of Pediatrics #35796, 1987
Board Certified, Neonatal/Perinatal Medicine #1758, 1987
Maintanance of Certification (MOC) of the American Board of Pediatrics - 2009

EDUCATION

Faculty of Medicine of Aleppo University, Syria
1971-1977, M.D. Degree

MILITARY SERVICE RECORD

None

7/20/12

POST-DOCTORAL TRAINING

Red Cross Children's Hospital, Pediatric Training (Aleppo, Syria) 1977-1979

Middlesborough Memorial Hospital Internal Medicine (visiting observer) Middlesborough, England 1979-1980

Darlington Memorial Hospital, Darlington, England 1980 (Passed PLAB exam for foreign graduates in England)

Practice in Critical Care Unit at Los Cedros Hospital, Buenos Aires, Argentina 1980-1981

Los Cedros Hospital, Buenos Aires, Argentina (clinical rotation critical care unit) 1980-1981

Wilmington Medical Center, Wilmington, DE (observer Pediatrics) 1981-1982 (passed VQE)

Wilmington Medical Center, Wilmington, DE Pediatric Residency 1982-1985

Medical College of Virginia, Richmond, VA Neonatology Fellow, 1985-1987

Henrico Doctors Hospital, Richmond, VA Clinical Neonatologist 1987-1989

Centennial The Women's Hospital, Nashville, TN Director of Neonatology 1989 – present
Summit Medical Center, Hermitage, TN 1989 – present
Southern Hills Medical Center, Nashville, TN 1989-2008
Hendersonville Medical Center, Hendersonville, TN 1992 – present
Nashville Memorial (Skyline Hospital), Nashville, TN 1992 – 2004
Metro General Hospital, Nashville, TN 1995 – present
Williamson Medical Center, Franklin, TN 2004 – present
Horizon Medical Center, Dickson, TN 2005 – present
StoneCrest Medical Center, Smyrna, TN 2006 – present
Middle TN Medical Center, Murfreesboro, TN 2007 – present

ACADEMIC APPOINTMENTS

Instructor of Pediatrics, Children's Medical Center, Medical College of Virginia, Richmond, VA July 1986 – June 1987

POSITIONS HELD

Director of Newborn Intensive Care Unit at Centennial The Women's Hospital

Director of Neonatal Nurse Practitioner Program
President of Mid-TN Neonatology Associates
Medical Director of Pediatrix Medical Group of TN
Board of Trustee for Centennial Medical Center

MEMBERSHIPS

American Medical Association
American Academy of Pediatrics
Tennessee Pediatric Society
Davidson County Pediatric Association
Arab American Medical Association
Nashville Academy of Medicine
Medical Director of Pediatric Nursing Specialist
National Perinatal Association
Centennial Board of Director
Tennessee Perinatal Association
District 4 Perinatal Section

RESEARCH

Significance and Application of the Ancient Medicine of Arabs, 1974

Group B Strep Infection in Newborns (Early Diagnosis) Study, Medical Center of Delaware

CPT and Incidence of IVH/PVH in Neonates

Incidence of Biliary Slugs/Gallstones in Newborns Receiving HAL, Accepted for Presentation in Poster Session at the April 1987 SPR Conference in Anaheim, CA

BIBLIOGRAPHY

Ismail, MS; Immunodeficiency Disease in Children, published by Aleppo University, 1977

Arectingy, R, Ismail, MS; Significance and Application of the Ancient Arab Medicine, published by the VI International Symposium of the Ancient Medicine of Arabs, sponsored by Aleppo University, 1974

Renewal No. 763064

License No. [illegible]

MD0000019241

State of Tennessee

Division Of Health Related Boards

This Certifies that

MUHAMMAD S ISMAIL, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through MARCH 31, 2014

DIRECTOR HEALTH RELATED BOARDS

DCF014 12038

From: appsmail@abpeds.org
To: neomomma@aol.com
Subject: American Board of Pediatrics - MOC Enrollment License Verified
Date: Mon, Dec 28, 2009 1:05 pm

Dr. Muhammad Sami Ismail:
ABP ID # 204946

You have successfully completed the enrollment application process for Maintenance of Certification (MOC) of the American Board of Pediatrics (ABP).

Please take note of the following information regarding your next MOC Cycle dates. These dates represent the start and end of your MOC cycle. You may complete activities for credit only during this time. Your specific MOC requirements can be found with your ABP Portfolio.

MOC Cycle Dates January 1, 2010 through December 31, 2014

This e-mail is generated automatically, and replies sent to this address cannot be answered. If you have any questions regarding your enrollment status, please feel free to visit the ABP Web site (www.abp.org) or e-mail us at moc@abpeds.org .

The American Board of Pediatrics

and its

Subboard of Neonatal-Perinatal Medicine

hereby declare that

Muhammad Sami Ismail, M.D.

who is certified in Neonatal-Perinatal Medicine
has completed the maintenance of certification program
as a Diplomate of
the American Board of Pediatrics

No. 01758

October 7, 2009

M. Douglas Jones Jr.
Chair, American Board of Pediatrics

James G. Hochmann
President, American Board of Pediatrics

The American Board of Pediatrics
ABP
Founded 1933

AMERICAN BOARD OF MEDICAL SPECIALTIES
EXCELLENCE
OPIBUSQUE

Richard J. Martin
Chair, Subboard

Carol Carraccio
Secretary, American Board of Pediatrics

The American Board of Pediatrics

hereby certifies that

Muhammad Sami Ismail, M.D.

has successfully fulfilled the requirements
of this Board and
is declared a

Diplomate of The American Board of Pediatrics

No. 35796 June 21, 1987

President Secretary

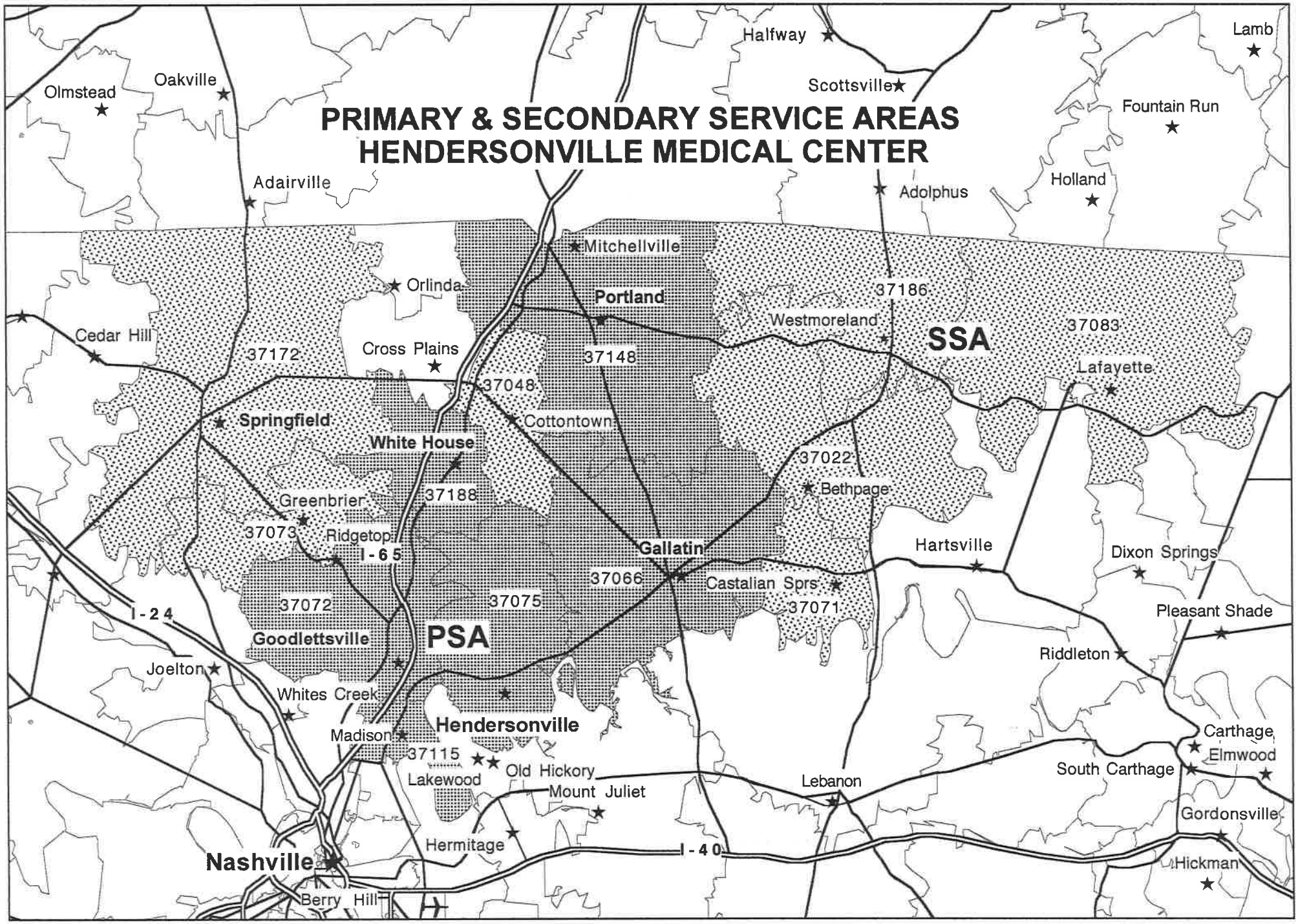
My Commission Expires Sept. 25, 2010

REBECCA A. BOND
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

THE SEAL · AMERICAN BOARD OF PEDIATRICS

AMERICAN BOARD OF MEDICAL SPECIALTIES
1933
EXCELLENCE
ORIBUSQUE

C, Need--3
Service Area Maps


PRIMARY & SECONDARY SERVICE AREAS
HENDERSONVILLE MEDICAL CENTER
Olmstead
Oakville
Halfway
Scottsville
Lamb
Fountain Run
Adairville
Adolphus
Holland
Mitchellville
Orlinda
Portland
37186
Westmoreland
SSA
37083
Cedar Hill
37172
Cross Plains
37148
Lafayette
37048
Springfield
Cottontown
White House
37022
Bethpage
Greenbrier
37188
37073
Ridgetop
I-65
Gallatin
Hartsville
Dixon Springs
37066
Castalian Sprs
37071
I-24
37072
37075
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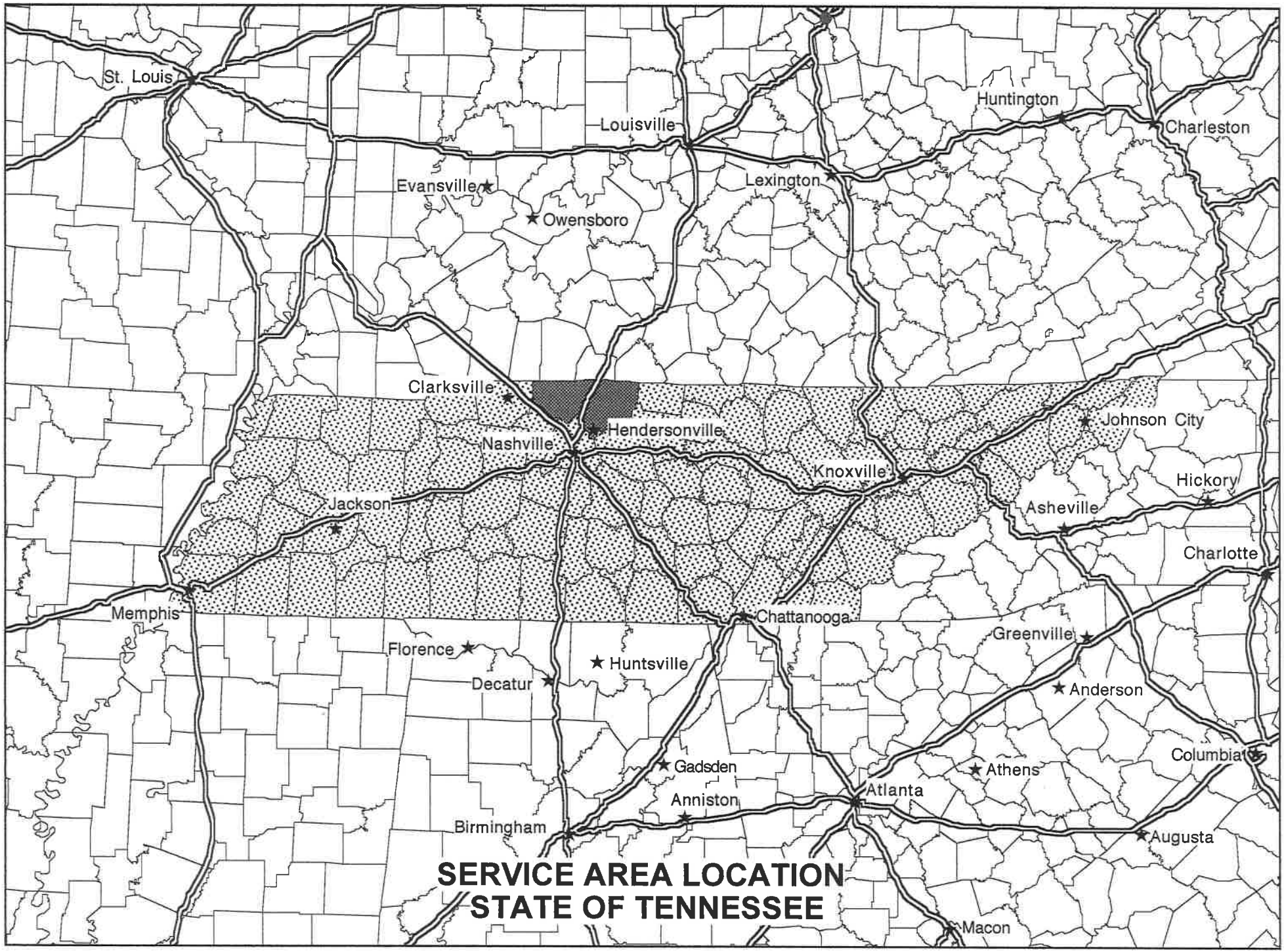

SERVICE AREA LOCATION
STATE OF TENNESSEE

C, Economic Feasibility--1
Documentation of Construction Cost Estimate

Lyman
Davidson
Dooley, Inc.

ARCHITECTS
INTERIOR DESIGNERS
PLANNERS

February 14, 2013

RE: Hendersonville Medical Center – Bed Expansion and NICU Project

To Whom It May Concern,

Lyman Davidson Dooley, Inc., an architectural firm registered to practice in Tennessee, has reviewed the cost data provided for the above bed expansion and NICU project. The stated construction cost is $21,068,150. It is our opinion that the proposed construction cost appears to be reasonable for this project type and size and compares favorably with other completed projects similar to this type and size.

This is a summary of the current building codes enforced for this project:

State of Tennessee Division of Health Care Facilities:

International Building Code	2006
NFPA 101 Life Safety Code	2006
AIA Guidelines for Design & Construction of Hospital and Health Care Facilities	2010
Americans with Disabilities Act (ADAAG)	2004 Amendments
North Carolina Accessibility Code	2002 with 2004 Amendments
International Mechanical Code	2006
International Plumbing Code	2006
International Gas Code	2006
International Electrical Code	2006

615.244.7399

fax: 615.244.6697

209 10th Avenue South
Suite 327, Cummins Station
Nashville, TN 37203

www.ldd-architects.com

ATLANTA
NASHVILLE
TAMPA

City of Hendersonville, TN:

International Building Code with City Amendments	2006
International Mechanical Code	2006
International Plumbing Code	2006
National Electric Code (NFPA 70)	2008
NFPA 101	2006
International Fuel Gas Code	2006 with City Amendments
ANSI 117.1	2003
International Energy Conservation Code	2006

Respectfully,
Lyman Davidson Dooley, Inc.

Thomas A. Dooley, AIA
AIA No. 30074467

C, Economic Feasibility--2
Documentation of Availability of Funding

TRISTAR
HEALTH SYSTEM

February 13, 2013

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: CON Application Hendersonville Medical Center, Sumner County
For relocation of Licensed Beds, Initiation of Level II-B Neonatal Intensive Care and structural updates of Campus facilities

Dear Mrs. Hill:

Hendersonville Medical Center is applying for a Certificate of Need for the subject project this month.

As Chief Financial Officer of the TriStar Health System, the HCA Division Office to which this facility will belong, I am writing to confirm that HCA, Inc. is prepared to provide through TriStar the approximately $32,255,000 in capital costs required by this project. HCA, Inc.'s financial statements are provided in the application.

Sincerely,

Eric Lawson
Chief Financial Officer

EL/vg

C, Economic Feasibility--10
Financial Statements

FINANCIAL STATEMENT REPORTS
HENDERSONVILLE MEDICAL CENTER
FINANCIAL STATEMENT
AS OF 12/31/12

BALANCE SHEET
ASSETS

CURRENT MONTH BEGIN	CURRENT MONTH CHANGE	CURRENT MONTH ENDING		YEAR TO DATE ENDING	YEAR TO DATE CHANGE	YEAR TO DATE BEGIN
			CURRENT ASSETS-			
44,097	10,537	54,634	CASH & CASH EQUIVALENTS	54,634	2,274	52,360
			MARKETABLE SECURITIES			
			PATIENT ACCOUNTS RECEIVABLES			
31,006,531	155,217	31,161,748	PATIENT RECEIVABLES	31,161,748	3,594,686	27,567,062
			LESS ALLOW FOR GOVT RECEIVABL			
17,225,403-	632,520-	17,858,011-	LESS ALLOWS - BAD DEBT	17,858,011-	4,465,777-	13,392,234-
13,781,040	477,311-	13,303,737	NET PATIENT RECEIVABLES	13,303,737	871,091-	14,174,828
			FINAL SETTLMENTS			
58,909-	82,635	23,726	DUE TO/FROM GOVT PROGRAMS	23,726	10,741	12,985
			ALLOWS DUE GOVT PROGRAMS			
58,909-	82,635	23,726	NET FINAL SETTLEMENTS	23,726	10,741	12,985
13,722,139	394,676-	13,327,463	NET ACCOUNTS RECEIVABLES	13,327,463	860,350-	14,187,813
3,068,483	79,312-	2,989,171	INVENTORIES	2,989,171	314,702	2,674,469
138,985	992,522	1,131,507	PREPAID EXPENSES	1,131,507	971,810	159,697
219,686	15,002-	204,684	OTHER RECEIVABLES	204,684	186,218	18,466
17,193,390	514,069	17,707,459	TOTAL CURRENT ASSETS	17,707,459	614,654	17,092,805
			PROPERTY, PLANT & EQUIPMENT			
4,700,340	6,240	4,706,580	LAND	4,706,580	36,189	4,670,391
25,128,316	290,000	25,418,316	BLDGS AND IMPROVEMENTS	25,418,316	1,450,032	23,968,284
57,893,900	732,403	58,626,303	EQUIPMENT - OWNED	58,626,303	3,794,045	54,832,258
632,913		632,913	EQUIPMENT - CAPITAL LEASES	632,913	632,913	
516,059	192,786	708,845	CONSTRUCTION IN PROGRESS	708,845	1,100,445-	1,809,290
88,871,528	1,221,429	90,092,957	GROSS PP&E	90,092,957	4,812,734	85,280,223
57,296,303-	369,670-	57,665,973-	LESS ACCUMULATED DEPRECIATION	57,665,973-	3,344,643-	54,321,330-
31,575,225	851,759	32,426,984	NET PP&E	32,426,984	1,468,091	30,958,893
			OTHER ASSETS			
			INVESTMENTS			
			NOTES RECEIVABLE			
1,638,694	23,140	1,661,834	INTANGIBLE ASSETS - NET	1,661,834	23,140	1,638,694
			INVESTMENT IN SUBSIDIARIES			
878,656	878,656-		OTHER ASSETS			
2,517,350	855,516-	1,661,834	TOTAL OTHER ASSETS	1,661,834	23,140	1,638,694
51,285,965	510,312	51,796,277	GRAND TOTAL ASSETS	51,796,277	2,105,885	49,690,392

FINANCIAL STATEMENT REPORTS
HENDERSONVILLE MEDICAL CENTER
FINANCIAL STATEMENT
AS OF 12/31/12

BALANCE SHEET
LIABILITIES AND EQUITY

CURRENT MONTH BEGIN	CURRENT MONTH CHANGE	CURRENT MONTH ENDING		YEAR TO DATE ENDING	YEAR TO DATE CHANGE	YEAR TO DATE BEGIN
			CURRENT LIABILITIES-			
1,760,939	1,346,426	3,107,365	ACCOUNTS PAYABLE	3,107,365	540,939	2,566,426
2,577,531	196,138	2,773,669	ACCRUED SALARIES	2,773,669	435,161	2,338,508
545,120	8,861	553,981	ACCRUED EXPENSES	553,981	1,764-	555,745
			ACCRUED INTEREST			
			DISTRIBUTIONS PAYABLE			
96,466	9,515	105,981	CURR PORT-LONG TERM DEBT	105,981	105,981	
38,557	1,111	39,668	OTHR CURRENT LIABILITIES	39,668	9,592-	49,260
			INCOME TAXES PAYABLE			
5,018,613	1,562,051	6,580,664	TOTAL CURRENT LIABILITIES	6,580,664	1,070,725	5,509,939
			LONG TERM DEBT-			
519,454	18,086-	501,368	CAPITALIZED LEASES	501,368	501,368	
39,826,129-	4,173,524-	43,999,653-	INTERCOMPANY DEBT	43,999,653-	11,953,310-	32,046,343-
			OTHER LONG TERM DEBTS			
39,306,675-	4,191,610-	43,498,285-	TOTAL LONG TERM DEBTS	43,498,285-	11,451,942-	32,046,343-
			DEFERRED CREDITS AND OTHER LIAB			
			PROFESSIONAL LIABBILITY RISK			
			DEFERRED INCOME TAXES			
67,714	493	68,207	LONG-TERM OBLIGATIONS	68,207	22,149	46,058
67,714	493	68,207	TOTAL OTHER LIAB. & DEF.	68,207	22,149	46,058
			EQUITY			
1,000		1,000	COMMON STOCK - PAR VALUE	1,000		1,000
			CAPITAL IN EXCESS OF PAR VALU			
69,977,170		69,977,170	RETAINED EARNINGS - START OF	69,977,170	6,202,568-	76,179,738
15,528,143	3,139,378	18,667,521	NET INCOME - CURRENT YEAR	18,667,521	18,667,521	
			DISTRIBUTIONS			
			OTHER EQUITY			
85,506,313	3,139,378	88,645,691	TOTAL EQUITY	88,645,691	12,464,953	76,180,738
51,285,965	510,312	51,796,277	TOTAL LIABILITIES AND EQU	51,796,277	2,105,885	49,690,392

FINANCIAL STATEMENT REPORTS
HENDERSONVILLE MEDICAL CENTER
MONTHLY OPERATING STATEMENTS
FOR PERIODS ENDING 12/31/12

SUMMARY P & L STATEMENT

CURRENT MONTH LAST YEAR	CURRENT MONTH BUDGET	CURRENT MONTH THIS YEAR		YEAR TO DATE THIS YEAR	YEAR TO DATE BUDGET	YEAR TO DATE LAST YEAR
			REVENUES			
2,543,324	2,684,573	3,909,846	ROUTINE	35,076,722	29,207,400	26,108,241
15,464,047	15,431,565	16,445,286	INPATIENT ANCILLARY	178,792,696	169,832,973	155,432,727
18,007,371	18,116,138	20,355,132	TOTAL INPATIENT REVENUE	213,869,418	199,040,373	181,540,968
23,061,433	23,601,134	23,612,555	OUTPATIENT ANCILLARY	271,075,427	263,102,718	244,645,494
41,068,804	41,717,272	43,967,687	TOTAL PATIENT REVENUE	484,944,845	462,143,091	426,186,462
17,542	18,800	18,923	OTHER OPERATING INCOME	249,701	225,600	230,349
41,086,346	41,736,072	43,986,610	TOTAL REVENUES	485,194,546	462,368,691	426,416,811
			REVENUE DEDUCTIONS			
8,523,883	9,933,376	10,058,833	MEDICARE CY CONTRACTUALS	107,564,334	108,779,623	97,172,052
3,079	58,713	44,475	MEDICAID CY CONTRACTUALS	337,670	640,704	518,986
687,965	483,096	572,449	CHAMPUS CY CONTRACTUALS	6,458,169	5,312,818	5,606,681
59,122-		260,430-	PRIOR YEAR CONTRACTUALS	1,027,713-	685,237-	589,728-
19,136,058	19,001,236	20,468,901	HMO/PPO DISCOUNTS	226,197,488	207,530,523	189,797,507
120,526-	674,979	340,098	CHARITY	6,655,715	7,471,434	5,642,674
4,293,258	3,044,014	2,842,344	OTHER DEDUCTIONS	31,506,206	33,215,718	31,134,068
740,358	725,918	1,125,115	BAD DEBTS	13,568,367	8,106,829	8,657,891
33,204,953	33,921,332	35,191,785	TOTAL REVENUE DEDUCTIONS	391,260,236	370,372,412	337,940,131
8,681,393	7,814,740	8,794,825	TOTAL NET REVENUE	93,934,310	91,996,279	88,476,680
			OPERATING COSTS			
2,173,003	2,297,843	2,362,305	SALARIES AND WAGES	26,189,401	25,762,184	24,792,121
70,262	21,863	115,358	CONTRACT LABOR	1,021,160	336,368	931,345
494,564	543,310	576,368	EMPLOYEE BENEFITS	7,400,233	6,721,550	6,454,602
1,428,055	1,249,371	1,122,181	SUPPLIES	14,001,729	14,150,325	13,871,100
67,391	75,392	62,738	PROFESSIONAL FEES	746,080	892,804	559,579
876,826	899,914	980,833	CONTRACT SERVICES	10,834,016	10,582,952	9,989,568
200,531	225,526	231,270	REPAIRS AND MAINTENANCE	2,630,575	2,665,722	2,465,421
77,681	28,824	43,670	RENTS AND LEASES	420,767	342,281	437,046
131,750	121,537	115,549	UTILITIES	1,355,631	1,477,218	1,391,755
40,001-	68,249-	36,020-	INSURANCE	635,400	600,394	609,073
			INVESTMENT INCOME			
33,507	32,831	4,862-	TAXES-NON INCOME	360,268	394,587	274,521
200,294	217,169	253,867	OTHER OPERATING EXPENSES	1,682,859	1,964,981	1,675,909
5,705,143	5,645,331	5,823,257	TOTAL OPERATING EXPENSES	67,278,199	65,899,366	63,452,040
2,976,250	2,169,409	2,971,568	EBDIT	26,656,111	26,096,913	25,024,640
			CAPITAL AND OTHER COSTS			
331,859	323,870	377,001	DEPRECIATION	4,193,956	4,048,142	3,974,100
			AMORTIZATION			
			OTHER NON-OPERATING EXPENSE			
1,105,657	341,053-	170,966-	INTEREST EXPENSE	1,772,903-	3,792,466-	1,469,363-
243,952-	532,618	373,845-	MGMT FEES AND MARKUP COST	5,567,537	6,391,416	6,010,516
			MINORITY INTEREST			
1,193,564	515,435	167,810-	TOTAL CAPITAL AND OTHER	7,988,590	6,647,092	8,515,253
1,782,686	1,653,974	3,139,378	PRETAX INCOME	18,667,521	19,449,821	16,509,387
			TAXES ON INCOME			
			FEDERAL INCOME TAXES			
			STATE INCOME TAXES			
			TOTAL TAXES ON INCOME			
1,782,686	1,653,974	3,139,378	NET INCOME	18,667,521	19,449,821	16,509,387

FINANCIAL STATEMENT REPORTS
HENDERSONVILLE MEDICAL CENTER
MONTHLY OPERATING STATEMENTS
FOR PERIODS ENDING 12/31/12

SUMMARY P & L STATEMENT
COMPARISON TO BUDGET

CURRENT MONTH VARIANCE	CURRENT MONTH BUDGET	CURRENT MONTH THIS YEAR		YEAR TO DATE THIS YEAR	YEAR TO DATE BUDGET	YEAR TO DATE VARIANCE
			REVENUES			
1,225,273	2,684,573	3,909,846	ROUTINE	35,076,722	29,207,400	5,869,322
1,013,721	15,431,565	16,445,286	INPATIENT ANCILLARY	178,792,696	169,832,973	8,959,723
2,230,994	18,116,138	20,355,132	TOTAL INPATIENT REVENUE	213,869,418	199,040,373	14,829,045
11,421	23,601,134	23,612,555	OUTPATIENT ANCILLARY	271,075,427	263,102,718	7,972,709
2,250,415	41,717,272	43,967,687	TOTAL PATIENT REVENUE	484,944,845	462,143,091	22,801,754
123	18,800	18,923	OTHER OPERATING INCOME	249,701	225,600	24,101
2,250,538	41,736,072	43,986,610	TOTAL REVENUES	485,194,546	462,368,691	22,825,855
			REVENUE DEDUCTIONS			
125,457	9,933,376	10,058,833	MEDICARE CY CONTRACTUALS	107,564,334	108,779,623	1,215,289-
14,230-	58,713	44,475	MEDICAID CY CONTRACTUALS	337,670	640,704	303,034-
89,353	483,096	572,449	CHAMPUS CY CONTRACTUALS	6,458,169	5,312,818	1,145,351
260,430-		260,430-	PRIOR YEAR CONTRACTUALS	1,027,713-	685,237-	342,476-
1,467,665	19,001,236	20,468,901	HMO/PPO DISCOUNTS	226,197,488	207,530,523	18,666,965
334,881-	674,979	340,098	CHARITY	6,655,715	7,471,434	815,719-
201,670-	3,044,014	2,842,344	OTHER DEDUCTIONS	31,506,206	33,215,718	1,709,512-
399,197	725,918	1,125,115	BAD DEBTS	13,568,367	8,106,829	5,461,538
1,270,453	33,921,332	35,191,785	TOTAL REVENUE DEDUCTIONS	391,260,236	370,372,412	20,887,824
980,085	7,814,740	8,794,825	TOTAL NET REVENUE	93,934,310	91,996,279	1,938,031
			OPERATING EXPENSES			
64,462	2,297,843	2,362,305	SALARIES AND WAGES	26,189,401	25,762,184	427,217
93,495	21,863	115,358	CONTRACT LABOR	1,021,160	336,368	684,792
33,058	543,310	576,368	BENEFITS	7,400,233	6,721,550	678,683
127,190-	1,249,371	1,122,181	SUPPLIES	14,001,729	14,150,325	148,596-
12,654-	75,392	62,738	PROFESSIONAL FEES	746,080	892,804	146,724-
80,919	899,914	900,833	CONTRACT SERVICES	10,834,016	10,582,952	251,064
5,744	225,526	231,270	REPAIRS AND MAINTENANCE	2,630,575	2,665,722	35,147-
14,846	28,824	43,670	LEASES AND RENTALS	420,767	342,281	78,486
5,980-	121,537	115,549	UTILITIES	1,355,631	1,477,218	121,587-
32,229	68,249-	36,020-	INSURANCE	635,480	608,394	27,086
			INVESTMENT INCOME			
37,693-	32,831	4,862-	TAXES-NON INCOME	360,268	394,587	34,319-
36,698	217,169	253,867	OTHER OPERATING EXPENSES	1,682,859	1,964,981	282,122-
177,926	5,645,331	5,823,257	TOTAL OPERATING EXPENSES	67,278,199	65,899,366	1,378,833
802,159	2,169,409	2,971,568	EBDIT	26,656,111	26,096,913	559,198
			CAPITAL AND OTHER COSTS			
53,131	323,870	377,001	DEPRECIATION	4,193,956	4,048,142	145,814
			AMORTIZATION			
			OTHER NON-OPERATING EXPENSE			
170,087	341,053-	170,966-	INTEREST EXPENSE	1,772,903-	3,792,466-	2,019,563
906,463-	532,618	373,845-	MGMT FEES AND MARKUP COST	5,567,537	6,391,416	823,879-
			MINORITY INTEREST			
683,245-	515,435	167,810-	TOTAL CAPITAL AND OTHER	7,988,590	6,647,092	1,341,498
1,485,404	1,653,974	3,139,378	PRETAX INCOME (LOSS)	18,667,521	19,449,821	782,300-
			TAXES ON INCOME-			
			FEDERAL INCOME TAXES			
			STATE INCOME TAXES			
			TOTAL TAXES ON INCOME			
1,485,404	1,653,974	3,139,378	NET INCOME	18,667,521	19,449,821	782,300-

HCA Reports Third Quarter 2012 Results

NASHVILLE, Tenn.--(BUSINESS WIRE)--Nov. 1, 2012-- HCA Holdings, Inc. (NYSE: HCA) today announced financial and operating results for the third quarter ended September 30, 2012.

Key third quarter metrics (all percentage changes compare 3Q 2012 to 3Q 2011 unless noted):

- Revenues increased 11.1 percent to $8.062 billion
- Net income attributable to HCA Holdings, Inc. totaled $360 million, or $0.78 per diluted share
- Adjusted EBITDA increased 8.6 percent to $1.533 billion
- Cash flows from operations declined to $655 million due primarily to changes in working capital items and higher tax payments
- Same facility equivalent admissions increased 2.6 percent while same facility admissions increased 2.1 percent
- Same facility revenue per equivalent admission increased 0.7 percent

HCA Chairman and Chief Executive Officer, Richard M. Bracken, said, "We are pleased with the results of the third quarter. Although we remain in a challenging economic environment, we remain focused on clinical and operational initiatives that position the Company for future changes in the healthcare industry."

Revenues in the third quarter totaled $8.062 billion, compared to $7.258 billion in the third quarter of 2011. Third quarter revenue growth was primarily driven by increased volume and the consolidation of our HealthONE venture, which was accounted for under the equity method for periods prior to November 2011. Equivalent admissions increased 8.3 percent, while admissions increased 7.0 percent.

Same facility equivalent admissions increased 2.6 percent in the third quarter of 2012 compared to the prior year period, while same facility admissions increased 2.1 percent. Same facility emergency room visits increased 7.4 percent in the third quarter of 2012 compared to the prior year period.

Revenue per equivalent admission increased 2.5 percent in the third quarter of 2012, primarily reflecting a continuing shift in service and payer mix. The Company's operating expense per equivalent admission increased 3.1 percent from the prior

year's third quarter (2.0 percent on a same facility basis). During the third quarter of 2012, salaries and benefits, supplies and other operating expenses totaled $6.666 billion, or 82.7 percent of revenues, compared to $5.965 billion, or 82.1 percent of revenues, in the third quarter of 2011.

Adjusted EBITDA for the third quarter of 2012 increased 8.6 percent to $1.533 billion compared to $1.412 billion in the prior year period. Adjusted EBITDA is a non-GAAP financial measure. A table providing supplemental information on Adjusted EBITDA and reconciling net income attributable to HCA Holdings, Inc. to Adjusted EBITDA is included in this release.

Net income attributable to HCA Holdings, Inc. totaled $360 million, or $0.78 per diluted share, compared to $61 million, or $0.11 per diluted share, in the third quarter of 2011. Results for the third quarter of 2011 include pretax losses on retirement of debt of $406 million, or $0.49 per diluted share. The effective tax rate for the third quarter of 2011 was favorably impacted by the finalization of settlements for the 1997 through 2001 tax years. These settlements resulted in a reduction to interest expense related to taxing authority examinations of $66 million pretax, or $0.08 per diluted share. (All "per diluted share" disclosures are based upon amounts net of the applicable income taxes.)

Nine Months Ended September 30, 2012

Revenues for the nine months ended September 30, 2012 totaled $24.579 billion compared to $21.913 billion in the same period of 2011. Net income attributable to HCA Holdings, Inc. was $1.291 billion, or $2.81 per diluted share, compared to $530 million, or $1.04 per diluted share, for the first nine months of 2011. Results for the nine months ended September 30, 2011 include pretax losses on retirement of debt of $481 million, or $0.60 per diluted share, and a pretax charge for the termination of a management agreement of $181 million, or $0.29 per diluted share.

Balance Sheet and Cash Flow

As of September 30, 2012, HCA Holdings, Inc.'s balance sheet reflected cash and cash equivalents of $472 million, total debt of $26.933 billion, and total assets of $27.302 billion. During the third quarter of 2012, capital expenditures totaled $484 million, excluding acquisitions. Net cash provided by operating activities in the third quarter of 2012 totaled $655 million compared to $880 million in the prior year's third quarter. The reduction in cash flows from operating activities was primarily due to reductions of $145 million from changes in working capital items and $107 million from higher income taxes.

Special Cash Dividend

On October 23, 2012, the Board of Directors approved a special cash dividend of $2.50 per share to be paid to stockholders of record as of November 2, 2012 with a payment date of November 16, 2012. The dividend is expected to be funded through borrowings under the Company's credit facilities.

As of September 30, 2012, HCA operated 162 hospitals and 112 freestanding surgery centers.

Earnings Conference Call

HCA will host a conference call for investors at 9:00 a.m. Central Daylight Time today. All interested investors are invited to access a live audio broadcast of the call via webcast. The broadcast also will be available on a replay basis beginning this

Diluted earnings per share	**$0.78**	$0.11
Shares used in computing diluted earnings per share (000)	**459,515**	527,515
Comprehensive income (loss) attributable to HCA Holdings, Inc.	**$369**	($24)

HCA Holdings, Inc.

Condensed Consolidated Comprehensive Income Statements

For the Nine Months Ended September 30, 2012 and 2011

(Dollars in millions, except per share amounts)

	01-Q3 2012		2011	
	Amount	**Ratio**	Amount	Ratio
Revenues before provision for doubtful accounts	**$ 27,245**		$ 24,077	
Provision for doubtful accounts	**2,666**		2,164	
Revenues	**24,579**	**100.0 %**	21,913	100.0 %
Salaries and benefits	**11,224**	**45.7**	9,948	45.4
Supplies	**4,216**	**17.2**	3,833	17.5
Other operating expenses	**4,496**	**18.2**	4,017	18.3
Electronic health record incentive income	**(256)**	**(1.0)**	(90)	(0.4)
Equity in earnings of affiliates	**(26)**	**(0.1)**	(217)	(1.0)
Depreciation and amortization	**1,254**	**5.1**	1,078	4.9
Interest expense	**1,336**	**5.4**	1,572	7.2
Losses (gains) on sales of facilities	**(4)**	**-**	3	-
Losses on retirement of debt	**-**	**-**	481	2.2
Termination of management agreement	**-**	**-**	181	0.8
	22,240	**90.5**	20,806	94.9
Income before income taxes	**2,339**	**9.5**	1,107	5.1
Provision for income taxes	**760**	**3.1**	307	1.5

Net income	**1,579**	**6.4**	800	3.6
Net income attributable to noncontrolling interests	**288**	**1.1**	270	1.2
Net income attributable to HCA Holdings, Inc.	**$ 1,291**	**5.3**	$ 530	2.4
Diluted earnings per share	**$ 2.81**		$ 1.04	
Shares used in computing diluted earnings per share (000)	**458,822**		509,583	
Comprehensive income attributable to HCA Holdings, Inc.	**$ 1,291**		$ 534	

HCA Holdings, Inc.

Supplemental Non-GAAP Disclosures

Operating Results Summary

(Dollars in millions, except per share amounts)

	Third Quarter		For the Nine Months Ended September 30,	
	2012	**2011**	**2012**	**2011**
Revenues	**$ 8,062**	$ 7,258	24,579	$ 21,913
Net income attributable to HCA Holdings, Inc.	**$ 360**	$ 61	**$ 1,291**	$ 530
Losses (gains) on sales of facilities (net of tax)	**(5)**	1	**(3)**	4
Losses on retirement of debt (net of tax)	**-**	256	**-**	303
Termination of management agreement (net of tax)	**-**	-	**-**	149
Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement (a)	**355**	318	**1,288**	986
Depreciation and amortization	**417**	362	**1,254**	1,078
Interest expense	**446**	519	**1,336**	1,572
Provision for income taxes	**220**	128	**759**	516
Net income attributable to noncontrolling interests	**95**	85	**288**	270
Adjusted EBITDA (a)	**$ 1,533**	$ 1,412	**$ 4,925**	$ 4,422

Diluted earnings per share:				
Net income attributable to HCA Holdings, Inc.	$ **0.78**	$ 0.11	$ **2.81**	$ 1.04
Losses (gains) on sales of facilities	**(0.01)**	-	-	0.01
Losses on retirement of debt	-	0.49	-	0.60
Termination of management agreement	-	-	-	0.29
Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement (a)	$ **0.77**	$ 0.60	$ **2.81**	$ 1.94
Shares used in computing diluted earnings per share (000)	459,515	527,515	458,822	509,583

(a) Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA should not be considered as measures of financial performance under generally accepted accounting principles ("GAAP"). We believe net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are important measures that supplement discussions and analysis of our results of operations. We believe it is useful to investors to provide disclosures of our results of operations on the same basis used by management. Management relies upon net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA as the primary measures to review and assess operating performance of its hospital facilities and their management teams.

Management and investors review both the overall performance (including; net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and GAAP net income attributable to HCA Holdings, Inc.) and operating performance (Adjusted EBITDA) of our health care facilities. Adjusted EBITDA and the Adjusted EBITDA margin (Adjusted EBITDA divided by revenues) are utilized by management and investors to compare our current operating results with the corresponding periods during the previous year and to compare our operating results with other companies in the health care industry. It is reasonable to expect that losses (gains) on sales of facilities and losses on retirement of debt will occur in future periods, but the amounts recognized can vary significantly from period to period, do not directly relate to the ongoing operations of our health care facilities and complicate period comparisons of our results of operations and operations comparisons with other health care companies.

Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are not measures of financial performance under GAAP, and should not be considered as alternatives to net income attributable to HCA Holdings, Inc. as a measure of operating

performance or cash flows from operating, investing and financing activities as a measure of liquidity. Because net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are not measurements determined in accordance with GAAP and are susceptible to varying calculations, net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

HCA Holdings, Inc.

Condensed Consolidated Balance Sheets

(Dollars in millions)

	September 30, 2012	June 30, 2012	December 31, 2011
ASSETS			
Current assets:			
Cash and cash equivalents	$ 472	$ 518	$ 373
Accounts receivable, net	4,598	4,485	4,533
Inventories	1,052	1,055	1,054
Deferred income taxes	322	323	594
Other	828	756	679
Total current assets	7,272	7,137	7,233
Property and equipment, at cost	29,145	28,742	28,075
Accumulated depreciation	(16,185)	(15,896)	(15,241)
	12,960	12,846	12,834
Investments of insurance subsidiaries	473	495	548
Investments in and advances to affiliates	103	102	101
Goodwill and other intangible assets	5,460	5,431	5,251
Deferred loan costs	266	281	290
Other	768	840	641
	$ 27,302	$ 27,132	$ 26,898

LIABILITIES AND STOCKHOLDERS' DEFICIT

2013 FEB 14 PM 2 19

Current liabilities:			
Accounts payable	$ 1,585	$ 1,517	$ 1,597
Accrued salaries	1,027	970	965
Other accrued expenses	1,498	1,651	1,585
Long-term debt due within one year	1,751	1,309	1,407
Total current liabilities	5,861	5,447	5,554
Long-term debt	25,182	25,732	25,645
Professional liability risks	962	1,039	993
Income taxes and other liabilities	1,860	1,857	1,720
EQUITY (DEFICIT)			
Stockholders' deficit attributable to HCA Holdings, Inc.	(7,859)	(8,243)	(8,258)
Noncontrolling interests	1,296	1,300	1,244
Total deficit	(6,563)	(6,943)	(7,014)
	$ 27,302	$ 27,132	$ 26,898

HCA Holdings, Inc.

Condensed Consolidated Statements of Cash Flows

For the Nine Months Ended September 30, 2012 and 2011

(Dollars in millions)

	2012	2011
Cash flows from operating activities:		
Net income	**$ 1,579**	$ 800
Adjustments to reconcile net income to net cash provided by operating activities:		
Changes in operating assets and liabilities	**(2,923)**	(2,336)
Provision for doubtful accounts	**2,666**	2,164
Depreciation and amortization	**1,254**	1,078
Income taxes	**250**	348

payments.

Year Ended December 31, 2011

Revenues for the year ended December 31, 2011 totaled $29.682 billion compared to $28.035 billion in 2010. Net income attributable to HCA Holdings, Inc. in 2011 was $2.465 billion, or $4.97 per diluted share, compared to $1.207 billion, or $2.76 per diluted share, for 2010. Results for the year ended December 31, 2011 include a pretax gain on the acquisition of a controlling interest in an equity investment of $1.522 billion, or $2.87 per diluted share, pretax gains on sales of facilities of $142 million, or $0.16 per diluted share, pretax losses on the retirement of debt of $481 million, or $0.61 per diluted share, and a pretax charge for termination of management agreement of $181 million, or $0.30 per diluted share. Results for the year ended December 31, 2010 include pretax impairments of long-lived assets of $123 million, or $0.18 per diluted share, and pretax gains on sales of facilities of $4 million, or $0.01 per diluted share. Adjusted EBITDA for 2011 totaled $6.061 billion compared to $5.868 billion in 2010.

Balance Sheet and Cash Flow

As of December 31, 2011, HCA Holdings, Inc.'s balance sheet reflected cash and cash equivalents of $373 million, total debt of $27.052 billion, and total assets of $26.898 billion. During the fourth quarter, capital expenditures totaled $509 million, excluding acquisitions, compared to $465 million in the previous year's fourth quarter. HCA's debt-to-Adjusted EBITDA ratio at December 31, 2011 was 4.46x compared to 4.81x at December 31, 2010. Net cash provided by operating activities totaled $1.387 billion compared to $534 million in the fourth quarter of 2010. The increase in cash flows from operating activities was primarily due to improved cash flows of $467 million related to income taxes and $388 million related to working capital items.

Special Dividend

HCA also today announced that its Board of Directors has approved a special cash dividend of $2.00 per share to be paid to shareholders of record as of February 16, 2012 with a payment date of February 29, 2012. The dividend is expected to be funded through existing cash and borrowings under the Company's credit facilities.

"We believe that a special dividend provides liquidity to our shareholders while not affecting our ability to invest in our markets or impair our acquisition strategy. Also, the impact of this dividend on the Company's leverage will be modest," stated R. Milton Johnson, HCA President and Chief Financial Officer.

2012 Guidance

Today, HCA issued the following estimated guidance for 2012:

	2011	2012 RANGE
Revenues (1)	$29.682 billion	$32 to $33 billion
Adjusted EBITDA	$6.061 billion	$6.20 to $6.45 billion
Adjusted EPS (diluted) (2)	$2.85	$3.35 to $3.55

Equity in earnings of affiliates	**(41)**	**(0.5)**	(72)	(1.0)
Depreciation and amortization	**387**	**5.0**	359	5.0
Interest expense	**465**	**6.0**	526	7.3
Gains on sales of facilities	**(145)**	**(1.9)**	(6)	(0.1)
Gain on acquisition of controlling interest in equity investment	**(1,522)**	**(19.6)**	-	-
Impairments of long-lived assets	**-**	**-**	4	0.1
	5,315	**68.4**	6,597	92.1
Income before income taxes	**2,454**	**31.6**	564	7.9
Provision for income taxes	**412**	**5.3**	170	2.4
Net income	**2,042**	**26.3**	394	5.5
Net income attributable to noncontrolling interests	**107**	**1.4**	111	1.5
Net income attributable to HCA Holdings, Inc.	**$1,935**	**24.9**	$283	4.0
Diluted earnings per share	**$4.25**		$0.65	
Shares used in computing diluted earnings per share (000)	**455,460**		437,568	

HCA Holdings, Inc.

Condensed Consolidated Income Statements

For the Years Ended December 31, 2011 and 2010

(Dollars in millions, except per share amounts)

	2011		2010	
	Amount	**Ratio**	Amount	Ratio
Revenues before provision for doubtful accounts	**$32,506**		$30,683	
Provision for doubtful accounts	**2,824**		2,648	
Revenues	**29,682**	**100.0%**	28,035	100.0%

Salaries and benefits	**13,440**	**45.3**	12,484	44.5
Supplies	**5,179**	**17.4**	4,961	17.7
Other operating expenses	**5,470**	**18.5**	5,004	17.9
Electronic health record incentive income	**(210)**	**(0.7)**	-	-
Equity in earnings of affiliates	**(258)**	**(0.9)**	(282)	(1.0)
Depreciation and amortization	**1,465**	**4.9**	1,421	5.0
Interest expense	**2,037**	**6.9**	2,097	7.5
Gains on sales of facilities	**(142)**	**(0.5)**	(4)	-
Gain on acquisition of controlling interest in equity investment	**(1,522)**	**(5.1)**	-	-
Impairments of long-lived assets	**-**	**-**	123	0.4
Losses on retirement of debt	**481**	**1.6**	-	-
Termination of management agreement	**181**	**0.6**	-	-
	26,121	**88.0**	25,804	92.0
Income before income taxes	**3,561**	**12.0**	2,231	8.0
Provision for income taxes	**719**	**2.4**	658	2.4
Net income	**2,842**	**9.6**	1,573	5.6
Net income attributable to noncontrolling interests	**377**	**1.3**	366	1.3
Net income attributable to HCA Holdings, Inc.	**$2,465**	**8.3**	$1,207	4.3
Diluted earnings per share	**$4.97**		$2.76	
Shares used in computing diluted earnings per share (000)	**495,943**		437,347	

HCA Holdings, Inc.

Supplemental Non-GAAP Disclosures

Operating Results Summary

(Dollars in millions, except per share amounts)

management agreement and Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

HCA Holdings, Inc.

Condensed Consolidated Balance Sheets

(Dollars in millions)

	December 31, 2011	September 30, 2011	December 31, 2010
ASSETS			
Current assets:			
Cash and cash equivalents	$373	$359	$411
Accounts receivable, net	4,533	3,925	3,832
Inventories	1,054	891	897
Deferred income taxes	594	643	931
Other	679	875	848
Total current assets	7,233	6,693	6,919
Property and equipment, at cost	28,075	26,647	25,641
Accumulated depreciation	(15,241)	(15,002)	(14,289)
	12,834	11,645	11,352
Investments of insurance subsidiaries	548	545	642
Investments in and advances to affiliates	101	837	869
Goodwill and other intangible assets	5,251	2,701	2,693
Deferred loan costs	290	297	374
Other	641	1,038	1,003
	$26,898	$23,756	$23,852

LIABILITIES AND STOCKHOLDERS' DEFICIT

Current liabilities:			
Accounts payable	$1,597	$1,334	$1,537
Accrued salaries	965	876	895
Other accrued expenses	1,585	1,336	1,245
Long-term debt due within one year	1,407	725	592
Total current liabilities	5,554	4,271	4,269
Long-term debt	25,645	25,871	27,633
Professional liability risks	993	993	995
Income taxes and other liabilities	1,720	1,683	1,608
Total liabilities	33,912	32,818	34,505
Equity securities with contingent redemption rights	-	-	141
EQUITY (DEFICIT)			
HCA Holdings, Inc. stockholders' deficit	(8,258)	(10,194)	(11,926)
Noncontrolling interests	1,244	1,132	1,132
Total deficit	(7,014)	(9,062)	(10,794)
	$26,898	$23,756	$23,852

HCA Holdings, Inc.

Condensed Consolidated Statements of Cash Flows

For the Years Ended December 31, 2011 and 2010

(Dollars in millions)

	2011	2010
Cash flows from operating activities:		
Net income	**$2,842**	$1,573
Adjustments to reconcile net income to net cash provided by operating activities:		
Changes in operating assets and liabilities	**(2,953)**	(2,847)
Provision for doubtful accounts	**2,824**	2,648
Depreciation and amortization	**1,465**	1,421
Income taxes	**912**	27

C, Orderly Development--7©
TDH Inspection & Plan of Correction

The Joint Commission

Hendersonville Hospital Corporation
355 New Shackle Island Road
Hendersonville, TN 37075

Organization Identification Number: 5174

Program(s)
Hospital Accreditation

Surveyor(s) and Survey Date(s)
Thomas L.Barton, MSN - (03/15 - 03/17/2010)
Michael A.Parmer, MD, MPH - (03/15 - 03/17/2010)
Richard A.Smith, CHFM - (03/16 - 03/16/2010)

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

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

Program:	Hospital Accreditation Program	
Standards:	IM.02.02.01	EP3
	NPSG.03.04.01	EP5
	UP.01.03.01	EP4

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

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.09	EP3
	HR.01.06.01	EP3
	LS.02.01.20	EP30
	MM.05.01.13	EP3
	PC.02.01.19	EP4
	RC.01.01.01	EP19
	RC.01.02.01	EP4
	TS.03.02.01	EP3

The Joint Commission
Summary of CMS Findings

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(1)(ii)	A-0454	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(1)(iii)	A-0457	HAP - RC.01.02.01/EP4	Standard

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

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

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

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP30	Standard

The Joint Commission
Findings

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09 ESC 60 days

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in building tour at Hendersonville Medical Center site.
During the building tour it was observed that the Oxygen Source valve at the bulk tank was not labeled as required.

Chapter: Human Resources

Program: Hospital Accreditation

Standard: HR.01.06.01 ESC 60 days

Standard Text: Staff are competent to perform their responsibilities.

Primary Priority Focus Area: Staffing

Element(s) of Performance:

3. An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. 4
Note: When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. Alternatively, the hospital may consult the competency guidelines from an appropriate professional organization to make its assessment.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in Competency Assessment at Hendersonville Medical Center site.
A Condition of Participation does not apply to this observation.
Reviewed the file of a staff OTR. His clinical competencies were evaluated by a physical therapist that is the director of the department.

Observed in Competency Assessment at Hendersonville Medical Center site.
A Condition of Participation does not apply to this observation.
During a discussion in this session it was determined that the Speech Language Pathologist had their clinical competencies reviewed by the department director a physical therapist.

Chapter: Information Management

Program: Hospital Accreditation

Standard: IM.02.02.01 ESC 45 days

Standard Text: The hospital effectively manages the collection of health information.

Primary Priority Focus Area: Communication

Element(s) of Performance:

3. The hospital implements its policy regarding the terminology, definitions, abbreviations, acronyms, symbols, and dose designations permitted for use in the hospital and the abbreviations, acronyms, symbols, and dose designations prohibited from use in the hospital. 3
Note: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in 2W at Hendersonville Medical Center site.
Observed multiple entries into the anesthesia record that had a decimal point without the preceding zero.

Observed in 2W at Hendersonville Medical Center site.
Observed the unsafe abbreviation, u, in this patient's orders.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20 ESC 60 days

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

30. Signs reading 'No Exit' are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text and any exceptions, refer to NFPA 101-2000: 7.10.8.1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 30
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in building tour at Hendersonville Medical Center site.
During the building tour it was observed that the doors going out onto the patio area from the dining room did not have a "Not an Exit " sign on the doors.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.13 ESC 60 days

Standard Text: The hospital safely obtains medications when the pharmacy is closed.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

3. When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: The hospital stores and secures the medications approved for use outside of the pharmacy.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in Pharmacy at Hendersonville Medical Center site.
According to the Director of the Pharmacy the Nursing Supervisors access the Pharmacy afterhours to retrieve medications when they are not available on the floors.

Observed in Pharmacy at Hendersonville Medical Center site.
I observed that since the first day of March 2010, the Nursing Supervisor had accessed the Pharmacy during closed hours three times.

The Joint Commission
Findings

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.03.04.01 ESC 45 days

Standard Text: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered. 3
Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
Observed in Endoscopy at Hendersonville Medical Center site.
A syringe filled with a white substance, identified verbally by the provider as Propofol, had been drawn up and stored in the anesthesia cart prior to the patient's entrance to the room. It did not appear to have a label. At the time of the procedure, it was removed from the cart and administered as an infusion.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: UP.01.03.01 ESC 45 days

Standard Text: A time-out is performed before the procedure.

Primary Priority Focus Area: Communication

Element(s) of Performance:

4. During the time-out, the team members agree, at a minimum, on the following: 3
- Correct patient identity
- The correct site
- The procedure to be done

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Cardiac Cath Lab at Hendersonville Medical Center site.
During the time-out I observed that the patient identity, correct site, and the procedure being performed were announced over the room speaker by the control room nurse. However I not see any active participation among members of the team, nor any acknowledgement from the team members. In fact there was no eye contact with each other and all team members were occupied with their tasks to prepare for the procedure.

The Joint Commission
Findings

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.19 ESC 60 days

Standard Text: The hospital recognizes and responds to changes in a patient's condition.
Note: Hospitals are not required to create 'rapid response teams' or 'medical emergency teams' in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.

Primary Priority Focus Area: Communication

Element(s) of Performance:

4. The hospital informs the patient and family how to seek assistance when they have concerns about a patient's condition. 4

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 4
Observed in Data System Tracer at Hendersonville Medical Center site.
Currently there is not a formal process in place to inform patient's family members how to access assistance in the event that they have concerns about a family member's condition.

Observed in Data System Tracer at Hendersonville Medical Center site.
Currently there is not a formal process in place to inform patient's family members how to access assistance in the event that they have concerns about a family member's condition.

Second observation of multiple person's comments.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01 ESC 60 days

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

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed. 4

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1)(ii) - (A-0454) - (ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under
§482.12(c) and authorized to write orders by hospital policy in accordance with State law.
This Standard is NOT MET as evidenced by:
Observed in CCU at Hendersonville Medical Center site.
Observed that the post procedure note for this patient's heart catheter procedure was not timed.

Observed in 2W at Hendersonville Medical Center site.
Observed that there was an order authentication that was not timed as required by this hospital's bylaws and regulations.

§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Endoscopy at Hendersonville Medical Center site.
During individual tracer activity, it was noted in the record that the anesthesia preoperative evaluation had been dated but not timed.

Observed in Endoscopy at Hendersonville Medical Center site.
During individual tracer activity, it was noted in the patient's record that the medication reconciliation discharge instructions had been dated, but not timed.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.02.01

ESC 60 days

Standard Text: Entries in the medical record are authenticated.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

4. Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. 4
Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.
Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: For a five-year period following January 26, 2007, all orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient (as specified at 42 CFR 482.12(c)), and who, in accordance with hospital policy and law and regulation, is authorized to write orders.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 4
§482.24(c)(1)(iii) - (A-0457) - (iii) All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.
This Standard is NOT MET as evidenced by:
Observed in Medical Surgical 2nd floor at Hendersonville Medical Center site.
During the individual based system tracer Medication Management, the record of the selected patient contained multiple orders not authenticated within 48 hours as required by medical staff and government rules and regulations: For example -on 03/06/2010-an order for "sips of water"; an order for an "air mattress"; an order for "ice chips"

Observed in Medical Surgical Second floor at Hendersonville Medical Center site.
During the individual based system tracer Medication Management, the record of the selected patient contained multiple orders not authenticated within 48 hours as required by medical staff and government rules and regulations: For example -on 03/08/2010; an order for"TPN"; on 03/07/2010; an order for "up to BSC."

Observed in Medical Surgical Second Floor at Hendersonville Medical Center site.
During the individual based system tracer Medication Management, the record of the selected patient contained multiple orders not authenticated within 48 hours as required by medical staff and government rules and regulations: For example -on 03/08/2010 an order for "wound care"; on 03/09/2010 an order for "Magnesium Sulfate"; on 03/11/2010 an order to "increase TPN".

Chapter: Transplant Safety

Program: Hospital Accreditation

Standard: TS.03.02.01

Standard Text: The hospital traces all tissues bi-directionally.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

3. The hospital documents the dates, times, and staff involved when tissue is accepted, prepared, and issued. (See also TS.03.01.01, EP 6)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in Operating Room at Hendersonville Medical Center site.
Review of the Tissue Transplantation Log showed that the dates and staff involved when tissue was accepted, prepared, and issued had been documented, but the times the tissue was accepted and issued from storage had not been noted.

Observed in Operating Room at Hendersonville Medical Center site.
Review of the Tissue Transplantation Log showed that the dates and staff involved when tissue was accepted, prepared, and issued had been documented, but the times the tissue was accepted and issued from storage had not been noted.

Miscellaneous Information

TennCare Enrollment Data for August 2012

MCO	REGION	Total
Amerigroup	Middle Tennessee	200,096
BlueCare	East Tennessee	218,391
BlueCare	West Tennessee	180,405
TennCare Select	All	46,926
United HealthCare	East Tennessee	194,457
United HealthCare	Middle Tennessee	200,602
United HealthCare	West Tennessee	174,750
Unknown	Unknown	1,838
Grand Total		1,217,466

	Female					Male					
COUNTY	0 - 18	19 - 20	21 - 64	65 -->	Female Total	0 - 18	19 - 20	21 - 64	65 -->	Male Total	Grand Total
ANDERSON	3,756	305	3,322	620	8,003	3,963	218	1,621	276	6,078	14,081
BEDFORD	3,290	251	2,159	252	5,952	3,379	144	971	109	4,604	10,555
BENTON	888	80	769	154	1,891	980	46	453	69	1,548	3,439
BLEDSOE	737	59	625	122	1,543	812	59	358	54	1,282	2,825
BLOUNT	5,220	443	4,420	691	10,774	5,274	281	2,033	296	7,885	18,659
BRADLEY	5,026	476	4,447	646	10,594	5,405	295	2,006	270	7,976	18,570
CAMPBELL	2,729	256	3,102	666	6,754	2,868	203	1,746	393	5,210	11,964
CANNON	710	68	600	131	1,510	793	47	325	56	1,221	2,730
CARROLL	1,700	139	1,577	342	3,759	1,839	110	794	145	2,889	6,648
CARTER	2,961	252	2,586	716	6,515	3,190	165	1,366	269	4,990	11,505
CHEATHAM	1,800	135	1,408	182	3,525	1,868	110	647	74	2,699	6,224
CHESTER	940	89	820	156	2,005	961	57	330	66	1,415	3,420
CLAIBORNE	1,880	160	1,861	545	4,446	1,935	118	1,174	253	3,481	7,927
CLAY	517	35	422	109	1,083	507	34	271	80	892	1,975
COCKE	2,547	231	2,340	464	5,581	2,601	163	1,330	224	4,318	9,899
COFFEE	3,180	263	2,652	380	6,475	3,258	151	1,165	167	4,740	11,215
CROCKETT	976	88	711	209	1,984	975	50	338	82	1,445	3,429
CUMBERLAND	2,865	226	2,318	502	5,911	2,979	185	1,157	235	4,556	10,467
DAVIDSON	36,418	2,606	27,311	3,260	69,595	37,665	1,777	10,163	1,467	51,073	120,668
DECATUR	577	62	530	193	1,363	673	41	300	74	1,088	2,451
DEKALB	1,161	73	988	196	2,418	1,255	61	535	87	1,938	4,356
DICKSON	2,555	167	2,159	322	5,203	2,645	136	915	94	3,790	8,993
DYER	2,566	218	2,308	423	5,515	2,678	146	981	146	3,952	9,467
FAYETTE	1,590	143	1,197	299	3,229	1,716	90	535	117	2,458	5,686
FENTRESS	1,290	110	1,256	378	3,034	1,396	90	804	184	2,474	5,508
FRANKLIN	1,782	160	1,516	283	3,740	1,851	82	712	109	2,753	6,493
GIBSON	2,925	251	2,596	655	6,427	3,090	212	1,112	274	4,688	11,115
GILES	1,446	139	1,250	271	3,106	1,486	85	661	113	2,344	5,450
GRAINGER	1,332	101	1,098	299	2,830	1,300	63	648	155	2,167	4,997
GREENE	3,300	258	3,076	728	7,362	3,395	176	1,674	358	5,603	12,966
GRUNDY	1,110	119	1,084	217	2,530	1,188	87	605	132	2,012	4,541
HAMBLEN	3,929	253	2,748	598	7,528	3,964	164	1,221	221	5,570	13,098
HAMILTON	15,370	1,232	13,585	2,299	32,486	16,108	811	5,343	824	23,087	55,573
HANCOCK	480	50	521	171	1,222	571	37	314	81	1,003	2,225
HARDEMAN	1,648	147	1,557	353	3,704	1,611	111	733	159	2,615	6,319
HARDIN	1,604	152	1,452	392	3,600	1,661	106	763	199	2,729	6,329
HAWKINS	3,057	297	2,821	568	6,743	3,228	164	1,444	267	5,103	11,847
HAYWOOD	1,423	138	1,312	304	3,177	1,517	95	401	112	2,125	5,301
HENDERSON	1,672	135	1,456	273	3,536	1,669	92	668	102	2,531	6,067

TennCare Enrollment Data for August 2012

HENRY	1,927	164	1,610	303	4,004	2,014	126	755	117	3,011	7,015
HICKMAN	1,432	130	1,290	178	3,030	1,552	103	668	84	2,408	5,437
HOUSTON	426	47	385	114	973	490	29	203	71	793	1,766
HUMPHREYS	947	81	813	157	1,998	957	48	393	69	1,466	3,464
JACKSON	641	43	611	153	1,449	655	32	352	95	1,133	2,582
JEFFERSON	2,847	202	2,223	531	5,802	2,882	141	1,102	193	4,318	10,119
JOHNSON	952	82	893	293	2,220	932	81	566	159	1,738	3,958
KNOX	17,545	1,334	15,673	2,409	36,960	18,214	886	6,542	961	26,603	63,563
LAKE	423	40	521	162	1,147	500	33	223	68	824	1,971
LAUDERDALE	1,983	171	1,828	323	4,304	2,046	127	724	124	3,021	7,326
LAWRENCE	2,337	174	1,986	413	4,910	2,527	140	939	165	3,771	8,681
LEWIS	692	59	581	130	1,462	762	42	270	60	1,134	2,596
LINCOLN	1,801	163	1,404	330	3,698	1,876	100	710	127	2,813	6,511
LOUDON	2,107	146	1,537	305	4,096	2,085	98	698	120	3,001	7,097
MACON	1,588	147	1,308	259	3,301	1,700	88	674	108	2,570	5,871
MADISON	6,023	531	5,387	826	12,767	5,979	312	1,776	327	8,394	21,161
MARION	1,659	175	1,593	270	3,696	1,661	103	682	140	2,585	6,282
MARSHALL	1,599	140	1,304	180	3,223	1,708	72	567	65	2,412	5,635
MAURY	4,248	323	3,538	568	8,677	4,554	250	1,349	199	6,352	15,029
MCMINN	2,771	248	2,468	536	6,023	2,948	175	1,163	226	4,512	10,535
MCNAIRY	1,722	171	1,666	410	3,968	1,777	141	927	204	3,049	7,017
MEIGS	755	64	636	86	1,540	724	47	324	49	1,145	2,685
MONROE	2,542	221	2,211	519	5,493	2,782	148	1,167	247	4,344	9,837
MONTGOMERY	6,983	572	5,793	652	14,000	7,225	302	1,804	220	9,551	23,552
MOORE	234	24	154	53	464	265	8	101	14	388	852
MORGAN	1,119	93	902	194	2,307	1,181	71	528	104	1,883	4,190
OBION	1,794	160	1,563	311	3,827	1,898	79	581	107	2,665	6,492
OUT-OF-ST CO	704	133	1,574	182	2,593	969	113	1,094	117	2,292	4,885
OUT-OF-ST NO	2		17	4	23	2		18		20	43
OVERTON	1,132	86	934	284	2,436	1,246	61	532	141	1,981	4,417
PERRY	515	39	381	90	1,025	524	29	215	44	812	1,837
PICKETT	224	20	188	97	529	280	12	122	47	461	990
POLK	917	57	857	156	1,987	956	50	457	80	1,543	3,530
PUTNAM	3,747	374	3,275	770	8,167	3,932	231	1,724	323	6,210	14,376
RHEA	2,230	180	1,802	353	4,564	2,264	133	867	138	3,402	7,966
ROANE	2,357	200	2,378	559	5,495	2,695	145	1,303	230	4,374	9,869
ROBERTSON	3,577	233	2,357	385	6,552	3,687	136	971	164	4,958	11,510
RUTHERFORD	11,385	950	8,021	1,004	21,360	11,857	601	2,880	365	15,703	37,063
SCOTT	1,847	171	1,705	412	4,134	1,870	127	975	194	3,167	7,301
SEQUATCHIE	921	86	765	146	1,918	966	48	438	63	1,515	3,432
SEVIER	4,814	328	3,154	460	8,756	5,110	199	1,253	176	6,738	15,494
SHELBY	69,355	6,442	55,837	6,601	138,236	70,997	4,453	15,908	2,395	93,753	231,988
SMITH	1,027	83	896	186	2,193	1,037	67	409	69	1,581	3,774
STEWART	694	55	638	121	1,508	707	28	322	56	1,113	2,622
SULLIVAN	7,098	614	6,751	1,366	15,829	7,391	405	3,361	617	11,774	27,603
SUMNER	6,703	552	5,363	810	13,427	7,122	353	2,083	307	9,865	23,292
TIPTON	3,422	336	2,599	375	6,733	3,627	208	900	147	4,882	11,615
TROUSDALE	461	35	369	81	947	468	32	182	40	721	1,668
UNICOI	913	77	810	285	2,085	986	55	376	125	1,541	3,626
UNION	1,271	100	917	167	2,456	1,308	73	523	88	1,992	4,448
VAN BUREN	296	26	261	59	643	336	14	159	46	554	1,197
WARREN	2,520	178	2,151	454	5,304	2,664	138	1,065	182	4,049	9,354
WASHINGTON	4,875	444	4,866	995	11,181	5,062	304	2,253	392	8,011	19,192

TennCare Enrollment Data for August 2012

WAYNE	774	60	651	174	1,659	841	38	343	84	1,306	2,965
WEAKLEY	1,692	217	1,497	313	3,719	1,746	124	721	116	2,708	6,427
WHITE	1,533	123	1,280	339	3,276	1,646	92	746	122	2,605	5,881
WILLIAMSON	2,633	191	1,725	350	4,900	2,818	133	706	112	3,770	8,670
WILSON	4,084	312	3,270	507	8,173	4,281	206	1,378	186	6,051	14,225
Grand Total	341,778	28,773	285,128	48,116	703,795	355,546	19,453	118,685	19,985	513,670	1,217,465

Sumner County, Tennessee

People QuickFacts	Sumner County	Tennessee
Population, 2011 estimate	163,686	6,403,353
Population, 2010 (April 1) estimates base	160,645	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	1.9%	0.9%
Population, 2010	160,645	6,346,105
Persons under 5 years, percent, 2011	6.4%	6.3%
Persons under 18 years, percent, 2011	24.9%	23.3%
Persons 65 years and over, percent, 2011	13.0%	13.7%
Female persons, percent, 2011	51.2%	51.3%
White persons, percent, 2011 (a)	90.3%	79.5%
Black persons, percent, 2011 (a)	6.7%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.3%	0.4%
Asian persons, percent, 2011 (a)	1.1%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.5%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	4.0%	4.7%
White persons not Hispanic, percent, 2011	86.7%	75.4%
Living in same house 1 year & over, percent, 2007-2011	83.3%	84.1%
Foreign born persons, percent, 2007-2011	3.6%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	5.5%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	86.0%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	23.0%	23.0%
Veterans, 2007-2011	13,262	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	27.4	24.0
Housing units, 2011	66,771	2,829,025
Homeownership rate, 2007-2011	73.2%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	15.5%	18.1%
Median value of owner-occupied housing units, 2007-2011	$171,800	$137,200
Households, 2007-2011	60,112	2,457,997
Persons per household, 2007-2011	2.61	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$27,212	$24,197
Median household income, 2007-2011	$55,211	$43,989
Persons below poverty level, percent, 2007-2011	9.9%	16.9%

Business QuickFacts	Sumner County	Tennessee
Private nonfarm establishments, 2010	2,876	131,582[1]
Private nonfarm employment, 2010	35,839	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	2.2	-5.3[1]
Nonemployer establishments, 2010	13,363	465,545
Total number of firms, 2007	15,402	545,348
Black-owned firms, percent, 2007	3.2%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.5%
Asian-owned firms, percent, 2007	S	2.0%

Davidson County, Tennessee

People QuickFacts	Davidson County	Tennessee
Population, 2011 estimate	635,475	6,403,353
Population, 2010 (April 1) estimates base	626,681	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	1.4%	0.9%
Population, 2010	626,681	6,346,105
Persons under 5 years, percent, 2011	7.1%	6.3%
Persons under 18 years, percent, 2011	21.8%	23.3%
Persons 65 years and over, percent, 2011	10.5%	13.7%
Female persons, percent, 2011	51.6%	51.3%
White persons, percent, 2011 (a)	66.2%	79.5%
Black persons, percent, 2011 (a)	27.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	3.2%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	2.1%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	9.9%	4.7%
White persons not Hispanic, percent, 2011	57.5%	75.4%
Living in same house 1 year & over, percent, 2007-2011	79.3%	84.1%
Foreign born persons, percent, 2007-2011	11.7%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	15.4%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	85.3%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	34.4%	23.0%
Veterans, 2007-2011	40,017	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	23.2	24.0
Housing units, 2011	285,020	2,829,025
Homeownership rate, 2007-2011	56.8%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	37.1%	18.1%
Median value of owner-occupied housing units, 2007-2011	$166,300	$137,200
Households, 2007-2011	254,111	2,457,997
Persons per household, 2007-2011	2.35	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$28,526	$24,197
Median household income, 2007-2011	$46,737	$43,989
Persons below poverty level, percent, 2007-2011	17.7%	16.9%

Business QuickFacts	Davidson County	Tennessee
Private nonfarm establishments, 2010	18,124	131,582[1]
Private nonfarm employment, 2010	370,484	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-7.0	-5.3[1]
Nonemployer establishments, 2010	54,350	465,545
Total number of firms, 2007	64,653	545,348
Black-owned firms, percent, 2007	11.1%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.6%	0.5%
Asian-owned firms, percent, 2007	3.4%	2.0%

Robertson County, Tennessee

People QuickFacts	Robertson County	Tennessee
Population, 2011 estimate	67,106	6,403,353
Population, 2010 (April 1) estimates base	66,283	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	1.2%	0.9%
Population, 2010	66,283	6,346,105
Persons under 5 years, percent, 2011	6.9%	6.3%
Persons under 18 years, percent, 2011	25.7%	23.3%
Persons 65 years and over, percent, 2011	12.1%	13.7%
Female persons, percent, 2011	50.8%	51.3%
White persons, percent, 2011 (a)	89.9%	79.5%
Black persons, percent, 2011 (a)	7.7%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	0.6%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.3%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	6.1%	4.7%
White persons not Hispanic, percent, 2011	84.4%	75.4%
Living in same house 1 year & over, percent, 2007-2011	87.3%	84.1%
Foreign born persons, percent, 2007-2011	4.1%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	5.8%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	82.7%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	15.2%	23.0%
Veterans, 2007-2011	4,816	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	29.1	24.0
Housing units, 2011	26,264	2,829,025
Homeownership rate, 2007-2011	77.0%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	8.6%	18.1%
Median value of owner-occupied housing units, 2007-2011	$153,900	$137,200
Households, 2007-2011	24,028	2,457,997
Persons per household, 2007-2011	2.70	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$22,937	$24,197
Median household income, 2007-2011	$50,759	$43,989
Persons below poverty level, percent, 2007-2011	13.2%	16.9%

Business QuickFacts	Robertson County	Tennessee
Private nonfarm establishments, 2010	1,060	131,582[1]
Private nonfarm employment, 2010	15,638	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	12.5	-5.3[1]
Nonemployer establishments, 2010	4,931	465,545
Total number of firms, 2007	5,745	545,348
Black-owned firms, percent, 2007	1.9%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.5%
Asian-owned firms, percent, 2007	S	2.0%

Macon County, Tennessee

People QuickFacts	Macon County	Tennessee
Population, 2011 estimate	22,485	6,403,353
Population, 2010 (April 1) estimates base	22,248	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	1.1%	0.9%
Population, 2010	22,248	6,346,105
Persons under 5 years, percent, 2011	7.0%	6.3%
Persons under 18 years, percent, 2011	24.9%	23.3%
Persons 65 years and over, percent, 2011	14.3%	13.7%
Female persons, percent, 2011	50.8%	51.3%
White persons, percent, 2011 (a)	97.2%	79.5%
Black persons, percent, 2011 (a)	0.8%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.6%	0.4%
Asian persons, percent, 2011 (a)	0.3%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	1.0%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	4.6%	4.7%
White persons not Hispanic, percent, 2011	93.3%	75.4%
Living in same house 1 year & over, percent, 2007-2011	88.3%	84.1%
Foreign born persons, percent, 2007-2011	4.0%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	3.9%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	75.3%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	8.3%	23.0%
Veterans, 2007-2011	1,296	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	30.9	24.0
Housing units, 2011	9,913	2,829,025
Homeownership rate, 2007-2011	74.6%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	8.0%	18.1%
Median value of owner-occupied housing units, 2007-2011	$92,300	$137,200
Households, 2007-2011	8,186	2,457,997
Persons per household, 2007-2011	2.67	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$17,409	$24,197
Median household income, 2007-2011	$34,747	$43,989
Persons below poverty level, percent, 2007-2011	23.9%	16.9%

Business QuickFacts	Macon County	Tennessee
Private nonfarm establishments, 2010	343	131,582[1]
Private nonfarm employment, 2010	3,282	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-19.5	-5.3[1]
Nonemployer establishments, 2010	1,688	465,545
Total number of firms, 2007	S	545,348
Black-owned firms, percent, 2007	S	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.5%
Asian-owned firms, percent, 2007	S	2.0%

State & County QuickFacts

Trousdale County, Tennessee

People QuickFacts	Trousdale County	Tennessee
Population, 2011 estimate	7,816	6,403,353
Population, 2010 (April 1) estimates base	7,870	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	-0.7%	0.9%
Population, 2010	7,870	6,346,105
Persons under 5 years, percent, 2011	6.0%	6.3%
Persons under 18 years, percent, 2011	24.0%	23.3%
Persons 65 years and over, percent, 2011	13.8%	13.7%
Female persons, percent, 2011	50.5%	51.3%
White persons, percent, 2011 (a)	87.8%	79.5%
Black persons, percent, 2011 (a)	9.8%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.6%	0.4%
Asian persons, percent, 2011 (a)	0.2%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	1.6%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	2.7%	4.7%
White persons not Hispanic, percent, 2011	85.5%	75.4%
Living in same house 1 year & over, percent, 2007-2011	85.8%	84.1%
Foreign born persons, percent, 2007-2011	1.4%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	3.3%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	79.0%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	12.9%	23.0%
Veterans, 2007-2011	720	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	33.1	24.0
Housing units, 2011	3,375	2,829,025
Homeownership rate, 2007-2011	79.4%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	7.9%	18.1%
Median value of owner-occupied housing units, 2007-2011	$112,500	$137,200
Households, 2007-2011	2,805	2,457,997
Persons per household, 2007-2011	2.73	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$20,973	$24,197
Median household income, 2007-2011	$44,163	$43,989
Persons below poverty level, percent, 2007-2011	14.9%	16.9%

Business QuickFacts	Trousdale County	Tennessee
Private nonfarm establishments, 2010	126	131,582[2]
Private nonfarm employment, 2010	1,079	2,264,032[2]
Private nonfarm employment, percent change, 2000-2010	-12.5	-5.3[2]
Nonemployer establishments, 2010	565	465,545
Total number of firms, 2007	899	545,348
Black-owned firms, percent, 2007	S	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	2.0%

2.2 Specific Requirements for General Hospitals

Appendix material, shown in shaded boxes at the bottom of the page, is advisory only.

2.2-1 General

2.2-1.1 Application

This chapter contains specific requirements for general acute care hospitals. The requirements described in Chapter 2.1, Common Elements for Hospitals, shall also apply to general acute care hospitals as referenced in this chapter.

2.2-1.2 Functional Program

For requirements, see 2.1-1.2 and 1.2-2.

2.2-1.3 Site

*2.2-1.3.1 Parking Capacity

2.2-1.3.1.1 Parking for general hospitals shall comply with the general requirements in 1.3-3.3 (Parking) and the specific requirements in this section.

***2.2-1.3.1.2** In the absence of local requirements governing parking, the following shall be provided:

(1) One space for each bed plus one space for each employee normally present on any single weekday shift. Reduction of this ratio shall be permitted in compliance with Section 1.3-3.3.

(2) Separate and additional space for service delivery vehicles and vehicles used for emergency patients

2.2-1.3.2 Transfer Support Features

For requirements, see 1.3-3.6.

2.2-2 Nursing Units

*2.2-2.1 General

2.2-2.1.1 New Construction

Nursing units in general hospitals shall meet the minimum design requirements described in Sections 2.2-2.2 through 2.2-3.8 as applicable.

2.2-2.1.2 Renovation

For renovation of nursing units in existing hospitals, see 1.1-3 for further guidance when compliance with these guidelines is impractical.

2.2-2.2 Medical/Surgical Nursing Unit

2.2-2.2.1 Reserved

2.2-2.2.2 Patient Room

2.2-2.2.2.1 Capacity

(1) The maximum number of beds per room shall be one unless the functional program demonstrates the necessity of a two-bed arrangement. Approval of a two-bed arrangement shall be obtained from the licensing authority.

(2) Where renovation work is undertaken and the present capacity is more than one patient, maximum room capacity shall be no more than the present capacity, with a maximum of four patients.

APPENDIX

A2.2-1.3.1 Parking

A formal parking/traffic study should be conducted to ensure that adequate parking and traffic flow is provided to accommodate inpatients, outpatients, staff, and visitors.

A2.2-1.3.1.2 Additional parking may be required to accommodate outpatient and other services.

A2.2-2.1 Most acute care hospitals are composed of some combination of the following units: medical/surgical unit, intermediate care unit, critical care unit, obstetrical unit, nursery, pediatric and adolescent unit, psychiatric unit, and in-hospital skilled nursing unit.

SUPPORT LETTERS

2013 FEB 14 PM 2 21

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he/she is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent 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 the agent's knowledge.

SIGNATURE/TITLE

Sworn to and subscribed before me this 14 day of February (Month), 2013 (Year) a Notary

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

BEVIN M. SHELLENBERGER
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

My Commission Expires August 6, 2016

NOTARY PUBLIC

My commission expires August 6 (Month/Day), 2016 (Year).

THE TENNESSEAN

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NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Hendersonville Medical Center (a hospital), owned and managed by Hendersonville Hospital Corporation (a corporation), intends to file an application for a Certificate of Need to construct a new fourth floor of medical-surgical beds, and to initiate neonatal intensive care services in a new 6-bed Level II-B neonatal nursery, on its main campus at 355 New Shackle Island Road, Hendersonville, TN 37075, at a capital cost estimated at $33,000,000.

Hendersonville Medical Center is licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Public Health. The project will not change the total licensed bed complement. The hospital currently holds a single consolidated license for 148 general hospital beds, of which 110 are at its main Hendersonville campus and 38 are at its satellite campus at 105 Redbud Drive, Portland, TN 37148. The project will relocate 13 beds from the satellite campus to the main campus, resulting in 123 licensed beds at the Hendersonville campus and 25 licensed beds at the Portland satellite campus. The project does not contain major medical equipment or initiate or discontinue any other health service.

The anticipated date of filing the application is on or before February 15, 2013. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215, (615) 665-2022. Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

the above mentioned Register's Office, notice is hereby given that I, the undersigned substitute trustee, or my designated agent, under the power and authority vested in me by said deed of trust, and having been requested to

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Carlene Mangrum of record in Book 1372, Page 763 in the Register's Office for Williamson County, Tennessee.

SUBJECT to any and all existing easements, setback lines and restrictive covenants of record in

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pursuant to this notice shall be sold "AS IS" and neither the Substitute Trustee nor the beneficiary of the Deed of Trust, nor any agent or attorney therefore, makes or shall make any warranty, whether express or implied, as to the condition, quality or quantity thereof, including, but not limited to, the enforceability of any lease affecting the property, the existence or absence of defaults under or the effect or this sale upon the rights of any party under such lease. The Substitute Trustee shall make no warranty of title, express or implied, and will sell and convey the subject real property by Substitute Trustee's Deed only.

The substitute trustee may adjourn or postpone the aforementioned sale of real property by public announcement at such time and place of sale, and from time to time thereafter may postpone such sale by public announcement at the time and place fixed by the preceding postponement or subsequently noticed sale, and without further notice make such sale at the time fixed by the last postponement, or may, in its discretion, give a new notice of sale.

If applicable, the Notice requirements of T.C.A. § 35-5-117 have been met.

The failure of any high bidder to pay the purchase price and close the sale shall, at the option of the Substitute Trustee, be cause for rejection of the bid, and, if the bid is rejected, the Substitute Trustee shall

0101627255

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 Tennessee Orthopedic Alliance owned and operated by Tennessee Orthopedic Alliance, P.C., located at 301 21st Avenue, No., Nashville, Tennessee intends to file an application for a Certificate of Need for the relocation of two MRI units from the current location to TOA's proposed future office space to be located at 3000 Charlotte Avenue, Nashville Tennessee. There are no inpatient beds, new services or new major medical equipment involved in this project. The estimated project cost is not to exceed $3,200,000.00

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

The contact person for this project is Jerry W. Taylor, Attorney, who may be reached at: Stites & Harbison, PLLC, 401 Commerce Street, Suite 800, Nashville, Tennessee, 37219, 615-782-2228.

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

Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

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

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

March 1, 2013

John L. Wellborn
Development Support Group
4219 Hillsboro Road, Suite 203
Nashville, TN 37215

RE: Certificate of Need Application -- Hendersonville Medical Center - CN1302-002

Dear Mr. Wellborn:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the construction of a new fouth (4th) floor of med/surgical beds and the initiation of neonatal intensive care services in a new six (6)-bed level II-B neonatal nursery on the main campus of Hendersonville Medical Center located in Hendersonville (Sumner County), TN. The proposed service area is Sumner, Robertson and Davidson counties. The estimated project cost is $32,255,000.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on March 1, 2013. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on May 22, 2013.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Lori B. Ferranti, TDH, PPA

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

MEMORANDUM

TO: Lori B. Ferranti, Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 Fifth Avenue North
Nashville, Tennessee 37247

FROM: Melanie M. Hill
Executive Director

DATE: March 1, 2013

RE: Certificate of Need Application
Hendersonville Medical Center - CN1302-002

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on March 1, 2013 and end on May 1, 2013.

Should there be any questions regarding this application or the review cycle, please contact Mark Farber, Deputy Director.

Enclosure

cc: John L. Wellborn

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

2013 FEB -8 PM 4: 14

The Publication of Intent is to be published in the Tennessean, which is a newspaper of general circulation in Sumner County, Tennessee, on or before February 10, 2013, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Hendersonville Medical Center (a hospital), owned and managed by Hendersonville Hospital Corporation (a corporation), intends to file an application for a Certificate of Need to construct a new fourth floor of medical-surgical beds, and to initiate neonatal intensive care services in a new 6-bed Level II-B neonatal nursery, on its main campus at 355 New Shackle Island Road, Hendersonville, TN 37075, at a capital cost estimated at $33,000,000.

Hendersonville Medical Center is licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Public Health. The project will not change the total licensed bed complement. The hospital currently holds a single consolidated license for 148 general hospital beds, of which 110 are at its main Hendersonville campus and 38 are at its satellite campus at 105 Redbud Drive, Portland, TN 37148. The project will relocate 13 beds from the satellite campus to the main campus, resulting in 123 licensed beds at the Hendersonville campus and 25 licensed beds at the Portland satellite campus. The project does not contain major medical equipment or initiate or discontinue any other health service.

The anticipated date of filing the application is on or before February 15, 2013. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215, (615) 665-2022.

John L. Wellborn 2-6-13 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

STITES & HARBISON PLLC
ATTORNEYS

SunTrust Plaza
401 Commerce Street
Suite 800
Nashville, TN 37219
[615] 782-2200
[615] 782-2371 Fax
www.stites.com

2013 APR 5 PM 2 50

April 5, 2013

Jerry W. Taylor
(615) 782-2228
(615) 742-0703 FAX
jerry.taylor@stites.com

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Hendersonville Medical Center
CN1302-002

Dear Ms. Hill:

This is to request a deferral of the consideration of the above referenced project from the May 22, 2013 meeting to the June 26, 2013 meeting. The reason for the request is a scheduling conflict on a behalf of a key representative of Hendersonville Medical Center. This is the first request for a deferral of this matter, and no opposition has been filed.

Please let me know if you have any questions, or if additional information is needed. Thank you for your assistance.

Very truly yours,

STITES & HARBISON, PLLC

Jerry W. Taylor

18636N:130080:989119:1:NASHVILLE

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

February 22, 2013

John Wellborn
Development Support Group
4219 Hillsboro Road, Suite 203
Nashville, TN 37215

RE: Certificate of Need Application CN1302-002
Hendersonville Medical Center

Dear Mr. Wellborn:

This will acknowledge our February 14, 2013 receipt of your application requesting review for the construction of a new fourth floor for medical surgical beds, for the establishment of a 6-bed level II-B neonatal intensive care unit and nursery on the campus of 233 New Shackle Island Road, Hendersonville (Sumner County), TN 37075.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Thursday, February 28, 2013. If the supplemental information requested in this letter is not submitted by or before this time, consideration of this application may be delayed into a later review cycle.

---

1. **Section A, Applicant Profile, Items 1-11**

   Responses to Section A Item 1-11 and pages 6-8 of the HSDA's "Instructions for Filing an application for a Certificate of Need" is missing from the application. Please respond to each question and attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.

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

   Please clarify if the applicant and its affiliate Centennial Medical Center are contracted in Blue Network P, CoverKids and Access Tennessee, Cover TN's Network V,

BlueCare or Blue Network S. If the applicant is not contracted with any one or more of these networks, where will those enrollees be referred for neonatal services?

If there was an infant at neighboring Sumner Regional Medical Center with BlueCare Network S insurance in need of Level II-B Neonatal Intensive Care Services, would the applicant be able to admit the infant to the proposed neonatal unit for services? (absent Federal Emergency Medical Treatment and Labor Act Requirements) If not, where would the infant be referred for treatment that would reimburse under BlueCare Network S insurance?

Please define the Blue Cross/Blue Shield plans Blue Network P and Blue Network S.

3. **Section B, Project Description, Item II (a).**

   Please submit the square footage and costs per square footage chart for the proposed project.

4. **Section B, Project Description, Item II (b).**

   The applicant states the 38 licensed beds at Portland are temporarily unstaffed waiting for partial relocation to the Hendersonville Medical Center main campus in phases. Please provide a brief history of the Portland campus including the reason why it is currently unstaffed and the planned phases of relocation over the next several years. Please indicate the age of the facility and future plans for the structure. Please indicate if the applicant plans to request critical access designation for the Portland campus.

5. **Section B, Project Description, Item II (c).**

   The applicant states in 2012 the hospital had to decline more than 100 admissions (med-surg) due to bed capacity limitations. Please indicate where those 100 patients were referred for services.

   The applicant states there were instances where a double room was converted to a single room to meet AIA guidelines to house patients in private rooms. How many double rooms were converted to private rooms?

   The table of Distance of one way drive times from the service area to the closest NICU destinations on page 30 of the application is noted. It appears the drive times are within 1 hour to Davidson County NICU's from the proposed service area. Please clarify why someone would go to a proposed Hendersonville neonatal level II-B nursery, when they go within an hour's drive to a fully equipped tertiary hospital that contains the continuum of neonatal care in case more acute symptoms arise? Would this not avoid an unnecessary possibly high risk transport?

6. **Section C. Need, Item 1 (Specific Review Criteria: Neonatal Intensive Care Unit-(1)**

   The applicant has provided a summary of hospital perinatal service levels. Please indicate the date of the State of Tennessee Perinatal Care System Guidelines the applicant intends to follow.

   Please indicate if the applicant has identified a neonatal nurse practitioner. If so, please provide license verification.

   Please discuss if the applicant will meet prenatal guidelines effective October 1, 2010 for antepartum, intrapartum and postpartum care.

7. **Section C. Need, Item 1 (Specific Review Criteria: Neonatal Intensive Care Unit-(5)**

   Please clarify if Hendersonville Medical Center has air ambulance capabilities.

   Please discuss the requirements of The Tennessee Perinatal Care System Guidelines for Transportation for Level II B neonatal transports in terms of consultation and transfer. In your response please indicate the requirements of neonatal transport personnel and how the applicant plans to meet the requirements during peak periods of high occupancy.

   Please provide the first name of "Dr. Ismael" and a copy of his Tennessee license and health practitioner profile.

   Who provides the actual neonatal transport service?

   Please provide the types of pediatric sub-specialties that will be available by the applicant.

   Please discuss the pool of primary care physicians who are board certified neonatologists that will be available to care for sick neonates. If possible, please provide a copy of their Tennessee Internet license and licensure profile.

   Please clarify if radiology services will be available 24 hours a day including the capability to perform portable radiological studies in the nursery.

8. **Section C. Need, Item 3**

   Please provide a replacement page for page 48. There is a portion of the page that appears missing.

   Please identify the mentioned twelve zip codes on page 46.

9. Section C. Orderly Development, Item 1

The applicant left out the part of the question "currently has or plans to have contractual and/or working relationships, e.g. transfer agreements" from the HSDA application. Please address the rest of the question and submit a replacement page. In your response please discuss list all inpatient facilities in the proposed service area and indicate if there are any existing contractual and/or working relationships and transfer agreements.

10. Section C, Orderly Development, Item 3

The staffing list of 9.5 RN's and 4.2 neonatal nurse practitioners for the proposed NICU unit is noted. However, please clarify how the following positions will be accounted for in the proposed proposed NICU staffing plan: Board Certified Obstetrician, Board Certified Pediatrician, Director, Assistant Director, Nurse Manager, Respiratory Therapists, Social Worker, Nutritionist/Dietician/Lactation Consultant and Pharmacist.

11. Section C, Orderly Development, Item 7 c. and 7 d.

The executive summary provided by the Joint Commission is noted. Please indicate the date of the survey. Also, the executive summary indicates a follow-up in the area (s) of Evidence of Standards Compliance (ESC). What was the result of the follow-up survey?

Please provide a copy of the current license of the facility.

Please provide a copy of the most recent/ licensure survey or inspection.

12. Development Schedule

The applicant is requesting an implementation period of four years. Please complete the Project Completion Forecast Chart to reflect the request so Agency members may review the anticipated schedule.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Tuesday April 23, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental

information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɜ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

Copy

Supplemental #1

Hendersonville Medical Center

CN1301-002

DSG Development Support Group

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

2013 FEB 26 PM 2 16

February 26, 2013

Phillip M. Earhart, Health Planner III
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: CON Application #1302-002
Hendersonville Medical Center

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section A, Applicant Profile, Items 1-11**

   Responses to Section A Item 1-11 and pages 6-8 of the HSDA's "Instructions for Filing an application for a Certificate of Need" is missing from the application. Please respond to each question and attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.

   The completed Section A is attached following this page. It appears to have been dropped out of the original application during copying.

   However, the attachments that Section A requires (deed, corporate organization papers, license, accreditation, etc.) were submitted in the original application, in appropriately labeled attachments. Please see Attachments A.4 and A.6.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

PART A

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

2013 FEB 26 PM 2 16

Hendersonville Medical Center		
Name		
355 New Shackle Island Road		Sumner
Street or Route		*County*
Hendersonville	TN	37075
City	*State*	*Zip Code*

2. *Contact Person Available for Responses to Questions*

John Wellborn		Consultant	
Name		*Title*	
Development Support Group		jwdsg@comcast.net	
Company Name		*E-Mail Address*	
4219 Hillsboro Road, Suite 203	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-66-2022	615-665-2042	
Association With Owner	*Phone Number*	*Fax Number*	

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

Hendersonville Hospital Corporation		
Name		
Same as in #1 above		
Street or Route		*County*
City	*State*	*Zip Code*

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

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

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

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

Name

Street or Route *County*

City *State* *Zip Code*

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

A. Ownership	x	D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of ____ Years			

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

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

8. *Purpose of Review (Check as appropriate—more than one may apply*

A. New Institution		G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, Designation, Distribution, Conversion, Relocation	x
B. Replacement/Existing Facility		H. Change of Location	
C. Modification/Existing Facility	x	I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify) NICU	x		
E. Discontinuance of OB Service			
F. Acquisition of Equipment			

9. *Bed Complement Data -- Combined Campuses (One License)*

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

	Current Licensed Beds	CON approved beds (not in service)	Staffed Beds	Beds Proposed (Change)	TOTAL Beds at Completion
A. Medical					
B. Surgical	108		60	-4	104
C. Long Term Care Hosp.					
D. Obsetrical	16		16	-2	14
E. ICU/CCU	24		20		24
F. Neonatal				+6	6
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolesc. Psych.					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	**148**		**96**	**NC**	**148**

10. Medicare Provider Number:	440046
Certification Type:	general hospital
11. Medicaid Provider Number:	44-0205
Certification Type:	general hospital

12. & 13. See page 4

2. Section B Project Description, Item I.

a. Please clarify if the applicant and its affiliate Centennial Medical Center are contracted in Blue Network P, CoverKids and Access Tennessee, Cover TN's Network V, BlueCare or Blue Network S. If the applicant is not contracted with any one or more of these networks, where will those enrollees be referred for neonatal services?

Contract Status		
	Hendersonville Medical Center	Centennial Medical Center
Blue Network P	yes	yes
Access Tennessee	Yes (Access uses Blue Cross Network P)	Yes (Access uses Blue Cross Network P)
BlueCare	Not operational in the Middle TN region	Not operational in the Middle TN region
Blue Network S	Actively seeking contract	Actively seeking contract
Cover Kids	This group uses Blue Network S; see above	This group uses Blue Network S; see above
Cover TN Network V	Network not known	Network not known

The applicant and Centennial Medical Center are contracted/in network with Blue Network P and Access Tennessee (Access enrollees use Network P). BlueCare is not operational in this service area. Cover TN Network V is not known by that name to the applicant.

HMC and HCA have sought, are currently seeking, and will continue to seek, contractual inclusion in Blue Network S, which is used by Cover Kids. But Blue Network S signed exclusive contracts with other providers in the region; so HCA facilities cannot currently participate. However, discussions are continuing; and the applicant intends to be in Blue Network S (and therefore available to Cover Kids) by the time HMC's proposed II-B NICU is open.

Until HMC is in Network S, most patients in Network S will continue to utilize NICU's at Baptist Hospital and Vanderbilt just as they do today. But if there are Blue Network S infants who need care at the HMC NICU for some special reason, they will be accepted just as they are currently accepted at the Centennial NICU. Please see the response immediately below.

b. If there was an infant at neighboring Sumner Regional Medical Center with BlueCare Network S insurance in need of Level II-B Neonatal Intensive Care Services, would the applicant be able to admit the infant to the proposed neonatal unit for services? (absent Federal Emergency Medical Treatment and Labor Act Requirements) If not, where would the infant be referred for treatment that would reimburse under BlueCare Network S insurance?

Yes; such an infant would be accepted at HMC if he or she did not have the necessary access to Blue Network S NICU's in Nashville (currently Baptist and Vanderbilt). For example, HCA's Centennial Women's and Children's NICU accepted 21 Network S neonatal admissions in CY2012, despite not being in that network plan.

c. Please define the Blue Cross/Blue Shield plans Blue Network P and Blue Network S.

Attached following this page are some plan definitions provided on the Blue Cross/Blue Shield web page, which the applicant is not able to expand upon—other than to note that the Blue Network S was developed as a limited network to sell lower-cost coverage to employers wanting a significantly smaller provider network for their employees.

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

BLUE PROVIDER NETWORKS

BlueCross BlueShield of Tennessee offers three distinct Blue Networks of providers. Each includes a its own group of doctors, hospitals and other health care providers that are committed to holding down costs and delivering quality care.

Choose from:

- Blue Network P - a wide variety of credentialed doctors, hospitals and health care providers.
- Blue Network S - based on a variety of credentialed providers, with a focus on affordability.

Our PPO health plans entitle members to visit any provider of their choosing. However, to receive the highest level of PPO plan benefits, and to keep out-of-pocket costs to a minimum, it is best to choose care from the health care providers that participate in their plan's Blue Provider Network.

For the most up-to-date listing of participating providers: Find a Doctor.

Additional Information

- Dental Plans
- Vision Plans
- Pharmacy Plans
- Other Products
- Blue Provider Networks
- BlueCard PPO
- BluePerks
- Glossary

Page Modified:May 18, 2012

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SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

cover tennessee

COVERKIDS

CoverKids provides free, comprehensive health coverage for qualifying children age 18 and younger.

The coverage includes an emphasis on preventive health services and coverage for physician services, hospital visits, vaccinations, well-child visits, healthy babies program, developmental screenings, mental health, vision and dental care.

There are low co-pays for medical services, though well child visits and immunizations are covered at 100 percent.

Families with uninsured children may apply online at www.CoverKids.com or by calling 1-866-620-8864.

Qualifications include:

- Age 18 or younger or a pregnant woman who meets eligibility criteria
- Household income up to 250% of federal poverty level (Buy-in is available for children in households with higher incomes)
- U.S. citizen or qualified legal alien (babies born in the U.S. will be considered U.S. citizens)
- Tennessee resident
- Uninsured for at least three months prior to application
- Not eligible for TennCare
- No access to state employee health insurance or other state-sponsored insurance

Refer to the table of qualifying incomes based on federal poverty guidelines to see if your child qualifies. If you meet the income guidelines, no monthly premiums will be charged, but each participant will pay reduced co-payments for services.

HEALTHYTNBABIES

HealthyTNBabies offers coverage for pregnancies and complications of pregnancies to qualified pregnant women. The CoverKids eligibility vendor will determine the date the coverage begins. Coverage ends after 60 days of postpartum care. HealthyTNBabies coverage is available through CoverKids.

Qualifications for HealthyTNBabies include:

- Household income up to 250% of the federal poverty level
- Without health coverage for three months
- Tennessee resident

Additional Information

- Benefits
- Premiums
- FAQ's
- How to Apply
- Pharmacy Details
- En Español

For more information

- **E-mail us** at coverkids@bcbst.com. EMAIL POLICY
- **Call us** toll-free at **1-888-325-8386** (Monday through Friday, 8 a.m. to 6 p.m. Eastern Time).
- **By mail**
  CoverKids
  c/o BlueCross BlueShield of Tennessee
  1 Cameron Hill Circle
  Chattanooga, TN 37402

Fair Treatment for All

You have a right to fair treatment. If you think you have been treated unfairly, here's information that can help you:

CoverKids Fair Treatment Information (En Espanol) PDF

CoverKids Unfair Treatment Complaint Form (En Espanol) PDF

Find a Doctor

Locate a doctor, pharmacy, hospital or other health care facility in our network.

begin your search

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

- Not eligible for TennCare or other state-sponsored insurance

In addition to coverage for the pregnancy and complications of pregnancy, HealthyTNBabies offers a comprehensive pharmacy plan.

CoverKids & HealthyTNBabies use Blue Network S. To see which providers participate in these programs, use the Find a Doctor tool on the right hand side of this page.

Page Modified:May 18, 2012

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SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

cover tennessee

COVERTN

Effective December 1, 2009, new enrollment in CoverTN is suspended until further notice as a result of reaching budget capacity. Visit www.covertn.gov for more information.

Current members and participating businesses will be unaffected by the suspension. **For current members and participating employers, new members can still be added to the plan under the following circumstances:**

- Current CoverTN members can add spouses due to a qualifying event
- Current participating employers can continue to enroll new employees

For more information click on Business Owner's Reference Manual under Additional Information to the right.

About CoverTN:

CoverTN limited benefits are designed to provide working Tennesseans and Tennesseans between jobs with low-cost coverage for basic medical service. These plans encourage regular doctor visits and preventive screenings that help decrease the need for high-cost care in the future. Not to be confused as an inexpensive replacement for traditional PPO coverage, CoverTN simply helps previously uninsured Tennesseans lower the need for potentially high-cost care in the future.

CoverTN plan benefits are limited compared to traditional insurance. For instance, these plans do not have an out-of-pocket maximum, so they do not protect against the potential of catastrophic medical costs. In other words, there is no limit to the amount of medical bills a member might have to pay for a major illness or injury, such as disease treatment, or injuries sustained in an automobile accident for example.

CoverTN uses Network V. To see which providers participate in these programs, use the Find a Doctor tool on the right hand side of the page.

Additional Information

- Benefits
- Premiums Split 3 Ways
- 2013 Premium Rate Chart PDF
- Maternity Benefits
- Eligibility Requirements
- How To Apply
- FAQs PDF
- Pharmacy Details
- Personal Health Covenant PDF
- 2013 Business Owner's Reference Manual PDF
- En Español

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- **E-mail us** at covertn@bcbst.com EMAIL POLICY.
- **Call us** toll-free at 1-888-887-3224 (Monday through Friday, 8 a.m. to 6 p.m. Eastern Time).
- **By mail**
  CoverTN
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  801 Pine St.
  Chattanooga, TN 37402

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Page Modified:May 18, 2012

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3. Section B, Project Description, Item II (a).

Please submit the square footage and costs per square footage chart for the proposed project.

That chart is attached following this page.

4. Section B, Project Description, Item II (b).

The applicant states the 38 licensed beds at Portland are temporarily unstaffed waiting for partial relocation to the Hendersonville Medical Center main campus in phases. Please provide a brief history of the Portland campus including the reason why it is currently unstaffed and the planned phases of relocation over the next several years. Please indicate the age of the facility and future plans for the structure. Please indicate if the applicant plans to request critical access designation for the Portland campus.

The Portland Medical Center ("PMC") was opened as Highland Hospital in 1983. In 1994, it was acquired by the Adventist Health System as a satellite campus of their Madison Hospital, and renamed Tennessee Christian Medical Center—Portland. HCA acquired the Madison facility and its satellite in 2006 and has operated it under the HMC license since that time. By 2008, it was clear that low demand for inpatient services at Portland made it financially unfeasible for it to continue offering a full scope of acute care services. In December 2008, HMC suspended its acute care services except for outpatient diagnostic services, which are still provided. In 2012, Hendersonville Medical Center committed funds to renovate and expand the PMC Emergency Department. That has begun and the Emergency Department will reopen later this year.

PMC's future scope of inpatient services, and the need for further transfers of bed capacity to the HMC main campus, have not yet been determined or scheduled. They will be determined by future growth of the communities close to PMC on the I-65 corridor.

Adventist Health System applied for Federal designation of the Portland facility as a Critical Access Hospital, but designation was denied because the facility is too close to other hospitals in Tennessee and Kentucky to meet Medicare's requirement for a minimum 35-mile distance to alternative hospitals. HCA research indicates that this is still a barrier to obtaining that designation.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
2nd FL O.B./N.I.C.U.					17,885		17,885	$193.00		$3,451,805.00
3rd FL Major HVAC Upgrade					17,870		17,870	$193.00		$3,448,910.00
4th FL. Med Surg						18,580	18,580		$279.00	$5,183,820.00
Penthouse						3,291	3,291		$279.00	$918,189.00
Elevator and Skin					639		639	$938.97		$600,000.00
Structural upgrades										$3,500,000.00
Powerhouse										$3,000,000.00
B. Unit/Dept. GSF Sub-Total										$20,102,724.00
C. Mechanical / Electrical GSF					14,557	8,748	23,305		$30.13	$702,135.79
D. Circulation / Structure GSF					5,459	3,280	8,739		$30.13	$263,290.25
E. Total GSF					36,394	21,871	58,265			$21,068,150.04
Renovation										
Canopies										
GRAND TOTAL					36,394	21,871	58,265	$442.00	$155.00	$21,068,150.00

SUPPLEMENTAL - # 1
February 26, 2013
2:13pm

5. Section B, Project Description, Item II (c).

a. The applicant states in 2012 the hospital had to decline more than 100 admissions (med-surg) due to bed capacity limitations. Please indicate where those 100 patients were referred for services.

This data is only partially available. When a physician with admitting privileges requests an admission, and a bed is not available, the physician does not inform the hospital where that patient was subsequently admitted. During 2012 there were 28 such requests for which a bed was not available.

However, records do exist on 81 more patients, who came through the HMC Emergency Department, or through TriStar's Transfer Center (centralized referral system), and were not able to obtain a room. Records indicate their subsequent admission to these facilities:

Admitted To	Number of Patients
Skyline	44
Centennnial	22
Summit	5
Vanderbilt	3
Southern Hills	3
St. Thomas	2
Sumner Regional	1
Baptist	1
Total	81

b. The applicant states there were instances where a double room was converted to a single room to meet AIA guidelines to house patients in private rooms. How many double rooms were converted to private rooms?

Attachment B.IV contains floor plans with 110 inpatient bed spaces numbered. Preceding the plans is a page titled "Key to Floor Plans". Circled numbers indicate bed capacity that is not available for various reasons. The table on the "Key" page shows eight double rooms that are being used as single rooms: spaces 103-4 on the second floor; and spaces 105-110 on the third floor.

c. The table of Distance of one-way drive times from the service area to the closest NICU destinations on page 30 of the application is noted. It appears the drive times are within 1 hour to Davidson County NICU's from the proposed service area. Please clarify why someone would go to a proposed Hendersonville neonatal level II-B nursery, when they go within an hour's drive to a fully equipped tertiary hospital that contains the continuum of neonatal care in case more acute symptoms arise? Would this not avoid an unnecessary possibly high risk transport?

It is neonatologists, not the hospital or lay persons, who recommend what is in the infant's best interests and what is needed medically. This application was submitted at the urging of neonatologists at Centennial Medical Center, which operates Nashville's second largest tertiary NICU program.

As the submitted data shows, there are four small level II-B nurseries operating and approved in central Davidson County, eastern Davidson County, northern Rutherford County, and central Rutherford County--all of which are within an hour's drive of the three Level III NICU's in Nashville. They have an important role to play in the neonatal care system.

They serve families whose infants are only moderately ill or vulnerable, with no indications of being at risk for worsening conditions. They are used because these newborns stay one to four or more weeks in the NICU, for observation and care, and their mothers spend as much time as possible with them every day. It is difficult for many families to spend two hours a day, for periods of weeks, in round-trip commuting to downtown Nashville NICU's. A suburban alternative is very appropriate, where the same professional teams (neonatologists and neonatal nurse practitioners) are providing the same level of competencies and care, with the same equipment and training, as that infant would receive at our tertiary hospital nurseries.

6. Section C. Need, Item 1 (Specific Review Criteria: Neonatal Intensive Care Unit-(1)

a. The applicant has provided a summary of hospital perinatal service levels. Please indicate the date of the State of Tennessee Perinatal Care System Guidelines the applicant intends to follow.

The applicant will meet or exceed the current Guidelines in effect when the HMC NICU opens more than three years from now. At this time, the applicant is conforming the program to the October 10, 2010, Sixth Edition of those Guidelines.

b. Please indicate if the applicant has identified a neonatal nurse practitioner. If so, please provide license verification.

The NNP is not yet identified because this NICU has not received CON approval and if approved will not be opening for more than three years. That position will be a contract employee recruited by Pediatrix, whose neonatologists are providing medical supervision to this NICU.

c. Please discuss if the applicant will meet prenatal guidelines effective October 1, 2010 for antepartum, intrapartum and postpartum care.

The applicant will meet the October 10 guidelines in every respect. The applicant already meets them for its current levels of care.

7. Section C. Need, Item 1 (Specific Review Criteria: Neonatal Intensive Care Unit-(5)

a. Please clarify if Hendersonville Medical Center has air ambulance capabilities.

HMC has a helipad and has personnel trained in coordinating air ambulance transport with the air ambulance staff onboard. The helipad was used an estimated 38 times in CY2012.

2013 FEB 26 PM 2 17

b. Please discuss the requirements of The Tennessee Perinatal Care System Guidelines for Transportation for Level II B neonatal transports in terms of consultation and transfer. In your response please indicate the requirements of neonatal transport personnel and how the applicant plans to meet the requirements during peak periods of high occupancy.

Attached at the back of this application are copies of those Guidelines. They will be complied with, in every respect. However, please note that HMC itself is not the transport team provider.

With respect to neonatal transport, HMC's affiliated facility, Centennial Women's and Children's Hospital, has operated a ground ambulance neonatal transport system serving all of Middle Tennessee, for many years. It is one of only two such neonatal ground ambulance providers in Middle Tennessee. This transport program's operating procedures, staffing, and equipment meet or exceed all standards set forth in the Guidelines for Transportation. Pediatrix's Sami Ismail, M.D. and Patti Scott, MSN, RNC, APN-NNP, sat on the Transportation Guidelines Workgroup that formulated the State's current Guidelines. Dr. Ismail and Ms. Scott have been closely involved with planning this proposed Level II-B NICU in Sumner County and its linkages with the NICU at Centennial Women's and Children's Hospital.

The Hendersonville NICU's census will not affect the availability of staff for neonatal transport, because the neonatal transport vehicle and all its staff come from Centennial Women's and Children's Hospital; they are not HMC personnel.

In terms of consultation and transfer, a transfer will begin with the transferring hospital's phone call to a receiving neonatologist on duty at the Centennial Women's and Children's Hospital (W&C) NICU, 24/7. The call establishes the condition and needs of the infant. If those needs cannot be met at the calling hospital through consultation with the neonatologist at W&C, the neonatologist and the clinical staff at the transferring hospital agree on how transport will be managed in terms of NICU destination, time, mode, records, staffing and equipment. The W&C neonatologist makes the needed arrangements with the receiving hospital NICU.

The neonatologist assembles the Centennial neonatal transport team and it leaves W&C within 30 minutes of receiving the phone call. The following personnel are aboard: a neonatal nurse practitioner, an EMT, a transport respiratory technician (neonatal specialty trained), and a driver. A neonatal specialty trained RN is often aboard for certain transfers. At least two members

of the personnel aboard are Neonatal Resuscitation Program providers and the personnel are STABLE trained, in compliance with the Guidelines. They are in communication with the transferring hospital concerning the infant's condition. Upon arrival at the referring hospital and the infant's bedside they take responsibility for the infant's medical care and transport the infant to the receiving NICU, all the while remaining in communication with the receiving NICU and if necessary the transferring NICU.

c. Please provide the first name of "Dr. Ismael" and a copy of his Tennessee license and health practitioner profile.

His name is M. Sami Ismail, M.D. His Tennessee license, board certification, and profile were included in Attachment C. Need--1.A of the submitted application (immediately after the narrative on compliance with Perinatal System Guidelines).

d. Who provides the actual neonatal transport service?

See response "b." above.

e. Please provide the types of pediatric sub-specialties that will be available by the applicant.

Pediatric subspecialties other than neonatologists are required for Level III NICU's. Such subspecialists available to the HMC NICU routinely will be medical staff of Centennial Women's and Children's Hospital. Currently, they include pediatric subspecialists in surgery, cardiology, neurology, urology, ophthalmology, genetics, plastic surgery, and anesthesiology. More are planned in the future.

f. Please discuss the pool of primary care physicians who are board certified neonatologists that will be available to care for sick neonates. If possible, please provide a copy of their Tennessee Internet license and licensure profile.

These materials are attached at the end of this response letter due to their volume. In addition to Dr. Sami Ismail, whose license, profile, and other materials were originally submitted, the unit will have available five more Board-certified, fellowship-trained neonatologists (*fellowship* training program indicated in parentheses): Dr. Eric Palmer (Vanderbilt); Dr. Sarah Hassell (Vanderbilt); Dr. Ashraf Hamdan (Vanderbilt); Dr. Hadeer Karmo (Vanderbilt); and Dr. Susan Campbell (Penn State).

g. Please clarify if radiology services will be available 24 hours a day including the capability to perform portable radiological studies in the nursery.

They will. This is a full-service community hospital with 24-hour imaging services both on its ground floor and in any patient area.

8. Section C. Need, Item 3

a. Please provide a replacement page for page 48. There is a portion of the page that appears missing.

Attached following this page. The copier at FedEx Kinko's appears to have attached a sticky note to page 48 of the original, which mistakenly was copied.

b. Please identify the mentioned twelve zip codes on page 46.

The zip codes mentioned on page 48 are listed in Table 9-B on page 49 of the submitted application.

9. Section C. Orderly Development, Item 1

a. The applicant left out the part of the question "currently has or plans to have contractual and/or working relationships, e.g. transfer agreements" from the HSDA application. Please address the rest of the question and submit a replacement page. In your response please discuss list all inpatient facilities in the proposed service area and indicate if there are any existing contractual and/or working relationships and transfer agreements.

Please see revised page 82R, attached after this page.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

Current Service Areas

The hospital's current primary and secondary medical-surgical service areas, defined by counties, consist of Sumner, Davidson, Robertson, and Macon Counties (which generate 94.7% of HMC's non-perinatal admissions.) Defined by zip codes, they consist of twelve zip codes based in those same counties. The primary service area for medical-surgical admissions (79.2% of admissions) is comprised of the four most populous Sumner County zip codes, plus the Goodlettsville and Madison zip codes in Davidson County. The secondary service area for medical-surgical admissions (10.0% of admissions) is comprised of two Robertson County zip codes, three additional Sumner County zip codes, and the zip code for Lafayette in Macon County. Another 11.0% of admissions originate from other areas, no one of which contributes 1% of the total hospital medical-surgical admissions.

The hospital's current primary and secondary perinatal (newborn) service areas, defined by counties, consist of Sumner, Davidson, and Robertson Counties (which contribute 96.3% of HMC's births). Defined by zip codes, they consist of twelve zip codes based in those same three counties. The primary service area for perinatal care (80.0% of the hospital's births) is comprised of the four most populous Sumner County zip codes, plus the Goodlettsville and Madison zip codes in Davidson County. The secondary service area for perinatal care (12.3% of the hospital's births) is comprised of two Robertson County zip codes plus four additional Sumner County zip codes. Another 7.8% of the births originate from other areas, no one of which contributes 1% of the total hospital births.

Tables Nine-A and Nine-B on the following page provide the relevant current service area data for both perinatal care and medical-surgical care.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AND/OR WORKING RELATIONSHIPS, E.G., TRANSFER AGREEMENTS, CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

Please see the following page for the providers to whom HMC most frequently discharges patients.

In this service area, HMC has close working relationships with both Sumner Regional Medical Center and NorthCrest Hospital, but has no formal contractual agreements or transfer agreements. For example, when both those hospitals recently had full ICU's, they worked with HMC to take the overflow until they could restore bed availability. This sort of mutual assistance is typical and continuous.

HMC's special relationship with Centennial Medical Center's Women's and Children's Hospital, with its Level III NICU, has been described elsewhere in this application. Women's and Children's has strongly urged and supported the filing of this application and its staff and neonatology group have worked closely with HMC staff in planning the project. They will continue to work with HMC in recruiting, training, and assisting the staff of this proposed II-B NICU. They will provide the majority of neonatal transports for the project.

NICU Core Staffing Plan

		M	T	W	Th	F	Sa	Su	Total
7a-7p	RN	2	2	2	2	2	2	2	168 Hours/4.2 FTE
	NNP	1	1	1	1	1	1	1	84 Hours/2.1 FTE
7p-7a	RN	2	2	2	2	2	2	2	168 Hours/4.2 FTE
	NNP	1	1	1	1	1	1	1	84 Hours/2.1 FTE

Productive Man-hours 504/40 = 12.6 FTE

8.4 FTE RN
4.2 FTE NNP (contracted)
1.3 FTE Non-productive
13.9 Total FTE

The proposed NICU is part of the Department of Women's Services of Tristar Hendersonville Medical Center. The following personnel/positions have responsibilities in all areas of Women's Services, including the proposed NICU.

Board Certified Obstetrician and OB specialty Chief: Brent Nason, MD

Board Certified Neonatologist and Newborn Specialty Chief: M. Sami Ismail, MD

Board Certified Pediatrician: Saggar Karlekar, MD

Director of Women's Services: Jan Alexander, RN 1 FTE

Clinical Coordinator/Manager Women's Services: Beth Gupton 1 FTE

Lactation Consultant: Kassandra Pack (7day per week coverage) .8 FTE

Respiratory Therapists in house 24/7.
RT Manager, Louise Collins

Social Worker available 24/7.
Social Worker, Anita McGrath

Nutritionist/Dietitian available 24/7
Lead Dietitian, Jennifer Stephens

Pharmacist available in house 24/7
Director of Pharmacy, Mark Ouellette

11. Section C, Orderly Development, Item 7 c. and 7 d.

a. The executive summary provided by the Joint Commission is noted. Please indicate the date of the survey. Also, the executive summary indicates a follow-up in the area (s) of Evidence of Standards Compliance (ESC). What was the result of the follow-up survey?

The date of the survey was March 15-17, 2010. The Evidence of Standards Compliance (ESC) findings were responded to by HMC in the appropriate time frames defined by the Joint Commission in the Executive Summary (i.e., 45 and 60 days). As a result, HMC received the Joint Commission's accreditation for all services in a letter dated June 7, 2010—attached following this page.

b. Please provide a copy of the current license of the facility.

It was provided in the original submittal in Attachment A.4.

c. Please provide a copy of the most recent/ licensure survey or inspection.

It is being submitted under separate cover.

12. Development Schedule

The applicant is requesting an implementation period of four years. Please complete the Project Completion Forecast Chart to reflect the request so Agency members may review the anticipated schedule.

Attached following this page is revised page 91R with an extended implementation period of 3.5 years requested, to provide a time "cushion" in case the opening date is delayed beyond the mid-2016 target in the Forecast Chart. We would like the Forecast Chart dates to remain unchanged.

The Joint Commission

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

June 7, 2010

Regina Bartlett, RN
CEO
Hendersonville Hospital Corporation
355 New Shackle Island Road
Hendersonville, TN 37075

Joint Commission ID #: 5174
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 06/07/2010

Dear Adm. Bartlett:

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

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning March 18, 2010. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

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

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

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

Sincerely,

Ann Scott Blouin RN, PhD

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

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

The applicant anticipates needing at least 36 months to completely implement the project. Almost a year of structural work will need to be done on the hospital and in its powerhouse, before any construction of bed areas can begin. To be cautious, the applicant is asking here for an implementation period of 3.5 years, or until January 1, 2017.

Further Supplemental Information

Attached immediately after this page are several more pages with minor changes in the originally submitted application.

- Pages 8R and 13R amend square footage tables and statements slightly to reflect the architect's latest updates shown in the Cost Per Square Foot Chart.

- Pages 25R and 56R amend statements about the longer lengths of stay for infants who are found after observation to have addictive substances in their bodies.

- Page 41R corrects the spelling of Dr. Sami Ismail's name, which had a typographical error.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

at HMC's Hendersonville campus, through relocation of older licensed beds existing at both its Sumner County campuses. Second, it will increase the number of LDRP (Labor/Delivery/ Recovery/Discharge) beds in Obstetrics on the second floor. Third, it will (b) establish a 6-bed Level II-B Neonatal Intensive Care Unit on the obstetrical floor of the main hospital, in an area vacated by moving beds to the fourth floor. The project will move a net total of 13 inpatient beds from HMC's satellite campus back to HMC's main campus, all within the same county and within the same facility license.

2. Physical Changes to the Building

Table Two: Summary of Construction and Changes in Size	
	Total Square Feet
Facility Before Project	160,015 SF
Facility After Project	181,886 SF
Net Increase in Size (%)	21,871 (+13.7%)
Area of New Construction	21,871 SF
Area of Buildout or Renovation	36,394 SF
Total New & Renovated Construction	58,265 SF

Source: Project architect.
Note: Additional detail on a departmental level is provided in Attachment B.II.A.

The addition of the new fourth floor will be the only new construction in this project. The NICU will be created in renovated second-floor nursing unit space that will become available as second-floor medical-surgical beds are consolidated on the new fourth floor for efficiency of staffing.

3. Changes in Location and Assignment of HMC's Licensed Beds

This project will make several adjustments in bed allocations within, and between, the two campuses. First, at the main campus in Hendersonville, it will construct a new fourth floor for medical-surgical patients. To that floor, it will relocate 19 licensed medical-surgical beds from the 2nd floor, and 13 of the 34 medical-surgical beds at the Portland campus. These relocations will give the new fourth floor a complement of 32 medical-surgical beds.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

Hospital construction projects approved by the HSDA in 2009-2011 had the following construction costs per SF:

Table Four: Hospital Construction Cost PSF Years: 2009 – 2011			
	Renovated Construction	**New Construction**	**Total Construction**
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$125.84/sq ft	$324.00/sq ft	$301.74/sq ft

Source: HSDA, from CON approved applications during 2009-2011.

This project, which is priced for a CY 2014-2016 construction period, is consistent with the HSDA's 2009-2011 average cost ranges, when five years of future cost inflation are taken into account. The project construction cost by the time it opens in 2016 is projected to be approximately $362 PSF overall. However, this includes some other campus construction that will be undertaken at the same time, but is only partly related to this project--upgrading of the campus's powerhouse and some major structural upgrades to the 35-year-old facility in several areas. As shown in the Cost PSF chart prepared by the architect in Attachment C, Economic Feasibility--1, the construction cost for the new fourth floor by itself is $279 PSF, and the renovation cost on the second floor (NICU area) is $193 PSF.

Table Five: This Project's Construction Costs			
	Renovation	**New Construction**	**Total Project**
Square Feet	36,394 SF	21,871 SF	58,265 SF
Construction Cost			$21,068,150
Constr. Cost PSF	$193-$939	$155	$361.66

Source: HCA Design and Construction data.

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

area in CY2012, (b) the experience of the Summit Medical Center NICU in eastern Davidson County, and (c) the anticipated increase of long stays (four or more weeks) of addicted infants of drug-using mothers, more of whom will be identified by mandatory newborn drug screening tests and observation, expected to begin later this year.

(2) Potential for Level II-B Care at TriStar Hendersonville Medical Center

As an HCA facility, HMC is affiliated with the Women's and Children's Hospital at Centennial Medical Center in Nashville. That dedicated 155-bed facility at Centennial has a highly utilized 60-bed NICU that is Middle Tennessee's second largest, in terms of both bed capacity and days of care provided). Its NICU utilization increased 18.2% last year, the highest growth rate of any NICU in the region. With multiple pediatric subspecialties available, and more coming online in CY2013, Women's and Children's has one of the State's most comprehensive NICU programs, and it is the neonatal destination of choice for most mothers who deliver at HMC and find that their infant needs Level II-B or Level III care.

That NICU's beds will also soon be full, consistently. See Graph 3 at the end of this subsection. So Women's and Children's Hospital clinicians are working with HMC to enable Sumner County area Level II-B newborns to safely remain in, or be more quickly returned to, Hendersonville for II-B care, freeing up beds at the downtown NICU. Women's and Children's is assisting TriStar Hendersonville Medical Center with NICU program definition, utilization projections, staff specifications and qualifications, recruitment screening and interviews, establishing training rotations through the downtown NICU, and continuing education for the NICU staff. Their coordination reflects HCA's "hub and spoke" approach to distributing high quality specialty services to suburban locations to improve patient care closer to home.

In planning this project, a medical records review of infants transported from HMC and its service area to Women's and Children's Hospital was conducted by a team of nurses from both facilities. The team concluded that approximately 9% of HMC's current births will require Level II-B care that can be cared for in a NICU in Hendersonville. The HMC NICU staff will be jointly recruited and trained by HMC and Women's and Children's Hospital, and will be medically supervised by the same

Table Twelve below provides 2009-2012 size and utilization data for all existing and approved NICU units in the 37-county Middle Tennessee Perinatal Planning Area.

There was a rapid increase from 2011 to 2012 (6.5%) in NICU utilization, and a 12.2% increase that year in the combined Level III NICU programs (which also treat large numbers of Level II-B infants).

The patient days in area NICU's were "flat" for several years, but in 2011-2012 resumed overall annual growth. In this period of time, restrictions were placed on physicians' induction of labor for premature babies, which reduced infant complications at birth. However, NICU demand is again on the rise. One factor is the normal population growth of childbearing-age women (strongest in suburban areas like this project's service area.). Another is that II-B infant days are expected to increase when hospitals begin testing all newborns for residual drugs in their system, to identify more at-risk newborns. At-risk newborns who prove to have addictive substances in their bodies will utilize the II-B nursery for long stays (often four or more weeks) or transfer to Level III care in some cases.

II-B care are between 8 and 12 beds (one at Williamson Medical Center operated only 5 NICU beds until CY2012). All of these units are medically supervised either by the Pediatrix neonatology organization that will supervise this project, or by Vanderbilt neonatologists; and their care appears to be of high quality and economically feasible.

4. The applicant shall designate a specific service area that is compatible with Department of Health guidelines pertaining to this service.

The application has defined the primary and secondary NICU project service area as Sumner County and parts of adjoining north Davidson County and eastern Robertson County.

5. The applicant should demonstrate the ability to comply with the standards developed in the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing, and Facilities.

The applicant's response to the Perinatal Care Guidelines is a fourteen-page document located in Attachment C, Need--I.A at the back of this application. It demonstrates that the project will meet or exceed every standard in those Guidelines.

This NICU's Medical Director, Dr. Ismail, is a highly trained Board-certified neonatologist whose Fellowship training was at the Medical College of Virginia in Richmond. He is Medical Director of the Level III NICU and Neonatal Transport Service at Centennial Women's and Children's Hospital. The group with which he practices, Pediatrix, directs medical care at five local hospitals in the region, through two large groups of neonatologists.

The HMC NICU will be staffed 24/7 not only with NICU-trained RN's, but also with Pediatrix neonatal nurse practitioners. The staffing of the NICU will vary with the needs and numbers of the infants on the unit; it will comply with the ratios of RN-to-infant prescribed in Perinatal System Guidelines Section III.B.3 (p. 11), which vary with the type of medical care needed by the infant. All staff education and training, and maintenance of staff competencies, will meet or exceed the State Perinatal Guidelines. The unit will work closely with the Centennial Women's and Children's Hospital in development, staff recruitment and training, and operations. The two NICU's will share

SUPPLEMENTAL ATTACHMENTS

1. TENNESSEE PERINATAL SYSTEM GUIDELINES FOR TRANSPORTATION, FIFTH EDITION

2. QUALIFICATIONS OF NEONATOLOGISTS AVAILABLE TO THE NICU, IN ADDITION TO ITS MEDICAL DIRECTOR

3. HMC'S MOST RECENT TDH LICENSURE INSPECTION

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February 26, 2013
2:13pm

TENNESSEE PERINATAL CARE SYSTEM

GUIDELINES FOR TRANSPORTATION

(Fifth Edition)

2006

Tennessee Department of Health
Women's Health & Genetics

Phil Bredesen
Governor

Kenneth S. Robinson, M.D.
Commissioner

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TENNESSEE PERINATAL CARE SYSTEM

GUIDELINES FOR TRANSPORTATION

(Fifth Edition)

Prepared by the
Subcommittee on Perinatal Transportation
of the
Perinatal Advisory Committee

2006

This document may be accessed electronically at the following:
http://www.state.tn.us/health/
Click on Forms and Publications and then Emergency Medical Services or Women's Health

SUMMARY OF HOSPITAL PERINATAL SERVICE LEVELS

LEVEL I UNITS

Level I units provide basic care for uncomplicated maternity and neonatal patients. All high-risk mothers and neonates must be promptly identified for referral and/or consultation for more specialized care. The Level I unit shall provide equipment and staff to care for maternity patients whose onset of labor occurs on or after the first day of the 35th week of gestation, for neonates whose birthweight is over 2500 grams, or for sick patients pending transfer to another hospital. The Level I unit can also provide care for convalescing neonates who are transferred from other institutions to be closer to home.

LEVEL II UNITS – OBSTETRIC

Level II obstetric units have the capability to provide a broad range of maternal-fetal services for normal patients and for those with mild or moderate obstetric illnesses or complications. These units provide planned delivery services for women whose infants are expected to be >32 completed weeks of gestation and have a birthweight of at least 1500 grams. Additionally, a need for immediate pediatric subspecialty care for these newborns should not be anticipated. Level II obstetric units also provide emergency care for unplanned births of younger, smaller, or sicker babies before transfer to a facility at which newborn intensive care is provided.

LEVEL II-A UNITS – NEONATAL

Level II-A nurseries provide specialty neonatal services. They provide care for infants born at >32 weeks gestation and weighing ≥1500 grams who have physiologic immaturity or who are moderately ill with problems that are anticipated to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. These units also resuscitate and stabilize preterm and/or ill infants before transfer to a facility at which newborn intensive care is provided. In addition, Level II-A units provide care for infants who are convalescing after intensive care.

LEVEL II-B UNITS – NEONATAL

Level II-B nurseries provide specialty neonatal services. They provide care for infants born at >32 weeks gestation and weighing ≥1500 grams who have physiologic immaturity or who are moderately ill with problems that are anticipated to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. Level II-B units also have the capability to provide mechanical ventilation for brief durations (<24 hours) or continuous positive airway pressure.

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TRANSPORTATION GUIDELINES WORKGROUP

April 2006

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PERINATAL ADVISORY COMMITTEE

March 2006

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LEVEL II-B FACILITIES

NEONATAL TRANSPORT

Level II-B

Level II-B units are capable of managing more complex maternal and neonatal abnormalities such as care of neonates that require umbilical vessel catheters and protracted mechanical ventilation. In exceptional circumstances, the Level II-B unit may receive patients transferred from Level I and Level II-A institutions.

When antenatal ultrasound and/or genetic testing has identified a fetus with congenital anomalies, prenatal referral to an appropriate subspecialty provider or fetal assessment clinic to provide families with prognostic information and facilitate a coordinated plan for deliver in a facility with the needed services is encouraged.

When transport is deemed safe for the mother and fetus, transfer of mothers to a Level III unit with the specialized services required by the fetus after birth is encouraged. The elective delivery of an infant in a hospital without the required pediatric sub-specialty services resulting in a planned neonatal transport is discouraged.

The obstetric co-director is board certified in that specialty. The pediatric co-director is board certified in neonatal-perinatal medicine.

INDICATIONS FOR NEONATAL CONSULTATION AND/OR TRANSPORT

I. Gestational age </= 28 weeks

II. Should be considered if birth weight is <1000 grams and must occur if birthweight is <750 gm

III. Severity of illness requiring a level of care that exceeds the capacity of the Level II-B facility

NEONATAL REFERRAL PROCESS

I. Neonatal transport is initiated by the health care provider responsible for the patient's medical care. Guidelines for the referral process are outlined below.

II. REFERRING CENTER RESPONSIBILITIES

A. The referring health care provider's decision to request consultation is the first step in the referral process.

B. Telephone consultation with the receiving physician is necessary to initiate the referral process and to prepare the receiving center. This consultation may aid the referring health care provider in developing a treatment plan for stabilizing the patient before transport.

C. A discussion between the referring health care provider and receiving physician regarding the neonate will result in one of three possible dispositions:

1. Required neonatal care can be provided at the referring center. The receiving physician under these circumstances has only a consultative role.
2. The neonate requires further observation, investigation, or other preparation before possible transport. Continued contact between the providers is necessary.
3. Transport of the neonate is necessary. The optimal time, mode of transfer, transport personnel, and additional information regarding the neonate should be discussed. The process of stabilization of the neonate at the referring center should be reviewed and documented.

D. If the neonate is transported by the referring center, the referring health care provider is responsible for the patient until arrival at the receiving center.

E. If the neonate is transported by the receiving center, the referring health care provider is responsible for the patient until the arrival of the transport team. If the transport team is sent by the receiving hospital, the receiving physician or designee assumes responsibility for patient care from the time the patient leaves the referring hospital. It should be emphasized that during the preparation for transport by the transport team, the referring physician and hospital have retained responsibility for the patient unless there have been other prior agreements which determine this responsibility (most recent edition, Guidelines for Perinatal Care, published by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics). The patient becomes the full responsibility of the transport team when leaving the referring center.

F. The medical record should be organized as the patient is prepared for transport and sent with the patient.

G. Consent forms to authorize transfer must be obtained.

H. Parents should be encouraged to see and touch the infant. Photographs of the infant should be provided to parents, if culturally appropriate.

I. Appropriate maternal/neonatal identification should be in place before transport.

J. All referrals should be directly admitted to the receiving unit to avoid unnecessary delays in the emergency room.

III. RECEIVING CENTER RESPONSIBILITIES

A. The receiving physician is responsible for the decision to accept the referring health care provider's request for transport and make preparations at the receiving center. If unable to accept the transport, assistance will be provided to the referring health care provider in locating appropriate care.
B. If the neonate is transported by the referring center, full responsibility begins with admission to the receiving center.
C. If the neonate is transported by the receiving center, the referring health care provider is responsible for the patient until the arrival of the transport team. If the transport team is sent by the receiving hospital, the receiving physician or designee assumes responsibility for patient care from the time the patient leaves the referring hospital. It should be emphasized that during the preparation for transport by the transport team, the referring physician and hospital have retained responsibility for the patient unless there have been other prior agreements which determine this responsibility (most recent edition, Guidelines for Perinatal Care, published by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics). The patient becomes the full responsibility of the transport team when leaving the referring center.
D. If a delay in transport occurs, a repeat telephone call should be made for further assessment and advice.
E. On arrival of the transport team, assessment and further stabilization of the neonate should be done in collaboration with the referring staff.
F. The transport team must verify proper identification of the neonate before transport.
G. Following stabilization of the neonate, the transport team should communicate with the parents to assure their understanding of the infant's condition, possible course, and therapeutic intervention that has been undertaken or anticipated. Information about the receiving center should be provided to the parents.
H. Consent forms to authorize transfer, treatment, and admission to the receiving hospital must be obtained.
I. Parents should be encouraged to see and touch the infant before departure. Photographs of the infant should be provided to parents, if culturally appropriate.
J. Before departure, the transport team should communicate with receiving center personnel regarding the neonate's history, current status, and planned management during transport.
K. Before arrival at the receiving center, the transport team should communicate the status of the neonate and anticipated needs on admission.
L. A telephone call should be made to the parents shortly following admission of the neonate.
M. Within 24 hours of admission, communication with referring center personnel regarding events during transport and since admission should occur.
N. Periodic communication with the referring health care provider should be maintained.
O. Consideration should be given to returning the care of the patient to the referring health care provider or primary care physician when practical and medically appropriate.
P. Upon discharge of the infant, a discharge summary should be sent to the referring health care provider.

NEONATAL TRANSPORT PERSONNEL

I. The composition of the transport team should be decided jointly by the referring health care provider and receiving physician(s) based on the condition of the neonate.

II. Transport team members should be selected from appropriately trained physicians, neonatal nurse practitioners, registered nurses, respiratory therapists, emergency medical technicians, and paramedics. The minimum number of transport team members should be three, of which one is the operator of the transport vehicle. The other team members should be comprised of a neonatologist, neonatal fellow, neonatal nurse practitioner, neonatal specialty trained registered nurse, or neonatal specialty trained respiratory therapist.

III. Transport team members should have the collective expertise sufficient to provide, if necessary:

A. observation of the neonate throughout the transport
B. monitoring of body temperature, respiratory status, and cardiovascular status
C. delivery and monitoring of oxygen therapy
D. advanced airway management and mechanical ventilation
E. advanced intravascular access and management skills
F. recognition and management of a wide variety of emergency conditions
G. administration of rescue and stabilization medication

IV. At least two members of the transport team should be current Neonatal Resuscitation Program (American Academy of Pediatrics and American Heart Association) providers. It is also recommended that team members maintain current S.T.A.B.L.E. training.

V. Transport team members should be oriented to the transport vehicle and use of transport equipment. All transport team members should follow state and national standards.

VI. The knowledge and skills required for a nurse to perform neonatal transport are listed in the most current edition of Educational Objectives for Nurses, Levels I, II, III Neonatal Transport Nurses, Tennessee Perinatal Care System, Tennessee Department of Health (Appendix I).

NEONATAL SPECIALTY TRANSPORT MODALITY

I. Selection of the mobile neonatal intensive care unit should be based on the condition of the neonate.

II. The vehicle used exclusively for the provision of neonatal intensive care and transportation between medical facilities shall conform with the following standards for design and construction as defined by the EMS Division of the Tennessee Department of Health (Tennessee Emergency Medical Services Statutes and Rules, Rule 1200-12-1-.02[4] Special Vehicle Requirements).

A. Exterior surfaces, emblems, and markings shall conform to Federal Specifications-Ambulance.

B. Additional markings, legends, or logos may be used to identify the provider and purpose for specific vehicles, except that no letter shall exceed 14 inches in height. Legends as "neonatal intensive care or critical care transport" may be substituted for the "Ambulance" in exterior markings.

C. Warning lights and siren shall be furnished in accordance with Federal Specification-Ambulance except that side floodlights shall not be required.

D. Vehicle crashworthiness shall be assured with roll-cage construction evidenced by compliance with the Ambulance Manufacturer's Division Standards of the Truck Body and Equipment Association or comparable construction under written statement and performance bond by the manufacturer.

E. Doors shall provide access to the rear and curbside of the patient compartment. Where the vertical lift distance of the patient loading area exceeds 28 inches, a ramp or electrical-hydraulic lift shall be furnished to facilitate patient loading.

F. Environmental systems on the unit shall meet heating/air-conditioning standards as specified in Federal Specifications-Ambulance.

G. Vehicle electrical systems shall be provided to furnish 110 volt AC power sufficient to sustain 3,000 watts at 60 cycles. The unit shall be equipped with a back-up power system sufficient to operate patient care equipment in the event of failure of the main power systems. The 110 volt system shall incorporate a ground fault interrupter device for protection against electrical hazards.

H. Patient compartment shall be so designed to provide the following:

1. a properly secured transport incubator allowing observation from at least two sides
2. compartments for appropriate storage of materials
3. illumination at the primary patient care area of at least 75 foot candles
4. safety features such as sculpted, padded, or recessed cabinet corners and latches to prevent undue injury during sudden deceleration
5. safety devices such as a grab rail or hand strap, secured according to Federal Motor Vehicle Safety Standards for safety restraints, safety belts provided at all attendant seats, and safety restraint devices for neonates

I. An oxygen system with sufficient capacity to deliver a minimum continuous flow of 10 liters per minute for at least four hours must be available. The installed oxygen system shall be capable of delivering specific monitored blended oxygen concentrations.

J. The vehicle shall provide environmental conditions for the neonate that minimize the risk of temperature instability and excessive noise and vibration.

III. In the event a RWA or FWA is used for neonatal transport, the following additional precautions should be observed:

A. use of a licensed air medical transport program with appropriately credentialed neonatal care providers
B. secure fastening of transport equipment
C. an independent power source to allow uninterrupted and fail-safe operation of the incubator and other supporting equipment
D. environmental conditions for the neonate that minimize the risk of temperature instability, noise and vibration
E. protective headgear for crew use during transport
F. system for easy communication among the members of the transport team and medical control at receiving center
G. seat belts
H. seating arrangement that permits close observation and handling of the patient

IV. Latex free equipment and supplies must be provided.

NEONATAL TRANSPORT EQUIPMENT

I. Organization and maintenance of neonatal transport equipment is the responsibility of the transporting facility. (See Appendix VIII)

II. Equipment to maintain a neutral thermal environment for the neonate should include:

A. transport incubator
B. thermometer
C. blanket, insulating blanket or chemically activated heat pack (appropriate for neonatal use)

III. The transport incubator should meet the following requirements:

A. approved by the manufacturer for use during transport and installed in the transport vehicle with crashworthy restraints.
B. if used in RWA and FWA it shall meet FAA requirements for crashworthiness and flammability of materials. The transport incubator and monitoring equipment should be tested by an FAA certified mechanic to assure equipment does not interfere with navigational instruments.
C. a heat source that requires minimal time for preheating and should maintain ambient temperature within the desired range of 29° to 36° C. The control for temperature setting should be readily accessible and easy to operate, and there should be provision for easy determination of ambient temperature. It is essential to have a fail-safe alarm system that will recognize overheating or underheating.
D. provide an environment in which the oxygen supply is constant and controllable.
E. provide unrestricted visibility of the neonate with a functional independent light source for general illumination provided in or on the incubator.
F. easy accessibility to the neonate resulting in minimal interference with thermal protection and oxygen supply.
G. safety restraint devices to secure the neonate inside the incubator that conform to Federal Motor Vehicle Safety Standards and FAA Standards.

IV. Equipment for oxygen delivery and monitoring should include:

A. oxygen tanks
B. air tanks
C. pressure gauges
D. flowmeters (needle control valve preferred)
E. oxygen analyzer
F. oxygen blender
G. oxygen tubing and adapters
H. oxygen hood or nasal cannula
I. neonatal oxygen mask
J. neonatal resuscitation manual bag and mask with manometer or T-piece resuscitator
K. continuous positive airway pressure apparatus
L. mechanical ventilator

V. The following guidelines are related to the use of oxygen during transport:

A. a portable supply of oxygen and compressed air in cylinders adequate to last the entire journey with surplus to cover unexpected needs and delays should be carried. Proper restraint of these cylinders is mandatory throughout the transport. An oxygen cylinder usage chart may be used in determining the number and type of oxygen cylinders necessary during transport (Appendix III).

B. oxygen cylinders in use should be provided with pressure gauges and flow meters.

C. the ambient oxygen concentration must be monitored continuously by an oxygen analyzer.

VI. Devices to maintain the patency of the airway and gastric decompression must be readily available and should include:

A. bulb syringe

B. regulated suction with gauge

C. suction catheters (#6, 8, 10 Fr)

D. feeding tube (#8 Fr) with a 20 mL syringe

E. Replogle tube (#8 Fr)

VII. Equipment for vital sign monitoring should include:

A. a continuous heart rate monitor

B. neonatal stethoscope

C. body temperature monitor

D. noninvasive and invasive blood pressure monitoring devices

E. pulse oximeter for noninvasive monitoring of oxygen saturation

VIII. Equipment for monitoring blood glucose must be available.

IX. If intravenous therapy is required, an infusion pump that is portable, battery-powered, fail-safe, and calibrated to ensure accurate delivery of calculated fluid volumes must be used. Critical neonates may require multiple intravenous lines requiring additional infusion pumps.

X. The equipment and supplies required for resuscitation of a neonate must be available, portable and should include:

A. Endotracheal intubation

1. laryngoscope handle with blades (#00, 0, 1)
2. laryngoscope spare bulbs
3. laryngoscope spare batteries
4. endotracheal tubes (#2.5, 3.0, 3.5, 4.0 mmID)
5. neonatal resuscitation manual bag and mask or T-piece resuscitator
6. pressure manometer (to monitor PIP and PEEP if manual ventilation is necessary)
7. disposable stylet (#6 Fr)
8. adhesive tape or commercial endotracheal tube holders
9. scissors
10. end tidal carbon dioxide (CO_2) detector

B. Intravenous infusion

1. intravenous needles and catheters (#22, 23, 24, 25, 26 gauge)
2. syringes (1, 3, 6, 12, 20, 35 mL)
3. intravenous armboard
4. intravenous tubing and T connector
5. infusion device
6. tape or site dressing
7. site preps
8. 3-way stopcock
9. umbilical catheterization equipment

C. Medications should include the following drugs or an approved therapeutic equivalent based on local program protocols.

1. adenosine
2. ampicillin
3. atropine
4. calcium gluconate
5. dextrose solution (D5W)
6. dextrose solution D10W)
7. dextrose solution (D25W)
8. dobutamine
9. dopamine
10. epinephrine (1:10,000)
11. fentanyl
12. furosemide
13. gentamicin
14. glucagon
15. heparin
16. insulin (regular)
17. morphine sulfate
18. naloxone hydrochloride
19. normal saline
20. phenobarbital
21. prostaglandin E_1 (requires refrigeration)
22. sodium bicarbonate (4.2%)
23. sterile water
24. surfactant (requires refrigeration)
25. THAM or other buffer

XI. Equipment for diagnosis and management of air leak syndrome

A. transilluminator
B. chest tubes (8, 10, 12 Fr)
C. chest tube kit
D. 18 to 20 gauge over the needle catheters
E. drain with one-way check valve

F. 3-way stopcock
G. luer lock and slip tip syringe (35/60cc)

XII. Equipment for handwashing and personal protection

A. antiseptic solution or towelettes
B. gloves
C. full face protection or goggles and masks
D. fluid-retardant and fluid-resistant gowns
E. infectious waste disposal bags
F. soiled linen disposal bags
G. sharps box

XIII. Latex free equipment and supplies must be provided.

NEONATAL REFERRAL DOCUMENTATION

I. Records are essential for continuing care of the patient and evaluation of the referral process. Both referring and receiving center personnel have responsibilities to provide adequate documentation of clinical data.

II. REFERRING CENTER RESPONSIBILITIES

A. The following documents should accompany the transported neonate:

1. copy of complete maternal prenatal record
2. copy of current maternal medical record
3. copy of current neonatal medical record
4. copies of any images in a format that can be reviewed by the transport team at the bedside
5. copy of record of care during transport

B. The referring center should maintain a record regarding disposition of transported neonates.

III. RECEIVING CENTER RESPONSIBILITIES

A. maintain a record of consultation/referral calls
B. maintain a record regarding the disposition of the transported neonate
C. send a summary of care to the referring perinatal health care providers

EVALUATION OF NEONATAL REFERRAL PROCESS

I. Interhospital care of the high-risk neonate requires the cooperation and coordination of many skilled persons. Outreach education efforts should include discussions of the regional referral process and can be used to reinforce cooperation and coordination.

II. Outreach education related to transport should focus on the following objectives:

   A. informing perinatal care and EMS providers in the region of specialized resources available to them through the perinatal network.
   B. assisting neonatal care providers in developing their abilities to identify high-risk neonatal patients, anticipate complications, and stabilize those patients before transport.
   C. continuing quality improvement through ongoing education of neonatal care and EMS providers (See Appendices I and II).

III. Planning of the neonatal referral process requires participation of those who will use the service and those who will provide it. Criteria considered in planning and evaluating the referral process are:

   A. availability
   B. accessibility
   C. responsiveness
   D. effectiveness
   E. safety

IV. Referring facilities should periodically review their neonatal referrals.

Renewal No.
770982

State of Tennessee
Division Of Health Related Boards

8274844
License No.
MD0000026999

This Certifies that
ERIC SCOTT PALMER, MD
whose credentials have been approved by the:
BOARD OF MEDICAL EXAMINERS
has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR
in the State of Tennessee through NOVEMBER 30, 2014

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS

DCF014 12283

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

Renewal No.
768148

State of Tennessee
Division Of Health Related Boards

8157351
License No.
MD0000022081

This Certifies that

SARAH E HASSELL, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through AUGUST 31, 2014

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS

DCF014 12199

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

The American Board of Pediatrics
and its
Subboard of Neonatal-Perinatal Medicine

hereby declares that

Sarah Emily Hassell, M.D.

has met the requirements of
the American Board of Pediatrics
and is hereby designated
a diplomate certified in neonatal-perinatal medicine

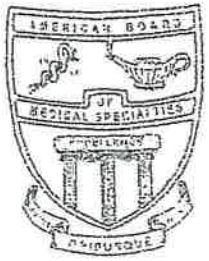
2005 - 2011

No. 003190

Chair, American Board of Pediatrics

Christine Bleasan
Chair, Subboard

November 10, 2004



President, American Board of Pediatrics

Secretary, American Board of Pediatrics

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February 26, 2013
2:13pm

The American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514
MOC@abpeds.org

Date Submitted: December 5, 2011

Enrollment: 2011 Maintenance of Certification
Fee: $1,070.00

Payment Information

Payment Method: MSTRCARD ******/******4738
Amount Charged: $1,070.00

ABP ID# 230223
Dr. Sarah Emily Hassell
2611 Essex Place
Nashville, TN 37212-4121

IMPORTANT: Please take note of the following information regarding your next MOC Cycle dates. These dates represent the start and end of your MOC cycle. You may complete activities for credit only during this time.

MOC Cycle Dates	December 5, 2011 through December 31, 2016

As stated during the MOC enrollment application process, all fees submitted for MOC are non-refundable. The ABP provides this receipt as confirmation of payment and no further documentation will be provided.

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

CURRICULUM VITAE

Sarah Emily Hassell, M.D.
2611 Essex Place
Nashville, TN 37212

Date of birth	*August 21, 1958*
Place of birth	*Charleston, South Carolina*
Office Address	*Mid-TN Neonatology Associates* *2300 Patterson Street* *Nashville, TN 37203*
Office Telephone	*(615) 342-4660*

EDUCATION:

Undergraduate	*College of William & Mary, Williamsburg, VA* *B.S., 1976 - 1980*
Medical	*Medical University of South Carolina, Charleston, South Carolina, M.D., 1984 - 1988*

POSTGRADUATE TRAINING:

Internship & Residency	*Vanderbilt University Medical Center* *Department of Pediatrics, July 1988 - 1991*
Fellowship	*Vanderbilt University Medical Center* *Department of Pediatrics, July 1991 - 1994*

CERTIFICATION:

National Board of Medical Examiners, July 1991
American Board of Pediatrics, No. 48964, October 1991
Sub-Board of Neonatal-Perinatal Medicine, No. 003190, November 1997
Neonatal Resuscitation Program Provider

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

LICENSURE: *State of Tennessee, M.D.*

PROFESSIONAL ASSOCIATIONS: *American Academy of Pediatrics*

PUBLICATIONS:

Butler MG, Hassell SE. "Picture of the Month." AJDC Vol 145 June 1991

Hassell SE, Butler MG. "Antley-Bixler Syndrome: Report of a Patient and Review of the Literature." Submitted, September 1993

REFERENCES: *Available upon request*

Renewal No.
756887

State of Tennessee
Division Of Health Related Boards

License No.
7850164
MD0000036669

This Certifies that

ASHRAF HOSNI M HAMDAN, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through AUGUST 31, 2013

THE GREAT SEAL OF THE STATE OF TENNESSEE
AGRICULTURE COMMERCE
1796

DIRECTOR HEALTH RELATED BOARDS

DCF014 11189

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February 26, 2013
2:13pm

The American Board of Pediatrics
and its
Subboard of Neonatal-Perinatal Medicine

hereby declare that

Ashraf Hosni Mahmoud Hamdan, MB, ChB

is certified as a
Diplomate in Neonatal-Perinatal Medicine
for the period of 2005 - 2012

No. 4236

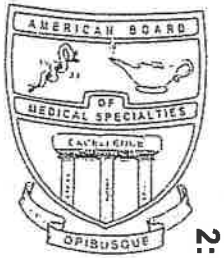
November 30, 2005

Chair, American Board of Pediatrics

Chair, Subboard

President, American Board of Pediatrics

Secretary, American Board of Pediatrics



SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

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MOC Progress Report Transcript
Current as of November 19, 2010 *
Dr. Ashraf Hosni Mahmoud Hamdan
ABPID#: **1003094**
Certification Area: **General Pediatrics**
MOC Cycle : **08/12/2010-12/31/2015**
Certification Status: **Certified - Meeting MOC Requirements**

Lifelong Learning and Self-Assessment (Part 2)

2009 PREP Self-assessment	Completed 09/30/2010	20 points
2008 PREP Self-assessment	Completed 09/16/2010	20 points

Performance in Practice (Part 4)

Patient Survey	Not Met
Performance in Practice	Not Met

Points needed: 40 points Part 2, 40 points Part 4, and 20 points either Part 2 or 4
Points Needed: 100 **Points Earned:** 40

Cognitive Expertise - Secure Exam (Part 3)

General Pediatrics Certifying Examination	Not Met Exam Due 2013

Professional Standing and Licensure (Part 1)

Enrollment License Verification	Completed 08/13/2010

Once you have met the requirements for all Parts of Maintenance of Certification (MOC) AND you are in the final year of your current MOC cycle, the system will allow you to enroll in your next MOC cycle. Failure to enroll in MOC before your cycle expiration date will result in a status change to **not board certified** in this area.

**The American Board of Pediatrics (ABP) provides this information as a service to our diplomates. The ABP makes every effort to ensure that the information presented here is accurate as of the date printed. However, the ABP makes no warranty or guarantee concerning the reliability of the content provided. Assessing the currency of the information provided is solely the responsibility of the diplomate.*

ASHRAF HOSNI HAMDAN

Office address: Pediatrix Medical Group of Tennessee, PC
2300 Patterson Street
Nashville, TN 37203

Phone: (615) 342-4660
Fax: (615) 342-4662
E-MAIL: ashraf.hamdan@vanderbilt.edu

PERSONAL DATA:

Home address: 106 Governors way
Brentwood
TN 37027

Marital status: Married to Sally El Saadawy

PRESENT EMPLOYMENT:

Clinical Assistant Professor Pediatrics. Vanderbilt University, Nashville, TN, USA.
Clinical Neonatologist. Pediatrix Medical Group of Tennessee, Nashville, TN.

EDUCATION:

MBBCh., Faculty of Medicine, Alexandria University, Egypt. November 1984
MSc. Pediatrics, Faculty of Medicine, Alexandria University, Egypt. July 1989
MD. Pediatrics, Faculty of Medicine, Liverpool University, UK. July 1999

CERTIFICATION:

MRCP Pediatrics, July 1995 (UK)
ECFMG, January 1998 (USA)
CCST Pediatrics and Neonatology, October 2001 (UK)
Pediatric Board, October 2003 (USA)
Neonatology Board, November 2005 (USA)

WORK EXPERIENCE IN THE USA:

A. Clinical Neonatologist (July 17th 2009 – current)
Pediatrix Medical Group of Tennessee.
Women's Hospital at Centennial, Nashville, Tennessee. 60 bed Level III NICU with HFOV, conventional ventilation and NO. The NICU has its own transport team to pick up sick or prematurely born babies from all the community hospitals in the TriStar family. The Unit offer care for up to 700 babies per year.
I perform all procedures required in the NICU including: UAC, UVC, PICC lines, arterial lines, endotracheal intubation, Chest tube placement and paracentesis. Also I can do and interpret head ultrasounds to rule out intraventricular hemorrhages.

A. Clinical Neonatologist (July 1st 2007 – July 16th 2009)
Mid Tennessee Neonatology Associates.
Women's Hospital at Centennial, Nashville, Tennessee. 60 bed Level III NICU with HFOV, conventional ventilation and NO. The NICU has its own transport team to pick up sick or prematurely born babies from all the community hospitals in the TriStar family. The Unit offer care for up to 700 babies per year.

B. Clinical Assistant Professor Pediatrics and Neonatology (July 1st 2007 – current)
Vanderbilt University and Monroe Carrel Children's Hospital at Vanderbilt.

C. Assistant Professor Pediatrics and Neonatology (July 1st 2004 – June 30th 2007)
Vanderbilt University and Monroe Carrel Children's Hospital at Vanderbilt.
222 beds dedicated to high-level pediatric, subspecialty treatment, and trauma care, a teaching and research facility. 78 Neonatal Intensive care beds, with ECMO, NO, HFJV, HFOV and conventional ventilation. The Unit offers care for up to 1200 babies per year.

D. NEONATOLOGY FELLOW (July 1st 2003 – June 30th 2004)
Vanderbilt University Children's Hospital, Nashville, TN, USA.

E. PEDIATRIC RESIDENT (July 1st 2001 - June 30th 2003)
Vanderbilt University Children's Hospital, Nashville, TN, USA.

F. NEONATOLOGY FELLOW (July 1st 1999 – June 30th 2001)
Vanderbilt University Children's Hospital, Nashville, TN, USA.

WORK EXPERIENCE IN THE UK:

A. REGISTRAR PEDIATRICS & NEONATOLOGY (August 1st 1996 – June 30th 1999)
Mersey Deanery NHSE (North West).
Trained at Alder Hey Children's hospital, Liverpool Women's hospital and Glan Clwyd Hospital.

B. LECTURER NEONATOLOGY & GENETICS (May 1st 1995 – March 31st 1996).
Liverpool Women's Hospital and Liverpool University. Liverpool, UK.
The Neonatal Unit has 52 cots, 16 intensive care, 18 for high dependency, 14 low dependency care and 4 transitional care.
The Unit offers care for up to 1000 babies and their families per year

C. RESEARCH FELLOW NEONATOLOGY (October 20th 1993 – April 30th 1995)
Liverpool Women's Hospital and Liverpool University.

WORK EXPERIENCE IN EGYPT

1. **INTERNSHIP** (March 1st 1985 –February 28th 1986)
Alexandria University Hospitals, Al Azarita station, Alexandria, Egypt.
2. **GENERAL PRACTITIONER** (March 1st 1986 –January 4th 1987)
Dahab Medical Center, South Sinai, Egypt
3. **PEDIATRIC RESIDENT** (January 5th 1987 –January 4th 1990)
Alexandria University Children's Hospital

4. **NEONATOLOGY FELLOW** (June 1st 1990 –December 31st 1991)
Alexandria University Children's Hospital

5. **ASSISSTANT LECTURER** (January 1st 1992 - October 19th 1993)
Suez Canal University, Ismailia, Egypt

LICENSURE:
Tennessee, Number 36669
Kentucky, Number 40382
Egypt.

PUBLICATIONS:

ABSTRACTS:
1. **A H Hamdan**, N J Shaw. Changes in pulmonary artery pressure in infants with RDS treated with 3 different types of surfactant. (Abstract) Ped Res 1995; 38 (3): 78.
2. **A H Hamdan**, N J Shaw. Changes in UOP in infants with RDS treated with surfactant. PRS (Swansea), Abstract.
3. **A H Hamdan**, N Subhedar, N J Shaw. Interobserver variation in Doppler ultrasound assessment of pulmonary artery pressure. J Perinatol 2000; 20(7): 472.
4. **A H Hamdan**, N Subhedar, N J Shaw. Inter-observer variation in Doppler ultrasound assessment of pulmonary artery pressure in preterm infants. Ped Res 2001; 49(4): 377.

5. **A H Hamdan**, W Walsh, A Hedding, J Bruner, N Tulipan. Early gestational age of fetal spina bifida repair does not decrease the gestational age at delivery. Ped Res 2001; 49(4): 318.

6. **A H Hamdan**, W Walsh, A Hedding, J Bruner, N Tulipan. Gestational age at intrauterine myelomeningocele repair does not influence the risk of prematurity. J Perinatol 2002; 21(7): 506.

7. K L Sandberg, **A Hamdan**, P A Minton, S Poole, H W Sundell. Prenatal nicotine exposure adversely affects large but not small airway function in young lambs. Ped Res April 2002; 470A.

8. K L Sandberg, **A Hamdan**, P A Minton, S Poole, H W Sundell. In utero nicotine exposure induces bronchial hyperresponsiveness in young lambs. Ped Res April 2002; 475A.

9. **A H Hamdan**, W Walsh, J P Bruner, N Tulipan. Intrauterine myelomeningocele repair: effect on the short term complications of prematurity. J Perinatol 2002; 22(7): 605.

10. Tracy M. Louis, Eric Sullivan, Derenda Hodge, Annette Norman, **Ashraf Hamdan**. Success of a Ventilator Associated Pneumonia Prevention Bundle in a Level IIIb Neonatal Intensive Care Unit. 2009 APIC conference.

THESIS:

A H Hamdan. Serological study of toxoplasma antibodies in infants with congenital heart disease. MSc. Thesis. Department of Pediatrics, Faculty of Medicine, Alexandria University, Alexandria, Egypt 1989.

A H Hamdan. Changes in the natural history of RDS with the advent of Surfactant therapy. M.D. thesis, Department of Child Health, Faculty of Medicine, Liverpool University, Liverpool, U.K. 1999.

PAPERS:

1. **A H Hamdan**, N J Shaw. Changes in the pulmonary artery pressure in infants with RDS treated with Exosurf. Arch Dis Child 1995; 72: F176 -F179.

2. N V Subhedar, **A H Hamdan,** S W Ryan, N J Shaw. Pulmonary artery pressure is an independent early predictor of chronic lung disease. Arch Dis Child 1998; 78: F20-4.

3. **A H Hamdan,** N J Shaw. Changes in pulmonary artery pressure in infants with RDS treated with 3 different types of surfactant. Ped Pulmon 1998; 25:191-5.

4. **A H Hamdan,** N J Shaw. Urine output in infants with respiratory distress syndrome treated with surfactant. Clinical Pediatrics 2000; 39(7): 421-425.

5. **A H Hamdan**, W Walsh, A Hedding, J Bruner, N Tulipan. Gestational age at intrauterine myelomeningocele repair does not influence the risk of prematurity. Fetal Diag Therapy 2002;17:66-68.

6. **A H Hamdan**, W Walsh, J P Bruner, N Tulipan. Intrauterine myelomeningocele repair: effect on the short term complications of prematurity. Fetal Diag Therapy 2004;19:83-6.

7. K Sandberg, S D. Poole, **A H Hamdan,** P Arbogast, H W. Sundell. Altered lung development after prenatal nicotine exposure in young lambs. Pediatr Res 2004;56(3):432-439.

8. **Hamdan A H**. Hydrops fetalis, eMedicine from WebMD. Updated 2009.

9. Kenneth L. Sandberg, Stanley D. Poole, **Ashraf Hamdan**, Patricia A. Minton, Hakan W. Sundell. Prenatal nicotine exposure transiently alters the lung mechanical response to hypoxia in young lambs. Resp Phys & Neuro 2007:156(3):283-292.

10. **Hamdan AH**. Neonatal Abstinence Syndrome. eMedicine from WebMD. Updated June 18, 2009. Available at: http://emedicine.medscape.com/article/978763-overview.

PRESENTATIONS AT SCIENTIFIC MEETINGS:

1. Irish and British Perinatal Society meeting, Dublin, Ireland (September 1994).
2. Pediatrics Research Society meeting, Liverpool, UK (February 1995).
3. Registrar prize meeting, Liverpool, UK (March 1995).
4. European Pediatrics Research Society meeting, Alicante, Spain (September 1995)
5. Pediatric Research Society meeting, Swansea, UK (February 1998).
6. AAP Meeting, Chicago, USA (October 2000)
7. SPR Meeting, Baltimore, USA (April 2001)

8. AAP Meeting, San Francisco, (October 2001)
9. AAP Meeting, Boston, (October 2002)
10. Hot topics in Neonatology, Washington DC (December 2002).

INVITED LECTURES:

1. National Conference of Neonatal Nursing. Nashville, TN. May 14-16, 2009
2. Maternal Fetal Medicine/ Neonatology conference. Meharry Medical College, Nashville, TN. June 18, 2009
3. We are learning for babies, a conference to benefit the March of Dimes, Nashville, TN, November 3, 2009

MEMBERSHIP:

Pediatrics Research Society (UK).

American Academy of Pediatrics.

Tennessee chapter AAP.

Tennessee Medical Association

AUDIT:

The use of Narcan in labor ward. Liverpool Women's Hospital, Liverpool, UK. 1994.

Sepsis screening in postnatal transfer to NICU, Liverpool Women's Hospital, Liverpool, UK. 1995.

TEACHING EXPERIENCE:

MRCP Course, Alder Hey Children's Hospital, (May 1997).

MRCP Course, Glan Clwyd Hospital, North Wales, (June 1998).

MRCP Course, Glan Clwyd Hospital, North Wales, (June 1999).

Residents and Fellows teaching, Vanderbilt University, (July 2003 - current).

Participate in the Neonatal Nurse Practitioner teaching, Mid Tennessee Neonatology Associates, (July 2007 – current)

HONORS

1. Participant, Evidence-Based Practice in Spina Bifida: Developing a Research Agenda May 9–10, 2003, Washington, DC, Sponsored by Centers for Disease Control and Prevention, Atlanta, Georgia, Agency for Healthcare Research and Quality, Rockville, Maryland, National Institutes of Health, Bethesda, Maryland, and Department of Education, Washington, DC.

2. Vanderbilt Ventilator Associated Pneumonia Prevention in the NICU award, 2006.

3. Serve on the Regional Advisory Committee (RAC) for the Middle Tennessee region, Tennessee Initiative for Perinatal Quality Care (TIPQC).

Renewal No.
763058

State of Tennessee
Division Of Health Related Boards

License No.
MD0000021215

This Certifies that

HADEER N KARMO, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through FEBRUARY 28, 2014

THE GREAT SEAL OF THE STATE OF TENNESSEE
AGRICULTURE
COMMERCE
1796

DIRECTOR, HEALTH RELATED BOARDS

OCF014 12038

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

The American Board of Pediatrics
and its
Subboard of Neonatal-Perinatal Medicine

hereby declares that

Hadeer Noori Karmo, M.D.

has met the requirements of
the American Board of Pediatrics
and is hereby designated
a diplomate certified in neonatal-perinatal medicine

2003 - 2009

No. 002920

October 21, 2003

Sarah S. Long
Chair, American Board of Pediatrics

Alan H. Jobe
Chair, Subboard

President, American Board of Pediatrics

Secretary, American Board of Pediatrics

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

The American Board of Pediatrics

111 Silver Cedar Court, Chapel Hill, North Carolina 27514-1513
Phone: (919) 929-0461 • Fax: (919) 929-9255 • E-mail: abpeds@abpeds.org • Web Site: http://www.abp.org

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

August 8, 2008
ABP ID# 217440

2008

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Paul V. Miles, M.D.
Michele J. Wall

**********AUTO**MIXED AADC 275
T10 P1 3571
Hadeer Noori Karmo M.D.
326 Whitworth Way
Nashville, TN 37205-5018

Dear Doctor Karmo:

We have good news! Due to recent policy changes, you have three more years to prepare for your Maintenance of Certification (MOC) examination! Your exam, previously required in 2009, is now due in 2012 and is a 10-year requirement.

However, the change in your examination requirement does not alter the expiration date of your certification, which is 12/31/2009 and your need to begin your next cycle of MOC January 1, 2010. To maintain uninterrupted certification, you need to enroll in MOC and submit proof of valid, unrestricted state medical licensure before the end of 2009. You can enroll beginning in October 2009. We will send you reminders, but ***please mark this on your calendar now.***

We anticipate that the MOC enrollment fee will be less than the current examination fee that you would have paid had your requirement not been extended. Your MOC enrollment fee includes the cost of resources and tools used to successfully complete MOC, ***and*** the MOC examination in 2012 at no additional charge. The ABP is planning enhancements to the ABP Web site (www.abp.org) by October 2009 that will allow you access to tools and resources that will help you advance your practice and continually improve quality of care for children.

As previously announced in the fall 2007 Diplomate Newsletter and now detailed on the ABP web site, five year MOC cycles start in 2010. That means once your MOC enrollment materials have been processed and approved by 12/31/2009, in January 2010 you will enter a five-year MOC cycle featuring a menu-driven, point-based system. During this cycle, your requirements will include maintaining unrestricted state medical licensure, completion of 100 required points in self-assessment and performance in practice activities, successful completion of the MOC examination in 2012, and completion of the patient survey component that assists in involvement of patients in care. In January 2010, MOC points can be earned by choosing and completing activities from the menu that will be listed within your personal web account on the ABP Web site.

We strongly encourage you to update and periodically visit your personal web account at www.abp.org to verify your mailing and e-mail addresses and to locate information specific to your circumstances and progress. Please be looking for reminder communications both via e-mail and US Mail as this very important deadline approaches.

Celebrating 75 Years of Certifying Physicians for Infants, Children and Adolescents

A MEMBER OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

MOC Progress Report Transcript

Current as of Thu, Jan 31 2013 *

Dr. Hadeer Noori Karmo
ABPID#: **217440**
Certification Area: **Neonatal-Perinatal Medicine**
Enrolled in MOC for the Cycle: **01/01/2010-12/31/2014**
Certification Status: **Certified - Meeting MOC Requirements**
Important Note: Activities completed after 12/18/2014 will not be counted for credit toward a 2014 enrollment.

Lifelong Learning and Self-Assessment(Part 2)

2012 NeoReviewsPlus	Completed 01/28/2013	20 points
2010 NeoReviewsPlus	Completed 11/28/2012	20 points
2012 Neonatal-Perinatal Medicine Subspecialty Self-assessment	Completed 11/12/2012	10 points
2010 Neonatal-Perinatal Medicine Subspecialty Self-assessment	Completed 08/04/2011	10 points

Performance in Practice(Part 4)

Central Line Associated Blood Stream Infection Reduction in the NICU: a TIPQC Inter-institutional Improvement Project.	Completed 08/02/2011	40 points

Points needed: 40 points Part 2, 40 points Part 4, and 20 points either Part 2 or 4
Points Needed: 100 Points Earned: 100

Cognitive Expertise - Secure Exam(Part 3)

2012 Neonatal-Perinatal Medicine Maintenance of Certification Examination	Completed 09/29/2012

Professional Standing and Licensure(Part 1)

Secure Examination License Verification	Completed 02/08/2012

Once you have met the requirements for all Parts of Maintenance of Certification (MOC) AND you are in the final year of your current MOC cycle, the system will allow you to enroll in your next MOC cycle. Failure to enroll in MOC before your cycle expiration date will result in a status change to **not board certified** in this area.

**The American Board of Pediatrics (ABP) provides this information as a service to our diplomates. The ABP makes every effort to ensure that the information presented here is accurate as of the date printed. However, the ABP makes no warranty or guarantee [illegible]ming the reliability of the content provided. Assessing the currency of the information provided is solely the responsibility of t[illegible]iplomate. Diplomates questioning the information provided should send an email to moc@abpeds.org.*

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

CURRICULUM VITAE

Hadeer Noori Karmo, M.D.
326 Whitworth Way
Nashville, TN 37205
Hadeer_Karmo@pediatrix.com

DATE OF BIRTH: *February 1, 1962*
Baghdad, Iraq

CITIZENSHIP: USA - 1988

OFFICE ADDRESS Mid-TN Neonatology Associates *(1995 – 2009)*
Acquired/name change to:
Pediatrics Medical Group *(7/17/09 – present)*
2201 Murphy Ave. #207
Nashville, TN 37203
Office# (615) 342-4660
Fax# (615) 342-4662

LICENSURE Tennessee, MD 021215
Georgia, MD 64117

PROFESSIONAL BOARDS AND CERTIFICATIONS:

ECFMG 368-330-7 (holding a permanent)

Neonatal-Prenatal Medicine – Board Certified – *1995 recertified 2009*
MOC exam 2012

Diplomat of the American Board of Pediatrics -*1990 recertified 1999*

Neonatal Resuscitation Program

EDUCATION & POST-GRADUATE MEDICAL TRAINING:

Undergraduate Baghdad College High School (Major: Science) Honor Graduate, 1979

AL-Mustansarya Medical College, Baghdad, 1979-1982

Medical Spartan Health Sciences University
St.Lucia, West Indies, M.D., 1982-1985

POST-GRADUATE TRAINING:

Internship Department of Pediatrics
Meharry Medical College, Nashville, TN
1987-1988 (affiliated program with Vanderbilt Children's Hospital)

Residency Department of Pediatrics,
Division of Neonatology, Vanderbilt University,
Nashville, TN 1990-1993

Fellowship Department of Pediatrics, Division of Neonatology
Vanderbilt University, Nashville, TN 1990-1993

Senior Staff Neonatologist, Henry Ford Hospital
Detroit, MI 1993-1995

ACTIVE HOSPITAL AFFILIATIONS:

Centennial The Women's Hospital, Nashville -*1995– present*
Summit Medical Center, Hermitage, TN -*1995 – present*
Southern Hills Medical Center, Nashville, TN -*1995-2008 (nursery closed)*
Hendersonville Medical Center, Hendersonville, TN -*1995 – present*
Nashville Memorial (Skyline Hospital), Nashville, TN - *1995 – 2004 (nursery closed)*
Metro General Hospital, Nashville, TN -*1995 – present*
Williamson Medical Center, Franklin, TN (clinical priv.2004 – present)
Horizon Medical Center, Dickson, TN- *2005 – present*
StoneCrest Medical Center, Smyrna, TN -*2006 – present*
Middle TN Medical Center, Murfreesboro, TN *2007 – present (Medical Director of NICU)*

MEMBERSHIPS & PROFESSIONAL ORGANIZATIONS:

Medical Director of Neonatology at Middle TN Medical Center,
Murfreesboro, TN 2009 - present

American Academy of Pediatrics
Tennessee Pediatric Society
Davidson County Pediatric Association
Nashville Academy of Medicine

HONORS & AWARDS:

Top 10% score in the country Baghdad College, 1979

Best Teaching Resident, Dept.of Ped., Henry Ford Hospital, 1989

PUBLICATIONS:

Effects of Tocolytic Indomethacin on Neonatal Renal Function. Hadeer Karmo, Kenny Robbins, Robert Parker & Robert Cotton. Accepted for publication in The Journal of Maternal Fetal Medicine.

Nicotine Enhances Reflex Apnea in Young Lambs, Hadeer Karmo, Robert Parker, Hans Larsson, Joseph Milerad, Hadan Sundell. Accepted for presentation at the Society for Pediatric Research 1994.

Renewal No.
774682

State of Tennessee
Division Of Health Related Boards

8443497
License No.
MD0000017455

This Certifies that

SUSAN B CAMPBELL, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through MARCH 31, 2015

THE GREAT SEAL OF THE STATE OF TENNESSEE XVI AGRICULTURE COMMERCE 1796

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS

DCFO 14 13039

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

Continue EDUCATION & POST-GRADUATE:

Research focus: ACE Inhibitors and the Amelioration of Oxidant Induced Lung Injury under the mentorship of Dr.Mildred Stahlman.

Internship/Residency – Pediatrics – University of Florida College of Medicine – Department of Pediatrics – Shand's teaching Hospital, Gainesville, FL -*July 1, 1991 to June 30, 1994.*

Medical Degree – Medical Doctor – The Temple University School of Medicine – Philadelphia, PA -*September 8, 1987 to May 23, 1991.*

Undergraduate Degree – Bachelor of Science with Honors in Biology – The Pennsylvania State University, University Park, PA – *August 26, 1983 to May 16, 1987* – University Scholar.

ACTIVE HOSPITAL AFFILIATIONS:

Centennial The Women's Hospital, Nashville -*1997– present*
Summit Medical Center, Hermitage, TN -*1997 – present*
Southern Hills Medical Center, Nashville, TN -*1997-2008 (nursery closed)*
Hendersonville Medical Center, Hendersonville, TN -*1997 – present*
Nashville Memorial (Skyline Hospital), Nashville, TN - *1997 – 2004 (nursery closed)*
Metro General Hospital, Nashville, TN -*1997 – present*
Williamson Medical Center, Franklin, TN (clinical priv.2004 – present)
Medical Director of Neonatology 2009 - present
Horizon Medical Center, Dickson, TN- *2005 – present*
StoneCrest Medical Center, Smyrna, TN -*2006 – present*
Middle TN Medical Center, Murfreesboro, TN *2007 – present*

MEMBERSHIPS & PROFESSIONAL ORGANIZATIONS

Medical Director of Neonatology at Williamson Medical Center 2009 – present
Chairman of Pediatrics 2001 - 2008
American Medical Association
American Academy of Pediatrics
Tennessee Pediatric Society
Davidson County Pediatric Association
Nashville Academy of Medicine

Confidential letters of recommendation available upon request.

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

ERIC SCOTT PALMER, M.D.

ACTIVE HOSPITAL AFFILIATIONS:

Centennial Medical Center, Nashville, TN 1997 to present
Hendersonville Medical Center, Hendersonville, TN 1997 to present
Horizon Medical Center, Dickson, TN 2005 to present
Metropolitan General Hospital, Nashville, TN 1997 to present
Middle Tennessee Medical Center, Murphreesboro, TN 1997 to present
Stonecrest Medical Center, Nashville, TN 1997 to present
Williamson Medical Center, Nashville, TN 1997 to present

PROFESSIONAL ACTIVITIES:

Medical Director of Neonatology. Williamson Medical Center. 2009 – present.
Chairman of Pediatrics. Centennial Medical Center. 2002 – 2008.
Medical Executive Committee. Centennial Medical Center 2002 – 2008.
Fellowship in Integrative Medicine. University of Arizona. 2009 – 2011.
Certified Medical Leader Program. Pediatrix Medical Group. 2012.

PROFESSIONAL HONORS / AWARDS:

Frist Humanitarian Award Nominee. Centennial Medical Center. 2011.
Distinguished Service Award. TriStar Health System. 2006 and 2008

PERSONAL INFORMATION:

Birthplace:	Madison, Wisconsin. November 15, 1964
Citizenship:	U.S.A.
Email:	ESPalmerMD@gmail.com
Office:	2201 Murphy Avenue. Suite 207 Nashville, TN 37203 (615) 342-4660 Office (615) 342-4662 Fax

Confidential Letters of Recommendation available upon request.

ERIC SCOTT PALMER, M.D.

Neonatal and Perinatal Medicine
Pediatrix Medical Group

PROFESSIONAL PRACTICE:

NEONATOLOGIST with Pediatrix Medical Group of Middle Tennessee
(formerly known as Mid-Tennessee Neonatology Associates)
2201 Murphy Avenue, Suite 207, Nashville, TN 37203.
July 1997 to Present.

MEDICAL LICENSURE:

Tennessee	MD026999	Active in good standing
Georgia	97-0238	Active in good standing
Pennsylvania	MD-062654-L	Retired in good standing
Florida	ME0063575	Retired in good standing
DEA Certificate	BP3560934	

PROFESSIONAL BOARDS AND CERTIFICATIONS:

Neonatal and Perinatal Medicne – Board Certified 1997 with current Recertification.
Diplomate of the American Board of Pediatrics – Board Certified 1994 with current recertification.
Diplomate of the National Board of Medical Examiners – 7/1/1992

EDUCATION AND POST-GRADUATE MEDICAL TRAINING:

Neonatal and Perinatal Medicine Fellowship: Vanderbilt University Medical Center. Department of Pediatrics. Division of Neonatology.
Nashville, TN. July 1, 1994 – June 30, 1997.
Research focus: ACE Inhibitors and the Amelioration of Oxidant Induced Lung Injury under the mentorship of Dr. Mildred Stahlman.

Pediatric Internship/Residency: University of Florida College of Medicine. Department of Pediatrics. Shand's Teaching Hospital. Gainesville, FL
July 1, 1991 – June 30, 1994.

Medical Doctor: Temple University School of Medicine. Philadelphia, PA
September 8, 1997 – May 23, 1991

Bachelor of Science with Honors in Biology: Pennsylvania State University. University Park, PA. August 26, 1983 – May 16, 1987.
University Scholar's Program Graduate.

ERIC SCOTT PALMER, M.D.

ACTIVE HOSPITAL AFFILIATIONS:

Centennial Medical Center, Nashville, TN 1997 to present
Hendersonville Medical Center, Hendersonville, TN 1997 to present
Horizon Medical Center, Dickson, TN 2005 to present
Metropolitan General Hospital, Nashville, TN 1997 to present
Middle Tennessee Medical Center, Murphreesboro, TN 1997 to present
Stonecrest Medical Center, Nashville, TN 1997 to present
Williamson Medical Center, Nashville, TN 1997 to present

PROFESSIONAL ACTIVITIES:

Medical Director of Neonatology. Williamson Medical Center. 2009 – present.
Chairman of Pediatrics. Centennial Medical Center. 2002 – 2008.
Medical Executive Committee. Centennial Medical Center 2002 – 2008.
Fellowship in Integrative Medicine. University of Arizona. 2009 – 2011.
Certified Medical Leader Program. Pediatrix Medical Group. 2012.

PROFESSIONAL HONORS / AWARDS:

Frist Humanitarian Award Nominee. Centennial Medical Center. 2011.
Distinguished Service Award. TriStar Health System. 2006 and 2008

PERSONAL INFORMATION:

Birthplace:	Madison, Wisconsin. November 15, 1964
Citizenship:	U.S.A.
Email:	ESPalmerMD@gmail.com
Office:	2201 Murphy Avenue. Suite 207 Nashville, TN 37203 (615) 342-4660 Office (615) 342-4662 Fax

Confidential Letters of Recommendation available upon request.

The American Board of Pediatrics
and its
Subboard of Neonatal-Perinatal Medicine

hereby declare that

Eric Scott Palmer, M.D.

was certified in Neonatal-Perinatal Medicine
on November 18, 1997 and issued certificate No. 3282
as a Diplomate of the American Board of Pediatrics

Ongoing certification is contingent upon meeting the requirements for
Maintenance of Certification

Chair, American Board of Pediatrics

Rayann deRegnier, M.D.
Chair, Subboard

President, American Board of Pediatrics

Secretary, American Board of Pediatrics

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

The American Board of Pediatrics

111 Silver Cedar Court, Chapel Hill, North Carolina 27514-1513
Phone: (919) 929-0461 • Fax: (919) 929-9255 • E-mail: abpeds@abpeds.org • Web Site: www.abp.org

2·0·1·1

Board of Directors

Marshall L. Land Jr., MD
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Carol L. Carracio, MD
Director, Competency-Based Assessment Programs

H. James Brown, MD
Senior Consultant, Physician Relations

October 24, 2011
ABP ID# 235963

Dr. Eric Scott Palmer
204 South Wilson Blvd.
Nashville, TN 37205

The American Board of Pediatrics (ABP) wishes to congratulate you on continuing to demonstrate your advanced medical knowledge, commitment to lifelong learning, professional development and ability to assess and improve your quality of care in Neonatal-Perinatal Medicine.

You originally obtained certification on November 18, 1997 and were issued certificate number 3282. You have completed the necessary activities and are meeting the requirements for maintenance of certification in Neonatal-Perinatal Medicine. Ongoing certification is contingent upon continuing to meet the requirements for maintenance of certification.

Congratulations and best wishes for your continued success in the field of pediatrics.

Sincerely yours,

James A. Stockman III, M.D.
President and CEO

Amer Bdy Ped. recertified 2015
neonatal recert. 2011

SUPPLEMENTAL - # 1
February 10, 2012
2:13pm

The American Board of Pediatrics

111 Silver Cedar Court, Chapel Hill, North Carolina 27514-1513
Phone: (919) 929-0461 • Fax: (919) 929-9255 • E-mail: abpeds@abpeds.org • Web site: www.abp.org

2012

Board of Directors

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Stephen Ludwig, MD
Dana C. Matthews, MD
Virginia A. Moyer, MD
A. Kim Ritchey, MD
Kenneth B. Roberts, MD
Joseph W. St. Geme III, MD

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Paul V. Miles, MD
Michele J. Wail, MA

Carol L. Carraccio, MD
Director, Competency-Based Assessment Programs

H. James Brown, MD
Senior Consultant, Physician Relations

Dear Diplomate, Ref: Dr Palmer

In accordance with the requirements for Maintenance of Certification with the American Board of Pediatrics (ABP), the certificate enclosed in **contingent upon meeting the requirements of Maintenance of Certification (MOC) and does not have an end date.** All requirements for your new 5-year MOC cycle and dates of important benchmarks can be viewed by accessing your ABP portfolio at www.abp.org.

The ABP recognizes that some entities may still require a certification end date to complete primary-source verification for credentialing purposes. To assist in this process, we are encouraging credentialers to utilize an annual re-verification date which we explain to them directly in the enclosed memorandum.

This annual re-verification date represents an interval of time during which your diplomate status will remain unchanged except as a result of disciplinary action. This date may not be reflective of individual MOC requirements, **nor does it indicate certification or MOC cycle end dates.**

Please provide the enclosed memorandum to your credentialing administrator(s) to ensure clarification of new ABP procedures regarding the verification of your current board certification status.

Sincerely,

James A. Stockman III, MD
President and CEO
American Board of Pediatrics

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

CURRICULUM VITAE

Eric Scott Palmer, M.D.
204 South Wilson Blvd.
Nashville, TN 37205
615-297-2127

2013 FEB 26 PM 2 17

DATE OF BIRTH:	*11/15/64* Madison, Wisconsin
CITIZENSHIP:	USA
EMAIL ADDRESS:	espalmermd@gmail.com
OFFICE ADDRESS	Mid-TN Neonatology Associates *(1997 – 2009)* Acquired/name change.to: **Pediatrix Medical Group** *(7/17/09 – present)* 2201 Murphy Ave. #207 Nashville, TN 37203 Office# (615) 342-4660 Fax# (615) 342-4662

LICENSURE

Tennessee	MD0000026999 - active
Georgia	97-0238 - active
Pennsylvania	MD-062654-L - retired
Florida	ME0063575 - retired
DEA certificate	BP3560934 - current

PROFESSIONAL BOARDS AND CERTIFICATIONS:

Neonatal Intensive Care – Board Certified - *11/18/97 recertified 2011*
Diplomat of the American Board of Pediatrics -*10/12/94 recertified 2015*
Diplomat of National Board of Medical Examiners – *7/1/92*
Neonatal Resuscitation Program – *10/14/96 - present*

EDUCATION & POST-GRADUATE MEDICAL TRAINING:

Clinical Fellowship – Neonatal Intensive Care – The Vanderbilt University Medical Center – Department of Pediatrics – Division of Neonatology, Nashville, TN *July 1, 1994 – June 30*, 1997.

PUBLICATIONS: (continued)

Minimizing pneumothorax and bronchopulmonary dysplasia in ventilated infants with hyaline membrane disease.
Rhodes P, Graves G, Patel D, Campbell S and Blumenthal B
J Pediatrics 1983 103:634

ABSTRACTS

Calcium Homeostasis in exchange transfusion.
Maisels, MJ, Friedman, Z, Marks KH, ***Uhrmann S***, Lee C, Denlinger JK
(Abstract) Pediatric Research 1977, 11:537.

Furosemide in Hyaline Membrane Disease.
Marks KH, Berman, W Jr., Friedman Z, Whitman V, ***Uhrmann S***, Lee C, Maisels, MJ
(Abstract) Pediatric Research 1977, 11:1220

The effects of furosemide in respiratory distress of the newborn.
Marks KH, Berman W Jr., ***Uhrmann SB***, Lee C, Friedman Z, Maisels, MJ
(Abstract) Pediatric Research 1977 April

Thyroid function in infants admitted to a neonatal intensive care unit (NICU): A longitudinal assessment.
Uhrmann SB, Marks KH, Maisels MJ, Friedman Z, Murray F, Kulin H, Kaplan M, Uitger R.
(Abstract) Pediatric Research 1977 11: 432.

Urinary excretion of prostaglandin E following the administration of furosemide and indomethacin to sick low birthweight infants.
Friedman Z, Demers LM, ***Uhrmann SB***, Marks KH, Maisels MJ
(Abstract) Pediatric Research 1978 12:381.

Frequency of transient hypothyroxinaemia in low birthweight infants. Potential pitfall for neonatal screening programs.
Uhrmann SB, Marks KH, Maisels MJ, Friedman Z, Murray F, Kulin, H, Kaplan M, Utiger R
(Abstract) Pediatric Research 1979 13:386.

RECENT CME'S ATTENDED:
Southeastern Association of Neonatologists 23rd Annual Conference; May, 2009
Southeastern Association of Neonatologists 24th Annual Conference; May, 2010
Neonatology Review, PEDIATRIX; February, 2010
Southeastern Association of Neonatologists 25th Annual Conference; May, 2011
Southeastern Association of Neonatologists 26th Annual Conference; May, 2012
Academy of Breastfeeding Medicine Meeting; October, 2012

QUALITY IMPROVEMENT PROJECTS:

Tennessee Initiative for Perinatal Quality Care (TIPQC):
- Temperature Project – Nashville General Hospital @ Meharry
- CLABSI Project – Centennial Medical Center
- HM4NICU Project – Nashville General Hospital @ Meharry
- BF Promotion: Delivery and Postpartum Project – Centennial Medical Center

PRINCIPAL RESEARCH INTERESTS:
Neonatal Thyroid Function
Breast-feeding
Breastmilk Banking
Necrotizing Enterocolitis
Cooling to Minimize Brain Injury Following Birth Asphyxia
Prevention of Central Venous Catheter-Related Infections
Grief Support
Magnesium Deficiency and Neurodevelopmental Outcomes

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

The American Board of Pediatrics
Quality Improvement Project for MOC
Attestation Form

QIPA Version 2.1

Complete this Attestation Form if you are an ABP-certified physician seeking credit under Maintenance of Certification for Performance in Practice (Part 4). To be eligible for credit, you must have satisfied all requirements for meaningful participation. See the document *"ABP Standards for Physician Participation in a QI Project"* for details.

After you complete this attestation form, submit it to your project's Local Leader or the QI Project Leader (depending on how your project is organized) for signature. The Leader will forward completion documentation to the ABP so that you can receive credit for MOC. The ABP receives only documentation of your successful completion of the project and identifying information to ensure your ABP record is accurately updated. No patient data, performance data, or project reports are sent to ABP, nor does ABP receive your attestation form or any attachments.

Attestation of Meaningful Participation

1. Participating Physician: SUSAN B. CAMPBELL, MD
2. ABP Diplomate ID #: 2683
3. Date of Birth: 3/14/1947
4. Quality Improvement Project Title: *Central Line Associated Blood Stream Infection Reduction in the NICU: a TIPQC Inter-institutional Improvement Project.*
5. Participated as a member of what organization? (practice, hospital, unit, network, etc):
6. Sponsor Organization: *(Organization sponsoring the Approved QI Project) Tennessee Initiative for Perinatal Quality Care (TIPQC)*
7. Did you meet the ABP meaningful participation requirements?
   - [x] I provided direct or consultative patient care in this improvement project.
   - [ ] I completed one or more tests of change to improve care.
   - [ ] My team's data were collected and submitted in keeping with the project measurement plan, and I reviewed my own data during the project.
   - [x] I attended four or more project meetings.
   - [x] I was active in the project for the minimum duration required by the project. The project's duration requirement is **12 months** and I met this requirement on 04/25/2012 *(fill in the date (mm/dd/yyyy) on which you met the minimum duration requirement, even if you continued working on the project beyond that date.)*
   - [x] I satisfied all of the above meaningful participation criteria under my current ABP certificate (within my current MOC cycle).

Project Description

8. Target Population: Infants admitted to the NICU who had a central line placed.
9. Project Aim: *(Explain the measurable goals and importance to patients and your organization.) The TIPQC state aim for this project* was to reduce CLABSI episode frequency with the immediate aim of this project is to reduce the frequency of CLABSI episodes in participating NICUs by 50% within the first year.

   In my facility:

10. Did you improve care for your patients through this project? ☑ Yes ☐ No
11. What are the Project's Performance Measures? The overall performance measures for this project included the CDC/NHSN CLABSI rate, days between CDC/NHSN CLABSI episodes, and cumulative line days between CLABSI episodes.

    In my unit we instituted the following changes: STERILE CHANGE OF FLUIDS & 2 NURSES WORKING TOGETHER

    We tracked compliance with the following measures: CLABSI INFECTIONS

    We followed the completeness of our project data by: REVIEWING RED CAP DATA OF ENTERE PATIENT
12. Describe the source(s) of data and methods of data collection that you used for this project. We collected data from our unit and submitted it into REDCap for aggregation and analysis. *Provide additional details about your local data collection and entry processes.*
13. What was the Comparison Group in your project? Statewide performance was compared to CDC/NHSN data reported to the Tennessee Department of Health, Hospital Acquired Infections Group, as well as data reported through the Tennessee Center for patient Safety. Our local performance was tracked through REDCap using SPC charting to follow changes in our CLABSI rates over time.
14. Did the interventions address important issues for your patients? ☑ Yes ☐ No
15. Describe your role in this project. CONSULTANT / TEAM MEMBER
16. Who else was involved in this project from your care team? PRACTICE PHYSICIANS / NNP'S / NICU NUR
17. How did you change your practice as a result of this project? INFECTIOUS DISEASE NURSE
18. What do you plan to do next to improve your quality of care? PLAN TO CONTINUE MONITORING FOR WE PLAN TO LOOK AT BACTEREMIAS SUSTAINA
19. Attach an example of an annotated run chart based on data from your patients. *TIPQC recommends each participant attach a locally generated REDCap report that is annotated to show when the diplomate was involved in the project as well as what changes and PDSA cycles were completed while the diplomate was involved. This can be done using a "Leadership Report" template, or by simply hand annotating a REDCap CLABSI frequency report.* ASSOC. C CLABSI ↓ THOSE

Signatures

I attest that I participated in this project as described above.

Susan B. Campbell MD — 4/25/2012

Signature of Participant Physician — **Date**

I have reviewed this attestation and affirm that Dr. Campbell *was an active participant in this project and met all requirements. I am designated by this QI project to review and approve attestations of participation.*

4/25/12

Signature of Project Leader — **Date**

Ashraf Hamdan

Name and Title of Project Leader

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Certificate of Participation

Physician
Continuing Medical Education

The American Academy of Pediatrics certifies that

Susan Beverin Campbell

---

has participated in the educational activity titled: **2012 NeoReviewsPlus, Jan** on 12/14/2011 - 01/13/2012 and is awarded **2.00** *AMA PRA Category 1 Credit(s)*™.

The AAP is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide Continuing Medical Education for physicians.

The AAP designates this educational activity for a maximum of 2.00 *AMA PRA Category 1 Credit(s)*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is acceptable for a maximum of 2.00 AAP Credit(s). These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the AAP.

The American Academy of Physician Assistants accepts *AMA PRA Category 1 Credit(s)* ™ from organizations accredited by the ACCME.

- Be sure to sign this form when completed as verification of the credits you recorded.
- **Please keep this copy for your records. The Academy does not require a copy.**

Susan Beverin Campbell, MD FAAP
5991 Edmondson Pike
Nashville, TN 37211-6727

_____
Signature

Please keep this copy for your files.

The American Board of Pediatrics

and its

Sub-Board of Neonatal-Perinatal Medicine

hereby certify that

Susan Beverin Campbell, M.D.

has successfully fulfilled the requirements of this Sub-Board
and is declared a diplomate in

Neonatal-Perinatal Medicine

No. 872

October 23, 1981

THE SEAL · THE AMERICAN BOARD OF PEDIATRICS

Warren W Quillian
President, American Board of Pediatrics

James M. Sutherland M.D.
Chairman, Sub-Board

Secretary, American Board of Pediatrics

AMERICAN BOARD OF MEDICAL SPECIALTIES EXCELLENCE

SUPPLEMENTAL #1
February 26, 2013
2:13pm

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

CURRICULUM VITAE

NAME: Susan Beverin Campbell, MD

HOME ADDRESS: 5991 Edmondson Pike
Nashville, Tennessee, 37211
HOME PHONE: 615-832-1978
HOME FAX: 615-832-1978

OFFICE ADDRESS: PEDIATRIX Medical Group of Tennessee
2201 Murphy Avenue, Suite 207
Nashville, Tennessee, 37203
OFFICE PHONE: 615-342-4660
OFFICE FAX: 615-342-4662

DATA PAGER: 1-800-437-9706
CELL PHONE: 615-243-7243

DATE AND PLACE OF BIRTH: March 14, 1947 - Wilmington, Delaware

MARITAL STATUS: Married; Husband – Bruce
Three Grown Sons
Two Grandsons
One Granddaughter

PREVIOUS PROFESSIONAL NAME: Susan Beverin Uhrmann, MD (Prior to 1981)
MAIDEN NAME: Susan Estelle Beverin (Prior to 1970)

MEDICAL PRACTICE / APPOINTMENTS:

Neonatologist
PEDIATRIX Medical Group of Tennessee
July, 2009 – Present

Director of Neonatology
Southern Hills Medical Center
Nashville, TN
1986 – Until Obstetrical Unit Closed , September 1, 2008

Clinical Appointment
Division of Neonatology
Department of Pediatrics
Vanderbilt University Medical Center
1987 - Present

MEDICAL PRACTICE / APPOINTMENTS: (continued)

Neonatologist, Staff Privileges
Centennial Medical Center – Women's Hospital (formerly, West Side Hospital)
Nashville, TN
1989 – Present

Neonatologist, Staff Privileges
Summit Medical Center (Formerly, Donelson Hospital)
Hermitage, TN
1988 – Present

Neonatologist, Consulting Privileges
Hendersonville Hospital
Hendersonville Hospital
1992 – Present

Neonatologist, Consulting Privileges
Skyline Medical Center (Formerly, Nashville Memorial Hospital)
1992 – Until Obstetrical Unit Closed, March 4, 2004

Neonatologist, Staff Privileges
Metropolitan General Hospital
Nashville, TN
1995 – Present

Neonatologist, Staff Privileges
Middle Tennessee Medical Center
Murfreesboro, TN
1998 – Present

Neonatologist, Staff Privileges
Williamson Medical Center
Franklin, TN
2004 – Present

Neonatologist, Staff Privileges
Horizon Medical Center
Dickson, TN
2005 - Present

MEDICAL PRACTICE / APPOINTMENTS: **(Prior to coming to Nashville, TN)**

Staff Physician
Hudspeth Center
Jackson, MS
February 15, 1985 – August 31, 1986

Assistant Professor of Pediatrics
Division of Newborn Medicine
University of Mississippi Medical Center
January 1, 1979 – June 30, 1984

Visiting Professor of Pediatrics
Division of Newborn Medicine
University of Mississippi Medical Center
December 1, 1978 – January 1, 1979

EDUCATIONAL BACKGROUND:
Undergraduate: University of Delaware - June 8, 1969 – **B.A./ Distinction in Biology**
Medical School: Thomas Jefferson University Medical School – June 8, 1973 – **M.D.**

POSTGRADUATE TRAINING:
Residency in Family Practice, Wilmington Medical Center, Wilmington, DE: 1973-1974
Residency in Pediatrics, Wilmington Medical Center, Wilmington, DE: 1974-1976
Fellowship in Neonatology, Milton S. Hershey Medical Center:
Pennsylvania State University: 1976-1978
Lactation Education (90 Hours) February – July, 2012

HONORS AND AWARDS:
Presented (Oral) Research at Society for Pediatric Research Meeting: May, 1977
Presented (Oral) Research at Society for Pediatric Research Meeting: April, 1979
Nominated for Frist Humanitarian Award: 1993

SPECIALTY CERTIFICATION:
American Board of Pediatrics/ Permanent Certificate (#25180) – 1980
American Board of Pediatrics: Neonatal-Perinatal Medicine/ Permanent Certificate (#872) – 1981
American Board of Pediatrics: Neonatal-Perinatal Medicine/ Maintenance of Certification – Current
Board Certified Lactation Consultant (IBCLC) – October, 2012 (IBCLE taken July, 2012)

LICENSURE:
Medicine/Surgery, Tennessee (9/2/1986 - Present) - #MD17455
Medicine/Surgery, Mississippi
Medicine/Surgery, Pennsylvania (3/1/1976 – 12/31/1982) – #MD017614E
Medicine/Surgery, Delaware

PROFESSIONAL MEMBERSHIPS:
Perinatal Section, American Academy of Pediatrics
American Academy of Pediatrics
American Medical Association
Southeastern Association of Neonatologists

OTHER ACTIVITIES AND APPOINTMENTS:
Advisory Board Member, Susan Gray School, Kennedy Center, Vanderbilt University 2000 - 2002
Advisory Board Member – Parents Reaching Out 1994 - Present
Advisory Board Member – SHARING 1987 - 1998
Coordinated (and Presented at) Nashville Conference on Grief Support : ***"Clinical Management of Perinatal Loss in the '90's"***– October 5, 1991
Presented at Perinatal Conference at Opreyland Hotel - (YEAR)
Member of Mayor's (Nashville) Child Death Review Team; January 1, 1996 to Present
Co-Founder of Shiloh Ministries International, Inc.; 1997 – Present

PUBLICATIONS:
D-fucose as a gratuitous inducer of the L-arabinose operon in strains of Escherichia coli B-r mutant in gene araC.
Beverin S, Sheppard DE, Park SS
J Bacteriology 1971 July; 107(1):79-86.

Thyroid function in the preterm infant: a longitudinal assessment
Uhrmann S, Marks KH, Maisels, MJ, Friedman Z, Murray F, Kulin HE, Kaplan M, Utiger R
J Pediatrics 1978 June; 92(6):968-973.

Urinary excretion of prostaglandin E following the administration of furosemide and indomethacin to sick low-birth-weight infants.
Friedman Z, Demers LM, Marks KH, ***Uhrmann S***, Maisels MJ
J Pediatrics 1978 September; 93(3):512-515.

Furosemide in hyaline membrane disease.
Marks KH, Berman W, Friedman Z, Whitman V, ***Uhrmann S***, Lee C, Maisels MJ.
Pediatrics 1978 62: 785-788.

Frequency of transient hypothyroxinaemia in low birthweight infants. Potential pitfall for neonatal screening programs.
Uhrmann S, Marks KH, Maisels MJ, Kaplan M, Utiger R
Archives of Diseases in Childhood 1981 March; 56(3):214-217.

SUPPLEMENTAL- # 1
February 26, 2013
2:13pm

AFFIDAVIT

2013 FEB 26 PM 2 17

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

HENDERSONVILLE MEDICAL CENTER

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of 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.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 26th day of FEB., 2013, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires 6-4-2013.

RYAN B. WALLACE
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

HF-0043

Revised 7/02

ORIGINAL-
ADDITIONAL
Info.

SUPPLEMENTAL-1

Hendersonville Medical Ctr.

CN1302-002

DSG Development Support Group

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

February 27, 2013

2013 FEB 28 PM 4:01

Phillip M. Earhart, Health Planner III
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: CON Application #1302-002
Hendersonville Medical Center

Dear Mr. Earhart:

This letter supplies the final information requested in your last supplemental questions. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section A, Applicant Profile, Items 1-11**

   Responses to Section A Item 1-11 and pages 6-8 of the HSDA's "Instructions for Filing an application for a Certificate of Need" is missing from the application. Please respond to each question and attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.

   A revised Section A, page 1 is attached. It corrects a typographical error in my phone number in the Section A that was submitted in the February 26 first supplemental responses.

3. **Section B, Project Description, Item II (a).**

   Please submit the square footage and costs per square footage chart for the proposed project.

   That chart is attached.

11. **Section C, Orderly Development, Item 7 c. and 7 d.**

    c. Please provide a copy of the most recent/ licensure survey or inspection.

    Attached. This 2007 survey is the most recent one and the facility is in compliance.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

Further Supplemental Information

Attached is revised narrative page 13R(2) reflecting the architect's recalculations in the revised Cost Per Square Foot Chart. Please discard the page 13R submitted to you on February 26, which reflected his prior data.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

PART A

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

Hendersonville Medical Center		
Name		
355 New Shackle Island Road		Sumner
Street or Route		*County*
Hendersonville	TN	37075
City	*State*	*Zip Code*

2. *Contact Person Available for Responses to Questions*

John Wellborn		Consultant	
Name		*Title*	
Development Support Group		jwdsg@comcast.net	
Company Name		*E-Mail Address*	
4219 Hillsboro Road, Suite 203	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-665-2022	615-665-2042	
Association With Owner	*Phone Number*	*Fax Number*	

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

Hendersonville Hospital Corporation		
Name		
Same as in #1 above		
Street or Route		*County*
City	*State*	*Zip Code*

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

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

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

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
2nd FL O.B./N.I.C.U.					17,885		17,885	$202.00		$3,612,770.00
3rd FL Major HVAC Upgrade					17,870		17,870	$202.00		$3,609,740.00
4th FL. Med Surg						18,580	18,580		$308.43	$5,730,602.27
Penthouse						3,291	3,291		$308.43	$1,015,038.33
Elevator and Skin					639		639	$938.97		$600,000.00
Structural upgrades							in above			$3,500,000.00
Powerhouse							in above			$3,000,000.00
B. Unit/Dept. GSF Sub-Total					36,394	21,871	58,265	$230.35	$579.90*	$21,068,150.59
C. Mechanical / Electrical GSF										
D. Circulation / Structure GSF										
E. Total GSF					36,394	21,871	58,265	$230.35	$579.90*	$21,068,150.59
Renovation										
Canopies										
GRAND TOTAL					36,394	21,871	58,265	$230.35	$579.90*	$21,068,150.00

*higher than $308.43 because it includes costs of powerhouse and structural upgrades,whose SF are already in the SF lines for floors 2,3,and 4.

SUPPLEMENTAL - # 1
February 28, 2013
4:00pm

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

Hospital construction projects approved by the HSDA in 2009-2011 had the following construction costs per SF:

Table Four: Hospital Construction Cost PSF Years: 2009 – 2011			
	Renovated Construction	**New Construction**	**Total Construction**
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$125.84/sq ft	$324.00/sq ft	$301.74/sq ft

Source: HSDA, from CON approved applications during 2009-2011.

This project, which is priced for a CY 2014-2016 construction period, is consistent with the HSDA's 2009-2011 average cost ranges, when five years of future cost inflation are taken into account. The project construction cost by the time it opens in 2016 is projected to be approximately $362 PSF overall. That includes some hospital-wide upgradings of the 35-year old infrastructure, e.g., new elevator, new powerhouse, major structural work on all stairwells, etc. As shown in the Cost PSF chart prepared by the architect in Attachment C, Economic Feasibility--1, the construction cost for the new fourth floor by itself is $308 PSF, and the renovation cost on the second floor (NICU area) is $202 PSF--well within norms for comparable approved projects in patient care areas.

Table Five: This Project's Construction Costs			
	Renovation	**New Construction**	**Total Project**
Square Feet	36,394 SF	21,871 SF	58,265 SF
Construction Cost			$21,068,150
Constr. Cost PSF	$230.35	$579.90	$361.66

Source: HCA Design and Construction data and project architect.

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
MIDDLE TENNESSEE REGIONAL OFFICE
710 HART LANE, 1ST FLOOR
NASHVILLE, TENNESSEE 37247-0530
PHONE (615) 650-7100
FAX (615) 650-7101

April 17, 2007

Mike Esposito, Administrator
Hendersonville Medical Center
355 New Shackle Island Rd
Hendersonville, TN 37075

Dear Mr. Esposito:

On April 12, 2007, a surveyor from our office completed a review of your plan of correction for deficiencies cited as a result of annual licensure survey of January 24, 2007. Based on the review, we are accepting your plan of correction and are assuming your facility is in compliance with all participation requirements as of April 12, 2007.

If this office may be of any assistance to you, please do not hesitate to call.

Sincerely,

Nina Monroe

Nina Monroe, Regional Administrator
Middle Tennessee Regional Office

NM: dv

received
4/19/07 MS

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

Action Plans for Hendersonville and Portland Medical Centers
State Licensure Findings from January 24, 2007

H665
Patient bed mattresses at Portland will be prioritized for replacement, and replaced on a monthly scheduled basis. Two-four will be replaced monthly. Prioritization will be based on the physical condition of the mattress with the most worn being the top priority. Replacement began 1/2007. Responsible person: Portland Medical Center Administrator.

H665
Add dusting of Crash Carts and Broslow Bags to Environmental Service staffs' routine cleaning checklist. Implement 2/13/07. Plant Operations Director and Nursing Directors to monitor compliance, during environmental rounds.

H696
Current Rules and Regs state that telephone and verbal orders are to be signed as soon as possible or at completion of record. This particular case, the physician resigned from staff and moved out of state prior to completing records. Physician made aware, returned and completed records and required signatures. Responsible Person: Director Health Information Management. Date competed 02/16/07.

H697
Via Medical Record Review data, the quality of physician H&Ps will be reported to the Medical Executive Committee no less than quarterly. Physicians with incomplete admission histories and assessments will be notified and information placed in credentialing file for consideration at re-appointment. Reporting for first quarter 2007 to begin April, 24 2007 committee meeting. Responsible person: Director Health Information Management.

H734

1) Develop policy that outlines diet substitutions. Policy to go to the February Medical Executive Committee for approval. (see attached)
2) Review Meditech Order Entry diet list and remove vague/ non-specific diet choices. List will mirror MEC approved diet choices.
3) Educate dietary staff and physicians on approved substitution diets by March 1, 2007.
4) For any diet orders received in the dietary department that is not on the substitution list, the dietician will be notified for direction and consultation with the ordering physician as needed.
5) Lead Dietician to monitor effectiveness of plan.

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

H737

1) A supplemental night meal will be served to every inpatient between the hours of 8pm-10pm. Policy PCM-08-017 will be revised to reflect this.
2) Food and Nutrition Service staff will prepare and deliver this supplemental meal to the nursing units every evening. The unit charge nurse will print a diet census report to identify appropriate diets when passing the meal.
3) Monitoring for compliance will be done by the House Supervisor and unit charge nurse. Additionally, the Administration team will monitor during evening rounds.
4) Plan will be implemented by March19, 2007.

H739

1) A Food and Nutrition specific Handwashing and Proper Use of Disposable Gloves policy will be developed and implemented by March 5, 2007. (see attached)
2) All Food and Nutrition Services staff will be required to complete training in implementation of the policy. Training will also be incorporated into all new hire training and competency.
3) All Food and Nutrition Service employees will be monitored no less than 5 times and randomly thereafter for competency.

P526

1) Materials Manager to order 2 Kendrick splints for Hendersonville and 1 for Portland to be housed in the Emergency Departments. Ordered 2/01/07.
2) After arrival to the facilities, the Emergency Department staff will be trained on use.
3) Director of Emergency Services to coordinate training and proof of competency.

H871
Dietary wall repaired 2/9/07 with stainless steel wall wrap.

H872
Work order issued 1/29/07 to remove and clean all vents by 3/30/07. Back pack vacuum purchased to utilize in scheduled routine cleaning of vents.

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

H901
Dietary 2 escutchon plates replaced 2/13/07.
Case Management escutcheon plate replaced 2/13/07.
Radiology corridor fire doors latch repaired 2/13/07.
Med/Surg fire doors latch repaired 2/13/07.
Second floor, next to room 238, fire door hold open loose- repaired 2/13/07.
Second floor, next to house supervisor office fire door hold open loose- repaired 2/13/07.

H902
Hendersonville-penetration in concrete ceiling- repaired 2/13/07.
First floor ceiling junction box missing cover- replaced cover 2/13/07.
Portland- Mechanical room fire penetrations caulked 2/2/07.
Dietary outlet not GFI- replaced 2/2/07.

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
MIDDLE TENNESSEE REGIONAL OFFICE
710 HART LANE, 1ST FLOOR
NASHVILLE, TENNESSEE 37247-0530
PHONE (615) 650-7100
FAX (615) 650-7101

2013 FEB 28 PM 4: 04

February 6, 2007

Mike Esposito, Administrator
Hendersonville Medical Center
355 New Shackle Island Rd
Hendersonville, TN 37075

Dear Mr. Esposito:

Enclosed is the statement of deficiencies developed as a result of the state licensure survey completed on January 24, 2007 at Hendersonville Medical Center.

Please provide us with documentation to describe how and when these deficiencies will be corrected. This information should be received in our office within ten (10) calendar days after receipt of this letter. We are requesting that you assure correction of the cited deficiencies no later than sixty (60) days from the date of the survey. A follow-up visit may be conducted, if your allegation of correction is reasonable and convincing. Failure to provide an acceptable plan of correction could result in a referral to the Board of Licensing Health Care Facilities for whatever action they deem appropriate.

In order for your Plan of Correction (PoC) to be acceptable, it should address the following:

1. How you will correct the deficiency;
2. Who will be responsible for correcting the deficiency;
3. The date the deficiency will be corrected; and
4. How you will prevent the same deficiency from happening again.

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

Should you have any questions, or if there is any way this office may be of assistance, please do not hesitate to call.

Sincerely,

Nina Monroe, Regional Administrator
Middle Tennessee Regional Office

Enclosure
NM/dv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	TNP531135		01/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE MEDICAL CENTER	355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 665	1200-8-1-.06 (3)(o) Basic Hospital Functions (3) Infection Control. (o) The physical environment of the facility shall be maintained in a safe, clean and sanitary manner. This Statute is not met as evidenced by: Based on observation, and interviews, the facility failed to provide a safe and sanitary environment. The findings included: Observations of Intensive Care Unit Room #1, at the Portland Campus, on January 23, 2007, at 2:45 PM, revealed the bed mattress was very worn, with rough/ragged edges and a deep sagging area in the middle of the mattress. Observations of the Medical Surgical Unit, at the Portland Campus, on January 23, 2006, at 2:00 PM, revealed the bed mattress in room #39 was soiled with dried brown residue and had a large worn area with rough/ragged edges, with a deep sagging area in the middle of the mattress. Observations of the Medical Surgical Unit, at the Portland Campus, on January 23, 2006, at 2:15 PM, revealed the bed mattress in room #51 had a large worn area with rough/ragged edges, with a deep sagging area in the middle of the mattress. Interview with the Director of Quality and Risk Management, on January 23, 2006, at 2:45 pm, confirmed the mattresses were being used for patients at that time. Observation during a tour of the Women's Services Department on January 23, 2007 at	H 665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531135	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	February 28, 2013 COMPLETED 4:00pm 01/24/2007
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 665	Continued From page 1 11:15 AM revealed a thick layer of dust on a Braslow bag attached to the unit crash cart. The findings were confirmed in an interview with the Clinical Coordinator and the Director of Women's Services at the time of the findings.	H 665		
H 696	1200-8-1-.06 (5)(j) Basic Hospital Functions (5) Medical Records. (j) All entries must be legible, complete, dated and authenticated according to hospital policy. This Statute is not met as evidenced by: Based on review of closed patient records it was determined the facility failed to ensure that physician's verbal orders were co-signed in a timely manner for one patient (#13) out of fifteen closed patient records reviewed. The findings include: Closed patient records review revealed that one patient (#13) out of fifteen closed records reviewed did not have a verbal order co-signed by the physician. On 12/03/06 at 2056 a telephone order was written for "Norvasc 2.5 mg po now." The nurse wrote the order but the physician did not co-sign the order.	H 696		
H 697	1200-8-1-.06 (5)(k)1. Basic Hospital Functions (5) Medical Records. (k) All records must document the following:	H 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	TNP531135		01/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE MEDICAL CENTER	355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 697	Continued From page 2 1. Evidence of a physical examination, including a health history, performed and/or updated no more than forty-five (45) days prior to admission or within forty-eight (48) hours following admission; This Statute is not met as evidenced by: Based on review of closed patient records it was determined the facility failed to ensure the physician completed the admission history and physical assessment for one patient (#15) out of fifteen closed records reviewed . The findings include: Closed patient records review revealed that one patient (#15) out of fifteen closed patient records reviewed had an incomplete admission history and physical assessment. There was no data documented for operations, allergies, medical history, medications, and transfusions.	H 697		
H 734	1200-8-1-.06 (9)(e)2. Basic Hospital Functions (9) Food and Dietetic Services. (e) Menus must meet the needs of the patients. 2. Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioners or practitioners responsible for the care of the patients. This Statute is not met as evidenced by: Based on review of the patient diet orders with	H 734		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	TNP531135		01/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE MEDICAL CENTER	355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 734	Continued From page 3 the observed diet provided and staff interviews, it was determined the facilities were not providing the ordered diet. The findings included: Review of the ordered diet list for the current in-house patients in Portland, provided by the staff in the dietary department in the Portland facility, revealed a 1 gram Sodium diet and a 1800 calorie ADA pureed diet. Review of the facility menu revealed the menu included a low salt and a diabetic diet. Interview with the Portland staff, on the afternoon of 1/23/07, revealed they would follow the menu for low salt for the 1 gram Sodium and the Diabetic menu and puree it for the 1800 calorie ADA pureed diet. Additional interview revealed that if a 2 gram or 3 gram Sodium were ordered that the low salt menu would be followed and if 1200, 1500 or 2000 calorie diet had be ordered that the diabetic menu would be followed. Review of the ordered diet list for the current in-house patients in Hendersonville, provided by the staff in the dietary department in the Hendersonville facility, revealed a 3 gram Sodium diet. Observation of the patient's mid day meal trayline, on 1/24/07 beginning at 11:30 AM, revealed the low salt menu was followed. Interview with the Registered Dietitian, during the observation, revealed the diet on the menu, low salt, was calculated to be a 2 gram sodium diet.	H 734		
H 737	1200-8-1-.06 (9)(g) Basic Hospital Functions (9) Food and Dietetic Services. (g) A minimum of three (3) meals in each twenty-four (24) hour period shall be served. A	H 737		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531135	A. BUILDING ____ B. WING ____	01/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE MEDICAL CENTER	355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 737	Continued From page 4 supplemental night meal shall be served if more than fourteen (14) hours lapse between supper and breakfast. Additional nourishment shall be provided to patients with special dietary needs. This Statute is not met as evidenced by: Based on staff interview, it was determined the facility failed to have evidence of a supplemental night meal being served due to the 15 hour lapse between supper and breakfast. The findings included: Interview, on the morning of 1/24/07, with Hendersonville dietary staff revealed the supper meal was served at 4:30 PM and the breakfast meal at 7:30 AM. Further interview revealed the facility was not aware of and did not provide a supplemental night meal.	H 737		
H 739	1200-8-1-.06 (9)(i) Basic Hospital Functions (9) Food and Dietetic Services. (i) Food shall be protected from sources of contamination whether in storage or while being prepared, served and/or transported. Perishable foods shall be stored at such temperatures as to prevent spoilage. Potentially hazardous foods shall be maintained at safe temperatures as defined in the current "U.S. Public Health Service Food Service Sanitation Manual". This Statute is not met as evidenced by: Based on observation of the dishroom practices and staff interview, it was determined the facility	H 739		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	TNP531135		February 28, 2013 4:00pm 01/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE MEDICAL CENTER	355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 739	Continued From page 5 contaminated clean dishes. The findings included: Observation during the department tour, the morning of 1/24/07, of the Hendersonville dishroom revealed one dietary staff member working both sides of the dishmachine. This staff member was wearing gloves while working on the dirty side, removed the gloves and then proceeded to remove items from 3 racks that had come out of the dishmachine and place these items in storage sites. Interview, with the dietary staff present with the surveyor on the tour confirmed the findings and directed the staff member to remove the gloves, wash their hands before removing the clean dishes. The staff member replied"OK" and proceeded to remove items from the racks without washing their hands.	H 739		

PRINTED: 01/25/2007
FORM APPROVED

Division of Health Care Facilities

SUPPLEMENTAL- # 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531135	A. BUILDING ____ B. WING ____	February 28, 2013 4:00pm 01/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE MEDICAL CENTER	355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075

2013 FEB 28 PM 4:03

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 526	1200-8-30-.05 (4)(e) Basic Functions (4) Facility Structure and Equipment. (e) An emergency cart or other systems to organize supplies including resuscitation equipment, drugs, printed pediatric drug doses and pediatric reference materials must be readily available. Equipment, supplies, trays, and medications shall be easily accessible, labeled and logically organized. Antidotes necessary for a specific geographic area should be determined through consultation with a poison control center. If the listed medications are not kept in the emergency department, they should be kept well organized and together in a location easily accessible and proximate to the emergency department. This Statute is not met as evidenced by: Based on interview the facility failed to have pediatric sized splints and traction supplies necessary to manage fractures of the lower extremities, available in the Emergency Department. The findings included: Interview with the Director of Quality and Risk Management, on January 23, 2007, at 1:50 PM, revealed there were no pediatric sized lower extremity splints or supplies for applying traction to a fractured limb available in the Emergency Department of the Portland Campus.	P 526		

Division of Health Care Facilities

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531135	A. BUILDING 01 - MAIN BUILDING B. WING _____	February 28, 2013 4:00pm 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE MEDICAL CENTER	355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Statute is not met as evidenced by: Surveyor: 16862 Based on inspection and observation, it was determined, the facility failed to maintain the safety of the residents and patients as required by the Standard Regulation 1200-8-1-08(1). The findings included: During inspection within the dietary, observation revealed, the lower corner of the wall next to the commercial cooking equipment was damaged and the ceramic tiles were loose.	H 871		
H 872	1200-8-1-.08 (2) Building Standards (2) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Statute is not met as evidenced by: Surveyor: 16862 Based on inspection and observation, it was determined, the facility failed to maintain the heating, ventilation and the air-conditioning system as required by both the Standard Regulation 1200-8-1-08(2) and the NFPA 90A; 90B-4; 101, 19.5.2.1. The findings included: On 01-23-2007 at approximately between 10:00	H 872		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED February 26, 2013 4:00pm 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE MEDICAL CENTER	355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 872	Continued From page 1 AM and 1:00 PM during inspection within the facility, observation revealed, the air-return grilles in hallways, staff restrooms and janitorial storage areas were found to have dusty grilles.	H 872		
H 901	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 16862 Based on inspection and observation, it was determined, the facility failed to maintain the sprinkler system as required by the Standard Regulation 1200-8-1-09(1) and the NFPA 13, 3.2.7.2; 101, 7.2.5.1. 101, 8.3.4.1; 101, 9.6.1.3. The findings included: On 01-23-2007 at approximately 10:30 AM during inspection within the dietary area observation revealed, there were two sprinkler heads without escutcheon plates. NFPA 13, 3.2.7.2. During inspection within the Case Management area, observation revealed, the sprinkler head in the closet had no escutcheon plate. During inspection within the Radiology corridor, testing of the fire doors revealed, one of the fire	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2007
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 901	Continued From page 2 doors did not close to latch. NFPA 101, 8.3.4.1. During inspection within on the third floor area, testing of the fire doors next to the Nurses Station, revealed, the doors did not close properly within the frame. During inspection on the second floor near room 238, testing of the fire doors revealed, the doors did not close properly within their frame. NFPA 101, 7.2.5.1. Further inspection of the fire doors by the Nurses' Supervisors office revealed, the magnetic holder was loose in the wall. Further observation of the fire door revealed, the magnetic holder was loose in the wall. NFPA 101, 9.6.1.3.	H 901		
H 902	1200-8-1-.09 (2) Life Safety (2) The hospital shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for hospital personnel in each separate patient-occupied hospital building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a	H 902		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2007
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 902	Continued From page 3 result of the fire. Initial reports by the facility may omit the name(s) of patient(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information. Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. This Statute is not met as evidenced by: Surveyor: 16862 Based on inspection and observation, it was determined, the facility failed to eliminate fire hazards as required by the Standard Regulation 1200-8-1-09(2) and the NFPA 101, 8.5.5.2. The findings included: On 01-23-2007 at approximately 12:30 PM during inspection within the first floor ceiling areas, observation revealed penetration within the concrete ceiling. NFPA 101, 8.5.5.2. Further inspection and observation within the first floor ceiling area, observation revealed a junction box with no cover plate. Violation of the NFPA 70, 410-56(d). PORTLAND MEDICAL CENTER Based on inspection and observation, it was determined, the facility failed to eliminate fire hazards as required by the Standard Regulation 1200-8-1-09(2) and the NFPA 101, 8.5.5.2. The findings included:	H 902		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED February 28, 2013 4:00pm 01/23/2007
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 355 NEW SHACKLE ISLAND RD HENDERSONVILLE, TN 37075		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 902	Continued From page 4 On 01-23-2007 at approximately 2:45 PM at the Portland facility during inspection within the mechanical room area, observation of the ceiling revealed penetrations around pipes, conduit pipes as well as ducts. During inspection within the dietary area, testing revealed, the electric outlet next to the sink was not wired as a Ground Fault Circuit Interrupter. NFPA 70, 210-8(a)(5).	H 902		

SUPPLEMENTAL- # 1
February 28, 2013
4:00pm

AFFIDAVIT

2013 FEB 28 PM 4:01

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

HENDERSONVILLE MEDICAL CENTER

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of 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.

John Wellborn
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28 day of Feb, 2013, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires 6-21-16, _____.

HF-0043

Revised 7/02

CHRISTOPHER D. DOBBS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 6-21-2016

KRAMER RAYSON LLP

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R.R. KRAMER (1888-1966)

2013 MAY 6 AM 9 42

May 3, 2013

Ms. Melanie Hill, Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

Re: Hendersonville Medical Center
Certificate of Need Application CN1302-002

Dear Ms. Hill:

This letter of opposition is submitted on behalf of our client, Baptist Hospital ("Baptist"), to the request by Hendersonville Medical Center to establish a six bed neonatal intensive care unit ("NICU"), which is included in the above-referenced certificate of need application. Baptist does not oppose the other two components of the project.

The services currently provided by Baptist, Vanderbilt University Medical Center, and Centennial Medical Center, the flagship facility of HCA's TriStar division, are more than sufficient to meet the need for neonatal nursery services in the proposed service area. The request to establish a new NICU unit is also inconsistent with the orderly development of health care because it seeks to add capacity to a service area where high quality and conveniently accessible services are readily available.

Accordingly, the request to initiate NICU services fails to meet the statutory criteria, and Baptist respectfully requests that it be denied.

Sincerely,

Warren L. Gooch

WLG:dt

cc: John Wellborn
Jerry Taylor, Esq.
Renee Kessler, Chief Operating Officer, Baptist Hospital
Deborah Bouressa, Director of Nursing, Baptist Hospital
Barbara Houchin, Executive Director, Planning, Saint Thomas Health